

37 Clinical Psychology: Training and Development

FERGAL JONES

LEARNING OUTCOMES

WHEN YOU HAVE COMPLETED THIS CHAPTER, YOU SHOULD BE ABLE TO:

1. Describe some of the key stages and choices in the training and career development of clinical psychologists.
2. Provide an overview of the main competencies needed by clinical psychologists, and how these are developed in training.
3. Have some sense of how these competencies relate to clinical practice.

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KEY TERMS

Assessment • British Psychological Society (BPS) • Cognitive-Behavioural Therapy (CBT) • Cognitive-Behavioural • Competencies • Consultant Clinical Psychologist • Continuing Professional Development (CPD) • Evaluation • Formulation • Graduate Basis for Chartered Membership • Intervention • Psychodynamic • Reflective Practitioner • Research • Scientist-Practitioner • Social Constructionist • Systemic

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ROUTE MAP OF THE CHAPTER

This chapter aims to explain how clinical psychologists put into practice some of the ideas discussed in the previous chapters. It will cover the key competencies that clinical psychologists need to develop during their training, and provide an overview of the training process. Some of the choices that clinical psychologists face, in terms of the approach that they take to clinical work and the client group(s) with which they work, will also be discussed. By the end of the chapter, you will hopefully have a clearer sense of what a clinical psychologist's role involves and how training equips them to fulfil this role.

How does someone become a clinical psychologist? What are the key skills and abilities that they have to develop during training? What choices do clinical psychologists have about how and where they work, once qualified?

This chapter will attempt to address these questions. In doing so, it will hopefully provide you with a clearer idea of how the principles and theories outlined in the previous chapters are applied in practice, and give you some sense of what it might be like to train and work as a clinical psychologist. Throughout, the points made will be illustrated by drawing on examples from the training and career of a clinical psychologist called Miranda. While Miranda is fictional, the examples are nevertheless relevant, because they are grounded in the author's experience working as a clinical psychologist and training clinical psychologists. Intentionally, the main focus of this chapter will be training and career progression in the UK.

It is worth acknowledging that the contents of this chapter, and particularly the examples that have been given, are influenced by the author's clinical practice, which has mainly involved working with adults with mental health problems using a cognitive-behavioural approach. Had a clinical psychologist from a different background written this chapter, it is likely that some of the content and emphases would have differed. Therefore, if you are interested in clinical psychology, it is well worth reading around the subject to gain a range of perspectives (e.g., Llewelyn & Murphy, 2014).

37.1 TRAINING TO BE A CLINICAL PSYCHOLOGIST

37.1.1 Career Choices

People can be drawn to a career in clinical psychology for a variety of reasons. Perhaps they have an interest in understanding people and their interactions; perhaps they find the prospect of the variety and intellectual and emotional challenge involved in the work appealing; and

perhaps they gain a sense of satisfaction and meaning from helping others. Moreover, in some cases, they may have had a personal experience of psychological therapy helping them, or someone they know, and so want to be able to use such approaches to help others. Whatever the reason or reasons for wanting to become a clinical psychologist, the path to achieving this goal can be a competitive and challenging one, though also rewarding.

One of the first challenges facing a prospective clinical psychologist is choosing from among the range of similar professions that provide psychological interventions. For example, one alternative to clinical psychology is to train as a psychotherapist, such as a cognitive-behavioural therapist. It would be a mistake to think that one form of training is necessarily better than another. Rather, the different training routes, and associated career paths, have different strengths and emphases. For example, by the end of training, cognitive-behavioural therapists may be more skilled and experienced in providing **cognitive-behavioural therapy (CBT)** than the typical newly qualified clinical psychologist, but the clinical psychologist will be familiar with a wider range of psychological models, interventions, and client groups.

cognitive-behavioural therapy (CBT) a class of psychological therapy that works by re-evaluating thinking and changing behaviour.

As detailed later, some clinical psychologists choose to undertake further training following qualification, to complement the breadth of their training with the depth provided by training in a specific intervention, such as CBT. Furthermore, some clinical psychology training courses in the UK have started to offer dual-accreditation pathways, enabling qualification both as a clinical psychologist and cognitive-behavioural therapist.

A full discussion of the relative merits of the different training routes is beyond the scope of this chapter, but perhaps it is sufficient to say that if someone is considering a career in clinical psychology, it would be worth them also investigating the range of similar professions to determine which fits best with their interests, abilities, and circumstances.

The beginning of Miranda's journey to becoming a clinical psychologist is described in Case History 37.1.

CASE HISTORY 37.1

MIRANDA'S CHOICE

Miranda studied an economics degree at university and while she enjoyed the subject, she was not sure what she wanted to do next, as the normal careers following this degree did not appeal to her. However, she particularly enjoyed the sections of her course that touched on theories concerning human behaviour and human systems. She also gained a lot of satisfaction from the voluntary work she did with the student support service and at a day centre for people with intellectual disabilities. Therefore, near the end of her degree and drawing on advice from the university's careers service and friends who were studying psychology, she decided that she would like to become a clinical psychologist.

37.1.2 Pre-Training Experiences and Qualifications

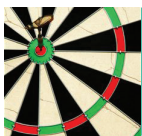
graduate basis for chartered membership an admissions requirement for clinical psychology training, conferred by certain undergraduate and post-graduate psychology degrees.

British Psychological Society (BPS) the professional society for psychologists in the UK.

Once someone has settled on clinical psychology as a career, they need to obtain the necessary qualifications and experience to be eligible for a place on a clinical psychology training course. In the UK, their qualification(s) will need to be sufficient for them to be eligible for **graduate basis for chartered membership (GBC)** of the **British Psychological Society (BPS)**. Most commonly, this is obtained by studying an undergraduate psychology degree, or conversion course, that the BPS recognises as conferring GBC. Beyond this, clinical psychology training

courses typically look for evidence of experience and capability in three areas: academic, clinical, and research.

There is some variability in the selection criteria that courses adopt (for more information, see the website for the Clearing House for Postgraduate Courses in Clinical Psychology [CHPCCP], detailed at the end of this chapter). However, at the short-listing stage, academic ability tends to be primarily assessed on the basis of degree class, with courses typically looking for a first or high 2.1 and also giving some weight to higher degrees, such as a Master's or PhD. Candidates are also usually expected to have had some clinically relevant experience. This can include working as an assistant psychologist or in some other healthcare or social-care role. Paid assistant psychologist posts can be rare in the National Health Service (NHS), so it may be that the clinically relevant experience is obtained on a part-time or voluntary basis. (See Focus Point 37.1 for further discussion.) Candidates also



FOCUS POINT 37.1 CLINICAL EXPERIENCE PRIOR TO TRAINING

Arguably, one limitation of the career structure in clinical psychology in the UK is that there is no formal route to gaining clinical experience prior to training, despite the fact that training courses usually require applicants to have had some clinical experience. This likely makes the profession less accessible to people from more disadvantaged backgrounds, who are less able to afford the cost of building clinical experience through unpaid internships and voluntary work.

