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The making of a clinician: testing Western psychology's assumptions: An initial empirical challenge

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Abstract

Purpose: The scientist-practitioner or Boulder model of pedagogy is a pivotal informant to the practice of Western psychology. The pedagogy privileges knowledge generated by the published results of randomised controlled trials, which it becomes the practitioner's role to apply. Yet despite the paradigm's legislated uptake, no formal evaluation of the model in terms of its impact on endorsed, and currently practicing clinicians, has been conducted. Our research provides an initial evaluation. **Methods:** Ten registered clinicians, representative of diverse theoretical and practical frameworks, were interviewed. Data were analysed using core tenets of Hollway and Jefferson's Free Association Narrative and Interview Method. Transcripts were read multiple times to identify key themes, slippages, ambiguities, contradictions, what was not said, and use of normative terms. **Findings:** Our data show that exclusive adherence to knowledge generated by randomised controlled trials may not be seen by clinicians as providing them with sufficient tools to treat their clients. Instead, over time, practitioners may draw on other resources, tested through the therapeutic relationship. Clinicians claiming to practice as scientist-practitioners may adhere only to its main tenets, resulting in a subtle evolution. **Conclusions:** Assumptions that 'best practice' psychology conforms to the scientist-practitioner model may be false and deny the value of practitioner-generated insight into, and experience of, what constitutes 'best practice' within the therapeutic space. Further exploration and research is required to explicate these findings. **Advances in knowledge:** Our research provides an initial empirical challenge to the scientist-practitioner or Boulder model of pedagogy on which Western psychology is built. Based on analysis of clinician's experience, findings suggest that, instead of entrance into, and progress through the profession being determined by academic acumen, of more value may be to recruit based on clinicians' capacity to: self-reflect on the therapeutic alliance; build relationship with their clients; and clearly identify and draw from their personal belief-sets and experience regarding what is the recovery journey. These findings may afford the discipline greater insight into how better to recruit, train and manage practitioners throughout their career.

Introduction

The Boulder, or scientist-practitioner model is the “single most important statement of training philosophy in clinical psychology.”¹ (p.253) As such, it dominates learning and practice within both Western, and formalised psychology. We use the term “formalised psychology” to describe psychology as it is understood, promoted and enforced, by regulatory bodies and associations such as: the American Psychological Association;² Australian Psychological Society;³ and British Psychological Society.⁴ Individuals cannot legally call themselves a psychologist without formal approval under the processes developed by these bodies.

The Boulder model has its origins in a report written by Shakow,⁵ exploring how best to train clinical psychologists. Recommendations from this report were used to inform discussions at the American Psychological Association’s conference, held at Boulder, Colorado, in 1949,⁶ from which the model received its name. The Boulder model paradigm “treats professional competence as the application of privileged knowledge to instrumental problems of practice,”⁷ (p.xi) and assumes problems faced by practitioners are generic. Additionally, it assumes all problems are “resolvable, at least in principle, by reference to the facts [upon which] professional knowledge rests.”⁷ (p.36) Within this frame, the skilled professional is one who draws on the “professionally sanctioned,” “accurate models” and “powerful techniques,” produced by science. Science here may be understood as that knowledge generated by the results of randomised controlled trials (RCTs), reported in peer-reviewed journals. This approach is viewed as providing all that is necessary for the varied client presentations the therapist may see in their career.⁷ (p.218) It is this approach to practice, which formalised psychology advocates.

How the Boulder paradigm is experienced by practicing clinicians

Contrary to its own tenets, there currently exists no systematic, objective, comprehensive evaluation of the Boulder model. What is available, is an eclectic selection of articles, themed as either pro or anti the Boulder frame, stretching from its commencement,^{2,6,8} to the present.⁹⁻¹¹ These articles are primarily philosophical

in nature, utilising thought-experiments or systematic logical forms as opposed to directly presenting and analysing clinicians’ experiences. Alternatively, research focusses on whether the course content of endorsed training programs conforms to the requirements of the scientist-practitioner model.¹²

Those researchers who have sought to directly capture the experience of therapists, generally through surveys, oftentimes target the student practitioner, not yet eligible for full registration. For example, the results of one author’s ¹¹ (p.1048) assessment of 653 clinical psychological graduate students indicated that whilst they had been trained in the scientist-practitioner model, and felt confident to implement its principles in their practice, “one third of students reported that they rarely use science-based decisions when informing clients of the clinical services they will be providing.” Beyond this, another researcher,¹³(p.81) cites the existence of only “18 publications [from] empirical studies” exploring the veracity of the Boulder paradigm, with “none of them specifically testing whether an interaction effect was observable between science and practice on any outcome.” One such, conducted by Nel, Pezzolesi, and Stott ¹⁴ (p.1058) found that 357 surveyed members of the Division of Clinical Psychology of Britain predominantly believed that “they learnt mainly through doing and by observing others’ clinical practice” as opposed to through reading and acting on results from published journal articles.

