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TWO PSYCHOLOGIES: AN EXPLORATION OF TRAINEE CLINICAL PSYCHOLOGISTS' RELATIONSHIP WITH EVIDENCE AND UNDERGRADUATE TEACHING

Section A: How do psychological practitioners and trainers make sense of the relationship between research literature and clinical practice? A literature review.

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Portfolio Summary

Part A presents the findings of a literature review comprising of a systematic search and narrative review. Eight qualitative studies were included to gain a better understanding of how clinicians and trainers make sense of the relationship between research evidence and clinical practice. 1220 articles were screened, with eight studies included in this review, focusing on the perspectives of clinicians and trainers from diverse backgrounds. Clinicians and trainers expressed a broad range of views regarding this relationship, with some finding evidence-based practice as non-negotiable, and others holding more sceptical positions. Clinicians' critiques mirror those made by academics, demonstrating an awareness of contemporary debates. More fundamental conceptual and philosophical critiques were also expressed, with some clinicians and trainers expressing a desire for more idiographic knowledge to be prioritised. The review makes specific recommendations to better utilise clinicians' expertise in research, and suggestions for the type of research that appears to be valued by some clinicians.

Part B presents the findings of a qualitative investigation of nine trainee clinical psychologists' sense of the relevance of their undergraduate degrees to their subsequent career in clinical psychology, using reflexive thematic analysis. Trainees reported an emphasis on diagnostic approaches and quantitative research methods during their degree, and that this was at odds with their later clinical career. They developed a sense of there being two psychologies with different theoretical assumptions and traditions. While trainees found aspects of their degree helpful, they reported that substantive learning took place

outside of this. This suggests a need for Clinical Psychology to engage more readily with academic psychology departments.

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Abstract

Psychological practitioners are expected to work according to the principles of evidence-based practice. Despite intense efforts to ensure this, there remains a perception of a gap between clinical practice and what is seen to be optimal practice (Stewart, 2012). This systematic review synthesised qualitative research in order to better understand how clinicians and trainers make sense of the relationship between research evidence and clinical practice. 1220 articles were screened, with eight studies included in this review, focusing on the perspectives of clinicians and trainers from diverse backgrounds. Clinicians and trainers expressed a broad range of views regarding this relationship, with some finding evidence-based practice as non-negotiable, and others holding more sceptical positions. Clinicians' critiques mirror those made by academics, demonstrating an awareness of contemporary debates. More fundamental conceptual and philosophical critiques were also expressed, with some clinicians and trainers expressing a desire for more idiographic knowledge to be prioritised. The review makes specific recommendations to better utilise clinicians' expertise in research, and suggestions for the type of research that appears to be valued by some clinicians.

Keywords: Evidence-based practice, therapist drift, systematic search, literature review, qualitative

Introduction

The concept of evidence-based practice

Psychological practitioners across multiple disciplines are expected to work in ways that are shown to be supported by research evidence. This is commonly understood through the concept of evidence-based practice (EBP), and exists in medicine (Straus & McAlister, 2000), nursing (Ingersoll, 2000), clinical psychology (Levant, 2005) and education (Davies, 1999) among other fields.

The concept of evidence-based practice in psychology has its roots in evidence-based medicine (EBM) (Berg, 2019), a term originating in the 1990s. A search of the MEDLINE database indicates the term was used only once in 1992, rising to 2957 in the year 2000 (Straus & McAlister, 2000).

A leading definition of evidence-based practice in psychology was published in 2005, when the American Psychological Association Task Force on Evidence-Based Practice described it as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (Levant, 2005, p. 5). This tripartite model is sometimes referred to as the ‘three legged stool’ (Spring 2007).

Of the three components of this model, research evidence has received by far the most intense amount of research and discussion (Peterson et al., 2016) and many clinicians, researchers, and policy-makers appear to consider the construct of evidence-based practice as synonymous with research, evidence-based treatments or empirically supported treatments. (Stewart, 2018).

In the UK, evidence-based practice is institutionalised through the National Institute of Clinical and Healthcare Excellence (NICE), a public body responsible for publishing

summaries of evidence for clinicians, with the aim of ensuring that clinical practice is informed by and in accordance with research literature. A review of NICE's first decade found it to be

> "Probably the most comprehensive and methodologically advanced mental health guideline programme in the world". (Kentall et al., 2011, p. 1)

Despite this, there is evidence that compliance with this guidance is low in mental health services (Mears et al., 2008), (Prytys et al., 2011).

The concept of evidence-based practice is not without critique. Critics are keen to caveat critique with statements that indicate they are not anti-evidence per se;

> "Healthcare professionals and nonprofessionals require […] knowledge to guide their performance" (Mitchell, 1999, p. 30).

But are concerned that evidence-based practice, as commonly understood, emphasises certain forms of research above others, and could be seen as perpetuating "a belief in the superiority of experimental science" (Wall, 2008, p. 37). This could arguably be seen in work published by Oxford Centre of Evidence-Based Medicine, who publish an influential guide for assessing the quality and significance of medical research (OCEBM Levels of Evidence Working Group, 2011). This document provides a hierarchy of study types depending on type of question asked about clinical presentations or interventions, ranking randomised control trials and systematic reviews among the highest forms of evidence. Qualitative methodologies are not mentioned at all in this influential document.

The scientist-practitioner model

In 1949 the Boulder Conference on Graduate Education in Clinical Psychology, held at the University of Colorado in Boulder agreed upon a training model for clinical

psychologists (Frank, 1984). This became known as the scientist-practitioner model, the most fundamental aspect of which was that clinical psychologists would be expected to offer and develop skills in both a clinical or therapeutic capacity as well as research contributions (Baker & Benjamin, 2000).

The influence of this model continues to this day and to the UK, where

> "Clinical psychology training programmes have reaffirmed the scientist practitioner model" (Hall et al., 2015, p. 162).

The 'scientist' part of this model not only involves the conducting and publication of research but of maintaining an awareness of research literature, and basing practice upon research findings. Despite this dual role, clinical psychology research activity is often low, with approximately three quarters of doctoral theses unpublished (Milne, et al., 2000).

A gap between research and clinical practice

In clinical psychology and other fields there is a concept of a discrepancy between published guidance or research literature and real-world practice. This is sometimes called the scientist-practitioner gap. In nursing literature, the concept of a theory-practice gap has been defined with three key attributes identified by Greenway et al. (2019).

- Relational problems between university and clinical practice
- Practice failing to reflect theory
- Theory perceived as irrelevant to practice.

This concept is not without controversy, some believe that a 'gap' of this sort is inevitable or, indeed, healthy (Rafferty et al., 1996).

Explanations for this gap between research and practice often centre around a lack of clinician awareness or knowledge. Literature on this topic often come in the form of articles from academics, with clinicians' voices often unheard.

> "Too often, this is treated as a unidirectional issue with researchers feeling frustrated that their findings from basic science and randomised clinical trials are not being used in everyday practice." (Teachman et al., 2012, p. 1)

While perhaps this may be a consequence of the differing responsibilities, there remains a lack of awareness as to the reasons for this gap from a clinicians' perspective within the field of mental health (Berry & Haddock, 2008).

Perspectives on putting evidence into practice

Implementation science is a field of study that seeks to increase the implementation of interventions, and has been defined as

> "The scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care" (Eccles and Mittman, 2006, p. 1).

This perspective argues that real world practice lags behind optimal evidence-based practice. This results in clinicians using outdated, ineffective and potentially inappropriate methods (Morris et al., 2011). One of the core tenets of this perspective is that implementing new findings is influenced by a complex interaction involving clinicians' attitudes to research findings, as well as a host of other factors, such as the influence of peers, organisational culture and policy (Damschroder et al., 2009). This approach has its

origins in medicine, and is also applied to psychological interventions with the aim of improving adherence and fidelity to evidence-based approaches.

Other perspectives adopt a different position. Rather than seeing individual interventions or treatments as having specific mechanisms of change unique to a particular intervention, common factors researchers claim that therapies may work though factors that they have in common with one another (Cuijpers et al., 2019), and that factors such as therapist empathy and the quality of the therapeutic alliance have a greater impact on outcomes (Horvath et al., 2011). This perspective was first adopted close to a century ago (Rosenzweig, 1936), and a contemporary advocate of this position may point to meta-analytic data that closer adherence and treatment fidelity is not always associated with improved outcomes (Webb et al., 2010).

One explanation for this gap that exists within the literature for Cognitive Behavioural Therapy (CBT) therapists is the concept of therapist drift (Waller, 2009). This perspective adopts the position that there is strong evidence base for the use of specific protocol based and manualised therapies, however “real world” therapy outcomes tend to be weaker. One argument for this is that that clinicians often drift away from optimal practice by avoiding aspects of CBT that are challenging both to the clinician and client, such as exposure protocols, challenging problematic cognitions, or focusing on immediate crises as opposed to the agreed intervention. A cognitive-behavioural approach has been taken to understanding this issue, framing it as a ‘safety behaviour’ on the clinicians’ part. That is, by trying to be kind to a client, clinicians inadvertently reinforce the same patterns of behaviour that are perpetuating their difficulties. (Waller & Turner, 2016). Another significant factor that is thought to be influencing drift away from manualised treatments

and protocols are clinicians' views and attitudes about manualised approaches (Parker & Waller, 2019, Rameswari et al., 2021).

In an adjacent field, psychoanalytic psychotherapy has had a more challenging relationship with contemporary ideas of evidence-based practice. Having been held in high regard, its status has come under scrutiny for not welcoming evidence-based practice as readily as other professions. (Fonagy, 2003, Whittle, 1999). There have been significant disagreements within the field about how to respond to the challenge of evidence-based practice (Briggs, 2004) as psychoanalysis has been reluctant to embrace these principles (Chiesa & Healy, 2009, Schachter, 2005). Some have argued that there are legitimate reasons for this. An example for this can be found in a paper arguing that the paradigm of evidence-based practice, by prioritising certain forms of knowing over others, can exclude the kind of "complex, multifaceted, holistic and humane" (Holloway, 2001, p. 21) evidence that is valued by analysts.

Replication crisis in psychology and clinical research

There is evidence that psychological practitioners are reluctant to accept research findings (Lilienfeld et al., 2013). This reluctance is sometimes dismissed as unscientific, with some advocates for evidence-based practice characterising this scepticism as "prescientific" (Baker et al., 2008, p. 16). However, this ambivalence among psychological practitioners may not be entirely misplaced.

There is increased concern and awareness within the field of psychology (Simmons et al., 2011), that many published research findings are not replicable (Ioannidis, 2005). This is thought to be perpetuated by opaque research practices, allowing researchers to engage in scientifically dubious practice such as hypothesising after the result is known ('HARKing')

(Kerr, 1998) and manipulating data and sampling in order to encourage statistically significant results ('*p*-hacking') (Head et al., 2015). This is thought to be influenced by pressures to 'publish or perish' within academia (Fanelli, 2010) and journals preferences for significant findings (Brodeur et al., 2012). This has led to calls for 'open science', or increased transparency, such as through preregistration (Simmons et al, 2011).

In addition to the field of psychology more broadly, authors have also expressed concerns about research practices within clinical research for psychological interventions. Clinical research is often organised by diagnosis, which some have found to be unreliable (Tackett et al. 2019) specifically in relation to concerns about interrater reliability (Frances & Widiger 2012). For example, there is significant heterogeneity in how depression is conceptualised and measured (Fried, 2017) leading some academics to conclude that there are foundational issues with how these concepts are operationalised (Fried, 2022). There is strong evidence of a publication bias (or 'file drawer effect') in which statistically significant findings are more likely to be published than negative findings (Hopewell et al. 2009). This can have a significant effect on important bodies of work, with a systematic review of CBT trials for depression concluded that the overall effect of these studies appeared to be considerably overestimated due to publication bias (Cuijpers et al, 2018).

The allegiances of editors, reviewers and researchers has also been considered as a source of bias (Leichsenring et al., 2017), with one study finding that research allegiance accounting for 69% of outcome variance (Luborsky et al., 1999). While clinical psychologist researchers are less likely to report engaging in questionable research practices than other fields of psychology, rates remain worryingly high and have the potential to undermine the credibility of clinical research (John et al., 2012). In order to combat this, Leichsenring and

colleagues (2017) published a list of thirteen proposed measures for addressing potential sources of bias in clinical research, and called for trial preregistration, increased transparency and more detailed statistical reporting, among other measures.

Review aims

While much has been written about how research and clinical practice relates to one another, this has often been from an academic perspective. There are areas of contestation among researchers, yet the views of clinicians *as clinicians* are often not present in these debates, and at times their views and actions in relation to the idea of a gap between practice and 'optimal' practice are potentially dismissed as being borne of a lack of knowledge, anxiety, or ignorance about research findings and practices. To date there is no review examining this in detail from a qualitative perspective.

The review aims to gain a better understanding of psychological practitioners and clinical trainers' views of the potential relationship between clinical practice and research evidence. A secondary aim of this review relates to how clinicians conceptualise any potential critiques of research practices, and how this relates to findings identified within academia.

Method

Design

According to a framework for identifying different approaches to conducting literature reviews (Grant & Booth, 2009), this review consists of a systematic search and utilised a narrative synthesis in order to make sense of the body of literature.

Eligibility criteria

Abstracts and full texts were screened to determine if the following eligibility criteria were met.

- Peer reviewed journal articles.
- Qualitative research.
- Manuscripts must be in the English language.
- Participants must be clinicians, academics or trainers involved in carrying out or teaching of psychological interventions.
- Findings must relate to their views and attitudes on research literature and clinical practice.

These criteria were altered slightly throughout the initial phase of the review. Initially, the reviewer intended to only include articles where the participants were clinical psychologists, however, this resulted in an insufficient number of results to conduct a review. For this reason, criteria were expanded to include other clinical professionals, academics and trainers.

Information sources

In September 2024, using the OVID search platform, the databases Psychinfo, OVID Medline and Embase were searched using with the following search strategy. ((theor* or scien* or guid* or evidence or empirical or academ* or "theory practice gap" or "research practice gap" or "training practice gap").ab. and (practice or practitioner or praxis or implement*)).ti. and (clinical psycholog* or counselling psycholog* or practitioner psycholog* or psycholog* practitioner).ab.