Some would-be clinical psychologists are lucky enough to obtain (paid) assistant psychologist posts. Assistant psychologists work under the supervision of a qualified clinical psychologist and might be involved in tasks such as collecting data in order to evaluate a service offered by a group of clinicians, conducting part of an assessment with a client (e.g., administering standardised questionnaires) and carrying out simple interventions, such as teaching clients relaxation techniques. In addition, recently a new role, the

clinical associate psychologist, has been introduced to the UK NHS. This can be thought of as sitting between assistant psychologists and qualified clinical psychologists and involves more autonomous working than in an assistant post. An alternative route to gaining relevant clinical experience is to work as a psychological well-being practitioner (PWP) in Improving Access to Psychological Therapies services. PWPs provide psychological interventions to people struggling with mild and moderate anxiety or depression, usually in the form of guided, self-help CBT.

However, regardless of the specific posts they have had, it is likely to be important that an applicant to clinical psychology training demonstrates what they have learned from their clinical experience that is of relevance to clinical psychology training. The website of the CHPCCP, which is given at the end of this chapter, provides a source of information about what sort of clinical experience different clinical psychology training courses are looking for.

usually benefit from having some research experience beyond their undergraduate degree. This can range from a PhD to involvement in an audit or service evaluation in a clinical setting. That said, conducting an undergraduate research project that is of relevance to clinical psychology may also be helpful. At interview, candidates' academic, research, and clinical abilities and potential are further assessed, and courses are usually also looking for a good interpersonal manner, strong communication skills, and self-awareness.

One advantage of the current selection process is that it is not unusual for candidates who are unsuccessful in one year to be successful the following year, if

they have amassed additional relevant experience and are more prepared for what the selection process will entail. That said, many applicants are also disappointed, given the high demand for places relative to supply. For example, as can be seen in Figure 37.1, in 2021, only 22% of applicants obtained a training place. Finally, as well as becoming university students, successful candidates also become salaried NHS employees during training and so need to pass the necessary criminal record and health checks.

Some of the points that have just been made are illustrated by the next steps in Miranda's journey to becoming a clinical psychologist, described in Case History 37.2.

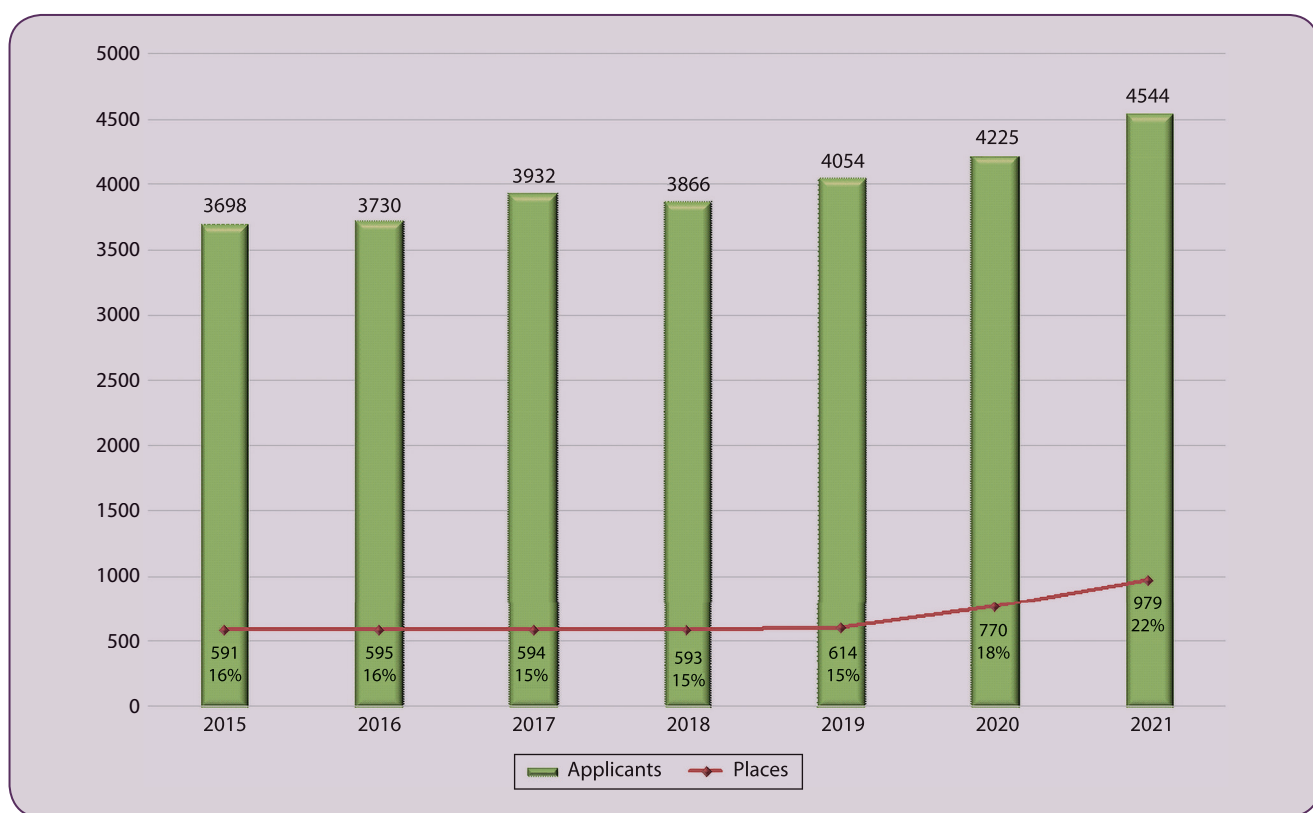


FIGURE 37.1 Bar chart showing the number of applicants for NHS funded places on clinical psychology training courses in Britain compared to the number of places available, for the years 2015 to 2021.

Source: Data obtained from the Clearing House for Postgraduate Courses in Clinical Psychology website, with permission.