Research which does explore what clinicians find useful to their practice, does not find this to be ‘science.’ For example, Roos and Werbart ¹⁵ (p.396) “reviewed [44] empirical studies [published between January 2000 and June 2011] with a wide range of methodological approaches, both those directly addressing questions of dropout rates in relation to therapist, relationship or process factors, and those including some of these variables in the analysis.” This research assumed that clients remaining in therapy, were more likely to achieve their recovery goals than those who dropped out. Unlike previous research, which focused on client-factors impacting therapy dropout, Roos and Werbart ¹⁵ (p.385) targeted “under-investigated” therapist-factors, in accordance with prior evidence that clinician qualities are pivotal in determining therapeutic outcome.¹⁶

Roos and Werbart ¹⁵ (p.394) found that “therapists’ experience, training and skills, together with providing [clients with] concrete support and...emotional support”

served as principal protective factors against client dropout. Lower drop-out rates equated with therapists being more experienced, irrespective of therapy delivered. As a result of this work, the researchers¹⁵ (p.413) hypothesised, “therapists become more responsive and focused on the relationship as they move beyond their years of basic training.”

Despite such research, Western psychology legislates clinicians’ practice using the Boulder paradigm. Yet developing an empirically-based understanding of how psychologists experience clinical work should provide the discipline with insight into how best to recruit, train and manage practitioners throughout their career. Additionally we may gain awareness of practitioner-generated wisdom about effective psychological practice.

The aim of this study therefore is to provide an in-depth qualitative exploration of the experience of registered and practicing psychological clinicians required to work within the Boulder frame.

Method

Due to limited previous research, and the need to elicit detailed clinician responses, a qualitative approach was used for our study. Ethics approval was granted by the Human Research Ethics Committee at Charles Sturt University. Eight semi-structured interviews were conducted with 10 participants between September 2012 and August 2013 (seven individual interviews, and one focus group with three participants). Six interviews took place in person (including the focus group). One interview was conducted over the phone, and one using Skype. This was to enable participation from interested clinicians across Australia, whilst keeping travel costs to a minimum. Additionally, current thinking supports the use of mixed qualitative methods to capture data, with epistemological frame (how knowledge is justified), as opposed to method being viewed as the critical component to any research questioning a status quo, or mainstream paradigm.¹⁶ Study participants were all fully-registered, and currently-practicing psychologists in Australia.

Initial participants were sourced through the professional networks of the authors. Later interviewees were sourced using a ‘snowballing’ sampling approach,

where people interviewed introduce the researcher to someone who may be interested in participating.

Participant’s (N = 10) ages ranged from 36 to 61 (M = 47.7, SD = 9.2). Six were female, and four were male. Eight participants were clinical psychologists, and two were registered. In Australia, whilst both pathways require six years of full-time study, and result in registration, the content of the final two years differ based on which pathway is chosen. There is a lively debate currently raging regarding the justification for this differentiation, particularly as clinical psychologists are both paid more, and afforded greater career options.¹⁷

Years practicing ranged from five to 38 (M = 19.6, SD = 10.7). Seven clinicians were of Anglo decent, one was European, one was Greek, and one participant’s cultural background has been withheld, to support anonymity. Six clinicians practiced in Sydney, one practiced in Western Australia, two practiced in rural New South Wales, and one practiced in coastal New South Wales. Clinicians’ practice-preference ranged from cognitive behaviour therapy (CBT) (two); eclectic (three); intensive short-term dynamic psychotherapy (one); psychodynamic (three); mindfulness (one). All participant’s names are pseudonyms.

Procedure

All interviews were recorded and transcribed verbatim by Dr. Goldney, using a digital recorder, and ranged from 90 to 180 minutes. Prior to commencing, Dr. Goldney outlined how the interview would be conducted, including using silence to allow participants space to reflect.¹⁸ Participants were also advised they were free to stop the interview at any time.