In addition to this, limits were applied using OVID to only show qualitative research and peer reviewed journal articles as results. The ASSIA and websofscience databases did not feature this function, and for these databases “and (qualitative.ab or interview).ab.*” was added to the search strategy. Some terms were applied at either the title or abstract level in order to generate results that achieved a balance of relevance and breadth. Research indicates that achieving a balanced and appropriate search strategy can be particularly challenging when searching for qualitative research, (Shaw et al., 2004). This search protocol identified 1024 studies to be screened. Following the screening process, eight texts were identified for examination in this review. Figure 1 outlines the process by which these studies were included and screened.

In order to achieve this balance, certain search terms that may have appeared relevant were not used. For example, including the term “clinician” resulted in close to two thousand results from one database alone, and the term “therap*” resulted in over fifteen thousand results, with a brief screen showing the majority of which most appeared to relate to occupational therapy and physical therapy.

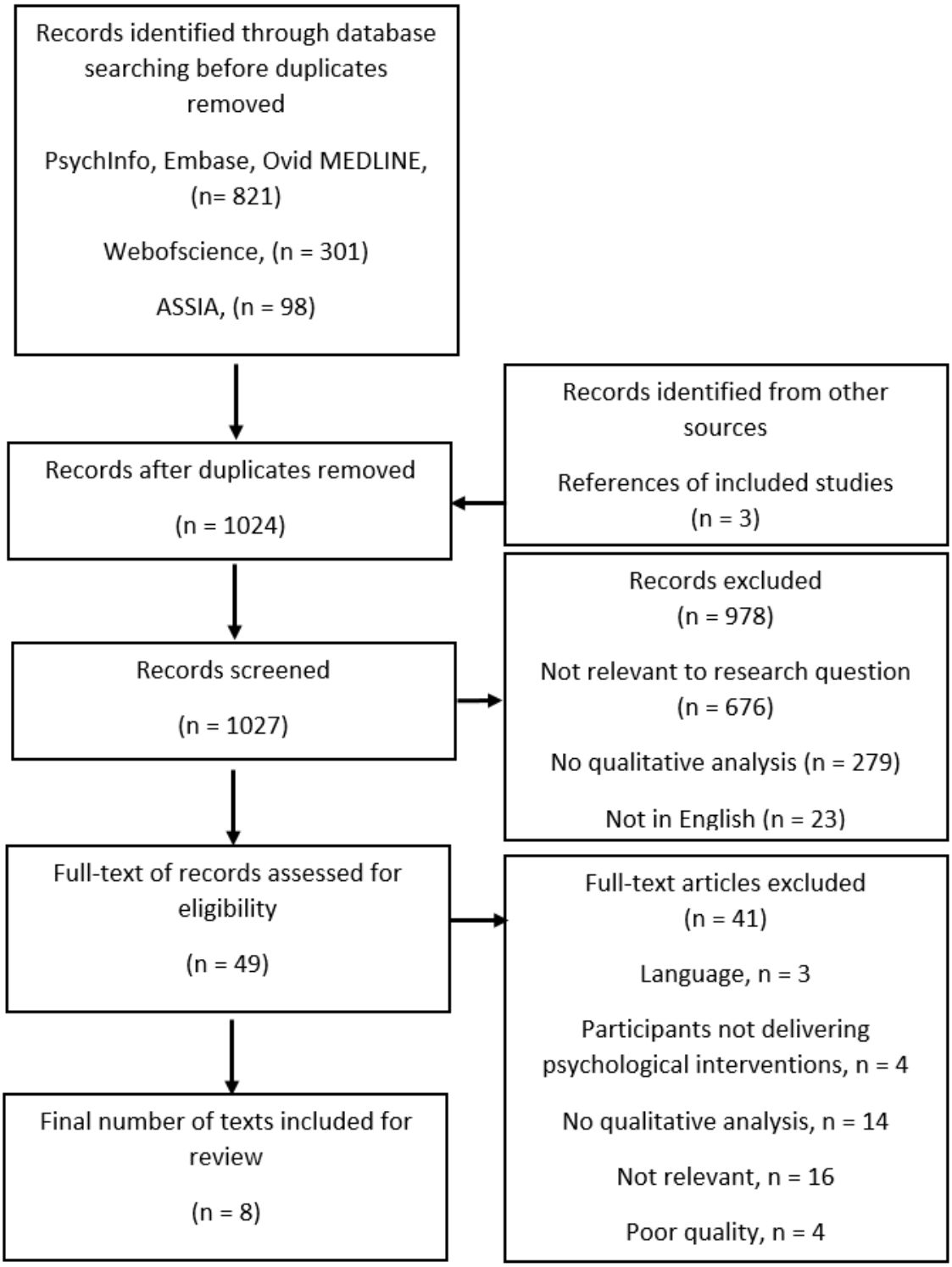

Figure 1. PRISMA Flow diagram outlining the flow of information through different stages of the review.

Synthesis

Guidance by Mays et al. (2001) for synthesising qualitative and mixed methods literature with a high degree of heterogeneity was used to inform the process of conducting this synthesis. This also informed other aspects of the review, such as initial scoping searches, the use of a quality assessment framework, the structure of the present report, and informed the use of a table as well as a narrative synthesis in order to aid transparency in the presentation of data (see Table 1). A contents table was used (Table 2) to visualise the frequency of different topics across the literature. These topics were generated by identifying points of similarity and difference between the included studies.

A thematic synthesis approach was considered. However, given the significant amount of heterogeneity in the reporting of findings in each study manuscript, this was not deemed to be a suitable approach. This heterogeneity was particularly evident in terms of the in terms of detail and amount of relevant findings, which some studies reporting extensive quotes and theme summaries, and others only offering minimal short summaries.

Quality appraisal

The Critical Appraisal Skills Programme (2018) Qualitative Checklist was used to assess the quality of texts included in this review. This checklist assesses various aspects of research design and methodology including clarity of research aims, appropriateness of methodology, research design, recruitment strategy, methods of data collection, the relationship between researchers and participants, ethical issues, analytic rigour, as well as the clarity and value of the findings.

Findings

Description of the studies and their quality

Each study included in this review is described below, along with a summary of the CASP checklist findings. Further details are available in appendix A.

Clinicians' and trainers' views and attitudes on evidence-based practice

Stewart et al. (2018)

Stewart et al. (2018) interviewed twenty-four practicing US psychotherapists about how they make clinical decisions, conceptualise failure and success, and how these decisions relate to a conceptualisation of evidence-based practice (EBP) involving three components; research evidence, clinical expertise and patient characteristics, culture and preferences (Levant, 2005), described by Spring (2007) as a "three-legged stool" of EBP. A content analysis was used to analyse interview data.

Using the CASP checklist, this was a mostly methodologically sound study, using an appropriate design for the author's stated aims. However, it is possible that a methodology other than content analysis may have led to more in-depth findings, which were reported in a quantitative way in the findings section. In addition to this, the researchers' potential relationship to the participants was not made clear in the manuscript.

Court et al. (2016)

Court et al. (2016) interviewed 11 practicing UK Clinical Psychologists (CPs) about their beliefs and use of NICE guidance. These interviews were transcribed and analysed using a Grounded Theory approach in order to generate a model of CPs beliefs about and use of NICE guidance.

This was rated as being a well-designed study, with grounded theory methodology being suitable for exploring and describing an under-investigated subject, and results described in detail. The authors were transparent about their relationship to the subject matter the co-creation of the findings.

Marques et al. (2016)

Marques et al. (2016) interviewed 28 clinicians at a community health service in Massachusetts, USA about their views on implementing evidence-based interventions, in an area that was described as having the highest poverty and violent crime rate in the state. This study was conducted as part of a larger trial for an intervention for Cognitive Processing Therapy for Posttraumatic Stress Disorder. A content analysis methodology was used.

This study utilised a rigorous analysis that was described in detail. Findings were presented clearly with appropriate quotes supporting claims made. However, the authors did not report clearly on ethical issues, including consent taking, and did not make clear their relationship to the participants and their reflexive position on the topic at hand.

Stewart et al. (2012)

Stewart et al. (2012) interviewed twenty-five US-based clinical and counselling psychologists and used a grounded theory approach to analyse interview transcripts about their attitudes toward research-informed practice. A grounded theory methodology was used to generate a model of how participants make sense of evidence in relationship to their clinical work.

This study utilised a rigorous analysis that was described in detail. Findings were presented clearly with appropriate quotes supporting claims made. However, the authors

did not report clearly on ethical issues, including consent taking, and did not make clear their relationship to the participants and their reflexive position on the topic at hand. While the authors relationship to participants and opinions on the topic at hand was not disclosed, this was otherwise a well-designed study.

Rous and Clark (2011)

Rous and Clark (2011) conducted interviews with seventeen child and adolescent psychotherapists working in the NHS, investigating child psychotherapists' views, understandings and actions in relation to evidence-based practice.

The CASP qualitative checklist found this to be a well conducted study, however there was a lack of detail around the type of analysis used, which appeared to be consistent with aspects of thematic analysis, content analysis and grounded theory.

Nelson et al. (2006)

Nelson et al. (2006) conducted focus groups with a total of nineteen US-based clinicians, including nurses, psychologists and social workers working with children, adolescents and families in order to examine their attitudes toward evidence-based approaches.

Using the CASP qualitative checklist, this study was rated as being of poorer quality than others included in this review. Notable issues included a lack of clarity around the type of analysis used, which was not named or described in detail, though appeared to be consistent with a content analysis. The use of a focus group methodology was poorly justified, based on their stated aims, creating a circular argument. In addition to this,

participants were misled about the topic of the focus groups, ostensibly to avoid recruiting participants with strong views about evidence-based practice. For these reasons, caution should be exercised when interpreting these findings in isolation.

Studies primarily focusing on cultural context

The final two studies included in the review primarily focused on cultural factors and clinical practice. While this differs from the aims of this review, parts of these studies findings were of interest to the reviews aims, and were included for this reason.

Geerlings et al. (2017)

Geerlings et al. (2017) used a mixed methods approach to examine how students, academics, and alumni of clinical psychology experience preparation for culturally competent clinical psychology practice. Five students, five academics and four alumni at a Dutch clinical psychology masters programme were interviewed. These interviews were analysed using an Interpretive Phenomenological Analysis approach.

This study's methodology was described in detail and was relevant to the authors stated aims. However, descriptions of the findings were brief and the presented quotes did not always relate clearly to the findings.

Kagee and Lund (2012)

Kagee and Lund (2012) were interested in how, and to what extent, evidence-based approaches were taught at psychology training programmes in South Africa. Eighteen directors of clinical and counselling psychology training programmes were interviewed to share their views and attitudes about this.

This study presented comprehensive findings with quotes representing a variety of rich accounts. However, the exact type of analysis used and how this was conducted was not described, with the authors instead describing information about computer-assisted qualitative data analysis software used. For this reason, caution must be exercised when interpreting these results in isolation

Narrative synthesis

Heterogeneity in the literature

There were challenges in this process, with differences in each study's phenomenon of interest, methodology. Despite this, each included study contains findings that were relevant to the present review's aim to different degrees. For example, one studies' primary aim was to investigate clinicians' perspective during an implementation trial of a particular intervention (Marques et al., 2016), with Geerlings (2017) mainly focusing on students, trainers and alumni views on cultural competence in clinical practice. Despite these different focuses, there were also findings that related to their views around the relationship between evidence and clinical practice, of interest to this review.

With eight studies included in this review, six focused on the views of clinicians with two including the views of trainers. These included clinicians from a wide range of professional backgrounds, including clinical psychologists, counselling psychologists, psychiatrists, nurses, social workers and child psychotherapists. Similarly, there were differences in the contexts in which these professionals worked, ranging from the NHS in the UK, private and community practices in the US, as well as trainers in the Netherlands and South Africa.

Analytical approaches also varied between studies, with the use of content analysis, interpretive phenomenological analysis, grounded theory, and some studies not naming an explicit analysis.

This review demonstrates that psychological practitioners and trainers understand and use research evidence in complex ways. The literature also showed that clinicians hold a diverse range of views on evidence-based practice, from those who see this as something non-negotiable that all clinicians and trainers must adhere to, to those who reject how it is conceptualised entirely, as well as those holding more equivocal positions.

Tables 1 and 2 show a summary of the findings of each study, and the frequency of different themes across each study.

Table 1.

Summary of studies and their findings

Study	Methodology, Population and Context	Findings
Stewart et al. (2018)	Content analysis of interviews conducted 24 practicing US clinical psychologists	While there were some differences, the majority of those interviewed The majority of clinicians relied on their own experience, expertise and intuition when making decisions, with a smaller proportion base decision primarily on research evidence. Clinicians in this sample rarely used protocol driven treatment approaches, and expressed a preference for using observation and clinical judgement to assess outcomes, with 8% using questionnaires or measurement.
Court et al. (2016)	Grounded theory of semi structured interviews data 11 NHS Clinical Psychologists.	Nice Guidelines Have Benefits in summarising research, or offering shorthand for certain clinical presentations, minimising time a clinician would spend conducting a literature review. NICE Guidelines can create an unhelpful illusion of neatness and detract from complexity of human experience – with psychologists critiquing conceptual validity of diagnosis, external validity of trials. Clinicians feel a pressure to be 'NICE Compliant' from commissioners and managers. Some CPs manage this by "not advertising" the work they do to management, or doing one thing and saying another. CPs report using guidelines flexibly, following them at times but at other times modifying them or deviating based on their own clinical judgement. CPs expressed a sense of difference between the way guidance understands distress and interventions to the way clinical psychologists do, such as through incorporating different therapy modalities and expressed view that psychological interventions cannot be assessed using same framework as physical illness.
Marques, et al. (2016)	Content analysis of interviews with 28 clinicians at community mental health service in Massachusetts, USA. 10 social workers 6 trainee social workers 5 psychiatrists 3 clinical psychologists 2 trainee clinical psychologist 1 nurse	Participants expressed the view that insurance companies increasingly require approaches to be supported by evidence, and were useful in that sense. They saw the process of training in and using evidence-based treatments as being time consuming and difficult to reconcile with high workloads. Clinicians who valued flexibility and the use of their own clinical intuition in interventions were less likely to value empirical evidence. Clinicians felt that using evidence-based treatments with clients with diagnostic complexity, ongoing violence, poverty, intellectual disabilities or significant environmental stressors would be challenging, and that more flexible approaches would be needed for these clients.

