Mapping Songlines of Contemporary Australian Psychology: 
An Exploration of the Subjective Experience of Registered Psychologists 
Required to Work within the Boulder Model Frame.

by

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June 2016

A thesis being submitted to the Faculty of Arts of Charles Sturt University for the 
degree of Doctor of Philosophy
“...the labyrinth of invisible pathways which meander all over Australia and are known to Europeans as ‘Dreaming-tracks’ or ‘Songlines’. To the Aboriginals as the ‘Footprints of the Ancestors’ or the ‘Way of the Law’.

Aboriginal Creation myths tell of the legendary totemic beings who had wandered over the continent in the Dreamtime, singing out the name of everything that crossed their path - birds, animals, plants, rocks, waterholes - and so singing the world into existence.”

(Bruce Chatwin 1940-1989)

The Lion was pacing to and fro about that empty land and singing...a gentle rippling music. And as he walked and sang, the valley grew green with grass. It spread out from the Lion like a pool...making that young world every moment softer.”

(C.S. Lewis, 2001, p. 64)
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Certificate of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with the normal conditions established by the Executive Director, Library Services or nominee, for the care, loan and reproduction of theses.

Signed

Jodie Goldney
Acknowledgments

A huge thanks to all the following, extraordinary people, who in some form or other have been pivotal to my submitting this PhD, and staying (mostly) in a good mood throughout :).

My supervisors, Ben and Jane - who have obviously been integral to the entirety of the process, your insights and ‘push’ are splashed throughout the following pages - and aspects of your positioning of the world are now woven into my psyche as I step out and beyond this space. I can't but have been influenced by you both.

My fabulous husband Stu, who I have to say is very long suffering! (He might not agree with the good mood comment above ;) ) - you have been on the brunt end of the rawness of this phd process - the good and the tricky-to-navigate. Hopefully you will now enjoy with me that sense of being a helium-filled balloon let go into an as yet unchartered horizon. However, we are all so used to this thesis thing now, that we all may feel an echo of emptiness when it's gone. But not for too long :).

To the beautiful Fin and Jesse - your mum’s study of psychology has walked alongside you both for almost the entirety of each of your lives. You have been so respectful and thoughtful, and tolerant. You have kept the noise down, closed the doors, and waited patiently while I finish a sentence, asking me if it is “okay to interrupt the thoughts inside my head.” You have also been happy to have a crazy dance with me in the break times - you are both so much fun. I hope my doing this PhD will also inspire you to fight for your dreams, and beliefs about the world as you journey into young adulthood.

To my beloved friend Max Rutherford, a Jungian psychologist. You have walked alongside me throughout this study. Tossing around ideas, reading through drafts, and feeding back to me from the stance of a weighted, reflective, and I think powerful practitioner - the practice of this profession is your calling. My hope is that formalised psychology will shift its thinking, so that artisans like yourself are not lost to the people that you serve, and work with, and heal.

To my Mum and Dad, Joan and David - so much practical support! Great food, caring for littlies, constant emails to touch base. I hope that as I age, I am able to continue to parent, in the incredibly supportive, enabling manner that you do.
To my friends, particularly Erica McIntyre. We met at the very beginning of our study of psychology, and are both now finishing off our PhDs. You are just so great! You are fun, unafraid to challenge, generous - ha, and you can sew! It has been a bit like a holiday attending the various conferences, and writing retreats with you over the last four or so years. Here’s to more of the same!

To everyone at my Taekwondo Dojang! Having a place to train, to clear my mind, and to just enjoy the physicality of life, and the sport, I think helped me stay sane throughout the writing/research process.

To the faculty of psychology at CSU, and the fabulous university library staff. To be able to access all of the necessary resources as a distance ed. student, and in such a timely manner. Thank you so much! And so many book packages through the post - felt like christmas each time I opened one.

To my fabulous editor Caroline Allen B.A., BSS (psychology) (honours – Class 1), whose attention to detail picked up all those little spelling, grammatical, and APA errors, which I still had missed even after reading through this thing so many times.

And finally, the amazing, gifted and I think wise clinicians who allowed me to interview them, dissect their comments, and reassemble. I still dream of your words at night, and the vignettes you have shared, still have the capacity to make me weep. You have given me glimpse into this extraordinary world which is the practice of psychology. May the recruitment and training of psychological practitioners ensure that the wisdom generated by practice is embraced and used as a foundational stone on which to build a pathway to wellness for those with a lived experience.

#Itisfinished:)
Abstract

The scientist-practitioner or Boulder model of pedagogy is a pivotal informant to the practice of Australian psychology (e.g. Australian Psychology Accreditation Council [APAC], 2010, 2014a). The express aim of this pedagogy is to shift psychology from a space of “rudimentary [scientific] knowledge” into “being a science” (Shakow, 1965, p. 353) through the privileging of knowledge generated by empirical research, which it becomes the practitioner’s role to apply. Yet despite the paradigm’s legislated uptake (APAC), no formal evaluation of the model in terms of its impact on endorsed, and currently practicing clinicians, has been conducted. Using core tenets of Hollway and Jefferson’s Free Association Narrative and Interview Method (FANI, 2013), and concepts delineated by Klein (1997), my thesis provides an initial evaluation.