CASE HISTORY 37.2

MIRANDA'S STORY CONTINUED

Miranda's degree did not convey GBC. Therefore, over the next two years, she studied a psychology conversion MSc, while also working as a research assistant. In addition, she continued with the voluntary work in the student support service and at a day centre for people with intellectual disabilities. The first year Miranda applied for clinical psychology training, she was unsuccessful, not least due to her relative lack of clinical experience. However, after a year working as an assistant psychologist in intellectual disabilities services, she re-applied and, this time, was successful.

37.1.3 An Overview of Clinical Psychology Training

Training courses in the UK are typically three-year programmes that lead to a doctorate in clinical psychology. This confers eligibility to register as a chartered psychologist with the BPS and as a practitioner psychologist with the Health and Care Professions Council (HCPC), the latter being a legal requirement before someone can practise in the UK as a clinical psychologist. The NHS usually covers all the course fees, and in 2022, trainees were paid a minimum starting salary of £32 306 per annum.

As with selection, training can be thought of as being divided into academic, clinical, and research components. The academic component involves university-based teaching and study regarding models of human development and interaction, psychological problems, and mental well-being. As well as drawing on psychological theory and research, the teaching sometimes includes the lived experiences of users of psychological services and their carers. Such ‘experts by experience’ can provide valuable insights into the difficulties that they struggle with and into what it is like to be a user of psychological, and other healthcare, services. The teaching also covers some skills development in various psychological approaches to alleviating suffering and improving or maintaining mental well-being. As is illustrated in Table 37.1, the range of approaches that is taught,

cognitive-behavioural
Interventions that involve targeting both cognitive and behavioural factors.

psychodynamic a class of psychological therapy that aims to work with unconscious processes.

systemic a class of psychological therapy that focuses on families and other human systems.

and the range of client groups to which they are applied, is relatively wide. Typically, three of the most prominent classes of models of understanding and alleviating suffering are **cognitive-behavioural**, **psychodynamic**, and **systemic**; you may recall some of these models from earlier chapters, and they are also considered in more detail later in this chapter. In addition, usually a key part of training is concerned with integrating ideas and techniques from different approaches, in order to produce interventions that best meet an individual’s or a group’s needs.

Learning how to apply these approaches in practice primarily takes place on clinical placements, which are usually based within the NHS. Typically, most placements last three days a week for six months and, over the three years of training, cover different settings and client groups. These usually include working-age adults with mental health problems, people with intellectual and/or other disabilities, children with mental health problems, older people, and supplementary placement(s) that may cover other settings and client groups, depending on the trainee’s learning needs and preferences. On placement, the trainee’s work and development are supported and

TABLE 37.1 Some examples to illustrate the range of client groups, models and competencies typically covered in clinical psychology training. This is by no means an exhaustive list (for a more in-depth picture, see Llewelyn & Murphy, 2014). Some of these examples will be explained later in the chapter.

Core client groups covered in clinical placements
Working-age adults with mental health problems
Children with mental health problems and their families
People with disabilities (including intellectual disabilities)
Older people with mental health problems
Examples of possible supplementary placements
Further experience in one of the ‘core’ areas
Adults with brain injury
Children with physical health problems
Adults with physical health problems
Main classes of models
Cognitive-behavioural
Psychodynamic
Systemic
Developmental
Neuropsychological
Key competencies
The ability to communicate effectively with a range of different clients
The ability to build and maintain effective relationships with others
The ability to work in a culturally competent manner
The ability to work alongside, and learn from, experts by experience (i.e., service-users and carers)
The ability to conduct assessments appropriate to different settings
The ability to develop ‘formulations’ by forming theory–practice links
The ability to facilitate interventions appropriate to particular clients and problems
The ability to evaluate clinical work
Sufficient self-awareness to be able to reflect on and learn from clinical work
The ability to understand, conduct, and apply the findings of psychological research

supervised by at least one clinical psychologist, sometimes in conjunction with other clinicians who provide psychological intervention, such as psychotherapists. In this context, the clinical psychologist and the other clinicians are referred to as ‘placement supervisors’.

Turning to the **research** component of training, research skills can be thought of as a core part of the identity of a clinical psychologist and are one of the reasons why clinical psychologists start on a relatively high salary band, compared to most other NHS professions. Research

research the development of new knowledge (e.g. about psychological difficulties) using research methods.



PHOTO 37.1 Trainee clinical psychologists regularly discuss their clinical work with their placement supervisor(s).

Source: Monkey Business/Adobe Stock.

skills are important for a number of reasons. First, they provide clinical psychologists with the ability to understand and critically appraise (and so appropriately apply) the scientific and clinical literature regarding new developments in psychological theory and interventions. Second, they enable clinical psychologists to use research methods to evaluate their own and others' clinical work, which is a key foundation to improving the quality of this work. Third,

scientist-practitioner
a practitioner who applies scientific principles to clinical work.

they support clinical psychologists in acting as **scientist-practitioners**, which includes applying a hypothesis-testing approach to their clinical work, a point that will be discussed in more detail later. And finally they mean that practising clinical psychologists can also be involved in research that supports the development of new psychological theories and interventions; arguably, this involvement helps to maintain the clinical relevance and applicability of academic research.

Usually, research skills are developed partly as a result of teaching and partly through carrying out two research projects during training, under supervision. The latter comprise a small-scale piece of service-based research, for example, an evaluation of an intervention that is already being offered as part of routine practice, and a more substantive project that forms the basis of the trainee's doctoral dissertation.

Overall, training to be a clinical psychologist can be a varied and stimulating process, but also a challenging and at times stressful one, not least because of the variety of tasks and demands that the trainee needs to remain on top of at any one time. Some of Miranda's experiences during training are described in Case History 37.3.

37.2 KEY CAPABILITIES AND COMPETENCIES

Some of the key capabilities and competencies that clinical psychologists develop during training will now be considered in more detail, both because this will give a clearer sense of what it means to be a clinical psychologist and also because it will provide a richer idea of what training involves.

37.2.1 Stages of Clinical Work

While clinical psychologists receive training in a variety of different approaches to clinical work (e.g., cognitive-behavioural, psychodynamic, and systemic), these are generally held within a wider framework that comprises four stages: **assessment**, **formulation**, **intervention**, and **evaluation**. These will now be considered in turn.

CASE HISTORY 37.3

MIRANDA'S EXPERIENCE OF CLINICAL PSYCHOLOGY TRAINING

At the beginning of training, Miranda felt quite daunted and somewhat overwhelmed by the amount of new things she felt she needed to learn. She also felt relatively inexperienced compared to some of her colleagues, who had worked full time in the NHS. However, after her first six-month placement working with adults with mental health problems and receiving a positive evaluation from her placement supervisors at the end of this, her confidence and enjoyment of clinical work began to return. Moreover, as the course progressed, her research experience meant that she found the small-scale and major research projects less challenging than some of her trainee colleagues.