		Clinicians saw benefits in training in an approach that had been found to be useful through research, rather than anecdote. Other clinicians concerned that trial findings were not generalisable, and expressed the view that statistics could be manipulated to produce positive outcomes. Some clinicians expressed view that certain treatments are too rigid and non-personalised.
Stewart et al. (2012)	Grounded theory of interviews with 25 US practicing psychologists 10 Ph.D. clinical psychology 10 Ph.D. counselling psychology 5 Syd clinical psychology	Majority of participants described themselves as eclectic, choosing aspects of different approaches based upon their judgement of what fits best with clients. Participants supportive of the idea of evidence-based practice in principle, and valued the idea of integrating this into their practice as opposed to following treatment manuals. Some participants reported positive experience consulting literature on an unfamiliar presentation, and found this helpful. Common complaint of research being too controlled and diagnostic system being too "nice and neat", not reflecting clients with multiple/comorbid difficulties, missing human component of therapy. Clinicians held a scepticism over how research was conducted, how outcomes were measured, and that findings could be manipulated. Participants often relied on respected colleagues and psychotherapy books over journal articles for learning. Participants discussed how approaches as designated as "evidence-based", with some finding this to be positive, and others sceptical of this label.
Rous et al. (2010)	Unnamed qualitative analysis of interviews 14 UK NHS child and adolescent psychotherapists	Psychotherapy and science Participants expressed views that it is not appropriate to assess effectiveness of therapy using the same methodology used to assess a drug treatment. Also felt that the philosophy of dominant evidence-based approach conflicts with psychoanalytic approach. For example, a psychoanalyst might not take self-report questionnaires at face value. Some therapists felt that qualitative approaches might be more appropriate, whereas others disagreed with the logic of applying the scientific method to psychological growth. Understanding of evidence-based practice Participants believed that there were aspects of therapy that could not be quantified, yet approaches that would explore these are not valued as highly by organisations such as NICE. Attitudes toward research A third of participants saw an importance of conducting and disseminating in order to benefit the standing and visibility of psychotherapy in the NHS, and that "hard figures" matter to commissioners.
Nelson et al. (2006)	Content analysis of focus groups with 19 Clinicians at community mental health centre in Midwest US	Positive views toward evidence-based practice in principle. However, expressed concerns that adhering to evidence-based treatments would involve being overly structured. Clinicians valued flexibility in their interventions, particularly with clients with more complex presentations, with whom they conducted most of their work. Concerns about eligibility criteria being overly strict and not applicable to "real world".

	12 social workers 4 Ph.D. clinical psychologists 2 masters clinical psychologists 1 nurse practitioner	Clinicians valued experience and judgement of themselves and others and if they have "seen it work". Clinicians also valued approaches that placed emphasis on the therapeutic relationship over other potential mechanisms of change. Clinicians expressed some possible apprehensions about learning a new approach, particularly if they did not have access to colleagues for supervision or advice. Clinicians expressed a concern that researchers and academics have little real world experience of clinical practice
Geerling et al. (2018)	Interpretative phenomenological analysis of interviews 14 participants from two Dutch clinical psychology training programmes 5 Students 5 Academics 4 Alumni	Clinical psychology has a western orientation, with foundations in behaviourism, mind-body dualism and psychoanalysis. This critique was more widely held among students and alumni than teaching staff. These western origins have resulted in models and practices that are tailored toward working with clients who are highly educated, and who value individualism, atheism, and "rationalism" Science can be overly rigid and reliant on biomedicine and ignores culture
Kagee and Lund (2012)	Semi structured interviews, analysis not named. 18 directors of clinical and counselling psychology training programmes in South Africa.	Differences of opinion among participants. Some expressed a belief that research and practice are inextricably linked and that there is ethical imperative to engage in research as a clinician Others made reference to the Cochrane Collaboration as a source of high quality evidence, stating that without rigorous research such as this, clinicians would otherwise be taking "a shot in the dark" Some participants stated that EBP held positivist assumptions that involved dismissing qualitative evidence. Some participants conceptualised evidence-based practice as a Western form of knowledge forced upon South Africans by Westerners and were concerned that this could not account for the influence of apartheid on South African people Trainers held a critique that some forms of therapy were more suited to measurement than others and would be more likely to be considered 'evidence-based' on that basis.

Positive views of research and evidence-based practice

Many interviewed shared the view that there is a need for clinicians and trainers to base their practice on research findings. This was highlighted by a programme director interviewed by Kagee and Lund (2012) stating;

> "As clinicians we need to be able to show that our interventions are effective and pragmatic" (p. 107)

This awareness of research evidence was understood as being useful and is, in principle, helpful for practitioners. Some of this was stated explicitly, such as clinicians interviewed by Stewart et al (2018) described how they utilised DSM diagnostic criteria when first meeting clients in order to make sense of difficulties they were experiencing.

CPs interviewed by Court et al. (2016) described how NICE guidance offered a practical and useful summary of relevant literature, meaning they did not have to

> "go through millions of literature searches [as] NICE have done it for you". (p. 4).

This could be understood to be particularly valuable as a common complaint across studies was clinicians' lack of time to adequately learn about or assess evidence themselves.

Clinicians' and trainers' positive views extended to the idea of evidence-based practice, as shared by a clinician interviewed by Nelson et al. (2006),

> "it's good to have what we know works be the thing that determines the decisions we make about treatment" (p. 405)

This sentiment was shared by programme director interviewed by Kagee and Lund (2006) sharing their view that basing practice on research evidence was essential.

> "We are (…) of the opinion that [research and evidence] are inextricably linked. You certainly cannot in my view be a practicing clinician without being able to read research or engage in research" (p. 107)

Another director shared a similar sentiment, comparing practicing without a clear research rationale for doing so to "taking a shot in the dark" (p. 107).

Critiques of evidence-based practice

This enthusiasm was not universal across all clinicians and trainers. Many held critiques of research evidence, their perceptions of how this is practiced, as well as more conceptual critiques of the principles that they understood clinical research and evaluation to be based upon.

Methodological critiques of clinical research

A criticism that was repeated across many studies was the perceived tendency within trials to have strict eligibility criteria that did not reflect the complex difficulties that clients often present with. This was summarised by a clinician interviewed by Nelson et al. (2006), stating;

> 'So many of the studies are done on ideal kids. You're disqualified from the study if you don't meet the criteria, but in real life, people don't meet the criteria.' (p. 402)

This was mirrored by Court et al. (2016), where CPs critiqued eligibility criteria for Randomised Controlled Trials (RCTs)

> "where somebody needs pure depression (…) it doesn't paint an accurate picture of the type of client groups you're actually dealing with). (p. 4)

Interviewees across different studies made reference to the applicability of research samples to clients with multiple and complex needs. For example, a clinician interviewed by Marques et al. (2016), working in a US urban area with high poverty rates, was asked what kind of clients wouldn't respond well to an evidence-based approach, described many on their caseload.

> "[The clients] with some cognitive or intellectual disabilities. A lot of my clients are very overwhelmed with psychosocial stressors. Having a lot of children at home. Just not being organized enough to do the homework and follow through. Or come in. Just being consistent with therapy. Coming to appointments." (p. 12)

Others were concerned that research evidence often relied too heavily upon the idea that human experiences must be quantified to be considered valid, and that doing so misses crucial aspects of the therapeutic process.

> ''So much of what I read is so inapplicable to what I actually do in terms of the level of complexity of cases, multiple diagnoses, and the parts of therapy that can't be quantified.' (Nelson et al., 2006, p. 404).

A similar critique was expressed by some child psychologists, who felt that those who participate in trials are different to children and young people they were likely to work with (Rous et at., 2010).

Clinicians interviewed in two studies expressed that they were reluctant to take research findings at face value. While this quote did not specifically identify or name any questionable research practices, they stated that findings had the potential to be manipulated.

> "I also feel like the science and the research can be set up in such a way to produce the desired outcome" (Marques et al., 2016, p. 13).

CPs practicing privately in the US also expressed similar views (Stewart et al., 2012) that findings could be manipulated through the use of questionable research practices.

A comparatively common finding among studies was that clinicians and trainers held a critique of the type of quantitative evidence that they saw being mainly used to assess interventions in research. Some described how they valued qualitative approaches and participants' narrative accounts and experiences of therapy, and felt this was not valued in by NICE as this data is not "measurable" in the same way (Court et al, 2016). This was also tempered with a sense of *realpolitik,* with some child psychotherapists calling for the profession to produce more of the "sort of evidence that is going to count" (Rous and Clark, 2011, p.576) in the eyes of commissioners, despite their personal views on this approach.

Conceptual and philosophical critiques of clinical research

A common finding across different studies was of clinicians and trainers critiquing what they saw as conceptual assumptions that underlie psychological research and theory. For example, CPs interviewed by Court at al., (2016) shared their view that

> "NICE needs to realise that psychological therapies are not like medication and you can't evaluate them in the same way" (p. 6).

This was echoed by child psychotherapists (Rous & Clark, 2011), some of whom also believed that it would not be appropriate to assess psychological interventions as if they were a drug therapy. For one therapist, this was based upon what they saw as a theoretical

understanding of growth and change in people, and that this view undermined how outcomes were assessed in trials.

> "A big thing in British object relations is John Keats's negative capability, which is about being able to think without having to know. Of course, that is the completely opposite to the idea of being able to rationally put everything down in a very positivist sort of way about evidence. So, there is a philosophical difference between the way the NHS is going and psychoanalytic work." (p. 5670)

Practitioners interviewed by Stewart et al. (2012, 2018) and Nelson et al. (2016) shared similar perspectives, with some believing that there were subtle human aspects of the therapeutic process that were not captured in clinical research.

This led some CPs interviewed by Court et al. (2016) to be concerned that certain types of therapeutic approaches lend themselves more readily to the quantitative measurement,

> "I think CBT also fits very nicely because it's the most medical of the therapies I think, and so I think it's attractive to psychiatrists and other professionals who can understand then, when it's in units, isn't it" (p. 6)?

A similar critique was offered by a programme director interviewed by Kagee and Lund (2012), who saw a tension between what is often considered "scientific" or legitimate evidence, and their own understanding.

> "Most of our students do qualitative studies (…) it is not evidence in the so-called scientific (…) way, but we believe that people's experience serves as evidence". (p. 105).

This mismatch was described as an “epistemological incongruence” (p.106). Many directors saw evidence-based approaches as relying heavily or exclusively upon quantitative methods and standardised measurement tools. This was understood as a sense of evidence-based practice being “rooted in a kind of logical positivism”.

This led to concern that other types of therapies might be dismissed not because of how helpful they could be, but rather because they did not incorporate measurement as part of the therapeutic process.

> “I can’t imagine some, one of the more traditional existentialist therapies like Yalom-based therapy, getting NICE backing because how they would define whether the therapy is working isn’t immediately measurable, and it’s that question of how measurable it is.” (Court et al., 2016, p. 6).

One programme director described a tension related to this within their department, seen as a function of the member’s primary field of work between staff who were more “research oriented” (p. 108) being more interested in evidence-based approaches compared to staff members who were primarily clinicians. A comment by a clinician interviewed by Nelson et al. (2006) reflected a similar tension, highlighting a concern that researchers had little understanding of what clinical work involved in reality. This was provocatively summarised by one clinician who suggested it would be useful for academics to ‘‘come spend a day” (p. 404) at the clinic.

Faculty members described how different belief systems around what constitutes knowledge led to tensions within the department that were, at time, irreconcilable.

> "We made a debate about traditional healing and indigenous knowledge systems. But rather than looking at the actual evidentiary base, you may find that the discussion goes into the realm of critical social theory (…) where you can fundamentally agree to disagree at the end of the day." (Kagee & Lund, 2012, p. 110).

Evidence-based practice and power

Issues of power and hierarchy were identified, particularly in relation to pressures to practice and follow research evidence or guidance. US Clinicians interviewed by Stewart et al. (2012) described a pressure to practice in a particular way partly to satisfy requirements set by insurance providers

> "I feel that [EBI's] are the direction that insurances are going in and [insurance companies] want to see treatment that's more evidence-based." (p. 10).

A similar concern was shared by a clinician interviewed in the same, expressing scepticism about how statistical tests can be manipulated, and were concerned that insurance providers could misinterpret research to dictate practice in a way that would not be helpful for clients.

> "I think information based on good research is important, but I think anyone who is not a psychologist should not be making these decisions" (p. 8)

While in a UK context this was not as directly linked to remuneration, a similar critique was offered by CPs interviewed by Court et al. (2016), stating that

> "[…]it can feel quite threatening actually, that there's almost an undercurrent of, of threat that if we're not doing what the NICE guidelines say then we won't be commissioned, because I think NICE is quite a powerful force" (p. 6).

There were exceptions to this. At times, the power and prestige afforded to evidence-based approaches could be seen to be well regarded.

> "An [evidence-based approach] is something that is regarded in the larger community, whether that is the behavioural health community or family practice or psychiatry, something that's bee—that has been reviewed in a peer-reviewed journal, published, and adequately documented to be useful, as opposed to just anecdotal-based practice" (Marques et al. 2016, p. 13).

There were similar findings among other samples. A clinical psychologist interviewed by Court et al. (2016) discussed how access to therapies for people with a diagnosis of schizophrenia has increased following their inclusion in NICE guidance. Psychotherapists interviewed by Rous and Clark (2011), some of whom were aware that their profession was not once as influential as it was, saw clinical research as an avenue to regaining this lost standing.

Power, culture and politics

Dutch Students, trainers and alumni interviewed by Geerlings et al. (2018) offered a critique of the philosophical origins of clinical psychology, Cartesian mind-body dualism, behaviourism and psychoanalysis, describing this as "western-orientated" and the knowledge of "old white men with beards" (p. 98). They concluded that this resulted in

models and practices adapted to western audiences with individualist assumptions about themselves and the world.

In a post-apartheid South African context, some Black programme directors were concerned that psychological research could constitute a form of colonialism, by which Western schools of thought are imposed upon post-colonial subjects.

> "I am part of the marginal group. I could not just buy into what was given to us by the Westerners" (p 106).

This application of western ideas, conducted among Western participants, onto South African services was described by another director as "both Knowledgably [sic] and ontologically unethical" (p. 106)

Valuing flexibility

Clinicians often perceived evidence-based approaches as being highly structured. This was at times considered helpful, as described by a psychotherapist interviewed by Stewart et al. (2012).

> "I went to the research and did some reading on eating disorders, particularly on binge-eating disorder, and the consequence was that I was more cognitive–behavioural, more concrete, and more directive than I might be in other circumstance"

This was reflected by Stewart et al. (2018), where the authors at times used the terms "evidence-based" and "structured" interchangeably.

