Clinical Psychology in Practice

Edited by Helen Beinart, Paul Kennedy
and Susan Llewelyn

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To our team and all those trainees, service users, supervisors, colleagues and fellow trainers who have contributed both directly and indirectly to what we have learnt along our own professional journeys

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About the Editors

Dr Helen Beinart is Clinical Director of the Oxford Doctoral Course in Clinical Psychology, where she has worked since 1994. Clinically, she works with children, young people and their families in a primary care setting. She trained in Cape Town and London and qualified as a Clinical Psychologist from the Institute of Psychiatry in 1979. She has worked in the NHS for the past 30 years as a clinician, service manager, consultant, supervisor, and trainer. She is Fellow of Harris Manchester College, University of Oxford. Over the past 15 years, she has been involved in clinical psychology training, supervisor training and research into the supervisory relationship. Prior to this she was Head of Child and Adolescent Health Clinical Psychology Services in Aylesbury and Kingston. Dr Beinart has chaired the Division of Clinical Psychology's Faculty for Children and Young People and was involved in providing psychological evidence to the Parliamentary Select Committee on Children's Mental Health. Professionally she has held several roles within the Division of Clinical Psychology and currently acts as National Assessor for senior appointments to the profession and as external adviser and teacher to a number of courses and services. She has a long-term interest in the development of professional competence and the contribution of clinical supervision and, in particular, supervisory relationships to the development of competent clinical psychologists.

Professor Paul Kennedy is Professor of Clinical Psychology at the University of Oxford, Academic Director on the Oxford Doctoral Course in Clinical Psychology, and Trust Head of Clinical Psychology based at the National Spinal Injuries Centre, Stoke Mandeville Hospital. He studied at the University of Ulster and Queens University, Belfast and has worked in clinical health psychology since graduating from his clinical training in 1984. Professor Kennedy is an active researcher with a broad portfolio of research on adjustment, coping and physical rehabilitation. He has published over 80 scientific papers for peer reviewed journals, been a chapter contributor to many books, and co-edited/edited a number of books on clinical health psychology and physical

disability. He serves on the editorial board of the *Journal of Clinical Psychology in Medical Settings*, *Rehabilitation Psychology* and *Neurorehabilitation*. He was elected a Fellow of the British Psychological Society in 1999, served on the Committee of the Division of Health Psychology, and became a Fellow of Harris Manchester College, University of Oxford in 2001. He is founding Chair of both the Multidisciplinary Association of Spinal Cord Injury Professionals (MASCIP) and the European Spinal Psychologists Association (ESPA). In 2002 he was awarded the Distinguished Service Award by the American Association of Spinal Cord Injury Psychologists and Social Workers, and in 2005 he was awarded a visiting Fellowship to Australia by the New South Wales Government, Ministry of Science and Medical Research. He became Professor of Clinical Psychology in the University of Oxford in 2006 and is an enthusiastic scientist practitioner who enjoys the interplay between service provision, research and training.

Professor Susan Llewelyn has held the post of Director of the Oxford Doctoral Course in Clinical Psychology since 1997. She trained at Sheffield and Leeds University and has worked in both the NHS and University sectors in Nottingham, Sheffield, Dorset, Southampton and Edinburgh. She has a particular interest in the psychological therapies, and has published widely, particularly concerning process issues in psychotherapy. Her clinical work has concerned therapeutic interventions for adult survivors of childhood sexual abuse, and she has also trained in Cognitive Analytic Therapy. She is a Chartered Clinical Psychologist and Fellow of the British Psychological Society, past Chair of CTCP, Professor of Clinical Psychology at Oxford University, and Senior Research Fellow, Harris Manchester College, Oxford. She also has a particular interest in professional issues, leadership and teamwork, and was been awarded a postgraduate certificate in Higher Education leadership by Leicester University in 2006. She has written or co-authored six books and over one hundred academic and professional papers, and was an Associate Editor of *The Psychologist*. She also provides advice to the Oxford English Dictionary regarding psychological words and phrases, and has been a member of the Wiley-Blackwell strategy group for psychology.