Each interview involved asking one primary open-ended question. “What is your experience of practicing as a psychologist?” In asking an open-ended question, as opposed to close adherence to a pre-determined interview schedule, participants have the opportunity to more fully inject their own experience (which may not as yet have been captured in the scholarly literature) into the interview. Moreover, this approach facilitates inductive analysis and the creation of new theory. This phenomenon is well documented in the qualitative literature, and indeed forms one of the strengths of this approach to research.¹⁹

In keeping with this inductive approach, the interview schedule evolved over the course of the interviews, such that by the sixth interview, we also asked “What is your experience of complexity and/or contradiction in psychology?” This was in response to both the analysis process we carried out in parallel with the interviews, and Hollway and Jefferson’s free association and narrative interview method (FANI).¹⁸ We also asked for some demographic details (name, age, years practicing, cultural background etc). More detail regarding the interview process, including de-identified transcript samples are available on request. During interviews, points of clarification were invited, using the words of participants. For example the interviewer would ask “A moment ago you said (comment). Would you be happy to talk a little bit more about that?” This is in keeping with the interview process outlined by Hollway and Jefferson.¹⁸

Transcripts were emailed to participants, allowing for comment and validation. The completed study was also emailed to participants, inviting their response. Data were analysed using Hollway and Jeffersons’¹⁸ method, with a focus on emerging themes, and areas of ambiguity and contradiction. Specifically, transcripts were read at least five times to identify key themes, slippages, ambiguities, contradictions, what was not said, and use of normative terms. Substantive notes were made with each reading, and included extended quotation examples supporting emerging impressions. Counter-examples were sought, to enhance rigour, and minimise confirmation-bias. Dr. Goldney conducted the initial analysis. Following final readings, interview chunks were written up around themes. This analysis was then subjected to in-depth critique from the research team, resulting in revisions, and including revisits to original interviews to ensure accurate, context-driven conclusions.

Results

Our analysis identified a series of six themes relevant to this paper: 1. “Legislated practice is experienced as synonymous with CBT;” 2. “If you don’t use CBT you’re sanctioned;” 3. “CBT (for some therapists) is “dangerous bullshit;”” 4. “And what about those clients that CBT, or short-term therapies do not work for?;” 5. “Over time, you tend not to use one pure approach, instead you “morph;”” and 6. “Diverse influences may be better at facilitating good outcomes for the client.”

It should be emphasised we make no claim to generalise these results to all clinicians. Rather we provide an initial empirical challenge to the Boulder paradigm with the understanding that further exploration and research is without doubt required. We support this challenge using a fourfold process, first we highlight how practitioners in psychology must reconcile a range of complex and often contradictory imperatives, guidelines, and traditions of therapy. Secondly, supported by qualitative methodologies, we describe how clinical psychologists can come to experience and manage the contradictory pressures of their profession, thereby attesting to the existence and power of these pressures. Thirdly, through our analysis, we provide insight into how clinicians in this context develop as practitioners over time. Fourth, we provide an alternate paradigm within which the discipline of psychology could choose to work.

Our focus is on understanding processes involved in growing as a clinician, not in making generalisations. To this end, our study may not represent the experiences and understandings of all or even a majority of practising clinicians. Instead, we draw a preliminary map of the domain in which clinicians respond to organisational and professional demands in constructing their practice. In particular, we highlight how clinicians come to split important aspects of their professional context into ‘good’ and ‘bad,’ formal and informal, CBT stranglehold and psychodynamics. These may be viewed as defences, a means to manage this complex environment. That the processes involved in responding to contemporary dilemmas can pan out in the ways described means the profession can reflect and address these dilemmas. The danger for clinicians is that such schisms may curtail productive, open communication with peers, as well as curtailing changes in organisational guidelines and requirements within which they seek to help others. We will now outline these themes in detail and then try to explain this conflict.

Legislated practice experienced as synonymous with CBT

Data-analysis showed that interviewed clinicians were understanding the “science” formalised psychology required them to employ in their therapy, as being synonymous with CBT. For example Phoebe (36, self-employed, clinical psychologist, with six years practice

experience) articulates an experience of external pressure to conform to a short-term CBT framework. She comments:

I feel I have a pressure to um.....wwwwork in a CBT framework...I feel that pressure from.....ah...AHPRA1, the Australian Psychological Society...from insurance companies that I might do work for.....and also because of Medicare2. So all these different bodies, um..suggest that you should work in a short-term...way, and using..structured methods...believing that structured methods are preferable.

The word “pressure” suggests Phoebe experiences the expectation to work in a CBT framework as an unpleasant restriction, at odds with her preferred practice mode which is “probably closer to psychodynamic,” being reflective of her “belief that real change does take time.” Her reference to “short-term...structured methods” and the word “believing,” suggest she views this restriction as being based on an unsubstantiated preference, or even bias, by “these different bodies.” This prescribed short-termism conflicts with her own belief that “real change does take time,” because effective practice requires “developing a very strong therapeutic relationship based on empathy, warmth, unconditional positive regard, and using at some point the therapeutic relationship to create change.” The validity of her approach is underlined (for her) by her observation that “change” occurs at “some point” within the development of the therapeutic relationship.