This perceived rigidity was seen as an issue. Marques et al. (2016) described how participants conceptualised evidence-based approaches as

> "non-personalised, time-consuming to learn, and not flexible enough to meet the needs of clients".

This was reflected in a comment by a clinician interviewed by Nelson et al. (2006), who was concerned that following an evidence-based protocol would require them to follow an inflexible approach, which they thought would not be feasible within their clinical context.

> ''You have to be able to stop and deal with real crises. You can't say, 'I am sorry, it's session 4 and we have to do this.''.

A common theme across the studies included was that many clinicians seemed to value flexibility and, to a lesser degree, relational aspects of therapy, which they saw as less likely to be emphasised in evidence-based approaches.

What does this look like in practice?

This led to a situation in which clinicians might use evidence flexibly while holding in mind their limitations, such as by practicing CBT but in a way that is "fudgy around the edges", as described by Court et al. (2016) or what "feels right" (Marques et al., 2016, p. 11). This was echoed by clinicians interviewed by Stewart et al. (2012), the majority of whom described using an eclectic approach based upon their assessment of what would be best for their clients, utilising aspects different therapy modalities. Others describe a conflict between what they understand as helpful and what NICE recommend.

A similar mismatch was described by Court et al. (2016), where the authors argued that NICE guidance result in a "perverse incentive" (p. 1) for clinicians to say that they are

following guidance but are in fact practicing according to their own sense of what is best for the client, but cannot disclose this to managers.

Some clinicians described not reading research directly, instead relying on the experience of themselves and others, with a preference for reading books written by clinicians that compiled evidence.

Table 2.

Frequency of subjects across studies

Content	Stewart et al. (2018)	Court et al. 2016)	Marques et al. (2016)	Stewart et al. (2012)	Rous and Clark (2011)	Nelson et al. (2006)	Geerlings et al. (2017)	Kagee and Lund (2012)
Questioning how evidence-based practice is defined and understood		X	X	X	X		X	X
Positive views of using research evidence in principle	X	X	X	X				X
Valuing own and respected colleagues' experience over research evidence	X	X	X	X		X		
There are important aspects of therapeutic process and outcomes that cannot be quantified	X	X		X	X		X	X
Some therapy approaches align more readily to measurement valued in evidence hierarchies	X	X			X			X
Believe that RCTs are too restrictive and not applicable to "real world" practice	X	X	X	X	X	X		X
Quantitative approaches are not the best approach to understand therapy outcomes	X	X		X	X		X	X
Adhering to principles of evidence-based helps promote therapy or the profession	X	X	X					X
Prefer to work in an integrated/eclectic approach	X	X		X	X			
Prefer to use guidance flexibly in combination with own experience/intuition	X	X		X		X		
Powerful organisations and policymakers demand evidence	X	X	X					X
Evidence-based approaches are inflexible and not suitable for people experiencing other stressors				X		X		
Statistics and research findings can be manipulated and should not be taken at face value			X	X				
Psychology and concepts of evidence have a Western bias that is not recognised							X	X

Discussion

This review offered an overview of research examining clinicians' and trainers' views of the potential relationship between clinical practice and research evidence, and how clinicians conceptualise any potential critiques of research practices, and how this relates to findings identified within academia. There was a clear sense that the concept of "best practice" appears to be an area of contestation, with some practitioners appearing to disagree with how the term is commonly understood.

Psychological practitioners appeared to be a broad church in terms of clinicians' perspectives on evidence, with some seeing evidence-based practice as highly instructional and non-negotiable, others agreeing with the concept in principle yet maintaining a certain degree of critique and not taking findings at face value, and some disagreeing with the concept on theoretical or philosophical grounds. The adherence of some clinicians to an evidence based therapy was in line, to some degree, with the views advocated by Waller and colleagues, who called for clinicians to faithfully adhere to treatment manuals (Waller, 2009; Waller & Turner, 2016). Others appeared to value other factors, such as the quality of the therapeutic alliance, a view that would be consistent with common factors research (Horvath et al., 2011).

Methodological critique often mirrored the literature on the replicability crisis within clinical research, particularly around the external validity of RCTs and concerns around diagnostic frameworks (Fried 2017, 2022), demonstrating an understanding of these issues. Some clinicians expressed some awareness of questionable research practices such as p-hacking (Head, 2015), as well as an understanding of publication bias.

The degree to which clinicians' views expressed in this review mirror the ongoing debates within the literature potentially indicates that, rather than being ignorant or unaware of clinical research, many clinicians may in fact be well aware of areas of contemporary contestation.

Dutch and South African trainers offered particularly robust and nuanced critique of the philosophical and cultural underpinnings of positivist research practices. While one cannot generalise these small scale qualitative studies, should these views be more prevalent among other trainers, they are likely to be influential in shaping the views of the clinicians of the future. These types of attitudes are unlikely to be swayed by methodological tweaks such as increased openness in research practices, and instead may require more of a paradigmatic shift in how concepts of psychological distress are understood in clinical research. It is beyond the scope of the current review to determine whether the field is on the verge of such a significant change, however there appears to be fruitful terrain for other frameworks of understanding, such as the use of formulation or the Power, Threat, Meaning Framework (Johnstone et al., 2018), which have the potential to offer a more sociologically informed view of psychological distress in clinical research.

This review's findings echo previous research in highlighting the importance of clinicians' attitudes and views about evidence based practice in carrying out psychological interventions. Some forms of divergence from manualised protocols may perhaps not be best understood as a 'safety behaviour' or an example of therapist anxiety (Parker & Waller, 2019, Rameswari et al., 2021), nor stemming from a lack of knowledge (Damschroder et al., 2009), but instead as a conscious decision, informed by live and ongoing debates within the literature.

Clinicians working in community settings connected with the idea of, at times, suspending a manualised intervention for a client presenting in crisis or with other stressors, for example, in order to address systemic or economic factors such as a client's housing situation (Marques et al., 2016 and Nelson et al., 2006). Differently to the literature on therapist drift (Waller, 2009 and Waller & Turner, 2016), clinicians seemed to find pausing or amending of an intervention to be an appropriate action, rather than an act of collusion with clients' anxieties.

Practice implications

While this review examined the views of a range of psychological practitioners, the findings have implications for clinical psychology. Despite clinical psychology training programmes' scientist practitioner orientations, very few clinicians participating in included studies reported also being researchers. Clinicians commented on a sense of distance between themselves and researchers, describing a sense of researchers not understanding the experience of being a clinician in a busy service. While this would likely be challenging for clinicians in busy settings, perhaps clinicians might be more open to the world of academia and research if this was to become a part of their work life beyond a single piece of possibly unpublished research written for a doctoral thesis. Knowledgeable clinicians will likely have much to contribute to the world of research should they have realistic avenues to do so. Universities and research and development departments may want to consider workshops with local health services. This would likely require flexibility on behalf of mental health services, which often have long waiting lists, placing additional pressure on already stretched services.

Clinicians from multiple orientations appear to hold scepticism about how clinical research is conducted. Clinical psychology training programmes could go some way to addressing this, by offering a robust education in the methods of open and transparent research practices, potentially adopting recommendations made by Leichsenring et al., (2017). Many clinicians, such as clinical psychologists and psychotherapists interviewed by Court et al., (2016) and Rous and Clark (2011) expressed that they hold differing perspectives about what kind of research is valuable compared to commissioners. This mirrors previous calls from psychoanalysts for therapy outcomes to be understood and researched in ways that are more "complex, multifaceted, holistic and humane" (Holloway, 2001, p. 21). Organisations such as NICE may wish to demonstrate how such literature, particularly those that offer a more idiographic or detailed perspective, was also taken into account in the generation of practice guidance. This may go some way to addressing these clinicians' concerns.

Clinical psychologists also have a potential role to play in addressing this tension. CP's, who are often expected to offer in house teaching and continual professional development to colleagues and have a responsibility to remain abreast of current research, could utilise their expertise in to provide contemporary updates on relevant developments to their colleagues, as well as demonstrate the value of incorporating ways to measure outcomes in ways that are consistent with what clinicians in this review appear to appreciate, such as by using idiosyncratic treatment goals that are relevant to clients, or using outcome measures in a meaningful and person-centred way.

While some clinicians saw value in the use of treatment protocols, many clinicians reported deviating from these, using their judgement and intuition to inform clinical decisions. Some clinicians also reported how they might conceal the exact details of their clinical work from management, for example by saying they are using CBT when they were using a different approach. This has significant ethical and practical implications in a UK context where services, and at times specific interventions, are commissioned to meet need at a local level. If there is a discrepancy between what is thought to be offered and what is actually happening, this could result in significant difficulties in effectively addressing mental health needs across the UK. This dilemma also speaks to a potential tension between offering particular interventions for particular problems, and the use of more idiosyncratic formulation based approaches where people's experiences may not fit neatly into particular diagnostic explanations of distress.

Limitations

Only English language literature was included in this report. Three studies were excluded on this basis. As a result, the findings of this review may not fully represent the diversity of perspectives and experiences in the broader international context. This limitation may impact the comprehensiveness and generalisability of these findings, limiting the applicability of the results to a narrower linguistic and cultural context. There were only limited references to methods taken to address issues around reflexivity in included studies, limiting the potential trustworthiness of findings.

A focus only on qualitative literature allowed for an in depth exploration of relevant parties' experiences and meaning making around evidence-based practice, yet limits the degree to which these findings can be seen as generalisable. Including quantitative

literature would allow for a broader investigation about the prevalence of these findings, and would also likely include perspectives from practitioners from CBT-based approaches, the opinions of whom were not well-represented in this review, despite its popularity as an orientation.

Future research

Given clinicians' descriptions of relying on their own clinical experience, at times at the expense of research evidence, there appears to be a need to gain a more in depth understanding of this. A grounded theory approach may allow for the development of a theory or model of how clinicians understand and make sense of this process. Some particularly pertinent questions are when, how and why do clinicians deviate from treatment protocol? Another potential avenue for exploration might be to explore the views of commissioners of formulation-based, rather than diagnostic approaches. Developing an understanding of this could be fruitful in addressing the potential impasse between real world practice and research evidence.

Given clinicians descriptions of experience a sense of difference or distinction between themselves and academics, there is a need to develop an understanding of how mental health professionals are trained and how contributes to attitudes toward evidence-based practice. This is particularly pertinent in Clinical Psychology, despite the prominence of a scientist-practitioner model. Future qualitative research would benefit from being sensitive to issues around reflexivity and transparency in this regard in order to be truly rigorous.

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Section B: Two Psychologies – How do UK trainee clinical psychologists experience and make sense of their psychology undergraduate degrees in relation to doctoral training and clinical practice?

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Abstract

In the UK, the undergraduate psychology degree is one of the most popular courses in higher education. Despite approximately half of undergraduates expressing a desire to pursue clinical psychology as a career, clinical psychology or mental health does not feature as part of the British Psychological Society's core undergraduate curriculum. What limited research exists on how psychological distress is understood and taught at undergraduate level indicates a focus on psychiatric or classification-based frameworks, distinct from formulation-based understandings used by clinical psychologists. This report presents the findings of a qualitative investigation of nine trainee clinical psychologists' sense of the relevance of their undergraduate degrees to their subsequent career in clinical psychology, using reflexive thematic analysis. Trainees reported an emphasis on diagnostic approaches and quantitative research methods during their degree, and that this was at odds with their later clinical career. They developed a sense of there being two psychologies with different theoretical assumptions and traditions. While trainees found aspects of their degree helpful, they reported that substantive learning took place outside of this. This suggests a need for Clinical Psychology to engage more readily with academic psychology departments, and considers the possibility of applied clinical psychology adopting a more central position in undergraduate teaching.

Keywords: Undergraduate psychology, clinical psychology, applied psychology, reflexive thematic analysis, qualitative

Introduction

Mental distress and health professionals

How psychological distress is understood, described and attended to is a contested topic, with fundamentally different approaches taken between and within psychology and psychiatry. Such approaches can range from describing distress as existing in the form of discrete categories resulting from "brain disorders" (Insel, 2013), as consequence of abuses of power (Johnstone et al, 2018), or resulting from a combination of biological, psychological and social factors (Engel, 1977).

This study focused on clinical psychologists (CPs) as one of the primary group of professionals working with people experiencing mental distress in the United Kingdom are CPs. Currently, CPs gain their qualification by completing a three-year doctoral programme, in which trainees are expected to meet standards of competence accredited by the British Psychological Society (BPS) and the Health & Care Professions Council (HCPC). To meet criteria to enter a doctoral training programme, candidates are expected to complete a BPS-accredited first degree or conversion course, most commonly through a three-year undergraduate course, typically a BSc or BA in Psychology. Twenty-four thousand students were accepted onto psychology degrees in 2019, accounting for roughly one in twenty of all undergraduate students (Palmer et al., 2021).

Political and recent historical context of the UK Higher Education Sector

Since 2010, government higher education funding has decreased significantly, with total public sector expenditure on tertiary education for the 2022/23 academic year representing 28.9% of 2010/11 levels (House of Commons Library, 2024, Statista, 2024), the

sector faces significant financial difficulty with the Office for Students (2024) predicting that 40% of all English public universities will be in financial deficit by the end of 2024.

Universities are therefore under pressure to seek funding from other sources. Since decreasing university funding by central government began from a high point in 2010 (Higher Education Policy Institute, 2020), this shortfall has been made up in England by an increased reliance on tuition fees (House of Commons Library, 2024). Many undergraduate degree courses sought to increase degree places and to appeal to as broad a range of students as possible in order to attract fee paying students, especially international students, with applicant numbers increasing after funding reform, with record numbers in 2020, 2021 and 2022 (Bolton, 2024). Psychology is also promoted to as a degree with a broad appeal. Florance et al. (2011, p. 699) wrote that. “Just about every job suitable for a general graduate will be done better by a psychology graduate.".

This is evident in the Quality Assurance Agency’s (QAA) subject benchmark statement, outlining a range of separate “subject specific” and “transferable” skills that students could be expected to learn at degree level.

Clinical psychology within UK undergraduate psychology

The UK undergraduate psychology curriculum set out by the BPS in the form of its accreditation standards (British Psychological Society, 2019). This comprises a broad array of teaching and instruction covering different fields in which psychologists work, with the purpose of students acquiring capabilities in multiple areas. This is in turn influenced by the Quality Assurance Agency’s (QAA) Subject Benchmark Statement for Psychology (QAA, 2023), a document intended to outline the purpose and distinctive features of a psychology degree in the UK.