List of Contributors

Dawn Bailham, Chartered Clinical Psychologist, Child and Adolescent and Mental Health Service, Clarendon House, 8–12 Station Road, Kettering, Northants NN15 7HH

Helen Beinart, Clinical Director, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX

Sue Clohessy, Clinical Tutor and Supervisor Training Lead, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX

Zoë Clyde, Consultant Clinical Psychologist, Chronic Fatigue Service, Cheviot House, Sutton Hospital, Cotswold Rd, Sutton SM2 5NF

Myra Cooper, Senior Research Tutor, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX

Denise Cottrell, Macmillan Consultant Clinical Psychologist, Buckinghamshire Hospitals NHS Trust, Cancer Care and Haematology Unit, Stoke Mandeville Hospital, Mandeville Road, Aylesbury, Bucks HP21 8AL

Andrew Cuthbertson, Programme Director, Doctorate in Clinical Psychology, Parkside West Offices, University of Teeside, Middlesbrough TS1 3BA

Stephen Davies, Deputy Course Director, School of Psychology, University of Hertfordshire, College Lane Campus, Hatfield, Herts AL10 9AB

David Dean, Consultant Clinical Neuropsychologist, Heberden Unit, Amersham Hospital, Whielden Road, Amersham, Bucks HP7 0JD and Clinical and Admissions Tutor, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX

Gráinne Fadden, Consultant Clinical Psychologist/Director, The Meriden West Midlands Family Programme, Birmingham and Solihull Mental Health NHS Foundation Trust, Tall Trees, The Uffculme Centre, Queensbridge Road, Moseley, Birmingham B13 8QY

Paul Flecknoe, Consultant Clinical Psychologist, Northamptonshire Service for the Treatment of Early Psychosis (N-STEP), Clarendon House, 8–12 Station Road, Kettering, Northants NN15 7HH

Kathryn Fordham, Clinical Psychologist, Child and Adolescent Mental Health Service, Clarendon House, 8–12 Station Road, Kettering, Northants NN15 7HH

Damian Gardner, Consultant Clinical Psychologist/Team Leader, St Mary's Hospital, London Road, Kettering, Northants NN15 7PW

Kim S. Golding, Consultant Clinical Psychologist, ISL, The Pines, Bilford Road, Worcester WR3 8PU

Cynthia A. Graham, Research Tutor, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX

James Gray, Consultant Clinical Psychologist for Long Term Conditions, City and Hackney Teaching PCT, St Leonard's Primary Care Centre, Nuttall Street, London N1 5LZ

David S.J. Hawker, Clinical Psychologist, Psychological Health Services, InterHealth, 111 Westminster Bridge Road, London SE1 7HR

Antje Horsch, Academic Tutor, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX and Clinical Psychologist, Berkshire Traumatic Stress Service, 25 Erleigh Road, Reading, Berks RG1 5LR

Paul Kennedy, Academic Director, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX, Professor of Clinical Psychology, University of Oxford, and Trust Head of Clinical Psychology, Buckinghamshire Hospitals NHS Trust, Aylesbury, Bucks HP21 8AL

Nigel S. King, Consultant Clinical Neuropsychologist, Community Head Injury Service, The Camborne Centre, Jansel Square, Bedgrove, Aylesbury, Bucks HP21 7ET and Clinical Tutor, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX

Adrienne Little, Consultant Clinical Psychologist/Head of Psychology and Psychological Therapy Services, Mental Health Older Adults, 1st Floor Administration, Maudsley Hospital, 115 Denmark Hill, London SE5 8AZ

Susan Llewelyn, Course Director, Oxford Doctoral Course in Clinical Psychology, University of Oxford, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX and Professor of Clinical Psychology, University of Oxford

Claire Luthwood, Consultant Clinical Health Psychologist and Head of Clinical Health Psychology, Berkshire Healthcare NHS Foundation Trust, 25 Erleigh Road, Reading, Berks RG10 9QX

Annie Mitchell, Clinical Director, Doctorate in Clinical Psychology, School of Applied Psychosocial Studies, Faculty of Health and Social Work, University of Plymouth, Peninsula Allied Health Collaboration, College of St Mark and St John, Derriford Road, Plymouth, Devon PL6 8BH

Rachel Purtell, Folk.us Coordinator, Room 407, Noy Scott house, Royal Devon and Exeter Hospital, Barrack Road, Exeter EX2 5DW

Ann Rowland, Consultant Clinical Psychologist, Child and Adolescent Health Psychology Service, Buckinghamshire Primary Care Trust, Sue Nicholls Centre, Bierton Road, Aylesbury, Bucks HP20 1EG

Judith Samuel, Head of Psychology Services, Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust), Slade House, Horspath Driftway, Headington, Oxford OX3 7JH

Stefan Schuller, Consultant Lead Psychologist for Psychosis, Oxon and Bucks Mental Health NHS Foundation Trust, May Davidson Building, Warneford Hospital, Oxford OX3 7JX

Rashmi Shankar, Consultant Clinical Psychologist, Berkshire Healthcare NHS Foundation Trust, Department of Clinical Psychology, Prospect Park Hospital, Honey End Lane, Reading, Berks RG30 4EJ

Selma Rikberg Smyly, Consultant Clinical Psychologist, Ridgeway Learning Disability NHS Trust, Abell house, Horspath Driftway, Headington, Oxford OX3 7JH