Around the middle of training, Miranda decided that one of her main interests lay in working with older people with mental health problems, and she was able to go on a supplementary placement that provided her with greater experience in this area. By the end of training, Miranda had passed all her clinical placements, all the necessary case reports and essays, and the oral examination of her major research project. Therefore, she was able to qualify at the end of three years and register as a clinical psychologist with the HCPC.

assessment

an information gathering process that usually happens at the beginning of clinical work.

formulation

an explanatory account of the development and maintenance of a psychological problem.

intervention

the broad descriptor for any activity that a clinical psychologist undertakes to try to help their client(s).

evaluation

the process of determining what effect an intervention is having.

37.2.1.1 Assessment

Usually, the first stage of clinical work, whether it be with an individual who is suffering from psychological problems, a group of people, or perhaps a team or organisation, is an assessment. The form that the assessment takes will vary depending on the model being used and the setting. However, typically, the aims of an assessment are to understand what it is that the client(s) would like to change and to gather enough information to build an initial understanding about what may have caused and be maintaining the difficulties that the client(s) would like to address. Sometimes,

for example, in solution-focused work, the assessment may focus more on clients' strengths and resources, and things that they have previously found helpful.

A number of different methods can be used to gather the information that is needed (Llewelyn & Murphy, 2014; Carr & McNulty, 2016). For clients who are able to communicate effectively, the primary among these is usually the clinical interview. This involves

meeting with the client or clients and asking them about their difficulties and how these developed, and perhaps also about their early life experiences, as these may have played a causal role. Where appropriate, questionnaires and psychological tests, such as tests of cognitive abilities, may be used, and sometimes family members, carers, or staff members may be consulted. In cases where the client is able to communicate and understand, many psychologists would view the assessment process as a shared process of exploration with the client. They would also see it as important to attempt to build a good working relationship (usually called a therapeutic relationship) with the client.

In addition, in whatever work they do, it is important that clinical psychologists act with as much cultural competence as possible. There are many ways in which a clinical psychologist may differ from the client(s) they are working with; for example, age, class, ethnicity, gender identity, religion, and disability, to name just a few. Culturally competent clinical practice involves valuing such diversity and taking a stance that seeks to understand and respect clients' cultural context and work collaboratively within that (Whaley & Davis, 2007). This begins in the assessment process and continues throughout the other stages of clinical work.

To make the assessment process more concrete, read Case History 37.4, which describes an assessment that

CASE HISTORY 37.4**ONE OF MIRANDA'S FIRST CLINICAL CASES**

As this was Miranda's first placement and she had limited previous clinical experience, her supervisor had selected a case that she thought sounded relatively uncomplicated, based on the general practitioner's referral letter. The client, Peter, was reported to be suffering from an episode of clinical depression and, as a result, was experiencing depressed mood for much of the week, was struggling to sleep properly, and had stopped doing many of the things that he used to enjoy. Given Miranda's inexperience, she conducted the assessment jointly with her supervisor.

They began by asking Peter to say something about why he had come along and then focused in detail on his current difficulties. As they were taking a cognitive-behavioural approach, this involved being curious about the thoughts and images Peter was experiencing (i.e., the cognitive) and the things he was doing or not doing (i.e., the behavioural), and how these affected and were affected by his depressed mood. They went on to explore how his problems had developed, the impact they were having on his life currently and his goals for the future. They also used some questionnaires to (a) establish a baseline estimate of the severity of Peter's depression and (b) explore whether Peter was experiencing depression-related thoughts that had not been covered in the interview. Throughout, they attempted to build a therapeutic relationship with Peter by listening carefully to what he was saying and then summarising their understanding, and also by conveying a sense of positive regard and kindness. They were transparent about the aspects of his cultural background that were not personally familiar to them, and asked him to help them understand these.

Crucially, during the assessment they also established that, while Peter sometimes experienced suicidal thoughts, he was at low risk of acting on these. In addition, for homework, Peter was asked to keep a record of his thoughts when he was feeling depressed, both because doing so might identify important negative thoughts that he had forgotten in the assessment, and because the process of recording could help him to become more aware of his thinking and the impact it had on his mood.

Later in training and once she was qualified, Miranda would usually carry out assessments of this type on her own, unless the difficulties with which the client was presenting meant that it would be helpful to have two clinicians present.

Miranda was involved in during her first clinical placement in training, a placement in a psychological therapies service for working-age adults with mental health problems.

37.2.1.2 Formulation

Following the assessment, an initial formulation is developed (Llewelyn & Murphy, 2014). The formulation combines psychological theory with the information gained from the assessment, to provide an account of how the client's or clients' problems developed and what is maintaining them, and an indication of what may help alleviate them. It can also include the clients' strengths and resources. In clinical psychology, the formulation usually focuses primarily on the psychological and social factors that play a causal and maintaining role, while acknowledging possible biological and genetic influences, since the former are more likely to form the basis of a psychological intervention. Depending on the model that is being used, formulations can sometimes be presented as diagrams, with arrows representing hypothesised causal links between different factors and processes (see Photo 37.2). As well as having knowledge of a range of psychological theories, in order to be able to develop a formulation, a key competency that a trainee clinical psychologist needs to develop is to be able to make theory–practice links. In some approaches, for example, CBT, the formulation would usually be developed together with the client, and it is seen as important that the client accepts the formulation, while in other approaches, sharing the initial formulation can be seen as unhelpful, as it may contain hypotheses about unconscious processes that the client may not be