The BPS standards of accreditation functions as a curriculum for the majority of undergraduate degrees in the UK, with eight core areas of psychology that an undergraduate degree should cover to be awarded BPS accreditation; biological, cognitive, developmental, and social psychology, individual differences, conceptual and historical issues in psychology, research methods, and an empirical research project.

Notably, clinical psychology does not feature in this list, despite over 90% of first year undergraduates reporting a desire to pursue a career in healthcare, over half of which specifically in clinical psychology (Palmer et al., 2021). In terms of actual destinations, this same survey found that over half of those who complete a degree go on to work in health, clinical psychology, social work or scientific research and development, with roughly 6% of total applicants in clinical psychology.

The role of CPs is increasingly recognised as important in mental healthcare as evidenced in the NHS Long Term Plan (NHS England, 2019), which called for an ambitious 60% growth in the number of psychological professionals, including practitioner psychologists, psychological therapists and psychological practitioners. This has been alongside 25% increase in training commissions for CPs (Health Education England, 2021), which is set to continue growing at a similar rate under the NHS Long Term Workforce Plan (NHS England, 2023), which sets out an ambition to grow training places by 26% by 2031/32.

While courses may offer optional modules in clinical psychology, the lack of a specified curriculum on this topic means that there may be significant variation in how clinical psychology is taught, if at all. Cromby et al. (2008) examined the content of mental health teaching in detail, and found that the two most common approaches were psychiatric and cognitive behavioural, with the majority of courses using textbooks

structured by diagnosis, such as Abnormal Psychology (Kring et al., 2006). The author's efforts to seek out more research on this topic indicated a lack of contemporary research examining how mental health or psychological distress is conceptualised and taught at degree level in the UK.

Clinical Psychology and understandings of psychological distress

This potential focus on classification or psychopathology-based frameworks at undergraduate level, if still widespread, appears to be in contrast to how CPs are expected to work. The Health and Care Professions Council's (HCPC) standards of proficiency document for CPs (Health and Care Professions Council, 2023) includes thirteen references to the term 'formulation' (or similar), with only one reference to a diagnostic or disease based approach. This sentiment is reflected in the BPS' practice guidelines for practitioner psychologists (British Psychological Society, 2017), which identifies formulation as an essential core skill for psychologists, but makes no reference to practitioner psychologists using diagnostic approaches, and was the focus of a position statement by the BPS' Department of Clinical Psychology (DCP), calling for a "paradigm shift" away from diagnostic approaches (Division of Clinical Psychology, 2013).

The Power Threat Meaning Framework (Johnstone & Boyle, 2018) was published as an ambitious framework for understanding psychological distress, diverging from more established theoretical approaches such as diagnosis. This approach, funded and published by the DCP, highlights how diagnostic approaches can hinder complex and nuanced understanding of people's experiences, diminish the role of psychological factors and social

context in favour of privileging biological explanations for distress. They argue that this is incompatible with the holistic formulation expected of CPs.

This potential mismatch, if it persists, may lead to aspiring CPs provided a foundational instruction in an approach that may be incompatible with key ideas or approaches they would be expected to become knowledgeable in later in their career. This relates to Social Cognitive Career Theory (SCCT) (Lent et al., 1994), which offers a framework for understanding how individuals developed interests in different careers, made choices around their career development, what subsequently influenced attainment or failure, and how this could create positive or negative feedback loops. Learning skills that match up closely with what is expected within clinical psychology could create a positive feedback loop, in which aspiring CPs experience their skills being useful and valued within their role. However, should there be a mismatch, individuals may find themselves feeling discouraged should their skillset not be suitable to their role in a way that they expect.

Similarly, this relates to Vygotsky's sociocultural theory of learning (1934). While this typically is used to make sense of child and adolescent learning, it has also been applied to adult learners, such as those undertaking an undergraduate degree (Wood & Wood, 1996). One aspect of this theory is the zone of proximal development, which describes how students learning is enhanced by collaborating with someone more knowledgeable. An opportunity for students to engage in applied task (such as a formulation exercise), would allow for students to develop this skill more effectively than through independent research.

Research methods and epistemology teaching

One of the core areas of a psychology degree is the topic of research methods. The HCPC standards of proficiency for practitioner psychologists highlight the need to be able to

use “a range of research methodologies” with reference to both qualitative and quantitative approaches (Health & Care Professions Council, 2015). However, there is research indicating a “quantitative culture” (Gibson & Sullivan, 2018) (p.1) among UK academic psychology departments, in which qualitative research is seen as “the alternative and lesser approach” (Thibault et al., 2023, p. 2), and not emphasised in teaching, which adopts a predominantly positivist epistemological perspective. In addition, a survey of statistics curricula at UK psychology courses found that quantitative methods are taught in a limited way, with the majority of departments emphasising null hypothesis testing and a lack of teaching on practical or clinical significance, replication or Bayesian statistics (TARG Meta-Research Group, 2022). In contrast to this, other undergraduate degrees in the UK encourage students to consider different epistemological perspectives, with the QAA’s Subject Benchmark Statements for anthropology and sociology encouraging students to consider “the social construction of knowledges” (Quality Assurance Agency, 2019, p. 2) and a recognition of how “knowledge is situated in multiple places” (Quality Assurance Agency, 2024). This demonstrates that questions of epistemology are entirely appropriate for students at degree level.

This emphasis on measurement and quantitative methods may reflect a broader valuing of quantitative, experimental data as the only legitimate forms of knowledge that can be considered scientific (Maxwell, 2004). From this perspective, qualitative methods are considered insufficiently rigorous in comparison to “gold standard” (Toyer, 2022, p.2) randomised controlled trials, meta-analysis, and other quantitative methods (Meldrum, 2000).

At times, qualitative and quantitative approaches have seemed irreconcilable, with some perceiving the teaching of qualitative methods to be akin to "telling [students] that the methods of science are no use" (Morgan, 1998, p. 483).

This emphasis on quantitative approaches in research methods, as well as the lack of clear curriculum for understanding psychological distress, leading to the possible emphasis on diagnostic approach may influence graduates' perspectives and understanding of what constitutes psychological distress, and the methods they might use to understand or address it. A potential mismatch in how these perspectives are taught and what is expected of graduates in clinical or research roles, or in doctoral training, may give rise to situations in which aspiring CPs may need to reconcile contrasting positions, holding onto one perspective while dismissing another, reminiscent of theories of cognitive dissonance (Festinger, 1957). Consistent with this, in their detailed theory of the development of counsellors and therapists based on numerous interviews, Rønnestad and Skovholt (2003) pointed to an early career stage in which the novice may hold onto initial theories to which they are exposed due to lack of experience, thus finding it effortful or even problematic to embrace new perspectives. Therefore, there is a need to understand how trainee CPs experienced the crucial undergraduate stage in their education in relation to their broader path to becoming a clinical psychologist.

Rationale and research aims

The BPS' own standards of accreditation for undergraduate degrees do not set out topics that relate directly to clinical psychology as an applied field despite the high proportion of undergraduates who hope to pursue this as a career and the expansion in

numbers of CPs and recognition of their vital role in the NHS. What literature does exist suggests that psychology undergraduates are provided explanations of psychological distress that may be at odds with how CPs work and the HCPC-consistent content of the clinical psychology doctorate. Research methods teaching tends to emphasise quantitative approaches, with a lack of focus on qualitative methods, while CPs are expected to be competent in both.

The main aim of this research study was to gain an understanding of how UK Trainee CPs understand the role of their undergraduate degree as part of their journey within clinical psychology. Within this research aim were two research questions

1. What are trainee clinical psychologists' experiences of how ideas about psychological distress were understood and taught in their undergraduate psychology course?
2. To what degree and how (if applicable) do participants feel that undergraduate teaching prepared them for their later clinical and academic career?

Method

Design

This was a qualitative research project. A Reflexive Thematic Analysis approach was used as a framework for gathering and analysing data captured in one-off semi-structured interviews. (Terry, Hayfield, Braun & Clark, 2017), (Braun & Clarke, 2023).

This approach was chosen on the basis of its flexibility, to allow the possibility of including different forms of data, such as university prospectuses, and the potential flexibility to utilise both inductive and deductive coding, including *a priori* theories from the field of critical pedagogy (Giroux, 2020, Friere, 1970, and Friere, 2000). These ideas were

eventually discarded early in the interviewing process. The researcher elected to focus on inductive or "data driven" coding in order to *"allocate interpretive primacy"* (Braun & Clarke, 2023) to participants' experiences, as the data did not appear to relate clearly to the theories identified. The use of Reflexive Thematic Analysis allowed this shift in approach to happen without compromising the integrity of the research design, as this approach can combine elements of both ways of analysing data.

Data collection

Semi-structured interviews were conducted both in person and over video calling software. These interviews were audio recorded and transcribed to text. An interview schedule (Appendix B) was used to guide interviews. This allowed the researcher to ensure that certain topics of interest to the research question were touched upon, while also remaining close to the participants' own experience. There was a focus on asking open ended questions with the aim of encouraging participants to share their experiences in their own words. The interview schedule contained possible follow up questions for the researcher to use, if needed.

The interview was pilot tested (Magnusson & Marecek, 2015) with a trainee clinical psychologist known to the researcher. This allowed for feedback on the degree to which questions elicited rich data. This interview was audio recorded and re-listened to by the researcher, allowing for reflection and scrutiny of moments where follow up questions were asked, or conversations cut off, for example. This resulted in some changes to the wording of questions and the addition of extra prompts for the researcher.

Participants

Nine participants were included to participate in this study. This was lower than the initial goal of 12-15 participants but within recommendations for a professional doctorate project using thematic analysis by Terry et al. (2017, p. 22). The researcher contacted programme directors and administrators at thirty clinical UK psychology doctoral training programmes by email to share information about the study and an invitation to participate to trainee CPs, who were invited to contact the researcher. Seven participants were recruited in this manner. Snowball sampling was also used by asking participants to contact other trainees who were eligible to participate. A further two participants were recruited in this manner.

Eligibility criteria for participation were as follows.

- Participants must have completed a UK-based, BPS-accredited undergraduate degree in psychology, or psychology alongside another subject.
- Participants must currently be a trainee CP in the process of completing a doctorate in clinical psychology in the UK.
- Participants who gained Graduate Basis for Chartered Membership of the BPS (GBC) through completing a psychology conversion course would not be eligible to participate.

The researcher had no prior relationship to any of the participants interviewed. One participant was a man, with eight participants being women. Seven participants described themselves as white British, one as white European, and one participant described themselves as having a mixed ethnicity. Six participants completed a BSc in Psychology, one studied Forensic Psychology, and two others psychology alongside Biology and Philosophy

respectively. All participants began their undergraduate degree prior to 2019, when the BPS published its latest standards for accreditation.

Table 1.

Table of participant characteristics

Pseudonym	Age	Gender	Ethnicity	Length of interview	Undergraduate degree details	Year completed	Master's degree?
Belinda	32	Woman	White British	01:33	Psychology BSc	2013	Yes
Rosie	26	Woman	White British	01:20	Psychology BSc	2020	No
Robbie	28	Man	White British	01:34	Psychology BSc	2017	Yes
Sophie	30	Woman	White British	01:25	Psychology and Philosophy BSc	2014	Yes
Lydia	28	Woman	White British	01:29	Psychology BSc	2015	Yes
Ffion	29	Woman	White British	01:24	Forensic Psychology BSc	2016	Yes
Nina	33	Woman	White European	01:20	Psychology and Biology BSc	2013	Yes
Bea	29	Woman	White South American	01:31	Psychology BSc	2015	Yes
Leonie	27	Woman	White British	01:03	Psychology BSc	2018	Yes

Data analysis

The researcher utilised a Reflexive Thematic Analysis methodology. The process of analysis followed a six-stage analytic process (Terry et al., 2017).

Familiarisation with the data offered an opportunity for immersion in the data corpus, in which the researcher first re-listened to each recording before re-reading each transcript while taking brief notes to generate provisional analytic ideas. An extract of these notes is provided in Appendix C

The researcher then began the process of coding. The researcher read an interview transcript and labelled sections of text at both the latent and semantic level. An anonymised extract of an interview transcript, with initial codes, is provided in Appendix D. This extract

illustrates how some codes relate to explicitly stated communication or describe the data (semantic coding), while latent coding involves an element of interpretation and "attempts to identify hidden meanings or underlying assumptions, ideas, or ideologies" (Byrne, 2022).

The researcher then generated initial candidate themes by clustering or combining codes into provisional categories, producing an initial map of themes (Appendix E). This was done using a paper and pen, allowing the researcher to identify patterns in the data and move and cluster codes by hand. This allowed the researcher to explore how provisional themes related to one another and consider how they could serve to explain an "overall story of the analysis" (Braun & Clarke, 2022, p. 85).

Theme development involved reviewing and developing these candidate themes. This was done by the researcher, holding the following in mind:

- Coherence of the data within each theme.
- The degree to which each candidate theme was distinct to other candidate themes.
- If there was enough meaningful data to evidence each theme.
- Their importance and relevance to the research question.

This was done in consultation with the lead supervisor, through sharing initial themes using an electronic document, allowing for comments, and through direct supervision and the discussion that arose from this. This supervision also offered an opportunity to discuss the lead researcher's position in relation to the data.

The researcher then renamed and defined themes. This involved providing clear names that reflected the content and meaning of the themes generated through the analytic process.

The final stage of analysis involved producing a written report, in which themes where described and extracts and quotes from the transcripts were selected to illustrate this.

Reflexivity and quality assurance

The researcher kept a reflexive journal as part of the analytic process and to help ensure transparency. Extracts of this journal are available in Appendix F. An anonymised extract of an interview, with initial codes, has been provided to aid transparency into the analytic process (Appendix D).

During an early stage of the research process, the lead researcher met with two supervisors to discuss his positionality in relation to the research topic. Given the researcher's positionality in relation to the topic, as someone who was a trainee clinical psychologist, and found their degree to be a useful introduction to some aspects of psychology yet found it challenging to integrate and what they had learned with what was expected in a clinical role. For the researcher this challenge this had been most evident in understanding qualitative literature, an area they felt was neglected in undergraduate teaching. Given this position as an "insider", it was important to use an approach that allowed for a reflexive position where this was made apparent and used as a form of quality control. This was done through a reflexive interview with the researcher and both supervisors, through regular supervision and though keeping a reflexive journal. This allowed the researcher to maintain an awareness of their own views during the design, interview and analysis stages.