Penny Spinks, formerly Consultant Clinical Psychologist Paediatrics, Berkshire Healthcare NHS Trust

Paul Stallard, Consultant Clinical Psychologist/Professor of Clinical Psychology, University of Bath/Avon and Wiltshire Mental Health Partnership NHS Trust, Mental Health Research and Development Unit, 22–23 Eastwood, University of Bath, Bath BA2 7AY

Graham Turpin, Professor of Clinical Psychology/Unit Director, Department of Clinical Psychology, University of Sheffield, Western Bank, Sheffield S10 2TP

Kobus Van Rensburg, Consultant Clinical Psychologist, Transition and Liaison Team, St Mary's Hospital, London Road, Kettering, Northants NN15 7PW

Tim I. Williams, Consultant Clinical Psychologist, Berkshire Healthcare NHS Trust and Fellow, School of Psychology and Clinical Language Sciences, University of Reading, 3/5 Craven Road, Reading, Berks RG1 5LF

Rachel Woolrich, Clinical Psychologist, Oxford & Bucks Eating Disorder Services, Tindal Centre, Aylesbury, Bucks HP20 1HU

Preface

Knowing is not enough; we must apply.
Willing is not enough; we must do. (Goethe)

This book provides a clear, authoritative and lively introduction to the practice of clinical psychology. It outlines the unique characteristics of professional practice, which is to make use of empirically based, ethical and reflective interventions in order to reduce human distress, by working in partnership with clients, carers, families and systems. Evidence and theories about how difficulties develop and the best methods for ameliorating distress will be outlined within the context of psychological and biopsychosocial frameworks of emotional, health, relational, developmental, social and behavioural problems.

We wrote this book because we have a clear view of what a good and competent clinical psychologist is able to do, and what therefore comprise the essential elements of training. We hope it will provide an effective companion for all trainee practitioners to show how the profession works in practice, provide a good overview of competencies for the trained practitioner, and provide our colleagues, managers, and those who use and commission psychology services with a clear vision of what can be expected from a competent clinical psychologist. While we will make reference to academic and research evidence, this is not intended to be a reference text, but rather a helpful and authoritative source of approaches to the range of issues clinical psychologists are likely to face in practice.

Clinical psychology offers an alternative to other models in health care, such as the medical, psychiatric, forensic, moral or sociological. The rapid development of the profession out of an initial quasi-medical focus on psychiatry and child guidance has led to clinical psychologists progressively becoming able to identify their unique competencies and interventions, which call upon scientific as well as ethical practices. The book introduces and delineates those competencies and how they are applied in a range of clinical settings with a variety of client groups across the lifespan. The key issues that

will recur throughout the book are likely to be awareness of the social context, the need for responsive and reflective practice, and respect for diversity and user perspectives. Examples and principles are provided which demonstrate the clinical psychologist in action, and explain why and how they work as they do.

Aimed at trainees as well as qualified psychologists and others in health and social care, the book aims not to oversimplify, but to explain succinctly the range of competencies which a psychologist is expected to possess, and how these can be applied in a variety of contexts. The book offers a unique partnership focus which reflects the nature of clinical psychology training, where academic, clinical and research aspects are offered in collaboration with clinical practitioners, who provide the clinical experience to foster the development of competencies in health and social care.

The structure and content of the book represent our belief that clinical psychology is an integration of academic theory, clinical practice and an evolving research base, delivered within an ethical and reflective framework. Contributors are drawn from both academic backgrounds and clinical practice, and most are involved in training tomorrow's practitioners. The range of topics covered in the short chapters cannot be comprehensive, because of the proposed size of this volume, but rather represent a demonstration of some significant innovations in practice as well as being clear examples of how competent clinical psychology is delivered in routine practice.

Helen Beinart, Paul Kennedy and Susan Llewelyn
Oxford 2008

Acknowledgements

Part I

Introduction

Philosophical, Practical and Ethical Underpinnings

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The Key Elements of Clinical Psychology Practice

Susan Llewelyn, Helen Beinart and Paul Kennedy

Introduction

The profession of clinical psychology has grown exponentially over the past 50 years and, as this book will show, has demonstrated its value in a wide range of clinical contexts, thereby proving itself able to make a unique and important contribution to health and social care across the lifespan. It has developed from its origins in child guidance and the provision of psychological assessment in psychiatric settings to become an independent profession providing treatment and advice to clients, carers and services in a wide range of settings including primary care, social services, and secondary and tertiary care, as well as specialist services such as forensic units, palliative care and physical rehabilitation services.