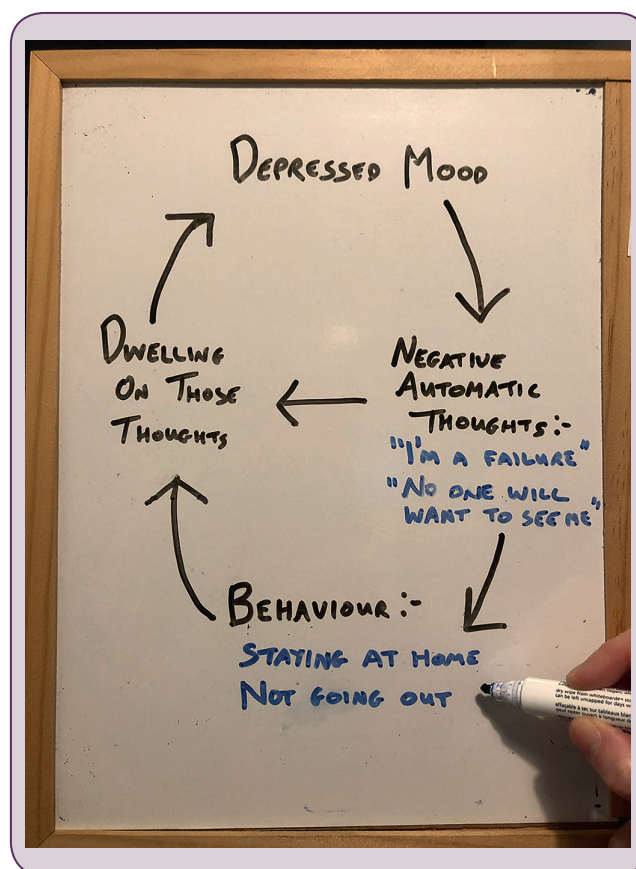


PHOTO 37.2 In some approaches, for example, cognitive-behavioural therapy, the formulation, or parts of it, may be drawn out as a diagram, either on paper or on a whiteboard. This can help the client to understand and remember it.

ready to hear. To understand how a formulation can be developed in practice, it is helpful to read Case History 37.5 at this point.

CASE HISTORY 37.5

AN EXAMPLE OF FORMULATION DEVELOPMENT

Following the assessment, Miranda looked again at some of the cognitive-behavioural models of depression she had recently been taught at university. One of the key ideas contained in these was that depressed mood is maintained by 'cognitive biases' that lead people to think and perceive things more negatively than they really are, and by changes in behaviour, such as becoming more socially isolated (see Chapter 2 and Kennerley et al., 2017). With these ideas in mind, in the next session, she worked with Peter to develop a simple formulation. Where possible, she attempted to develop the formulation by a process of 'guided discovery', which involved asking questions that would elicit from Peter, and help him understand, the way in which his mood, thinking and behaviour affected each other.

For example, she asked Peter 'So when you had the thought "I'm completely useless" how did it make you feel?' and Peter replied 'I felt even lower'. She then asked him 'What do you make of that?' and this led into a discussion about how negative thinking can help maintain and worsen depression. In this way, both Peter and Miranda came to understand how Peter's depressed mood would lead him to notice all the things he thought he did badly and to minimise anything he did well, leading him to have thoughts such as 'I'm completely useless', which he strongly believed and would repeatedly play over in his mind. Ruminating on these thoughts in this way lowered his mood further and so made such thoughts more likely. Thus, he would become trapped in a vicious cycle, in which his negative thinking, rumination, and depressed mood interacted to help maintain the depression. In a similar manner, Peter and Miranda came to understand a second maintaining cycle in which his depressed mood led him to think that people would not want to see him and that he would not enjoy going out,

and these thoughts led him to stay at home, which in turn gave him more time to ruminate and so made him feel more depressed.

Throughout this process, Miranda attempted to convey that it was understandable that Peter had become trapped in these vicious cycles and that it was not his fault, in order to try to reduce the chances of the depression itself being seen by Peter as another example of personal failure. In addition, they drew out a summary diagram of these cycles, which Peter could take away and think further about for homework. Finally, Miranda shared with Peter the fact that the formulation fitted with psychological models of depression and was similar to other people's experiences of depression. This helped him to feel more normal and also to have more confidence and hope.

Formulations, such as the one Miranda developed with Peter, can be viewed as a series of hypotheses, whose usefulness and accuracy can be tested during a psychological intervention by examining the extent to which they fit with new information that becomes available. Often formulations will be developed and revised during the course of an intervention, as new information comes to light or new aspects of a client's difficulties take centre stage.

37.2.1.3 Intervention

Once a formulation has been developed, a psychological intervention can be implemented on the basis of this, if the formulation suggests that one may be helpful. Sometimes the intervention may stick closely to one particular approach that has been previously researched and shown to be effective, at least for the majority of clients; for example, Miranda's cognitive-behavioural intervention described below (cf. Beck, 1995). In other cases, the trainee or qualified clinical psychologist may need to draw on their experience and integrate ideas or

techniques from different approaches, in order to offer an intervention that seems more likely to be effective. Sometimes it can be helpful for the psychologist to invite the client(s) to play a collaborative role in planning the intervention, for example by helping the client(s) to make choices from a range of options or by guiding them to develop their own intervention plan, based on the formulation and what has helped them in the past.

When the formulation suggests that systemic factors are playing a key maintaining role in a client's difficulties and the client has little direct influence over these, the intervention can be directed at altering the system the individual is in. For example, a formulation may suggest that a client with moderate intellectual disabilities is harming themselves because they are bored. In such a case, the intervention could involve the psychologist working with the people who care for the client to develop an activity schedule that the client is likely to find more stimulating. Miranda's intervention with Peter is described in Case History 37.6.

CASE HISTORY 37.6

MIRANDA'S INTERVENTION WITH PETER

Based on existing cognitive-behavioural treatment guides (cf. Kennerley et al., 2017), Miranda suggested to Peter that it could be helpful first to address the vicious cycle that included his social isolation, and he agreed. Therefore, together they devised some 'behavioural experiments' that would test the idea that being more active and social would lift Peter's mood. Peter carried out these experiments for homework, by deliberately spending time with friends or doing something else that he once used to enjoy, even when he didn't think he wanted to, and then recording the impact on his mood. At the next appointment, Miranda and Peter reviewed the information collected from these experiments and agreed that it supported the idea that usually being with friends or doing something else lifted Peter's mood slightly, or at least stopped it lowering further. Based on this finding, Peter and Miranda drew up an 'activity schedule' comprising a plan of how Peter was going to use his time until the next appointment. They repeated this process over several appointments, until Peter no longer needed the support of a schedule.

Once this behavioural component of therapy was established, Miranda also invited Peter to start regularly keeping a diary of his negative thoughts. Then, during appointments, they would choose thoughts that frequently reoccurred and re-evaluate these. The re-evaluation process involved Miranda and Peter discussing the evidence for and against the thought and then seeing whether there was a more realistic or helpful alternative. For example, Peter came to see that 'I'm good at some things but not so good at others' was a more realistic alternative to 'I'm completely useless'. For homework Peter would practise re-evaluating thoughts, in a gentle rather than critical way, and then would deliberately do something else rather than continuing to dwell on the old thought. Gradually, with practice, Peter's ability to do this grew, and slowly he came to believe less in the truth of the depressing thoughts. Together with the behavioural strategy, this helped Peter's mood gradually to lift.