In the interview stage, this was done through ensuring questions were worded to encourage openness and avoid leading participants as much as possible. This was especially important when asking follow up questions during interviews.

The researcher held in mind his own views and positionality during process of coding and theme generation, in order to analyse points of similarity and difference within the data reflexively. Regular research supervision allowed this to be discussed during the analytic process.

The researcher contacted participants after an initial version of the analysis was completed, during the fifth stage of analysis, as a form of member checking (Côté & Turgeon, 2005). Participants were invited to share their perspectives on these provisional findings, and the degree to which they fit with their experiences. One participant responded by email, who consented to an excerpt of their email be shared in this report's [Appendix G]. Their response to the initial findings was one of broad agreement, and of the findings resonating with their experience.

Ethical Considerations

Ethical approval for this project was granted by Canterbury Christ Church University, Salomons ethics panel prior to the commencement of the project (Appendix H)

Prior to interview, each participant received an information sheet (Appendix I) outlining the study's purpose, procedures, and potential risks and benefits and were informed of their right to withdraw their participation. All participants provided written informed consent to participate in the study, signing a consent form containing key

information about the study (Appendix J). Password protected consent forms were stored on an encrypted hard drive, as were anonymised interview transcripts.

Findings

Analysis of the data resulted in four key themes. These will be described in this section, along with subthemes and interview quotes.

Table 2.

Summary of themes and subthemes

	Theme	Subtheme
1	An interest in people	Asking the question "why?" Something to draw upon Competition and sacrifice
2	Scientific knowledge	Positivist Western canon Dominance of diagnostic and biological explanations of distress Comfortable with quantitative Whose voice(s)?
3	Two psychologies	An experience of two fields disconnected Discouraged Different people in a different place
4	Developing a broader understanding	Useful foundations Helpful but optional Learning outside of the degree

An interest in people

While this theme did not immediately relate to the project's research question, this pattern within the data provides important context for participants' experience. This is therefore presented in order to offer a richer description of participants' relationship to their degree, to clinical psychology as a field, and to their journeys to becoming a trainee clinical psychologist.

Participants described how they developed interest in pursuing psychology as a profession. Some described this stemming from a sense of curiosity or wanting to help others. For many participants, this drive was described as powerful, as it had to overcome significant hurdles along the way, including competition, a lack of development opportunities, particularly around jobs and doctoral training places.

Asking the question "why?"

Participants recalled a variety of influences in their life driving their passion and curiosity about people. Sophie described how she began to wonder about why people acted in particular ways on reality TV shows,

> "they're put in really random situations and it's just really interesting to see how they respond to that. Different people respond so differently and I'm always like, "Oh, well, why's that? Like, what's going on there?" (Sophie)

For others, this curiosity based on what was going on around them growing up, as illustrated by Ffion's description of wondering why some of her classmates seemed to be in trouble with the law.

> "There was a lot of criminal activity within school. A lot of friends that I had ended up involved in the criminal justice system. [There was] quite a lot of poverty. So, I suppose I really became interested not necessarily in psychology but in why were people that I knew, who were really nice people, ending up in contact with Criminal Justice Service? Why was that happening?" (Ffion)

For most participants, this led them to decide to study psychology, either at undergraduate level or earlier at A level. One participant first considered medicine, before later deciding that clinical psychology was a more suitable avenue to satisfy this curiosity.

Something to draw upon

Participants described a sense of being drawn to psychology based on what they saw they could offer to the field. Robbie, made reference to his personal experience of psychological distress, and finding this to be helpful in clinical work.

> "I've got something to draw on here" (Robbie)

For others, some of this stemmed from challenging early life experiences.

> "I grew up in a household which was quite violent, quite aggressive, there was lots of drug use, and alcohol use […]. In growing up in that environment, I think I took on the role of peacemaker. That environment fostered this person who was able to be really attuned to other people's emotions, and also be quite skilled at deescalating, and spotting when things are going off the rails. And, actually, those are things that make a very good psychologist, I think." (Belinda)

Participants voiced a desire to help others through their work. For one, this was based on their experience of receiving therapy:

> "What I got from my therapists, and what they meant to me, you know, in my life, the roles they had for me, meant that, in a way- yeah, in a way, I'm like, "Oh, could I do that for others?"" (Bea)

Competition and sacrifice

Most trainees described going to great lengths to pursue this passion. Many worked multiple demanding clinical roles, sometimes alongside further study, such as a masters' degree.

> "I graduated and then worked as a support worker in three different services, which sounds mental […] I had, like, one day off a month and it […] it probably wasn't healthy" (Sophie)

For some, this involved moving house multiple times for (sometimes honorary) assistant psychologist posts. Some participants described working in roles that they found to be ethically challenging.

Scientific knowledge

Positivist Western canon

Participants described their experience as an undergraduate as a broad introduction to psychology as a science in which they were introduced to prominent psychological theories and studies.

> "We talked, obviously, about the classics, the Milgram experiments, or attachment theory or things like that" (Rosie)

Some participants recognised a Western bias underlying the theories discussed at degree level,

> "It was very… a, kind of, Western history of clinical psychology and looking at Pavlov, and Piaget, and Skinner and all that kind of stuff […] there were these obligatory modules on, like, neuropsychology, and cognitive psychology and perception. […] it was so, kind of, positivist" (Robbie)

Rosie found that this was done without being explicitly labelled as such.

> "I'm not sure they were explicitly said, "This is how this works. This is a fact," but it wasn't not said" (Rosie)

Dominance of diagnostic and biological explanations of distress

Participants reported an emphasis on neuropsychological and biological approaches during their undergraduate degrees. One trainee described how teaching on mental health was structured around a diagnostic classification system

> "There was no focus on clinical psychology. And the mental health modules were not about therapy, they were about the ICD/DSM" (Belinda)

Among those interviewed, this was a common experience.

> "You could pick different modules. One of them was around mental health and clinical psychology […] it was quite diagnosis based. Like each lecture was on a different diagnosis, that kind of thing." (Leonie)

Lydia recalled how biological explanations, such as those that involved ideas about brain functioning were prominent.

> "In undergrad, it was very, yes, brainy" (Lydia)

Participants, during their undergraduate developed a more biologically oriented understanding of distress, centred around genetic predispositions.

> "I would have said, in my undergraduate, "There's a strong genetic reason, like, a stress diathesis reason why people get mental health difficulties and these studies say that 60% of twins get this because of this reason and you can clearly identify it in the brain,"" (Robbie)

Robbie then shared his view that this would not be sufficient to work therapeutically.

> "you get all the teaching on, like, the guy who had the bar through his head. What was his name? […] Phineas Gage. It's interesting, those sorts of stories, but I guess it

> felt quite divorced from… like, I can't imagine myself being a therapist just learning about these studies" (Robbie)

Some stated explicitly that they did not come across the concept of formulation until later in their careers, after graduation. One participant shared a sense of shame that they worked in a clinical setting with what they later understood as a potentially harmful understanding of distress.

> "I look back on now and I cringe inside, the way I perceived their distress. I'm just like, "Oh, like, that is just so…" I don't know the word. I want to say narrow-minded, but it's probably just the medical model, like […] it's that whole thing of the phrase of, like, "Oh, it's behavioural. They're doing it on purpose. They're doing it because they're being manipulative."" (Sophie)

Some participants had different experiences. One trainee describe how their undergraduate degree contained a module covering understandings of distress beyond diagnostic approaches.

> "[We] looked at the history of mental health, and how mental health has been managed throughout the years, and also looking at the historical context of mental health and how it's positioned within society, and changing views on that. I really enjoyed that module" (Ffion)

Comfortable with quantitative

Participants consistently reported an emphasis on quantitative research methods during their degree. One trainee described how this gave them a robust and practical grounding in these methods.

> "With quantitative data, they gave us, like, real examples of how you do it and we read articles all the time in undergrad. You could see the methodology, you could see what you were learning and how that was applying to real life, in terms of being a researcher." (Nina)

Some trainees were proud of their statistical knowhow, while other trainees found this approach aversive.

> "In terms of stats I absolutely hated it. It was all SPSS, putting stuff into boxes. I was putting things into the wrong boxes […] It turned me off research." (Lydia)

Most participants found that there was less of an emphasis on qualitative approaches. Bea, who was an undergraduate at a highly regarded research oriented university, wondered if there was more collective expertise on quantitative methods among the psychology department, and how this might influence teaching.

> "I am aware that a lot of people don't see it as science, as in, qualitative work was questioned, at the time I was in my undergrad. The staff were like, "Oh, no, don't do that." Again, I think because they didn't know how to do it, was my feeling. Like, they're not experts in it." (Bea)

Bea found that this teaching felt tokenistic and meaningless, and led her to dismiss this as method of inquiry. There were some exceptions to this. One participant, while recalling that there was less qualitative instruction, also recalled a mini qualitative project that involved using thematic analysis to conduct and analyse short interviews.

Whose voice(s)?

Very few participants described learning about lived experience perspectives during their undergraduate degree. One participant noted a sense that psychology amplified some

voices over others, saying that there was no perspective shared from experts by experience during their undergraduate degree, and shared their hope that this has changed since. In contrast, another trainee recalled a memorable optional module in their undergraduate course, that featured teaching by people with lived experience of psychological distress. They recalled this fondly.

> "The most memorable part was definitely the people who came in to speak to us who had lived experience, and how that was positioned, and then thinking about the development of mental health as a concept, as well, from the historical influences through until now. So, it was really good." (Ffion)

Two psychologies

An experience of two fields disconnected

Trainees noted a disconnect between what was considered essential or foundational knowledge presented at degree level, and what is required as a trainee. This focus on psychological distress being outside the norm was shared by other participants, many of which also reported being offered an optional module with similar terminology.

> "We had a lecture called abnormal psychology. It was basically listing all the mental health problems. When I look back it was very stigmatising and very poorly… Yes. Abnormal, do you know what I mean? Just the language used." (Lydia)

Another participant, Sophie, shared that she had not learned about the concept of formulation throughout her degree, which led to a challenging moment during her later clinical practice.

> "What the heck is this? This isn't psychology. This isn't the psychology I know [...] I just couldn't get my head around it in that time. I was like, "I don't understand."

> They used lots of words that I didn't understand. I didn't understand what a formulation was". (Sophie)

This led Sophie to feel frustrated, jokingly describing her degree as "a bit shit and completely unrelated" to her later career. This was echoed by another participant, particularly in relation to clinical work.

> "Clinically, zero. Well, not zero, but, like… yeah. The theory, a little bit" (Rosie)

After graduating from their undergraduate degree, participants described their experience of working clinically without a basic understanding of some common clinical presentations

> "It was my first time coming into learning disabilities and then just thinking about, kind of, assessing them and how to work with them and thinking about positive behavioural support and things like that. I was like, "God, this would have been really useful to have just some knowledge of, like, people with learning disabilities. It would have fit really nicely into the individual differences module. Why were we never taught about this?" (Rosie)

One participant was concerned that the Power Threat Meaning Framework, a clinical approach that they had found useful after graduating, might not fit neatly into an undergraduate curriculum.

> "I think other members of the faculty would go, "Where would this fit? Where could we put this into our already perfect, like, content criteria for things we have to cover? Where does it fit in with the BPS guidelines?"" (Rosie)

In contrast, many participants found their undergraduate provided a good grounding in research skills that proved useful when conducting research.

> "when it's coming to designing research […] I'm like, "Yeah, I remember this. I did this." I got to do, like, a… like, my thesis, I had to get the ethics […] so I know what getting approval through external things looks like and I was supported to do that. So, academically, very relevant." (Rosie)

Participants wondered about the role of the BPS in amending the core curriculum, reconciling these strands of psychology that they saw as disconnected.

> "The BPS have a role […] they set out that there's a focus on, in undergraduate degrees, individual differences, social psychology, something else, something else, and they set out what the doctorate does. I wonder if they need to look at themselves and go, "Is there a better way to connect those two things for people that are doing that?"" (Rosie)

Discouraged

Some trainees described how they were actively discouraged from pursuing clinical psychology on account of its competitiveness.

> "I do remember in our first day of our undergrad they were basically saying, "Most of you think you are going to be clinical psychologists, but only 10 of you in this room will make it. Don't even think about it." (Lydia)

Some trainees recalled losing interest in clinical psychology on account of this, and not recovering an interest until later in their career, while others were not deterred. One trainee recalled a particular conversation in which she felt discouraged.

> "I came to them in second year and said, "I want to do clinical psychology in the future. What would you recommend I do?" They laughed and said, "You'll never

> become a clinical psychologist. Nobody from our degree has ever become one," (Rosie)

This was recalled with a sense of humour, noting that both she and another student from that cohort are both trainee CPs.

Different people in a different place

Trainees noted a sense of distance between clinical training courses and the rest of the psychology department, undergraduate courses. They noted the lack of CPs involved in undergraduate teaching, including at universities that offered doctoral training as well as an undergraduate degree.

> "Thinking through the kind of list of people on the undergraduate programme, they weren't CPs. And they aren't, here in [doctoral training programme], either. They're a completely separate team, a completely separate department" (Belinda)

Others wondered about the group dynamics at play between faculty staff.

> "Lecturers on the psychology course had taken more of a theoretical route into psychology and maybe hadn't taken this clinical route. The clinical people were, kind of, seen as other." (Rosie)

Nina noted a physical distance, with undergraduates and doctoral training taking place in completely different buildings, and this being true for academic and teaching staff too.

> "And that's bearing in mind, the clinical psychology doctorate, totally different building, totally different department at the same university." (Nina)

Some trainees considered how this distance could also be self-sustaining in how it reduced the potential for bridging this perceived gap in the future, for example by discouraging

trainees from seeking doctoral research supervision with staff at the broader psychology department.

> "[The programme] is very small, […] you have a small teaching staff, as well, so you kind of get what you get. And if the skillset for a particular type of research isn't within that research team, […] it's just an extra layer of challenge, isn't it? Whereas if we were more connected with the wider academic population within the university, chances are, we'd be able to expand" (Belinda)

Developing a broader understanding of psychology

Useful foundations

Trainees described how the degree offered a foundational understanding in psychological theory. Some participants found this useful in clinical practice

> "Because it was academic and very theory-based, the models sit quite nicely in my head. Because I'm CAMHS-focused, I'm very much thinking about attachment and we did a lot about Piaget and when I see a child, I can think about, "Right, what stage of development are they in?" and things like that. So, actually, I've got those models, they're sitting in my head." (Leonie)

While not every trainee thought this was relevant day to day as a clinician, this offered a useful frame of reference for doctoral training and for formulation, for example when using neuropsychological testing that called upon certain concepts such as working memory or attention, or when working with people in a brain injury service.