This book presents an introduction to the essential features of the work of clinical psychology in practice, and demonstrates how clinical psychologists apply their knowledge and skills in a wide range of specialist settings. It is intended that this book will be of interest to both pre- and post-qualification clinical psychologists and also to a wider audience, and will remind all its readers of the value of the particular synthesis of theory, practice, a strong ethical base and commitment to the worth of people and evidence that the discipline represents. In line with social, political and academic developments, this book will also show how much further there is still to go in ensuring that the psychological is truly embedded in health and social care, particularly in the UK. Hence, the book raises questions about the future, and how important it is both that research continues to broaden and deepen the discipline theoretically and also that services continue to develop that enable users or carers in health and social care to have access to good quality psychological input, across the lifespan.

Clinical Psychology and How People Are Understood: Conceptual Models

Whilst medicine conceptualises the person primarily as a biological entity, albeit with emotions and thoughts, and the law thinks of people primarily as legal entities with rights and obligations, absolutely central to clinical psychology today is the notion of the person as a holistic, meaning-seeking body living within a particular social context. This approach, sometimes described as the biopsychosocial, indicates that each individual is best understood in terms of their psychological functioning and their physical and developmental history, but should also be understood in terms of the social context in which they live. The theoretical and empirical foundations of clinical psychology originated within empirical psychology, in academic centres and universities, where behavioural and subsequently cognitive models and approaches were dominant. When applied in the health context, these models fit reasonably well with an individualist medical approach, and have remained the dominant models. A more systemic approach has nevertheless been a consistent strand within the discipline, and community-based models have been developed which draw upon social conceptualisations of the person and their distress. Psychodynamic and interpersonal models have also played a significant part. Other important influences from psychology as an academic discipline include developmental psychology, personality psychology and neuropsychology. Nowadays most psychologists work in an integrated way, calling flexibly on a variety of models, all more or less subsumed within the biopsychosocial understanding of the person. Indeed, clinical training is deliberately generic, enabling the competent clinical psychologist to access and apply a variety of models as appropriate to the needs of the client or situation, in a range of settings, across the lifespan and with a range of presentations.

Although a multitude of approaches are used in clinical practice, the dominant models will now be examined in a little more detail. The behavioural model has historically played a highly significant role in the development of the discipline, and continues to be influential. Behavioural approaches focus primarily on changing current behaviour, and de-emphasise internal events and subjective experience. They are based on the premise that human behaviour, including various patterns of psychopathology, is learned and thus can be modified by new learning, or relearning of old patterns of behaviour. Both classical conditioning (Pavlov) and operant conditioning (Skinner) models have been applied to clinical practice (see Eysenck, 1976; Kanfer & Goldstein, 1980; O'Donohue & Krasner, 1994). Assessment and treatment aims to understand and manipulate the cues or antecedents that elicit behaviour, and the consequences or 'rewards' that follow it. Clinical psychologists were influential in the early application of behavioural theory and principles to a range of clinical problems. These included token economies (Allyon, 1999) for long-stay psychiatric patients, social skills training (Hollin & Trower, 1986), acquisition of speech, specific behaviours and skills in those with learning disabilities (Yule & Carr, 1980), and treatment of childhood conduct problems and parent training (Herbert, 1981). Behavioural models still flourish and

are widely applied, particularly in work with children, parents, those with learning disabilities and in neuropsychological rehabilitation. Some of the core principles and strategies, for example those of reinforcement, role playing, extinction and modelling, have become embedded in everyday practice, even by those whose predominant orientation is not behavioural. Behavioural approaches continue to develop, and have recently been applied to eating disorders, psychosis, dementia care, and behavioural activation for depression, among other problems (Sturmey, 2007).

In response to behaviourism's lack of attention to internal, mental events, the cognitive model has become increasingly influential, and it is now the dominant model in clinical psychology in the UK. Cognitive models focus on thinking or cognition. Cognitive events (e.g. thoughts, images) are thought to be responsible for the maintenance of dysfunctional behaviour and mood disturbances. Cognitive assessment and therapy thus focuses on understanding and altering the cognitions that maintain disturbed mood and behaviour. Ellis devised rational emotive therapy (Ellis, 1961), while Beck (1976) simultaneously developed cognitive therapy. Beck's therapy has become particularly well known in the UK, where it is often referred to as cognitive behaviour therapy (CBT). Originally developed for depression, it has expanded to cover the range of clinical problems most typically seen by clinical psychologists, such as anxiety, trauma, obsessive-compulsive disorder (OCD) and eating disorders. It has also been adapted for use in healthcare settings, for work with children and for those with learning disabilities. While much of therapy is concerned with 'here and now' problems, schema-focused work has also been increasingly developed (e.g. Young, 1990) in order to treat those with chronic, severe and long-standing personality problems. Therapy is formulation driven, with the construction of an idiosyncratic formulation in collaboration with the client. A range of cognitive and behavioural strategies can then be used to challenge or modify cognitions, including verbal restructuring and behavioural experiments.