Annette (58, self-employed, Anglo, clinical psychologist, with 38 years practice experience) talks about CBT as “not the be all and end all...It’s not the only, well it’s not the only therapy that’s evidence-based, even though it’s touted as really being that way.” Annette places CBT within the historical framework of her own professional development, commenting; “CBT didn’t exist when I went through university.” However, Annette does not feel her training lacked thereby. Rather, she feels she gained an “advantage” by “having been taught other ways first.” Implied by her is that today’s “touting” of “CBT” as the only therapy with an evidence-base, disadvantages recently-trained clinicians, who are exposed to fewer therapeutic approaches.

If you don’t use CBT, you’re sanctioned

Callithump (42, male, Anglo, registered psychologist with 18 years practice experience) and Ted (48, male, Anglo, clinical psychologist with 24 years practice experience) refer in the focus group to how clinicians are effectively forced into embracing those therapies which “fit into 10 sessions” (i.e. CBT). They present this expectation as resulting in formalised psychology’s neglect of approaches (however efficacious) which do not fit within this timeframe. As vignette, during a discussion around the Hearing Voices Network (HVN20) based initially in the UK, and viewed by these practitioners as “an exciting direction,” Callithump comments sarcastically; “there’s nothing there that fits into 10 sessions, or 12 last year...so why would you [the ideal clinician according to formalised psychology] study it [the HVN]?” Ted responds caustically by highlighting “it’s [the HVN] being run by consumers,” and caricatures the HVN’s political and structural rejection by formalised psychology, with such statements as:

T: Ohhh they’re [the HVN] not a member of the APS!!!! what are they doing? [laughs uproariously] How dare they?!!! ‘They’re not even registered!’ you know.

C: It’s terrible...how could they [the consumer-run HVN] possibly know anything?!!

Here, Ted and Callithump present formalised psychology as screening, and even censoring, practice approaches which do not fit into its specified time frame (“10 sessions, or 12 last year”). Additionally, by highlighting their perception that rejection of 10-session approaches by formalised psychology is, at least in part, informed by the fact that the creators of the HVN are “consumers” who are “not members of the APS” and are “not even registered,” Ted and Callithump provide additional evidence for their perception of the existence of a hierarchy within the discipline which preferences formalised psychological knowledge, over anything else—particularly a client’s lived experience. This hierarchy may be understood as favouring knowledge created within the Boulder frame (i.e. CBT).

Phoebe, whilst stating that she does not “pay too much attention” to the pressure to work in a particular

way, contradicts herself to some extent, by stating that her reports do “toe the line.” Hence she seems to experience the system as sufficiently stringent or punitive to require a level of deceit for clinicians, such as her, who practice in a way that is not short-term or CBT.

Phoebe further suggests that “it doesn’t bother [her] that [she’s] not obeying the rules as such.” Yet later in her interview, she shares a vignette whereby she talks about a dinner with two psychologist friends, where she very much minds that she isn’t “obeying the rules” stating:

After that evening I came to feel like I’d done something wrong...I think it’s probably reflective of.....um.....what’s happening in psychology broadly though at the moment in terms of um.....the massive voice around CBT and, as supported by the APS, and government, andand it’s almost criminal the idea of doing anything different.

Here it appears that Phoebe perceives professional peers, who “work differently” from her (by implication, they use CBT), feel a level of entitlement, supported by professional and political bodies (the “broader” “psychology,” “supported by the APS, and government”), to critique her “different” approach, and provide censure. Her almost immediate use of the word “criminal” suggests Phoebe feels the perceived sanction is highly unpleasant, implying separation from the fold, and punishment, meted out on those who practice in a “different” way. Furthermore, her use of the word “massive” to describe the “voice around CBT” underlines that Phoebe experiences herself as part of a minority in psychology. Meanwhile, the hint of scorn in her tone suggests that she views the formalised perspective with some disdain.

CBT (for some therapists) is “dangerous bullshit”

The focus group of Callithump, Elizabeth (37, Anglo, clinical psychologist with seven years practice experience) and Ted, has a scathingly contemptuous discussion regarding their experience of a CBT-based practice approach. Their contempt is evidenced by choice of words, dark and at times riotous laughter, sneering sarcasm, impersonations, and tone of voice.

Here they may be seen as using these mechanisms, to resist, and defend against the expectations of formalised psychology, with which they disagree vehemently.