> "Now, when I'm doing neuropsych and there are statistical parts of that, when you're writing it up and interpreting it, and I often think, like, Oh, man. I learnt about

> confidence intervals in my undergraduate degree and it was difficult learning, but useful" (Robbie)

Helpful but optional

Trainees described how a significant portion of what later became useful were an elective part of their degree. These included optional modules that involved a lived experience based approach, introductions to psychological formulation, or history of psychological ideas.

> "I don't know how much the standard psychology modules did prepare me for clinical training. I think they gave me a generic and brief understanding of different types of understandings and how they can be used. [The] Mental Health and Distress module and all the forensic modules had much more focus on clinical practice and how you'd work […] prepared me to go out into the world, to the work that I was doing as an assistant. (Ffion)

Learning outside of the degree

Despite this learning, trainees were aware of the broad set of skills required to be a clinical psychologist, and described how they set out to develop as professionals. While Bea adopted a comparatively steadfast position among those interviewed,

> "It didn't prepare me, in any way, for my doctorate, in the clinical sense. And maybe I was sleeping during those lectures, but I don't think so. I don't think the undergrad was geared towards the clinical training." (Bea)

Instead, these opportunities often had to be sought in addition to their degree. Trainees described working in complex and demanding services, and these experiences served as foundational learning moments for their development as clinicians.

> "They gave me lots of training in different therapy modalities, like ACT, and DBT and all that kind of stuff, like CBT. They were quite thorough with what they were offering, so that really opened my eyes and built my skillset up." (Sophie)

Discussion

Participants found aspects of their undergraduate learning beneficial as part of their journey in clinical psychology, for example as a formative grounding in Western experimental psychology and a robust introduction to quantitative research methods and appraisal.

However, there were inconsistencies in participants' reports of learning other essential skills. The majority of participants reported learning about psychiatric distress through a predominantly diagnostic lens, which some participants found difficult to reconcile with formulation based approaches as their career progressed. All participants reported that these modules on mental health were elective, reflecting how clinical psychology or mental health is not among the eight core modules set out by the BPS for undergraduates.

Five of the nine participants interviewed made references to a sense of a disconnect between their initial learning and what was later expected of them pursuing a career in clinical psychology, such as fundamental differences in ideas presented explaining psychological experiences, or in the physical spaces occupied by university staff.

Trainees described opportunities outside of their degree as essential in aiding their development within clinical psychology. These included key relationships with mentors, using supervision in assistant roles, and masters level education. Through this, participants

developed their understanding of formulation based approaches, therapeutic skills, fostering a broader understanding of psychology.

Inconsistency in approaches to understanding psychological distress

There was also significant variation among the experiences described by participants during their undergraduate degree. The majority of participants learned about psychological distress in their undergraduate teaching through optional modules which were structured around a psychiatric classification system. This is in line with findings from a survey conducted over 15 years ago (Cromby et al., 2008). This is particularly troublesome given that some participants described experiencing diagnostic and formulation-based approaches as difficult to reconcile, with one participant recalling how they first rejected this concept, stating “this isn’t psychology”. This is consistent with the theory of cognitive dissonance, where new ideas that too distinct from previously held ideas are rejected (Festinger, 1957).

A smaller number of trainees reported receiving teaching in formulation based approaches, with one participant describing how this also involved experts by experience. This variation in experiences could be explained by the fact that content that relates directly to clinical psychology is not part of the core BPS curriculum (British Psychological Society, 2019) and universities have more freedom to present this differently.

Qualitative and quantitative research methods

A common finding among this dataset was how participants found quantitative teaching to be robust and helpful later in their career, for example in terms of conducting, writing or making sense of evidence. In contrast to this, many found that there was less

focus on qualitative approaches, leaving them with a limited understanding of these methods at graduation.

This is consistent with research findings of a "quantitative culture" in UK Psychology departments (Gibson & Sullivan, 2018). While quantitative research skills are an essential part of a CP's skillset, this potential dominance represents a problematic finding for the field of clinical psychology, as qualified CPs are expected to be proficient in a range of methodologies, including qualitative methods.

Implications for clinical psychology

While psychology degrees are not intended to function as a foundation in clinical psychology, this small and detailed examination of trainees' experience may indicate that there are aspects of the training pathway for clinical psychology that do not function as smoothly as they could. This was particularly evident in participants' descriptions of optional modules on psychological distress being structured around psychiatric diagnosis. Some trainees recalled how they struggled to reconcile the concept of psychological formulation with this earlier teaching, which was particularly problematic given the centrality of formulation as a competency for clinical psychologists.

A shared experience among participants was of having to seek additional learning outside of the undergraduate degree in order to make sense of clients' distress. While this is expected given their early career stage, this also represents how there may be a missed opportunity during the undergraduate degree to offer an education in an approach that is consistent with how CPs are expected to work, such as a grounding in formulation as opposed to a more medical, diagnostic understanding. This is in line with Vygotsky's sociocultural theory of learning (1934), which suggests that individuals develop more

effectively with support and scaffolding. Supervisors of aspiring clinical psychologists may benefit from holding in mind the variety of experiences at degree level, and that some trainees, assistants or placement students may have "gaps" in their knowledge base, and ensure they have opportunities to examine and develop these.

Some participants described how much of their most significant learning that prepared them for a career in clinical psychology came outside of their degree, such as through relationships with mentors, or through highly competitive assistant psychologist roles. These experiences are less accessible in comparison to undergraduate degrees, and while these findings alone cannot be generalised across the broader UK, this could perpetuate or widen inequalities in career development opportunities within clinical psychology.

While many psychology graduates do not eventually become CPs, the majority do have a desire to pursue a career in mental health, and a significant proportion do eventually work in the field of mental health in some capacity (Palmer et al., 2021). If participants' experiences in this study were representative of the broader experience, this could have negative consequences for the NHS. For example, the potential lack of teaching in formulation could represent a missed opportunity to develop psychological literacy in a population where a significant number end up working in mental health. This could be problematic for the planned training of psychological practitioner of different backgrounds as part of the NHS Long Term Plan (NHS England, 2019).

Limitations

This study represents findings from in depth qualitative interviews with nine trainee CPs, aiming to explore in detail their subjective experience of learning during the psychology

degree, and the relevance of this to their later career in clinical psychology. Given this small sample, caution should be exercised extrapolating these findings to the larger psychology cohort across the UK.

The present study has a 'time lag'. By recruiting current trainees who completed their undergraduate degree in the past, it is possible that psychology degrees are now taught or structured in different ways. The present study also relied on participants' autobiographical memory of events some years prior. However, given that the main aim of this project related to trainees' experiences and sense making as developing professionals, rather than to make claims about the exact content of psychology undergraduate degrees in the past, the use of autobiographical memory is appropriate for this end.

Directions for future research

A survey methodology would be useful in clarifying the degree to which these findings can be generalised across the UK. A study such as this would represent the first such survey since Cromby et al. (2008) and would also address the time lag in this present study, to evaluate how ideas of psychological distress are taught and are conceptualised at degree level. A particularly pertinent question for clinical psychology would be to investigate who is involved in optional modules on psychological distress, be it clinical psychologists, academics, and the degree of involvement from experts by experience.

Surveying current students, or recently graduated psychology graduates would also investigate if there have been any changes in students' experiences since the BPS' latest curriculum was introduced in 2019. This could also evaluate a more experiential aspect of

this learning, such as how students potentially integrate this knowledge with the broader psychology curriculum.

Investigating CPs views on working with undergraduates, both through offering placements or through teaching at undergraduate level could help move toward a deeper understanding of what influences the disconnect between academic and clinical psychology in the UK.

There is also a need among the field of psychology to resist narrow interpretations of what constitutes evidence, and to encourage broader methodological approaches in psychology, specifically the rigorous use of qualitative approaches at undergraduate level. Clinical psychology has a role to play in this, by looking outside of NHS and private clinics and looking to university psychology departments as a means to share psychological thinking both with future psychology cohorts and with academic staff.

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Christopher Emlyn Ioakim BSc Hons

SECTION C: APPENDICES

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JUNE 2025

SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A

CASP Quality Checklist

	Stewart et al. (2018)	Court et al. (2016)	Marques et al. (2016)	Stewart (2012)	Rous et al. (2010)	Nelson (2006)	Geerlings et al. (2018)	Kagee and Lund (2012)
Was there a clear statement of the aims of the research?	YES	YES	YES	YES Some issues as aims statement specifies quantitative methodology	YES	YES	YES	YES
Is a qualitative methodology appropriate?	YES	YES	YES	YES	YES	YES	YES	YES
Was the research design appropriate to the aims of the research?	YES	YES	YES	YES	YES	YES	YES	CANNOT TELL Lack of explicit reporting on why this methodology was chosen
Was the recruitment strategy appropriate to the aims of the research	YES	YES	YES	YES	YES	YES	YES	YES
Were the data collected in a way that addressed the research issue?	YES	YES	YES	YES	YES	YES	YES	YES
Has the relationship between researcher and	NO No information	YES	NO No information	NO No information was provided on the	YES	NO No information was provided on the	NO	NO No information was provided on the

participants been adequately considered	was provided on the background of the researchers		was provided on the background of the researchers	background of the researchers		background of the researchers		background of the researchers
Have ethical issues been taken into consideration?	YES	YES	YES	NO No mention of issues around consent, ethics etc in the report.	YES	YES	YES	YES
Was the data Analysis sufficiently rigorous?	YES	YES	YES	YES	CANNOT TELL Specific analytical approach not named nor described in detail	CANNOT TELL The specific qualitative method use was not named nor described in adequate detail.	YES	NO No mention of what type of analysis was used and limited description of analysis.
Is there a clear statement of findings?	YES	YES	YES	YES	YES	YES	NO Descriptions of the findings are brief. Quotes at times do not relate clearly to findings.	YES
How valuable is the research?	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable

Appendix B. Interview schedule

Interview Schedule

Demographic information for context

- Age, year of study, year completed undergrad degree.
- How would you describe yourself in terms of gender, class, race, cultural background?
- Where did study for your undergraduate and where are you training at the moment.
- Route into training.
- What therapy models or approaches have you used and are currently using?

Introductory questions

- Tell me how you became interested in clinical psychology as a potential career.
    - Potential prompt: experience of mental distress
- Is there anything else important that would be useful for me to know about you in order to better understand your perspective?

What are trainee clinical psychologists' experiences of how ideas about psychological distress are understood and taught at UK undergraduate psychology courses?

- Thinking back to your degree, can you tell me about how were ideas about mental health or psychological distress understood and taught?
    - Prompts: What do you remember in terms of any focus on mental health/clinical psychology/psychological distress? What kind of explanations of mental distress or difficulties were discussed? To what degree were service user perspectives present?
    - Can you describe the approaches to teaching and learning during your degree? Prompt: For example, lectures, roleplaying exercises, experiential approaches, lab sessions,

To what degree do participants feel that undergraduate teaching prepared them for their later clinical and academic career?

- How, if at all, do you think your degree prepared for your clinical and academic career?
    - Are there particular ways in which you have found your degree useful? Have there been times when you felt it was unhelpful? In what way? What was that like?

- How were concepts you encountered in undergraduate education similar or different to what you came across in your clinical work or your current training?
    - Prompts: How did it feel when you came across a different approach? How did you manage this? What was going on in your mind?
    - How did it feel when you came across a familiar approach? How did you manage this? What was going on in your mind?
    - Can you tell me about your current experience as a trainee, thinking about the relevance or not of your undergraduate education?

What, if any, changes do trainees describe in their understanding of psychological distress after their undergraduate degree and what do they attribute this to?

- How, if at all, has your understanding of psychological distress changed in any way since your time studying for your degree?
    - Can you tell me about what influenced this?
        - Reading or own learning, experience, later formal education (e.g. Masters/PhD), clinical experience.

Are there other areas in which trainees notice a difference in approach?

- What images come to mind when you think of your psychology degree?

- What images come to mind when you think of your doctoral training

- Have there been any other areas where you noticed a similarity or difference in approach between your degree and clinical training?
    - How were qualitative and quantitative methods understood during your degree and during your current training?
    - How were different epistemologies discussed during your degree? To what extent were ideas discussed as facts?
    - Service user perspectives (if not already discussed)
    - Racism and its relationship to psychological distress
    - Social inequalities approaches

Appendix C. Extract of data immersion notes

Log

Participant 1

Had a fond sense of their degree, formed important relationships and grew as a person

Emphasis on neuroscience during degree

Emphasis on academic research skills

Felt that degree didn't cater to clinical psychology much

Sense of a divide between degree and clinical psychology. Attended universities with both and both were different departments in different buildings, different staff groups with no connection

Participant 3

Keen interest in social constructionist approaches with a critical perspective on western forms of knowledge, encouraged by elective modules during degree

Understanding of psychology shifting over time as a result of elective module, qualitative methodologies used during masters and direct clinical work as an assistant psychologist

Canonical psychological theories and studies (Asch, Milgram, Pavlov) seen as essential learning but also regretting that these were taught as facts in a positivist sense – conflicting feelings

Interesting that more critical perspectives were taught at a former poly university

Interview 5

Described degree as being very neuro heavy

Research oriented, highly ranking university with a heavy emphasis on “abnormal psychology” diagnostic led approach with an emphasis on quantitative approaches

A lot of the learning that was necessary to work clinically had to come through clinical work as a support worker or assistant or was self-initiated through reading.

Sense of a conflict between the type of knowledge presented during degree – diagnosis led classification separated from human experience was incompatible with ‘being with’ clients and developing relationships.

Interview 8

Middle class participant at a research oriented training programme

Talking about the conflict between what is considered scientifically rigorous and a more human understanding that arose from her own experience of therapy

Hypothesis around the pressures of academia filtering down to students and the psychological effects of this (anxiety, stress)

Undergraduate university staff were well versed in quantitative approaches. Qualitative were neglected in comparison leaving the teaching feeling meaningless.