Contrary to what is required of them, findings from my data show that clinicians claiming to practice in an evidence-based manner, may adhere only to the main tenets of that approach. Consequently, the pure form of the evidence-based approach may undergo a subtle evolution, such that it is no longer quite that evidence-based practice tested using randomised controlled trials, and presented as “best practice” by formalised psychology. I term this phenomenon “morphing”.

Clinicians may also refer to the existence of an othered psychology, experienced by the practitioner as an externally imposed expectation to practice within an evidence-based frame, understood as synonymous with CBT. Othered psychology may be presented as a divisive force separating those who practice in accordance with its expectations, and those who do not, obfuscating their professional role, and capacity to facilitate effective treatment outcomes for their client.

Moreover, in direct contrast with the legislated requirement for therapists to apply scientifically generated knowledge, I provide evidence that a practitioner’s preferred therapeutic approach may arise out of influences that are not necessarily evidence-based. Instead, clinicians may draw on their autobiographical experience, personal belief sets and professional reflections.

Practitioners may also draw on many and varied metaphors or theories. Clinicians may “throw” each metaphor into the therapy, and “test” for its usefulness using the therapeutic relationship. If one metaphor does not work,
they seek to create another metaphor in collaboration with their client, or draw out another possibility from their “bag”. Viewed in this way, it is the therapeutic alliance (as opposed to a capacity to apply published techniques) which forms the ultimate arbiter of what does or does not constitute effective therapy. This finding is in direct contrast to how formalised psychology portrays “best practice”.

In providing evidence to demonstrate how these problems may manifest and be resolved (or not) by some therapists, I am providing the broader discipline with insight into how best, or how better to train and manage practitioners throughout their career. Instead of entrance into the profession being determined by academic acumen and capacity to maintain a distinction average in statistical subjects, of greatest value is the individual’s propensity for phronesis thinking, belief sets around what it is they are seeking to move their clients towards, and the ability to self reflect and build relationships.
Preface

Personal Praxis: Consideration of Self, and Ontological Belief Sets leading to, and Informing this Research

1.1 Introduction

My understanding, and enactment of the Qualitative research produced within this thesis, has grown out of my own experience of a rich tradition of scholars, and activists (e.g. Bradley, 2005; Brown & Gilligan, 1992; Davies, 1989; Fanon, 2005; Fox, Prilleltensky, & Austin, 2009; Gilligan, 1982; Greenhalgh, 1998; 1999; 2014; Mauthner, 2002; Oliver, 2004; Teo, 2009; Tuhiwai Smith, 2012; Wilkinson & Pickett, 2010). Each of these authors seek to question a status quo, resulting in one dimensional, even overtly biased research, facilitating the interests of the few (generally white anglo-saxon males)\(^1\), at the expense of the many.

Integral to my understanding of qualitative research, is the concept of praxis, which I define as the researcher taking responsibility for the knowledge/s they are bringing into the world, and giving consideration to the potential impact of that on the population worked with (Teo, 2009). In my case, this includes psychological practitioners, (and less directly clients) as well as students seeking to enter the profession. Thus for me, research from the outset, has an ethical element to it, a concept I expand on throughout my work.

Developed more formally in the 1960s-1970s, and led by the work of Gilligan critiquing Kohlberg’s six stages of moral development (1982), the tradition of qualitative research emerged as a direct response to positivism which was argued to assume knowledge is an absolute ‘truth’ uninfluenced by social, cultural and historical forces (e.g. Gergen, 1973; 1985). An additional assumption is that research within this frame translates unproblematically across gender, race and culture. This was the case with Kohlberg’s theory. At the time of its publication, the results of his work (normed on men) were assumed to apply unproblematically to women’s moral development. However,

\(^1\) As a middle-class, white anglo-saxon female, I want to acknowledge here, that I too have benefited, and continue to benefit from this state of play at the expense of other societal groups.
when his theory was applied to the experience of women, they were found to be less morally developed, and therefore inferior to men (Gilligan, 1982).

Instead of applying positivist thinking and accepting these findings, Gilligan questioned the validity of applying a theory developed on men’s experience to women. Gilligan found that as women are socialised differently, they require an alternate scale against which to test their morality. Using a frame developed on women’s experience, females were found to be as morally advanced as their masculine counterparts (Gilligan, 1982). Of note here is that in presenting this argument, I am not seeking to question the validity of the research itself, rather the generic assumptions which are then attached uncritically to resultant findings. Instead, such research, especially within a qualitative framework, may be understood as generating nuanced (as opposed to blanket) insight into a complex puzzle.