In recent years, a number of highly specific cognitive models have been developed for a range of adult psychological problems, including panic, social phobia, bulimia nervosa and OCD (see Wells, 1997, for an overview). Some of the models and treatments have been manualised and also published in the form of self-help guides. These have played a key role in the development of stepped care models of service provision, with minimal interventions (e.g. self-help) being offered before more intensive interventions (e.g. individual cognitive therapy). Cognitive behavioural interventions have been systematically evaluated for several disorders and shown to be highly effective (Roth & Fonagy, 2004), although, when thorough and even-handed comparisons have been made, cognitive therapy has not actually been shown to be more effective than other psychotherapies. Models for bipolar disorder, psychosis and also for personality disorders have been outlined, and preliminary treatment studies have produced encouraging results, although further development and evaluation are needed. Guidelines in the UK (e.g. National Institute for Health and Clinical Excellence (NICE)) and other countries strongly support the use of CBT, and a large programme to train new psychological therapists (Improving Access to Psychological Therapies (IAPT)) is under way in the UK, in order to make these therapies available to many more people.

A number of other therapies also focus on cognition, many of them developed in healthcare settings to facilitate adjustment to serious illness or chronic conditions, for example coping effectiveness training (Chesney & Folkman, 1994). Specific therapies to enhance motivation, for example in those with substance abuse (Marlatt *et al.*, 2002) or eating disorders (Geller, 2006), have been devised, with a focus on cognition. More recently, 'third wave' cognitive therapies have appeared, partly in response to criticisms of the proposed mechanisms of action in cognitive therapy, but also because a proportion of people do not improve significantly with cognitive therapy. These new developments focus on both control and acceptance, and typically aim to alter the person's relationship to their thoughts. They have been developed in a variety of formats, including mindfulness-based CBT (Segal *et al.*, 2001), metacognitive therapy (Wells, 2008) and acceptance and commitment therapy (Hayes & Strosahl, 2004).

Psychodynamic models have as their foundation a number of fundamental principles derived from psychoanalysis. These include the belief in unconscious material, the notion of intrapsychic conflict and mechanisms of defence to master anxiety, the presence of resistance and a developmental model which gives primacy to the oedipal conflict. As a developmental model, the psychodynamic perspective holds that infancy and childhood experience is formative for the adult personality. Initially, Freudian psychoanalytic theory was focused on unconscious desires based on the infant as primarily pleasure-seeking. However, following the advent of attachment theory (Bowlby, 1973) greater emphasis was placed on the infant's relational capacities. The psychodynamic infant is less pleasure-seeking than seeking the relational. This has informed the 'object relations' (Greenberg & Mitchell, 1983) school of contemporary psychodynamic practice which has given primacy to the therapeutic relationship in clinical practice with its notions of transference, counter-transference and defence mechanisms. For a contemporary account of the use of this in current clinical practice, see Coren (2001) and Stadter (1996). There are numerous theories which can be subsumed under the overarching psychodynamic label, but most share an emphasis on the use and analysis of the therapeutic relationship with the therapist to understand and work through the meaning of the symptom and its relation to the client's previous developmental, relational and family history. In this sense the symptom acts as a form of communication, and its relief, while desirable, is viewed as but one aspect of the treatment aims. Mutative change happens via the therapeutic relationship which, in the case of open-ended longer-term treatments, places considerable emphasis on therapist neutrality and relative passive therapeutic stance, whereby the client's difficulties are revealed via transference as if onto a 'blank screen'. For example, a young man presenting with social anxiety, who has experienced erratic or inconsistent parenting which may make him wary of successfully establishing relationships, may approach the clinician with the expectation that a similar response is likely from the therapist and utilise a number of defensive responses to deal with this expectation which would form the focus for the treatment. Other, more short-term, focal treatments work more collaboratively with clients using the therapeutic relationship more actively to address the current difficulty and its historical antecedents. Although it is sometimes claimed that this approach has less research evidence for effective outcome than CBT, for example, in fact there is good

evidence particularly for brief time-limited therapies, such as interpersonal therapy (IPT) (Weissman & Markowitz, 1994) and psychodynamic interpersonal therapy (PIP) (Moorey & Guthrie 2003) and for the importance of the therapeutic relationship in all therapies (Lambert & Ogles, 2004).