During their discussion, Callithump presents CBT as completely inadequate for dealing with the seriousness of varied client presentations. He calls CBT, the clinician’s “prepackaged response...to whatever [is] the first little bit that comes out” of therapy, and questions whether “that...prepackaged response might remotely [T:yees] um....address...you have panic attacks do you, ohww I’ve got a great six week program for panic attacks.”

In context, Callithump may be construed as equating a “prepackaged,” “six week program” with external expectations to practice within a short-term, CBT frame. His use of the phrase “the first little bit that comes out,” and his rhetorical statement “that their prepackaged response might remotely...address...the client’s real issues,” supports an interpretation that short-term CBT forms the “antithesis” [T] of “good psychological practice” [J/E]. Conversely, “good psychological practice” is created by responding to later bigger “bits that come out” of the “co-created” [T], therapeutic “connection” [C/T/E)].

The trio deplores the fact that this way of practicing psychology heavily informs the current curriculum for trainee practitioners within “clinical masters programs,” sharing their experience of working with graduates from this system. Ted comments “every second client is resistant to their techniques.” Worse, according to Ted, is that new recruits position such resistance as being their client’s fault because “they’re not doing their homework.” Ted’s scorn seems apparent as he further posits “just listening to them [the newly-qualified psychologists] [I’m] going...oh my god!”

After the interviewer commented that “there’s a DSM-5 diagnosis for that, being resistant to therapy” (formally termed “nonadherence to medical treatment”²¹ (p.726), the following interaction ensued:

T: Is there?

J: There is...."patients who are resistant to therapy"

E: (Laughs uproariously)

J: It’s in there [the DSM] T: Oh, in there...

E: That’s hilarious!

C: *Oh, for fucks sake!*

Callithump then interjects with:

Does a clinical Masters degree leave you with that diagnosis by default...that you're then resistant to actually having some kind of real responsiveness, real engagement with the person sitting in front of you?

Callithump also complains about CBT being used as a panacea for all mental illness. He questions the efficacy of applying this approach, to for example, domestic violence situations or in any situation where a client has experienced, or is experiencing ongoing abuse. He comments:

That somehow if you [the client] adjust your thinking e e e e even presupposing that is possible in any real um lasting, or or or or meaningful way, that if you adjust your thinking then the horror of the situation is ameliorated by that, and that your feelings will then follow is is....dangerous bullshit....

And what about those clients that CBT, or short-term therapies do not work for?

Ted talks about his experience of working with clients who have had “unbelievably bad, traumatic” experiences in “hospital...and with other treatment providers,” stating; “you often spend the first year [of therapy] working those [bad experiences] through.” He gives the example of a female client who:

Had seen six clinical psychologists under Medicare in the last couple of years, who had not, even though she told them about her child sexual abuse history, all six of them said that: “We’re not going to focus on that, we’re going to focus on this....anxiety”... We’re talking six! One after another!

Here Ted expresses a belief that traumatic experience (e.g. child sexual abuse), is central to the creation of some client’s mental distress. The problem

for him, and his clients, is that other clinicians, supported by structured expectation (e.g. he is meant to refer suicidal clients onto psychiatrists for drug therapy), do not share this view. Lacking suitable therapy options to deal with a client’s presenting problem (sexual trauma); such clinicians give their clients inappropriate CBT-style therapy, because it fits with their narrow training. Ted also apparently perceives that “clinical psychologists under Medicare” feel a need to fit their client’s therapy into known categories such as “anxiety,” so that treatment may be carried out within a short-term frame, as opposed to focusing on the real problem which for Ted, is the “sexual abuse history.”

Ted presents such therapeutic approaches as “shit,” saying that people “get total crap, and pay for it. I think it’s disgusting.” For Ted, this: “happens all the time. It’s become the norm.” He shares an experience of working with a client who had been living with the diagnosis of “schizophrenia,” and had thus been prescribed “20 years of Clozapine.” He talks about the side effects of the drug for this patient, and how it had distorted her perceptions of what was “memory” versus “hallucination.” Ted comments “she was talking about what she thought was an hallucination, and my intuition was that it was a memory,” of a “sexual assault” which was “so awful that you’re outside the sexual assault, and the sexual assault was happening outside your room, because it was just too painful.” Additionally, Ted talks about “intuiting” that “she hasn’t got schizophrenia, she’s got a trauma history,” which “no one had asked her (about) of course...um...even though she [had] disclosed” it. Rather than tackling the trauma of her abuse, “they discharged her... case closed, they’re happy, they diagnosed her with schizophrenia anyway, just to be safe, shoved her on Clozapine, just cos she’s a bit out there...ahh..I can’t tell you how angry that makes me.”

