‘You can safely and effectively stretch the traditional ideas of how we create change’

Our editor Jon Sutton meets Consultant Clinical Psychologist Dr Jenny Taylor

Having seen you talk about your work, I’m intrigued by the way you do psychology. Has it changed over the years?
The way I ‘do’ psychology, and what I think I mean by that, has changed considerably over the years.

Before my training, and during it, the prevailing narrative seemed to be that ‘doing clinical psychology’ was a way of working as a therapist or healer, albeit in a slightly different way than traditional psychotherapy. The phrase ‘collaborative empiricism’ is one I remember from preparing my training application… as psychologists we would work collaboratively and empirically with a client to figure out what was happening for them, and how to change it. That idea still appeals to me today. But my ideas of who the ‘client’ might be, and how we might effect change, have definitely broadened from my original understanding of this as a 1-1 process between a psychologist and a specific client.

Can you recall when that began to shift?
In my very first job after qualification, which was a post within Children’s Social Services in a London borough. The focus of the role was on reducing the number of children in care who experienced placement breakdowns, and the expectation was that I would do that by providing accessible specialist therapy to children at risk of placement breakdown. Two things soon became clear, due to using those applied psychology formulation skills.

Firstly, that the causes of placement breakdown were multiple and occurred at different levels in the systems around the children. Surely this meant these causes were unlikely to be effectively addressed solely by individual therapy with the child? Interventions needed to be delivered at multiple levels. For example, the difficulties the children ‘came with’ in terms of experience of trauma and broken attachments interacted, obviously, with the needs of the carers to feel competent, needed, and loved, and their skills and knowledge of parenting children with these complex experiences. Then there were the beliefs and skills of the social workers supporting the system, for example the social worker who told me that she believed that infertility problems ‘were God’s way of saying that you weren’t right to be a parent’. ‘Training courses’ might focus on paperwork rather than supporting the development of attachment, and there were structural issues around recruitment of foster and adoptive carers – who were we targeting, what were we paying, and what were they told about what the role would be.

Considering all of these issues led to me working further and further ‘upstream’, with the carers of the child, the birth families they were still in contact with, the social workers supporting them, the panels that recruited and matched carers and children, and the training programmes.

Academic knowledge and clinical experience also both pointed towards the difficulty and possibly inappropriateness of trying to engage a child in care in a new 1-1 relationship with an individual therapist who will only be working with them for a limited time and only in a professional capacity. Should the child be our focus, or should we be focusing on developing the skills of those with closer and ongoing relationships with the children – their foster carers, birth families, social workers, teachers? After all the main influences on children are their home and school environments,

Tina Vedrine/www.thevedrines.com

Dr Jenny Taylor is a Consultant Clinical Psychologist at Taylor Conway
jenny@taylorconway.org.uk
Find out more about STAIRS approaches at https://www.taylorconway.org.uk/stairs

so logic suggests that focusing on what goes on during those 167 hours rather than the one hour of individual therapy might have the greater impact.

And did your next role reinforce that approach?
After eight years I moved to another inner London borough, to focus on work with teenagers at risk of custody due to offending behaviour. I trained in multi-systemic therapy (MST) and led one of the sites of the national research trial on MST.

MST pushes its therapists to try to understand why the young person's behaviour is occurring by formulating and intervening at multiple levels, rather than any assumed prioritised focus on child factors. Formulating with a school as to the various ways their structure or staff may be inadvertently increasing the likelihood of further oppositional behaviour can be very powerful. Making it clear to a parent who has been marginalised and blamed by services that you believe that they are the most important influencer of their child's life and environment, and that they have the most knowledge about their child… co-opting them to work as a co-therapist with you… that can be life-changing.

Following those two long-term roles I've had the pleasure of working across a variety of local authority children's services and across the entire children's secure estate, and relished the opportunity to try to formulate the multiple factors influencing the problems we were trying to solve. These experiences led to myself and colleagues (Risthardh Hare, Lisa Shostak) developing the STAIRS framework, a method

of developing collaborative formulation skills in social workers, prison officers and voluntary sector staff, amongst others. The aim was to skill-up the people with most direct contact with the children and families to be able to work out with those children and families what was leading to or increasing their difficulties, and how to create change… that might or might not involve the use of formal psychological therapies. A key focus of the STAIRS training programmes is finding sustainable ways of creating change, rather than assuming a need for ongoing professional involvement.

That's interesting… so you're not necessarily casting the psychologist as expert, or even expecting any professional involvement in the longer term?
The way I describe psychologists here is as applied scientists. We're usually the people in the team with the highest level of academic training in psychology, and we can apply that knowledge to complex human problems in a scientifically rigorous fashion. As such we are likely to enhance any team aiming to create changes in human behaviour. Like medical doctors and psychiatrists, our role is to consider and collate the information from the client and their system with our particular scientific knowledge and clinical experience, to co-create an assessment and treatment plan. That's broader in scope but potentially less specialist in depth in one particular therapy, by contrast with, for example, a CBT therapist, who has focused on gaining particular skills in that form of 1-1 therapy rather than in applied psychology more broadly.

Similarly, when working alongside the main carers of identified clients, such as foster carers or prison officers at a youth offending institute, I see the role of the applied psychologist as bringing the *breadth* of what our scientific knowledge and clinical experience tells us about *the sorts of things* that impact on children in these situations and the sorts of things that create change. But, crucially, this needs to be blended with the *depth* of knowledge that a child's carer / officer will have about that particular child, given their far greater levels of day-to-day contact with that particular child.