Alternatively, the systemic model considers that people are best understood in a relational context and that any individual will be shaped and will develop in relation to their family and social context. Thus relationships, communication and interaction are central to the development of identity and experience and are the key to understanding problem development. Pathology is understood as resulting from interpersonal processes. General systems theory (von Bertalanffy, 1968) holds that any system is hierarchically organised and that change at any one point inevitably leads to disequilibrium which the system will resist in order to maintain stability. A system is understood as interacting parts structured by feedback that mutually communicate and influence one another. Fundamental to systemic family therapy are the patterns that develop which connect family members in a coherent and meaningful way (described as circularity). Within circular understandings of causality each person's behaviour is maintained by the actions of the other, thus problems are interpersonally maintained and may be shaped by broader contexts such as dominant gender or cultural roles. The epistemological basis of systemic family therapy has evolved from modernism, through postmodernism to constructionism (Dallos & Draper, 2000) and a large number of specific models have been derived from this overarching model and its evolution. These include structural family therapy (e.g. Minuchin, 1974) which focuses on boundaries and decision making between parental and child subsystems within the family. The more postmodern Milan approach (Palazzoli *et al.*, 1980) uses hypothesising, circularity and positive connotation to help families shift their underlying beliefs, and sees the therapist as part of the system both being influenced by it and having influence upon it. Narrative therapy (e.g. White & Epston, 1990) and solution-focused therapy (e.g. Berg, 1991) are examples of therapies where experience and meaning are constructed in the stories that people tell about their lives, often influenced by multiple layers of context. Problems are understood as arising from personal idiosyncratic perceptions and meanings held by family members and the task of the therapist is to facilitate family members to explore their individual beliefs or narratives so that more positive, less problem-focused explanations can emerge. Therapy often utilises reflecting teams in order to generate many different perspectives, meanings or possible narratives. Therapy is seen as a collaborative process involving co-constructions of new ways of approaching a problem. Applications of systemic models include work with families, individuals, therapeutic letters, systemic consultation and in understanding organisations and teams. Dallos and Stedmon (2006) show how concepts such as power, influence and hierarchy are important in understanding the functioning of all organisations, no matter the size, and suggest that psychologists must factor this into both formulation and intervention.

A large number of other models and approaches are also used within clinical psychology (for example, Gestalt therapy, transactional analysis, cognitive analytic therapy), some of which will be mentioned later in this book. Many psychologists aim

to work integratively across several models, and some may call upon concepts from developmental models and neuropsychology or spirituality in their work. But what most of the models noted above share in common to a lesser or greater degree is the assumption that people become who they are, and have the difficulties that they have, in part because of the context in which they develop, and in part because of what the individual brings and their ability to make unique sense of that context. In order to formulate or intervene, clinical psychologists therefore need to assess in some depth the origins of people's difficulties, their family context and their own particular psychological processing, as well as to understand the contribution of any developmental, medical, biological or physical factors to the difficulty (Johnstone & Dallos, 2006). Critical to the application of all these models is the ability to apply theory to practice, and vice versa, so that the psychologist's work is based on evidence but also contributes to the evidence base for the future. There are, of course, many similarities and much common ground between clinical psychology and other related professions, including psychiatry and psychotherapy. What particularly distinguishes the clinical psychologist, however, is this combination of the use of a range of psychological models, the scientific-practitioner stance, and an embedded emphasis on reflection and ethical awareness (see also Chapter 3).

In practice, this means that clinical psychologists need to take enough time and resources to assess people in some depth prior to reaching an adequate understanding of their difficulties, and in some cases may use detailed standardised measures to assist in the process. Their ability to conduct a thorough assessment means that the resulting formulation can be complex, and relatively time-consuming. Clinical psychologists will normally seek to address a wide range of issues, many of which may be ambiguous, and may need to call on a diverse range of theoretical understandings by which to make sense of what is presented, in order to contribute most effectively.

Clinical Examples

A good clinical example might be a man who is the survivor of a car accident in which he received a closed head injury, and who is finding it hard to readjust to work and family life post-injury. While the injury itself has physical consequences, with brain lesions linked to difficulties in memory and intellectual functioning, this will probably be compounded by a range of other factors which may well be more significant than the extent of the injury in determining the success of his recovery. These factors include the nature of his interpersonal relationships prior to the injury; the quality of support provided by his spouse and the attitude of his employers; the circumstances of the accident and whether or not the man has experienced any post-traumatic distress; the man's personality and history which will in part determine his own emotional reaction; and the man's own attitudes and appraisal of the significance and meaning of what has happened, that is, whether he sees it as a disaster with no opportunity for rehabilitation and growth, or whether he is able to build on personal and other resources to react as positively as possible to the circumstances. All these factors will vary from person to

person, which means that although broad trends can be expected in how people react to such events, large differences also occur which need to be assessed and understood. The theoretical models which may need to be drawn upon in this work might include models of coping, post-traumatic stress disorder (PTSD), neuropsychological models and an understanding of brain–behaviour links, interpersonal relationship models and cognitive models which together can build an understanding of this man's situation and how best to intervene to help him.