Annette (38 years practice experience) demarcates the limited use of CBT, stating: “I don’t use CBT with DID [dissociative identity disorder] clients. They’re too smart for me anyway. They’d run rings around CBT...But it’s [CBT is] very very useful stuff in terms of managing anxiety and depression.” Like some other practitioners interviewed, Annette drew on differing theory and practice approaches, not because they were “required” of her, but because she has found a variety of different approaches to be “really valuable” in working with diverse client populations. Here, like others, Annette raises a question as to how well an approach such as “CBT” generalises across different

client groups. Whilst the “required” approach may be effective with presentations of “anxiety and depression,” from Annette’s perspective, it is ineffectual with her “DID clients”, because “they’re too smart.” For Annette, diverse strategies add to her “bag” of therapeutic techniques to use with the range of clients who walk through her door. It is this diversity that defines “who [she is] as a psychologist now.”

Over time, you tend not to use one pure approach, instead you “morph”

Anna (61, self-employed, clinical psychologist with 25 years practice), describes her therapeutic approach with any one client, as a “flowing in together,” informed by her experience of how different therapies “blend.” She expresses that “[she] must be operating from some theoretical base.....and applying it because it’s not just chatting to someone.” Yet, subscribing to one theoretical framework appears to hold no value for Anna. Instead, she draws on “all these principles,” using “what [she] thinks is appropriate for the person at that moment.” As vignette, Anna describes a client who came to her, following ineffectual therapy with another clinician: “she was starting to get...panic attacks, and got quite depressed.” Anna’s treatment for this woman, was “just problem-solving stuff, which is basic counselling technique...you empathise, and then you do the problem-solving, and action.” For Anna, what constitutes effective therapy is not necessarily informed by formalised psychology, but by the process of observing, for example, client outcome “I sort of think, well I don’t know what (specific therapy) I’m doing, I don’t know what to call it, but for that individual it’s working, so that’s all that’s important.”

Michelle (36, Anglo, registered clinician with five years practice), also alludes to an experience of morphing inherent to her therapeutic approach. Michelle says she “practices from a theoretical framework of cognitive behaviour therapy,” “but [she adds she’s] taken so much from the biopsychosocial model.” As the interview unfolds, Michelle talks about the powerful impact of “starting to supervise...intern psychologists” on her practice-process. She presents this experience as “causing [her] to reflect a lot on whether [she] learned that [particular therapy], and how helpful was that in the learning and [does she] ever use that, or [is she] just

making shit up (laughs).” Michelle goes on: “I find that these types of things tend to morph over time where it’s hard to know [where her practice process stems from].” She goes on to say that whilst “you might develop a bit of a formal education about things...the actual learning of how to apply that goes on.....on a practical basis with clients when they come into the room.”

Like Anna, Michelle says she has learnt that the best application of theory derives from what goes on in the therapeutic space. Good practice is a fluid coming together involving a “definite...evolution of what is a legitimate strategy for the next patient.” For Michelle, requires constant “reflection on what works and what doesn’t,” because, even when “the integration of both the training and the practice” seems to “work with a particular person,” it “might not work” with the next. So it seems, that whilst Michelle’s overall practice may still be informed by CBT, she no longer practices CBT in a pure form. Increasing practical experience has led to “a definite evolution” that gives new relevance to “the biopsychosocial model.” However, the biopsychosocial model does not form part of CBT, as delineated by, for example, the Beck Institute website, or online training modules.²²⁻²³ Instead the biopsychosocial model was forwarded by Engel,²⁴ (p.129) as a “challenge for biomedicine” not to make a contribution to CBT.

Diverse influences may be better at facilitating good outcomes for the client

Dukie (48, self-employed, female, clinical psychologist, with 17 years practice experience) presents her preferred approach as favouring “mindfulness.” During her interview, Dukie says she uses herself as a “guinea pig,” in combination with “reflecting on what it is to be human,” to determine the efficacy of her approaches. She states, that whilst there is not “anything [she’s] come across really that [makes her] think. “Jeez, that’s dodgy!,” or that’s really not helpful,” the psychological practice Dukie finds most useful needs crucially to “resonate” with her, to be consistent with her “values,” and help her become “the human being [she] wants to be.” As if to underline her self-first philosophy, Dukie adds: “Of course I only do courses that interest me anyway [laughs]...So it’s a skewed-up sample.”

Instead of using a peer-reviewed, evidence-based approach to determine what is good practice, as advocated by formalised psychology, Dukie articulates her use of:

Anything...that assists [her].....in being.....the human being [she] wants to be, to live by [her] values, to live a rich and meaningful life...and [she] doesn't really draw the line...between ways that do and ways that don't.