EVALUATION OF MIRANDA'S INTERVENTION WITH PETER

By the end of the intervention, Peter was feeling substantially better than at the time of the assessment, in that he experienced depressed mood far less frequently, was sleeping better, and was enjoying life more. His scores on the validated depression questionnaires were consistent with this, since they had dropped from the moderately depressed to the mild range. Furthermore, these changes did not seem wholly due to medication, since he had remained on the same dose since before the beginning of the psychological intervention.

Having looked at the overall level of effectiveness, Miranda and Peter reviewed the intervention in detail and talked about which components had seemed most helpful. On the basis of this information, they drew up a 'relapse-prevention plan', which outlined what Peter planned to continue to do in order to improve his mood further and reduce the chances of depression returning. (It is worth adding that the effectiveness of psychological interventions can depend on the complexity, severity, and longevity of the difficulties with which clients present, and that sometimes smaller levels of change or very little change may occur.)

37.2.1.4 Evaluation

As an intervention progresses and once it is complete, it is important to evaluate its impact, to see whether it is having the desired effect. Sometimes this can be achieved through discussion with a client; for example, by asking them what changes they have noticed. However, as change can be gradual or subtle, it can be helpful to complement this with the use of validated questionnaires (e.g., the *Patient Health Questionnaire 9*, which measures levels of depression). In the NHS, the use of such questionnaires to measure the effectiveness of psychological interventions is becoming more widespread and expected. The collection of such data is not only valuable in relation to the specific client being worked with, but can also add to a pool of outcome data that can be used to make the case for continued funding of specific psychological services. It can also highlight interventions that seem to be less effective and so may benefit from being altered or replaced.

However, the interpretation of outcome data is not always straightforward. For example, if a client is receiving medication at the same time as a psychological intervention, how is it possible to know which treatment is responsible for any change or, indeed, whether improvement would have occurred without treatment anyway? Also, if a client says that an intervention is helping but no change is apparent on the validated questionnaires, what does that mean? And, if an intervention that has been designed to help prevent relapse is offered to clients who are currently well, then how can change be measured? When grappling with issues such as these, trainee and qualified clinical psychologists can draw on their research experience and competencies. For example, in the latter case, comparing validated questionnaire scores from the beginning and end of the preventative intervention is unlikely to show much change, since the clients were well to start with. Instead, one option could be to compare rates of re-referral to the service for a group of clients who had

completed this preventative intervention with a similar group who had not. Case History 37.7 provides an example of evaluation in action.

37.2.1.5 Summary

In summary, in relation to clinical work, a clinical psychologist needs to have the **competencies** necessary to assess, formulate, intervene

competencies areas that a clinical psychologist needs to be competent in.

and evaluate, and be able to do so in a culturally competent and collaborative manner. In addition to this, some authors include a stage referred to as 'communication'. This covers the competencies needed to provide clear information to clients and colleagues, both in writing and verbally, along with the competencies required to understand communications from clients and colleagues. Communication can also be viewed as a theme that cuts across the other four stages, since communication with the client(s) and others involved in their care is usually important throughout.

37.2.2 Choices Regarding Philosophy and Approach

Hopefully, it will have been apparent from the previous sections that some of the competencies that can be helpful to the clinical psychologist overlap with those needed by a scientist. For example, we have seen how trainee and qualified clinical psychologists need to be able to interpret and draw on both empirical and theoretical literature when formulating and planning interventions; how psychologists can treat formulations as a series of hypotheses that can be tested; and how they can utilise research skills when evaluating clinical work. In addition, some clinical psychologists also carry out scientific research to better understand the causes of psychological problems and to develop new interventions to alleviate them. Therefore, it has been argued that clinical

psychologists can be thought of as 'scientist-practitioners' (e.g., Barlow et al., 1984).

However, not all clinical psychologists are happy with this label. For example, some prefer to adopt a respected philosophical position called social constructionism, which argues that there can be no objective truths about reality, but rather that we construct our realities through language and social interaction (Nightingale & Cromby, 1999). For example, in family therapy, one fam-

social constructionist
the philosophical idea
that the way people
construct reality is
dependent on social
interaction and language.

ily member's perception of an event may differ from another's. Taking a **social constructionist** philosophical position can allow the psychologist to accept that both views may be equally valid.

One of the exciting aspects of clinical psychology is the degree of choice that is available, and during training, trainees start to make some of these choices and so begin the process of shaping their identity as a clinical psychologist. Choosing a philosophical position, as discussed above, is one example of this. Another choice concerns the approach that the clinical psychologist will adopt, at least once they have more of a free hand after training is complete. We met one class of approach in Miranda's work, namely CBT. As we have seen, this primarily focuses on the relationships between thoughts, mood/emotions, and behaviours and attempts to alleviate suffering through changes in thinking (and the relationship to thinking) and changes in behaviour (see also Chapter 2).

In addition, there is a wide range of alternative approaches. A full discussion of these is beyond the scope of this chapter. However, two main alternative classes of approach are 'psychodynamic' and 'systemic' (e.g., Dallos & Draper, 2015; Howard, 2017). In brief, psychodynamic approaches tend to be more concerned with the impact of early relationships, such as the relationship the client had with their parents, and unresolved unconscious conflicts. In contrast, systemic approaches mainly focus on the system in which the client(s) are immersed, for example, the family unit, and how changes in relationships within the system may lead to improvement in the clients' well-being. Of these three, the systemic approach is perhaps the most strongly connected with a social constructionist philosophical position.

The approach chosen influences the sort of questions that are asked during the assessment, the manner in which the formulation is developed and its content, and the nature of the intervention. Different clinical psychologists vary in their views as to the relative merits of different approaches and as to the interpretation of the research literature in relation to this, and it may well be that some clinical psychologists are more suited to working within one approach and others in another.

During their training, clinical psychologists are typically exposed to a variety of approaches, and on each placement usually need to follow the approach that their placement supervisor adopts. An advantage of this breadth of experience is that it provides trainees with an opportunity to decide which approach or approaches best fit with them, and it also helps them to develop the ability to integrate ideas and techniques from different approaches. For example, if marital difficulties had been significantly contributing to Peter's depression, Miranda might also have drawn on systemic ideas in the formulation, and perhaps met with both Peter and his wife for parts of the intervention and employed some systemic techniques. One limitation to this form of training, however, is that it means that trainee clinical psychologists tend to have less opportunity to strengthen skills within one particular approach. Given this, some clinical psychologists decide to do further training in the specific approach that most appeals to them, once they are qualified. Furthermore, some clinical psychology training courses are starting to offer dual accreditation, such that trainees qualify both as clinical psychologists and psychological therapists specialising in a particular model (e.g., CBT).