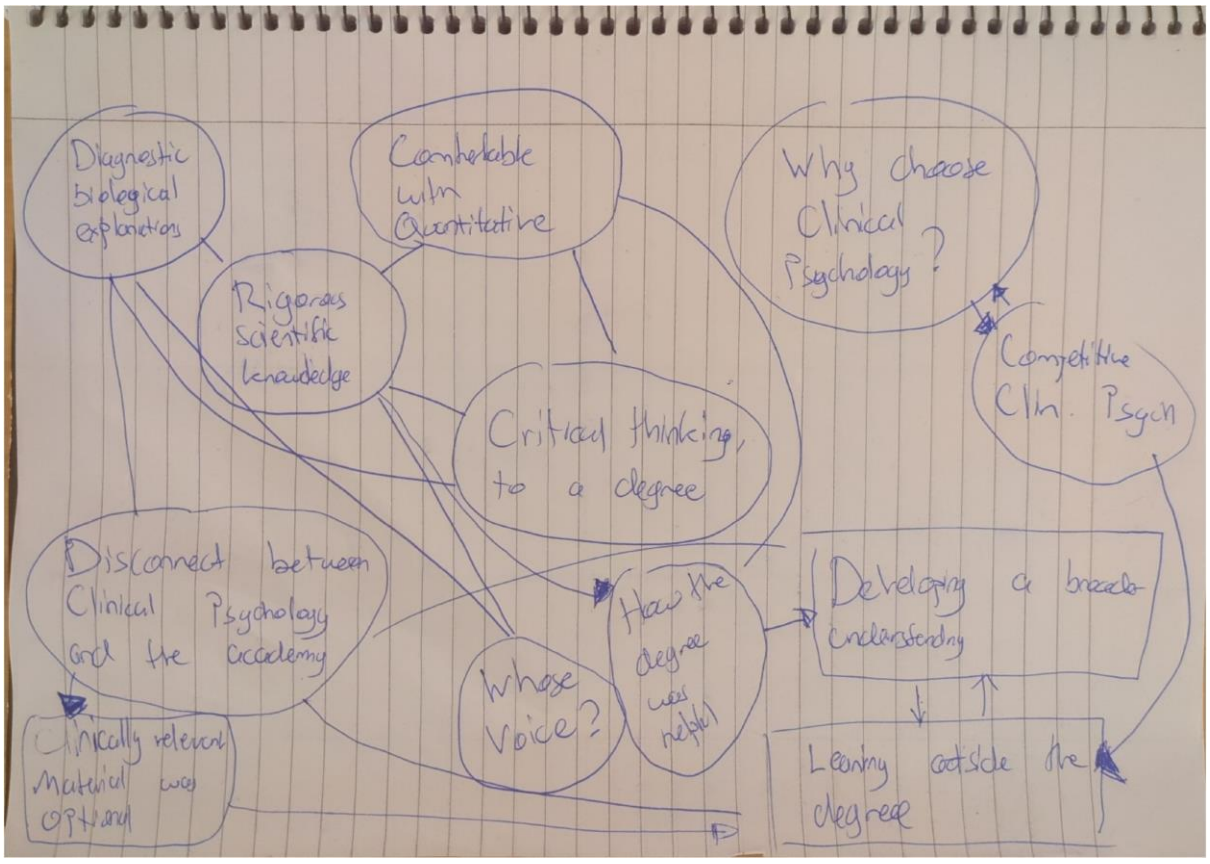
Staff mostly oriented toward quantitative approaches and hypothesis testing. Led to qual being taught in an overly rigid way that did not feel “human” or “real”

A lack of joined up thinking and not much sense of how this expert knowledge could be applied

Appendix D. Extract of interview schedule with codes

This has been removed from the electronic copy

Appendix E Initial map of themes



This handwritten diagram shows an early map of patterns across the dataset. After all interviews were completed and coded, I re read through the interview transcripts and codes. This stage, early in the process of theme generation, allowed me to visualise patterns of meaning and possible connections within the data. This helped me make sense of the dataset as a whole while the dataset was fresh in my mind. I also cut out some of the labels in this diagram, placing them on the floor alongside codes and quotes from the dataset.

Some items in this map were combined to form themes later in the analysis, for example, I found that four items in the upper left in the diagram grouped together neatly to eventually become the theme “scientific knowledge”, a theme centred around the prioritisation of a particular understanding of what constituted legitimate knowledge within trainee’s undergraduate degrees.

Two further items in this diagram, “disconnect between clinical psychology and the academy”, was fleshed out in to become “two psychologies” – a theme centred around trainees

experiences of differences and disconnects between clinical and academic university departments

Appendix F. Reflexive Log

Ethical approval 6/4/23

Just heard back from the ethics panel! Had some corrections to make, nothing huge thankfully. It's quite strange to think that I'll soon just be able to get on with this with nothing in the way except my own motivation. To be honest I'm quite nervous. I've conducted interviews before, and use thematic analysis, but only for the odd focus group and for some practice based research a few years back.

Pilot interview 10/4/23

I've finished a trial run of the interview with a friend. It's quite a busy time for me as I'm moving out of London in a week so it was nice to have a task to just focus on and not worry about boxes and so on. I was surprised at how well it went! I listened back to it though and found that there were parts when I just kind of said yeah, and let him talk when maybe I could have been thinking a bit more actively and asking why. I definitely spotted some missed opportunities there. Regardless I think we had a good conversation and I think I would be happy if most of my interviews were like this. I know I have a tendency to be quite self critical which is sometimes useful and sometimes paralysing – I need to watch this but I'm glad that this exercise has felt ok. I've tweaked some of the questions as they looked alright when I wrote them down but saying a couple of them out loud seemed clunky. I've also added some prompts that I can use too.

Meeting with both of my supervisors 25/5/23

I've just met with Paula and Sue to discuss my own stance in relation to the topic. It was interesting and I appreciated their expertise on some of the philosophical underpinnings of qualitative research. This was unfamiliar to me as a lot of my background and formal teaching was quantitative, which is part of my motivation for doing this.

They asked the questions – what findings do I expect, and what would surprise me.

I think I have a sense of the degree being very rigid and experimental. I found it so different to my doctorate. I think if you talked to some of my degree tutors about something like psychodynamic approach theyd be shocked and call it pseudoscientific. I remember last year I spoke to a friend of a friend who is an academic psychologist and we had a disagreement about measurement in psychology, with me saying I'm not sure if it's always the best approach and the importance of qualitative stuff. It's funny to me because during the degree I would've taken his view – I remember I used to get into arguments with my housemate's anthropology coursemates about this!

So I do kind of expect others to have had similar experiences, but I also know that some courses had placement years and so on so I wonder how much variation there will be. I think it would really surprised me if someone came along and said we had this great module with lots of experts by experience and those sort of perspectives weaved in.

1st Interview 20/6/23
I really enjoyed the first interview. Felt that went surprisingly smoothly. It surprised me how much she enjoyed her degree, not necessarily for the content of what was taught but because of some key figures in the faculty that served as mentors. This is something I hadn't really expected would come up – the 'extra curricular' stuff that university offers that could enable growth. She also just talked about making friends and being social and this being important. This was so unexpected!

Also a quick note on my anxiety levels. I've definitely procrastinated on this. Hopefully I'll get some kind of handle on it. I think managing this and my focus is the biggest challenge for me right now.

Writing the report 1/10/23
I've finished all my interviews now. I've got a sense of what people were saying broadly but I've yet to code all of them let alone get onto themes. People saying about the focus on experimental psychology, quantitative stuff, focus on diagnosis and so on – that didn't surprise me one bit, that's what I experienced too. I need to be careful not to over egg that in my report because there were some exceptions, even though they were quite rare – actually maybe only one or two? I think the biggest one was a particular participant who said they had this great optional module with clinical psychologists that talked about the history of clinical psychology, in a really critical way and they had lots of current and former service users in. I think I was actually a bit jealous cause I didn't really come across that stuff until a good few years after I graduated. I wish more people said that sort of thing – I wonder how many psychologists have dismissed more experience based knowledge as it doesn't fit in to certain notions of what is proper.

Appendix G. Response from participant, member checking

From [redacted]
Sent [redacted]
To [redacted]
Subject: Re: Research findings and respondent validation

CAUTION: This email originated from outside of CCCU. Do not click links or open attachments unless you recognise the sender and know the content is safe.

[redacted]

[redacted]

Here are my reflections:

I agree with undergraduate focus being mainly biological, and how clinical psychology was presented in a way as 'abnormal disorders' or 'disorders of the mind'.

In my experience, I agree that the modules were mainly focussed on quantative principles, and qualitative principles not being focussed on much. This has led me to question up until doing qualitative research on the doctorate, whether qualitative research is 'real science' and 'taken seriously' in the research field. However now I am undertaking qual research I really see the benefit and wonder if more could be done at undergrad to support these methodologies.

I was also discouraged to take up CP as an undergraduate student, being told on the first day 'not to bother' really resonates with me. There was also a module in 3rd year in which only people of 'high academic standard' could participate in the modules, once again reinforcing the difficulty of getting on the course, and that it is perhaps for more academic individuals.

I also agree with the CP and undergraduate psychology courses being so separate and think this is a really interesting reflection and wonder if they were to link up and integrate whether this would enhance trainees learning.

[redacted]

Appendix H. Letter of ethical approval

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Appendix I. Participant Information Sheet

Participant information sheet

Study title: - How do UK Trainee Clinical Psychologists experience and make sense of their undergraduate psychology degree in relation to their doctoral training?

Researcher name and title: Christopher Emlyn Ioakim, Trainee Clinical Psychologist

c.e.ioakim80@canterbury.ac.uk

I would like to invite you to participate in this research study that explores people's experience of completing an undergraduate degree in psychology in the UK. Before agreeing to participate it is important you understand what this will involve. If you have any questions about the study that are not addressed in this sheet, please ask ne.

I am a trainee clinical psychologist studying at the Salomons Institute for Applied Psychology, Canterbury Christchurch College. This research project will form part of my major research project and is supervised by Dr Sue Holttum and Professor Paula Reavey.

What is the research about?

This project examines how trainee clinical psychologists experienced their undergraduate degree, any ways in which they felt this was relevant or not to the rest of their career and their experience of how ideas about mental health are understood and taught through different stages of this process.

What will this involve for me?

If you agree to take part, I will invite you to an interview where you will spend up to an hour and a half talking about your experience of studying psychology at undergraduate level.. You will be asked about how this relates to your experiences that followed this, such as in your clinical training and on placement. In order for me to record what you say accurately I will record the interview digitally.

Are there any risks to participating?

The interview may involve talking about times when experienced tension or uncertainty making sense of ideas around mental health. If you feel uncomfortable, distressed, or at any point want to end the interview, you can let the interviewer know, and we can pause or stop the interview. If any questions during the interview make you feel uncomfortable, you do not have to answer them.

How do I withdraw from the study?

You can withdraw from the study at any point without having to give a reason, until a month after your interview, by which time I will have transcribed and anonymised your interview and may have begun incorporating your data into that from other participants, making it harder to disentangle it. Withdrawing from the study will have no repercussions. If you withdraw from the study I will not retain the information you have given.

What are the potential benefits?

Your participation will contribute toward understanding the role of undergraduate psychology degrees in the UK in relation to people's later careers. This will be published with the aim of informing our understanding of this stage in the education pathway for clinical psychologists.

Confidentiality

All interview transcripts are anonymised by changing key details of participants and allocating ID numbers rather than names. All digital recordings will be erased after transcription, and transcripts will be stored on an encrypted USB drive in a locked cabinet at the chief investigator's home for 10 years after submission, and for 10 years securely at the Salomons Institute for Applied Psychology, Tunbridge Wells. After this time these transcripts will be destroyed securely. If during the process of interview, I believe that there is a serious risk of harm to yourself or another individual I may have to break these limits of confidentiality.

What if I have any concerns?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for me [Christopher Ioakim] or my project supervisor [Dr Sue Holttum] and we will get back to you as soon as possible. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology: fergal.jones@canterbury.ac.uk

Who has scrutinised the project?

The proposed design for this project has been evaluated has been evaluated and approved by academic staff at Salomons Institute of Applied Psychology, and has been approved by the institute's Ethics Board.

Where can I find out more…?

If you would like any further details about this project that are not provided in this sheet, please contact me by email at c.e.ioakim80@canterbury.ac.uk. You may also leave a message on the 24-hour voicemail phone number 01227 927070.

How do I let the researcher know I would like to take part?

If you are interested in participating in this project, please contact me by email at c.e.ioakim80@canterbury.ac.uk. I will then contact you to arrange a time for interview.

Appendix J. Participant consent form

Salomons Institute for Applied Psychology

One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Ethics approval number: 1.0
Version number: 1.0
Participant Identification number for this study:

CONSENT FORM

Title of Project: How do UK Trainee Clinical Psychologists experience and make sense of their undergraduate education in relation to doctoral training?

Name of Researcher: Christopher Emlyn Ioakim

Please initial box

1. I confirm that I have read and understand the information sheet dated 26/01/23 (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	☐
3. I understand that my interview will be recorded and that portions of my anonymised interview transcript may be looked at by the project supervisors, Dr Sue Holttum and Prof. Paula Reavey. I give permission for these individuals to have access to this.	☐
4. I agree that anonymous quotes from my interview may be used in published reports of the study findings	☐
5. I agree for my anonymous data to be used in further research studies (optional)	☐
6. I agree to take part in the above study.	☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix K. End of study Letter

End of Study Report

Two Psychologies – An exploration of trainee clinical psychologists' relationship with evidence and undergraduate teaching

In the UK, the undergraduate psychology degree is one of the most popular courses in higher education. Despite approximately half of undergraduates expressing a desire to pursue clinical psychology as a career, clinical psychology or mental health does not feature as part of the British Psychological Society's core undergraduate curriculum. What limited research exists on how psychological distress is understood and taught at undergraduate level indicates a focus on psychiatric or classification-based frameworks, distinct from formulation-based understandings used by clinical psychologists. This report presents the findings of a qualitative investigation of nine trainee clinical psychologists' sense of the relevance of their undergraduate degrees to their subsequent career in clinical psychology, using reflexive thematic analysis. Trainees reported an emphasis on diagnostic approaches and quantitative research methods during their degree, and that this was at odds with their later clinical career. They developed a sense of there being two psychologies with different theoretical assumptions and traditions. While trainees found aspects of their degree helpful, they reported that substantive learning took place outside of this. This suggests a need for Clinical Psychology to engage more readily with academic psychology departments, and considers the possibility of applied clinical psychology adopting a more central position in undergraduate teaching.

Christopher Emlyn Ioakim

Trainee Clinical Psychologist

Salomons Institute of Applied Psychology, Canterbury Christ Church University

ci80@canterbury.ac.uk

Supervised by Dr Sue Holltum and Professor Paula Reavey, London South Bank University