

# The Key Elements of Clinical Psychology Practice

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## 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 post-modernism 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 post-modern 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 post-graduate 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

unique position in the professional marketplace, defining its intake via the British Psychological Society's training accreditation procedures. All clinical psychology training has thereby become formalised, overseen by relatively stringent external quality assurance processes, which define specified aims and competencies to be attained by all trainees. The ability of training programmes to meet these standards is regularly assessed, and only trainees who have completed accredited courses are eligible for Chartering. Additionally, in common with other NHS-funded training programmes, clinical psychology courses are subject to quality assurance assessment procedures. These apply standard criteria which evaluate the ability of training programmes to provide opportunities for students to fulfil specified educational and clinical outcomes. A regular quality assurance assessment process is now carried out by local NHS commissioners in collaboration with local NHS service providers. The content of training is broad and competency-based, that is, it is designed to allow trainees to demonstrate competence by attaining key learning outcomes. This is discussed in much greater depth in Chapter 2. Through training, trainees are encouraged to become aware of a variety of service models and to understand and apply different ways of working. They are encouraged always to work from the evidence base where that exists, and to feed back into the evidence base by both practice-based audit and research, and also through research into basic processes. The importance of working with users is also stressed, as is the need to work in collaboration with other professional groups.

Almost uniquely amongst NHS professions in the UK, all pre-qualification clinical psychologist trainees have been fully funded by the NHS since the 1980s. In the UK, health services are publicly resourced, and the precise arrangements whereby this is achieved are therefore subject to change, since political views about the best way to organise and distribute services and resources inevitably change. The current situation is for contractual agreements to exist between Strategic Health Authorities in England, or Health Boards or their equivalent elsewhere in the UK, and Universities, to deliver training in partnership with the local NHS, to agreed numbers, for trainees in each local area. Whilst academic teaching, research supervision, professional development support, appraisal and assessment, as well as some skills training, can be provided in academic settings, the bulk of training is provided via practical clinical work carried out under supervision in local NHS or social services settings.

A critical issue is therefore the quality of the relationship between the academic and the clinical sides of the training partnership. Most programmes provide additional training and support for clinical supervisors, and this helps to build and maintain positive relationships. Most programme staff also work part-time in local clinical services. The relationships between stakeholders, including commissioners or purchasers of training, are also important, and on the whole these have been reasonably good too, in part because, in contrast to many other NHS professional groups, the retention and eventual recruitment of clinical psychology trainees as NHS employees has been outstanding (British Psychological Society, 2005b). Finally, a crucial issue is the relationships within and between members of the programme itself (trainees and staff). Just as individuals learn relationship patterns and self-care strategies within their family of origin, so it seems likely that trainees learn much of their professional identity and

standards within their training environment and clinical placements. Ideally this should include an expectation of a high standard of personal conduct and a commitment to both evidence and service user welfare, while at the same time fostering a tolerance of genuine mistakes and a willingness to learn.

In the UK, the training community (staff on all University programmes) works closely together, and although there is diversity between training providers, there is also a high degree of communication and mutual help between training programmes, which has helped to ensure a reasonably consistent standard of training across the UK. This has in turn helped to build and support the wider profession's identity and standards. It is notable, for instance, how prominent training programme staff have been in the professional leadership of UK clinical psychology as a whole, and how many initiatives for innovative services are often led by NHS and University training staff working together. These issues are discussed further in Chapter 29.

## **Clinical Psychology Services**

Clinical psychology training covers a wide range of issues across the lifespan because clinical psychology services operate in a wide range of settings, including adult, child and family, people with learning disabilities, older people and specialist services. Clinical psychologists also work across social and health care, and need to work collaboratively with management and commissioners in order to meet the needs of both service users and carers, and of other service providers, as far as is possible within existing resources. Unlike training, however, there are no accepted patterns or standards of service organisation, and so a huge variety of types of provision exist across the health and social care sector. Limitations in resources mean that many service users do not in fact have good access to clinical psychology, and one constant problem remains inequality of provision, especially for hard-to-reach groups. An important principle here is recognition that services should be provided to all populations in need. For example, learning disabled and older people have poorer access than other client groups to evidence-based psychological therapies for emotional distress, despite evidence that they may benefit from such interventions. Clinical psychologists therefore have an important function in developing such services in areas where there are none. All the qualities and competencies noted in this chapter will be needed for such service development, including the establishment of good working relationships, the ability to assess and formulate problems, the competence to communicate effectively and to establish what form of intervention will be most appropriate, and the ability to implement and evaluate change. Since areas which are well researched are those most likely to receive funding, and hence better services, one important role for psychologists may well be to conduct research with under-served populations and thereby to encourage extension of good practice. In all circumstances the ability to evaluate the services provided will be critical. One further important issue is the dissemination of effective practices, so, for example, effective techniques in parenting can be passed on to health visitors and to families, leaving psychologists to work with more complex cases or in areas of work which have yet to be explored.

Within the UK, a recent government initiative has been to finance a large expansion of evidence-based therapy in primary care, the Increasing Access to Psychological Therapy (IAPT) programme designed to address the substantial amount of untreated level of emotional distress (depression and anxiety) which is reported in the community. Much of this work will be provided by therapists with less training than clinical psychologists, so an important future role is likely to be the provision of supervision and training for others. This ties in closely with recent proposals to revise how psychologists should work, to include a greater emphasis on teamwork, leadership and collaboration (New Ways of Working, 2007); see Chapter 29 for further discussion of this initiative.

## This Book: Brief Overview

This book is structured to show how clinical psychologists think and work, and hence it comprises a series of chapters which present the key elements of practice, competency approaches and the conceptual base. Included is discussion of models, ethical issues and values, and the need to work in partnership with others who also provide or receive services. These discussions recognise the need for clinical psychologists to take both a reflective and a scientific stance to psychological practice, and hence to ground the discipline securely on sound empirical evidence as well as on clear ethical foundations. Examples of services across the lifespan will be presented in a series of short chapters by specialists in their fields, most of whom have roles as providers of services and also as educators for tomorrow's practitioners. The breadth of clinical psychology services now available means that this cannot be comprehensive, and it is inevitable that some important innovations and areas of work will have been omitted. Nevertheless, it is hoped that a reasonably wide range of areas of practice will be covered. The final section of the book discusses contextual questions, skills-sharing and the centrality of user involvement, and also raises questions about the future of the discipline. It is hoped that this volume will thereby provide a stimulating and illuminating coverage of the practice of clinical psychology as it exists in the first part of the 21st century.

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