Here, Dukie's practice approach is informed by self-tested understanding, of "what it means to be human," and the processes involved in becoming that. This clinician says she practices, not in alignment with the Boulder approach, but within an ontological framework. Dukie presents a clear idea of what she is seeking to move her clients towards, ("being the human being [they] want to be") – an approach akin to that advocated by Leader.²⁵ Within her approach, she blends "biomedical" components such as "sending people for blood tests," "the story of buddha," "meditation" and "mindfulness."

Annette also speaks of her therapeutic process as being informed by self-learning regarding experiences of dealing with emotional discomfort caused by, for example, people criticising her. The process she employs to move past her discomfort is to explore whether "the cap fits or not," stating "that's the way that I tend to deal with things." Here, Annette advocates being open to criticisms from a place external to herself, whilst retaining her autonomy. Her own self-learning is then transposed to clients for whom Annette proposes: if "the cap fits," (i.e. if Annette's interpretation is valid) there is space for the client's personal reflection and behavioural change, and if it doesn't fit, they can move on. Annette explicitly uses her own experience of how "to deal with things," as inspiration for her therapeutic approach: "I get my clients to do that too." Inherent to this approach is Annette's value of: "choice," "choosing what we can change, and what we can't." She challenges her clients "about taking on what other people impose. If there is some truth about it, what are you going to do about it? And if there's not, how are you going to repel those statements?" Her example is a domestic violence situation where:

You can't change the other person...but you can change how you..react to that...or you can change whether you allow yourself to stay in the situation, and even if you do stay in the situation, I want you to accept that you've chosen that, not that it'sthe only option you have.

Captain (male, 54, self-employed, clinical psychologist with 33 years practice experience) too, identifies an interaction between the personal experience of the therapist and treatment efficacy. In particular, he talks about his experience of having grown up "mixed race," and "not really belonging to a tribe." Captain suggests this life experience, placed him in situations where, unsure of his ethnicity, those around him would make assumptions about him, and, or, "project" those assumptions onto him, ultimately viewing him as alien to themselves. As evidence he states:

When I go to [Country X], people always say to me "Can I help you" in the trains...um train stations, and I always reply back in [the language of Country X], they're so disappointed because they thought look at this guy, [and think: I'm going to] get a chance to speak [the language of country Y].

Captain elucidates this claim further with the statement, "you are whoever people think you are." In context, this may be interpreted to mean Captain has found it difficult to develop a solid sense of his own identity, due to assumptions "projected" onto him by others. Yet it is exactly because of this experience, and the implied "work" Captain has had to do to process not being "whoever people think you are," which underpins his claim that he "work[s] very well with people who project – paranoid people." Because Captain has also been on the receiving end.

Captain presents his experience of growing up "mixed race" as contributing to his being able to "study it [paranoid projection] first hand" and explore "how some of these [paranoid projection] things work," "cos [Captain is] able to actually sit there and try and work out what's actually going on." Whilst some may view the capacity to "work out what's actually going on" as inherent to the role of the psychologist, the difference

here is that Captain's first hand experience of "projection," facilitates his working with this "very very difficult" client group "at the extreme end" of difficulty for clinicians: people who you "avoid eye contact with," "out on the street."

Discussion and Summary

As outlined previously, formalised psychology reiterates the long-running case that clinicians best practice using evidence-based approaches, primarily determined by results of randomised controlled trials (RCTs), reported in peer-reviewed journals. However, we have provided evidence that practitioners may perceive that CBT is formalised psychology's gold standard for clinical work. We have also provided evidence that some clinicians view neither CBT, nor other therapies defined as best practice, as the only form of best practice. Instead, clinicians may value access to a diverse range of practice options, even presenting this as necessary for professional development, and the best outcomes for clients.

Additionally, as predicted by the Nel, Pezzolesi, and Stott,¹⁴ study, therapists in our study did not speak of their professional maturation in terms of their knowledge of discrete, published, peer-reviewed treatments. Rather they use the language of autobiographical events, personal philosophy, practice-based evidence, and the "morphing," or "flowing in," of a "mish-mash" of influences. This form of experiential practice and professional development, sits outside formalised psychology's depiction of best practice.

We now argue that interviewed clinician's accounts of their professional experience accord better with a model of practice defined by 'phronesis' thinking, rather than the model provided by formalised psychology. We expand on this in the next section.