37.2.3 The 'Reflective Practitioner' Model

Another key competency that trainee clinical psychologists need to develop is the ability to reflect on their own experience when working with clients, and to reflect on the process of interaction between themselves and the client. This capacity to reflect is important for a number of reasons. First, the psychologist's own emotional reactions to a client can sometimes be a useful source of information. For example, if a psychologist feels a strong urge not to upset a client, and this is not something they normally experience when working with clients, then a working hypothesis, which could be tested and perhaps included in the formulation, could be that the client might be very afraid of experiencing distressing emotion. Second, the ability to reflect means that the clinical psychologist is less likely to have their behaviour automatically driven by their reactions. Continuing the above example, if the psychologist was not aware of the urge not to upset the client, they might automatically steer away from asking about potentially distressing topics that need to be addressed in order to make progress. Of course, it may be that steering away from such issues is the most helpful thing to do; what is important is that the psychologist makes a conscious choice in relation to matters like this, perhaps in conjunction with the client and based on the formulation. Third, the ability to

reflect can help the clinical psychologist to maintain their own mental well-being, since it can help them understand how their mood and feelings may have been influenced by the clinical work they have been doing, and so perhaps help them to let go of such feelings more easily.

It has been argued that this capacity to reflect is not adequately covered by the scientist-practitioner model.

reflective practitioner
a practitioner who reflects on their work, both while undertaking it and afterwards.

Therefore, the concept of the ‘**reflective practitioner**’ has also been introduced (cf. Schön, 1983). Arguably, these two models are not mutually exclusive, but rather a clinical psychologist can act as both scientist-practitioner and reflective practitioner.

It is probably fair to say that training courses vary, to some extent, in how much emphasis they give to the development of the capacity to reflect. For example, on some courses, the trainees will be required to attend

regular reflective practice groups, in which they discuss and reflect on their experiences. Discussing their experience of working with clients in meetings with their placement supervisor can be another way in which this is developed. Receiving psychotherapy is a third possibility. However, while personal psychotherapy can be a requirement for some forms of psychotherapy training, there is disagreement within clinical psychology as to the value and necessity of this. Ultimately, it is for trainees to decide themselves whether receiving psychotherapy will be personally and professionally valuable for them.

37.2.4 Consultancy and Team Working

Often clinical psychologists work as part of a multidisciplinary team and so need to have the skills necessary to help their healthcare and social-care colleagues to think about their clinical work in a psychological manner. Providing support to colleagues can take a number of forms, including facilitating discussions or offering opinions at team meetings, meeting individually with colleagues to think with them about challenging cases they are working with, supervising colleagues’ clinical work, and providing training. The type of support offered will usually depend on the time available and the needs of colleagues. For example, some healthcare and social-care workers may have little psychological knowledge and so may benefit from training or direct advice, whereas others may be experienced at thinking and intervening psychologically and so may benefit from the clinical psychologist facilitating a meeting in which they have space to reflect psychologically about their clinical work. Case History 37.8 describes how Miranda started to develop some of these competencies during training.



PHOTO 37.3 On some clinical psychology training courses, the trainees are required to attend regular reflective practice groups, at which they discuss and reflect on their experiences during training.

Source: stockbroker/123RF.

CASE HISTORY 37.8

AN EXAMPLE OF MIRANDA DEVELOPING COMPETENCIES DURING TRAINING

When Miranda was on a placement working with people with intellectual disabilities, she attended ‘multidisciplinary’ team meetings that included nurses, social workers, and psychiatrists, among others. At these meetings, colleagues regularly presented information about complex or challenging clients with whom they were working and about whom they wanted advice. At the start of the placement, Miranda observed how her supervisor would offer tentative psychological formulations and suggestions for the way forward, in relation to these cases. Initially, she found it difficult to contribute, partly due to low confidence and partly because she found it hard to develop formulations as quickly as her supervisor. However, as her confidence and experience developed, she was able to share her hypotheses concerning some of the clients who were discussed. Her confidence and ability to do this continued to develop over training and once she was qualified.

37.3 POST-QUALIFICATION

37.3.1 Continuing Professional Development

The previous sections have given you some understanding of what it is that a clinical psychologist does, the key competencies that are needed to fulfil this role, and how these are developed during training. Training, however, is just the beginning of the process of developing these competencies and, similar to other professions, usually they continue to strengthen and broaden after qualification, as the clinical psychologist gains more experience. Furthermore,

continuing professional development (CPD) ongoing training and skills development that occurs after qualification.

clinical psychologists are expected to receive supervision and undertake **continuing professional development (CPD)** throughout their career. CPD can include reading about the latest research or

theories, attending conferences and training workshops, carrying out new activities (e.g., supervising trainee clinical psychologists or applying for a research grant), and undertaking further qualifications (e.g., specialist training in a particular type of psychological therapy). Sometimes it may be possible to obtain funding from the NHS to pay for CPD, though often clinical psychologists will need to make at least some contribution themselves.

37.3.2 Choice of Speciality and Setting

As has hopefully become apparent from this and previous chapters, clinical psychologists work with a range of different client groups and in a range of different settings. A detailed overview of this is beyond the scope of this chapter (though see Llewelyn & Murphy, 2014). However, some of the main client groups include:

1. Children and families.
2. Working-age adults with mental health problems.

3. Older people with mental health problems.
4. People with intellectual disabilities.
5. People with cognitive problems, for example following a head injury.
6. People with physical health problems that have associated psychological issues.

Clinical psychologists typically specialise in working with one, or sometimes two, of these client groups. Unlike medicine, there are no formal post-qualification training routes that determine specialisation. Rather, specialisation is primarily determined by the posts that the clinical psychologist works in once qualified, and the associated CPD that they undertake. Sometimes a newly qualified clinical psychologist will choose their speciality based solely on their personal preferences. On other occasions job availability may play a role. Miranda's choices are discussed in Case History 37.9.