Another example might be a 15-year-old girl presenting to services with depression and an eating disorder. Here it is necessary to understand both the nature of her depression and the eating disorder, what triggered and maintains them both and how they relate to each other, as well as understanding her developmental stage and relationships and her current physical condition. It is likely that an adequate formulation would also need to take account of early life experiences, family relationships and circumstances, sexual and emotional development, any cultural issues and any significant life events, as well as cognitive/emotional attitudes and appraisals. A full understanding would probably only develop over time, and would probably be modified as the intervention progressed. It is also likely that the psychologist would work together with other professionals, or the girl's family. Models or theories that might be relevant here include cognitive models of eating disorders and depression, risk assessment, adolescent developmental models, family systems, peer relationships, psychodynamic issues and cultural perspectives. Interventions might draw upon studies of effective treatments which relate to the chosen explanatory models, while the ability to work with and to appreciate the roles of other professionals such as psychiatrists, dieticians and family therapists would also be essential.

Key Qualities of Clinical Psychologists

It is possible to identify at least five equally important key qualities that characterise an effective clinical psychologist. First is an understanding of theory and research. The range of models and theories which may apply in the face of clinical complexity means that clinical psychologists need to have a good grasp of theory and evidence from within the base discipline of psychology. There is therefore a requirement that all clinical psychologists prior to training have a first degree in psychology, because the fundamental approach to people is psychological, that is, it concerns how people function in terms of making sense of and processing their experiences (cognition), as well as how they react to those experiences (emotion, motivation, personality) and what influences them (social, developmental, biological and environmental factors). The clinical psychologist applies those understandings to solve problems in practice, using evidence and theory. The point of theory is that it guides the practitioner, and tells the practitioner what is likely to be going on and what is likely to work. Clinical psychology has historically positioned itself as a science-based discipline, espousing the scientific-practitioner model in training (Hall *et al.*, 2002; and see also Chapter 3 of this book), which has meant that the aspiring clinical psychologist has had to possess a number of

academic and research competencies. The current dominance in clinical practice of the therapeutic role for psychologists sometimes outweighs the scientific, research-based role; nevertheless the government's emphasis on evidence-based practice, clearly favours the scientific stance of the profession. Hence although sometimes somewhat obscured by the exigencies of immediate clinical practice, a key quality of clinical psychologists must be their ability to utilise a broad and evidence-based psychological understanding of how people function. Related to this is their competence in applied research methods: indeed, clinical psychology provides the highest level of pre-qualification clinical research training in the UK.

The second key quality for clinical psychologists is the ability to make positive working or therapeutic relationships with clients, carers or colleagues. Having emphasised the scientific and research-based competences of clinical psychologists, plenty of evidence also suggests that in addition to being able to draw on a range of conceptual models, and evidence about what works for whom, delivery of treatment relies very crucially on the ability of the psychologist to make good relationships with the recipients of services, since psychological techniques are delivered in large part through the personal qualities of the psychologist. It is now broadly accepted, for example, that although specific theoretically based techniques do play a significant role in bringing about change in psychological therapies with adults with mental health difficulties, a large part of the variance in outcome studies can be explained by the quality of the therapeutic relationship (Lambert & Ogles, 2004; Lambert, 2007). It is, of course, neither possible nor appropriate for psychologists to attempt to deliver therapeutic relationships without techniques, and indeed specific techniques have been demonstrated to be important factors when working with specific disorders; nonetheless, the quality of the relationship between psychologist and client is both the foundation and the medium for therapeutic work. As a further example, attention specifically paid to therapeutic relationship issues following a rupture or breakdown in therapy, however minimal, leads to substantially improved outcome (Bennett *et al.*, 2006), supporting the centrality of the personal interaction between psychologist and client in determining effectiveness.

The ability to make good professional relationships requires a number of personal qualities, including the ability to listen to another person, to attempt to understand them in their own terms, to respect diversity and difference, and to communicate clearly. The value base of the profession is critical here, since a commitment to the importance of each unique individual is needed if genuine and open communication is to take place. Arguably the key tool that psychologists use in their work is their ability to influence or facilitate people to think or behave differently.

Clearly linked with this is the third key quality, an ethical approach to professional work, whereby psychologists' ability to influence is used for the benefit of the client or colleague who seeks help or advice. All Chartered Clinical Psychologists are required to act according to the British Psychological Society's Code of Ethics and Conduct (2005a), which promotes high standards of conduct based on the notion of 'ethical thinking'. This document promotes an appreciation that ethical dilemmas are often complex and call for thoughtful judgements based on ethical standards, whilst also recognising that

there are often contextual and cultural constraints and assumptions that influence what we do and believe. Nevertheless, it also enshrines a commitment to the importance of respect for persons and evidence, and to the need for psychologists to act with integrity, primarily in the interests of the recipients of their services (see Chapter 2 for more detailed discussion).