Theories of practice in Western thinking

The notion of learning from experience is by no means foreign to Western thinking. Aristotle coined the term phronesis to describe "knowledge that addresses the concrete situation," being the kind of knowledge that underpins an individual's capacity "to grasp an infinite

variety of circumstances" when acting into a given context.²⁶ (p.12) According to Gadamer,²⁷ phronesis-thinking is what informs ethical action, it cannot be split, on the one hand into generalisations, theory, or formulae – to which, on the other hand, applications must conform. It embraces openness to the unexpectedness and particularity of the novel situations faced in practice, involving both observation, and nuanced response. It is this reflected-on capacity which, over time, produces the kind of professional judgement and expertise that we call "being experienced."²⁶

In nursing and teaching, the process of becoming experienced is entwined with capacity for reflexivity, defined as the ability to "construct informal theory out of practice, apply that theory back into practice, and reflexively modify the theory as a result of the changed clinical situation."²⁸ (p.93) The generation of informal theory is thus an enmeshed, circular process, "contained in practice by definition, because without it practice is merely random and uncoordinated activity."²⁸ (p.95) Furthermore, the interrelationship between informal theory-development, and practice, facilitated by reflexivity, results in the flat-lining of a knowledge hierarchy that privileges knowledge generated by RCTs, thereby "closing the theory-practice gap."²⁸ (p.96) The value of such a reflexive practitioner is that "each expert [clinician] has his/her own situation-repertoire of paradigm-cases which is unique to him/her, and which constitutes a body of personal knowledge which is very different from public, academic knowledge."²⁸⁻²⁹

Experienced practitioners "have come to grips with the culturally avoided or unchartered and can open ways of being and ways of coping for the patient and the family."²⁹ (p.407) Benner and others,²⁹⁻³⁰ further argue that a clinician's capacity for processing experience in a reflexive manner is what differentiates novices from experts. For both Benner,²⁹ (p.407) and Gadamer,²⁷ "experience is not the mere passage of time or longevity; it is the refinement of preconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theory." Moreover, whilst both theory and aggregate data, "offer what can be made explicit and formalised," "clinical practice is always more complex and presents many more realities than can be captured" by these means alone.

Clearly, knowledge conforming to formalised psychology's idea of best practice has value.⁷ Yet knowledge generated within this frame may deny the

relativity of the promulgated theory and approaches, variance in responses, or existence of outliers oftentimes made to disappear using statistics. Moreover, as every statistician knows, the individuals who face a clinician within the therapeutic space may seldom be easily understood in terms of the analysis of aggregated data adduced from samples described in peer-reviewed journals reporting RCTs. Furthermore, if they were to assume that each client will conform to such published presentations, practitioners might impede their capacity to attend to the presentness of exactly what it is their clients are presenting with.

Of additional importance from an ethical perspective, is evidence that the most unwell people, who may have experienced extreme trauma and abuse, may not always be included in empirical trials due to the extremity or singularity of their presentations. When they are included, it tends to be assumed in the research that they can never become, or are highly unlikely to ever become, well.³¹⁻³² Yet research or thinking which sits outside what is made available by empirically supported trials, may provide effective treatment.

For example, such research provides evidence that recovery is not linear, and may be heavily influenced by: subjective factors;³³⁻³⁵ relationships including the therapeutic alliance;¹⁵ or may occur without any professional intervention.³³ In short, what might constitute effective treatment methodologies for this extreme group can become inaccessible to the clinician trained under the auspice of formalised psychology, rendering the profession potentially unable to adequately deal with the most unwell in our communities. Hence our data raises the question: Does formalised psychology's definition of best practice, understood as a one-way arrow from theory to application, provide clinicians with adequate resources to deal with clients on a daily basis?

Additionally, we have illustrated, that whilst formalised psychology advocates the use of evidence-based practice approaches, which have been tested using RCTs, the pure forms of resultant therapies, may not be what practitioners are using in the field, however these practitioners may label themselves. Instead, some clinicians morph pure forms of a therapy, using many and varied inspirations as muse, or they may be understood as using self-learnt ontological and epistemological insights to direct what it is they are seeking to move their client's towards. Moreover, in

contrast to any privileging of knowledge generated by the peer-reviewed science, as per Boulder, this paper has provided evidence that it may in fact be in the space of practice that the most valuable new clinical knowledge is created, or evolves, according to practitioners. This way of thinking arguably flips the status quo of psychology on its head, with the – as yet under-researched processes of practice-based learning setting the gold standard through which best practice should be measured and taught. With mental and substance abuse disorders identified as the leading cause of disability worldwide,³⁶ an understanding of clinicians' practical experience may be crucial to the facilitation of wellness within the Australian, and more broadly, the Western population.

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