37.3.3 Changes in Roles and Responsibilities

Across the different specialist areas, there tend to be commonalities in how the roles and responsibilities of clinical psychologists change as their careers progress. Newly qualified clinical psychologists, such as Miranda, typically will have greater direct contact with clients than more senior clinical psychologists. Two to three years after qualification, clinical psychologists will usually start to supervise trainee clinical psychologists who are placed with them, and possibly also other colleagues. As they gain further experience, clinical psychologists can become involved in the supervision and management of more junior qualified clinical psychologists, and those who subsequently become **consultant clinical psychologists** would

consultant clinical psychologist a senior grade of clinical psychologist.

normally be expected to play a significant role in NHS service development and management. For example,

CASE HISTORY 37.9

SOME OF MIRANDA'S CAREER CHOICES

Miranda had particularly enjoyed both her children and families placement and her older adult placement. Therefore, she was somewhat torn between the two specialities. However, in the region where she wanted to work, there were more posts available in the latter speciality when she was nearing the end of training. Therefore, once qualified, she ended up working with older adults. Her roles included providing individual and group-based psychological interventions, providing consultancy and support to staff at some residential homes, and conducting cognitive assessments with clients suspected of having dementia. Miranda was line managed by the social worker who managed the older adult mental health team and received fortnightly supervision from a more senior clinical psychologist. A year after qualification, Miranda decided to do some specialist neuropsychology training, to help increase her ability to interpret the results of the cognitive tests.

if an NHS organisation wanted to provide a new clinical service, aimed at supporting a client group that it had not previously worked with, a consultant clinical psychologist might help to plan what the new service would need to look like, including what new staff would need to be employed. The consultant clinical psychologist might be involved in managing some of these staff.

In addition, after spending a period consolidating their clinical skills in the NHS, some clinical psychologists

choose to return partly to academia, in order to conduct clinical psychology research or to train the next generation of clinical psychologists. Other clinical psychologists choose to work in the private sector part time or full time. For some, one of the appeals of the profession is the variety of roles that a clinical psychologist can take over the course of their career. The answers to some frequently asked questions about being a clinical psychologist are provided in Table 37.2.

TABLE 37.2 *Frequently asked questions about a career in clinical psychology.*

What income can I expect while I am training?	Usually starting from £32,306 (for 2022)
What salary can I expect when I am fully trained?	Usually starting from £40,057 within the NHS (for 2022)
What job opportunities are there?	The majority of clinical psychologists are employed within the NHS. Some may work in academia or privately.
What unique skills will I learn?	A wide range of skills, for example, skills in assessment, formulation, intervention, and evaluation, and research skills.
What qualifications and experience should I have prior to training?	A good undergraduate degree that confers GBC with the BPS, and clinical or clinically related experience. Some applicants will have relevant higher degrees and/or further research experience.
What further training and development can I do once I have qualified?	Once qualified it is expected that clinical psychologists will receive ongoing supervision from a more experienced colleague and undertake CPD. Sometimes the latter involves reading papers or attending short workshops. Some clinical psychologists choose to do more substantial further training, for example, a degree or diploma in a specific form of psychological therapy. Further training may have to be self-funded in part or in full.
What particular qualities will employers look for?	This is likely to vary between employers. However, NHS Trusts now typically expect clinical psychologists to provide more than direct clinical work with clients. For example, they will typically expect clinical psychologists to provide training and consultation to other staff members, and to be involved in supporting audits and service evaluation.
What career progression opportunities are there?	As clinical psychologists become more experienced they are expected to become involved in supervising more junior colleagues. Some go on to become consultant clinical psychologists, whose jobs will include a significant management component.
Will my training make me an attractive proposition for other careers? If so, which careers?	Perhaps, but given that the training is quite specific, it would probably only be worth doing this training if you planned to work as a clinical psychologist either clinically and/or in academia.
What are the hours of work?	Within the NHS clinical psychologists are typically paid to work a 37.5-hour working week, excluding breaks, if they work full time. Some clinical psychologists may work longer hours than this, without additional pay, given the busy nature of their jobs. Part-time posts are also available.
What are the working conditions like?	Before applying to clinical psychology training it is worth gaining some experience working within a clinical setting in the NHS, to see if this is an environment that suits you.
Will I have a job for life?	In the past this has tended to be the case. The future is likely to depend on economic conditions.
Where can I go for further information?	www.clearing-house.org.uk and www.bps.org.uk

37.4 INTERNATIONAL COMPARISONS

This chapter has focused on clinical psychology training and practice in the UK. However, it is probably fair to say that many of the key principles that have been discussed apply in other countries too. That said, there can be significant differences in training and career structures in different countries (e.g., Huey & Britton, 2002). If you are interested in finding out more about clinical psychology internationally, some websites are provided at the end of this chapter.

37.5 SUMMARY

In this chapter, we have seen that, in order to obtain a place on clinical psychology training in the UK, the applicant needs to have a degree or diploma that

confers GBC and be able to provide evidence of their academic, clinical, and research abilities and potential. The training itself usually comprises a three-year doctorate combined with a salaried post in the NHS. Key competencies developed during training include the ability to conduct, evaluate, and apply research, the ability to assess, formulate, intervene, and evaluate interventions, the ability to support other staff, the capacity to reflect, and the capability to work in a culturally competent manner. These competencies are further developed following qualification through CPD and by receiving supervision.

During their training, clinical psychologists work with a range of different client groups using a range of different approaches. Once qualified, they tend to specialise in working with one or two of these client groups and may decide to do further training in a specific therapeutic approach. As clinical psychologists become more senior, the amount of direct client contact they have tends to reduce and their supervisory and management responsibilities tend to increase.

SELF-TEST ESSAY QUESTIONS

- What are the key stages involved in the clinical work of a clinical psychologist?
- What is a formulation and how are formulations developed and used by clinical psychologists?
- Compare and contrast the scientist-practitioner model and the reflective-practitioner model.
- Describe, with examples, the main competencies that a clinical psychologist will develop during their training.

TEXTS FOR FURTHER READING

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- Dallos, R. & Draper, R. (2015) *An Introduction to Family Therapy: Systemic Theory and Practice*, 4th edn, Buckingham: Open University Press.
- Howard, S. (2017) *Skills in Psychodynamic Counselling & Psychotherapy*, 2nd edn, London: Sage.
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- Llewellyn, S. & Murphy, D. (2014) *What Is Clinical Psychology?* 5th edn, Oxford: Oxford University Press.

RELEVANT JOURNAL ARTICLES

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RELEVANT WEB LINKS

American Psychological Association, www.apa.org
 British Psychological Society, www.bps.org.uk
 Clearing House for Postgraduate Courses in Clinical Psychology, www.clearing-house.org.uk
 European Federation of Professional Psychologists' Associations, www.efpa.eu

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