Most health and social care is delivered through teamwork and collaboration (Health Care Commission, 2006), hence the ability to understand and work constructively with groups and colleagues is critical. This can be seen as the fourth key quality. Since clinical psychology as a profession is very small in comparison with other professions such as medicine and nursing, one significant way of increasing the impact of clinical psychological knowledge and techniques is to work through other professional groups via teaching and consultancy and being involved in multidisciplinary teams. A number of writers, for example Ovretveit (1997) and West (2004), have described the factors which promote effective team working, including trust, positive leadership, organisation, having clear objectives and role clarity. Ideally psychologists should be able to work to enhance these factors. A critical understanding of the downside of group functioning, such as group think, stereotyping, conformity and inter-group conflict, can also be helpful, since these factors can impede good team working if not checked. Awareness of group dynamics can therefore be seen as crucial (see also Chapter 30).

The final key quality is that of a reflective practitioner, who is able to think carefully and creatively about his or her professional work. Lavender (2003), drawing on the work of Schön (1987), has distinguished four types of reflection: reflection in action (where, for example, the psychologist is able to respond flexibly to a client's particular needs); reflection on action (where, for example, the psychologist may reformulate a problem after discussing it in supervision); reflection on others (where, for example, the psychologist would consider the impact their particular gender or culture might have on a service user); and reflection on self (where, for instance, the psychologist might think carefully about how to mitigate the impact of working with sex offenders on their own sexual functioning). All these components of practice are needed for effective professional work and are implicated in ethical practice, besides contributing to the ongoing improvement of the psychologist's own professional work. A key component here is a commitment to ongoing supervision, and the willingness to subject one's own work to scrutiny and thought (see Chapter 28).

The Complexity of Clinical Problems

In essence, as shown in the two brief case examples above, clinical psychology is both multimodal and tailor-made in its approach to individual predicaments. Thus the practitioner has to attempt to understand and respond to the complexity of psychological problems, which often necessitates making use of a multiplicity of approaches when formulating and intervening. The psychologist is, however, also a practitioner operating in real time, and hence may often have to be pragmatic and act on incomplete evidence. Pisek and Greenhaigh (2001) suggest that most problems in health and

social care are complex, where change at one level will inevitably affect another, and where coordinated skills and knowledge are almost always required. They argue, however, that we may spend too much time trying to apply complex solutions, and that sometimes we should just aim for 'good enough' solutions. Certainly many psychologists are aware that they do not always have a very sound evidence base for everything they do, and that many clinical problems do not fit neatly into textbook or research categories. It is here, however, that the creativity of the profession is needed, whereby the practitioner makes use of what evidence there is, applying it as a flexible scientist-practitioner to new and untried contexts or problems. An example might be applying a CBT model developed with adults to a child presenting with similar issues, but adapting the model for use in the new context. Overall there is a clear need to promote translational research and to engage in studies that refine laboratory-based work for clinical application.

One critical source of the complexity inherent in most clinical problems is the importance of context in determining and maintaining people's clinical difficulties. Appreciation of the crucial role of social and cultural issues is sometimes difficult to hold on to when focusing on individual clinical problems. Yet individuals do not live in a vacuum, and as the systemic model suggests, one of the major determinants of health problems is the social context in which people live. Smail (2005) suggests that we are often blind to macro-forces such as global economic interests and consumerism which have major and often destructive impacts on our lives, focusing instead on our own, or our clients', apparent inadequacies. Issues such as social class and comparative wealth, status and power are often overlooked in clinical formulations, where individuals are easily seen as living outwith social and economic structures. In fact some models risk encouraging such a focus. Cultural factors apply to everyone, although they are often most starkly observed when working with particularly disadvantaged groups such as some ethnic minorities or people with disability. Conversely, it is of course also likely to be the case that individuals vary widely in how they develop, and that biological factors play a significant part in both the genesis and maintenance of most health and psychological problems, and this again adds to the complexity of clinical work. Here again the value of generic training is demonstrated as it allows flexibility of response, and provides a broader evidence base on which to draw.

It seems that there is no shortage of distress in current society which needs to be addressed, and that a variety of models and interventions will always be needed as a response. These issues are discussed further in Chapter 30.

Clinical Psychology Training: The UK Example

Over the past 40 years, clinical psychology training in the UK has evolved from a fairly haphazard apprenticeship model to a carefully monitored and generic three-year postgraduate University-based doctoral training which is carried out in partnership with local services offered by the National Health Service (NHS). As described in Hall and Llewelyn (2006), the profession in the UK has sought to define itself by laying out its