> "We should always aim to mobilise the existing systems around our clients to support them more effectively, and always aim not be needed anymore"

This feels like a fairly subtle extension of when / where / how psychologists might 'do' psychology. Are there limits to how far you take this?
I try to be pragmatic and evidence-based. For example, supervisees might say that you obviously can't 'do psychology' whilst sitting in a café with someone or in their home, or that it would surely be inappropriate to talk to a client on Whatsapp, or that you should never share any personal information with a client. I would ask them why they thought that, what their concerns were, and think with them about the evidence for those concerns and possible pros and cons of each course of action.

There will of course always be things that are more or less likely to be helpful for clients, or feel more or less safe to us as professionals. But we should think those through on a case-by-case basis, rather than making sweeping generalisations about something as complex as how we interact with people to create change. In my experience you can safely and effectively stretch the traditional ideas of how we create change much more than many people think. I worry that we sometimes don't as it suits us as professionals better to work in some ways rather than others…

So have you encountered resistance to building the confidence of non-psychologists to be involved in intervention? Might psychologists worry that it undervalues their training, or risks professional status?
I have definitely experienced resistance from a range of colleagues with specialist trainings – psychologists, psychiatrists, psychotherapists – to the idea that frequently the most appropriate focus of our work should be on improving the 'milieu' in which our clients spend the majority of their time.

Many mental health experts have, to my mind, conflated the idea of mental health expertise with the idea that change can only occur via (them) providing individual therapy, in a room, for 50 minutes at a time. This seems extraordinary when we have limited evidence for many of the 1-1 psychological therapies we offer. My preference is that we use our knowledge of how children develop emotionally and what they need to do so healthily… of how people get confused and stuck in patterns of thinking and interacting with one another that make them or others unhappy and what can create change in that… to think with them, our clients, and the main other people in their lives, about how to change those things, in an open, collaborative, psychoeducational approach. There is no requirement for this to be done in clinic rooms in particular, or in 50 minute blocks, or only once every week, or only face-to-face. Sharing our understanding of psychology with people to help them live more fulfilling lives doesn't threaten our professional status as experts in psychology, but does possibly affect the extent to which we are seen as boundaried, awe-inspiring, unknowable therapists. Which is fine by me!

I have encountered these types of concerns in relation to the Improving Access to Psychological Therapies, and it always seems to me that it's shortsighted… there should be more, and more senior, roles for psychologists, not less.

IAPT is interesting, as its focus is on getting particular versions of psychological therapies that we do have good evidence bases for out there to as many people as possible. That is an excellent ambition, and I see no reason why the delivering of a specific psychological therapy should be restricted to those who have studied the full gamut of psychological science to doctoral level, as doing so doesn't necessarily mean they have focused on that particular therapy in depth. Surely we want anyone who has good people skills and who has mastered that particular therapy approach for that particular client group to be able to deliver it?

If such work is to be based on shared values, what might they be? What are the building blocks of a broadly psychological approach?
This brings me back to the STAIRS framework and the key values of collaboration, of a scientific rather than instinctive approach – as I always say to my supervisees, if the solution was simple then people living with the problem would almost certainly have stumbled upon it already – and of a focus on and desire to be part of creating sustainable change for clients, rather than believing that some people will 'always need our services'.

In terms of the building blocks, real collaboration to me always starts with spending time on creating clear collaborative goals with the person requesting the change / being told they have to change, before you even get going. This is not a straightforward thing to do, especially when the client has been told they need to change (e.g. parents at risk of having their children removed, young people on community orders). It requires real skill and emotional intelligence to think about what you want to change and why, what your service/institution wants and why, what the person wants and why, and what common ground can be found. Without this basic start the likelihood of creating real change is slim, not to mention the potential for it to be oppressive. This collaborative creation of shared aims for the future is a core part of the STAIRS training we do effectively with staff from a variety of backgrounds – it is definitely not something only psychologists could/should do.

The Kuriologist – 'Art of Kuriology'/kuriology.com

As an unashamed applied scientist, the building block for a scientific approach is using a robust empirical approach to the work we do, rather than working in a certain way 'because I like working in that way', or because 'I think it works'. The power imbalance when we work with people as professionals is such that I think we have to take very seriously that we have no right to try to interfere with other people's psychological functioning without very good reason to believe we will create the change they want to see.

Finally, in line with the value I place on creating sustainable change, my final building block is seeing humans as part of complex networks with their non-professional family, neighbours etc, and valuing those connections *much more highly* than their relationships with those of us who work with them professionally. We should always aim to mobilise the existing systems around our clients to support them more effectively, and always aim not be needed anymore.

What might 'taking an empirical approach' and 'working collaboratively' mean in practice?
Well, when I am training people, it means that any 'interventions' must relate to a clear hypothesis about what was causing the issue in the first place, and therefore why that intervention is likely to be helpful, and that these hypotheses and ideas about what might help are co-developed with the client and their network. Then there must be a robust way, that makes sense to the client as well as the 'professional', of following up whether doing that intervention is in fact impacting on the issue they are trying to solve, and being fully prepared to go back to the drawing board if it isn't! Going through this whole process openly and transparently with the client models for them that no-one will always get things right first time. That is normal. The important thing if our first attempt at change doesn't work is to go back and look again at our ideas about what was going on, and try an alternative approach.

People are complicated. Rather than starting from the assumption that as a professional you are probably right, see the value of being open to being wrong. In doing so, as well as actually being more realistic, you will also be helping to equalise the power imbalance between yourself and whoever you are working with. This helps build their esteem and sense of efficacy as someone on the collaborative empirical journey with you, rather than them feeling like the passive recipient of your expert advice!