Even more pronounced than this, is the epistle within the popularised academic field of psychology, which ignores the work of scholars identifying a rich tradition of alternate ways of knowing about, and Being in the world. For example, a review of the literature suggests that consideration of: culture (Bernal, Jimenez-Chafey, & Domenech Rodriquez, 2009); intuition (Welsh & Lyons, 2001); therapeutic alliance (Baldwin, Wampold, & Imel, 2007); socio-economic status (Charman & Barkham, 2005) and originating paradigm of diagnostic categories, and acknowledgement of whose interests are being served e.g. pharmaceutical company, government policy or dominant ideology (Harris, 2009; Stainton Rogers, 2003), may all enhance practice efficacy, and research outcomes (Greenhalgh, 1999; Welsh & Lyons, 2001). I expand on these ideas further throughout the body of my thesis.

1.2 Big Q and Little q Qualitative Research: Language and Experience

However, whilst qualitative research refers generically to the use of language to explore or define the world (Willig, 2013), according to Kidder and Fine (1987) there are two distinct philosophical types: “Little q” and “Big Q” qualitative research. The former refers to work producing findings, which still rest within that positivist frame. Language is used as if it were a statistic, and respondents are assumed to attach identical meanings to words used. Such
research generally begins with a formal hypothesis, and analysis identifies key words, and themes. An example of this type of research involves placing a qualitative question in a forced answer survey, and then scoring that response. For an extensive critique of this type of qualitative research, beyond the aims of this thesis, refer to Hollway and Jefferson (2013).

Conversely, Big Q refers to research conducted using open-ended research methodologies, typically without a formalised hypothesis. This style of work seeks to understand how participants construct meaning, and experience the world. Insights gleaned during analysis may then be used to develop new theory, challenge existing assumptions, or bring new language into being. Additionally such research often seeks to uncover what discourses (expectations, assumptions and judgments) inform the experience of individuals and groups of individuals, and how language is used to embed, or maintain that experience for that population (e.g. Foucault, 1965; Goodwin & Huppatz, 2010; Tuhiwai Smith, 2012).

Oliver (2004), and others (e.g. Bradley, 2005; Brown & Gilligan, 1992; Corcoran, 2009; Gergen, 1973; 1985; Shotter, 1993) also highlight the interrelationship between language and experience. Additionally, they explore how language is both informed by, and shapes ensuing research, which in turn influences what can be experienced. Shotter argues research provides a powerful forum from which to create new language, understandings, and the ontological basis necessary for new research. I use the term ontology here to denote assumptions around what can be known about the world (Willig, 2013), and in the context of my thesis, what it is that the practice of psychology is seeking to move its clients towards. In short, what does it mean to Be a person, and to be well, and what are the best practice processes via which this can be facilitated and researched? I will further expand on my understanding of ontology in the following section.

1.3 Language and Ontology

Shotter (1993) identifies a need for appropriate language to explore the concept of ontology. For Shotter, such language emerges from research. Correspondingly, the current absence of such research (according to him) in
psychology results in impaired “ontological skills” (p. 78) necessary for future explorations. For Shotter the result is an inescapable hermeneutic circle (Heidegger, 1993) which, without appropriate research, we lack the necessary language tools to escape.

For Shotter, if we lack appropriate language to explore ontology we are left describing ourselves as a complex interplay of ligaments, bones, and neurons. And psychology is left describing the multitude of human experiences and emotions as the play out of our nervous system. As quoted in an undergraduate psychology textbook, “the human nervous system makes possible all that we can do, all that we can know, and all that we can experience” (Carlson, 2007, p. 3).

Whist ontology is difficult to define, an attempt must be made in an effort to provide the starting point from which to explore our psycho-social inter-relationship with the world (Hollway & Jefferson, 2007), necessary for any research into experience. Heidegger (1993) describes ontology as the exploration of applied existence made known through the process of observation and reflection. For Heidegger, ontology is “what-it-is” (p. 67), and can never be known in its entirety, instead it is understood in terms of that which it is, and isn’t. Bradley (2005) concurs suggesting that we are “radically intersubjective-unavoidably relational and engaged with others” (p. 99). Thus ontology can only be inferred through reflective consideration of co-created intersubjectivity (Bradley; Heidegger). The qualitative exploration of people’s psycho-social narratives provides one such avenue (Hollway & Jefferson). Tillich (1980) supports this view adding that an exploration of ontology is necessary for emotional health and well-being.

Fromm (1987) suggests that a concrete understanding of ontology is elusive exactly because its tendency is towards ongoing evolution and growth. Rogers (1995) concurs adding that whilst ontology may be experienced at the individual level, it does not exist in a vacuum. For Rogers, the evolutionary tendency of ontology is experienced as an interconnectedness between all things, and whispers of its presence are observable from the stand-point of all disciplines. Interestingly he cites the work of the physicist Capra (1975) who states: “In modern physics the universe is thus experienced as a dynamic, inseparable whole which always includes the observer in an essential way” (p.
86). Thus the notion of connectedness is incorporated into an understanding of ontology from the onset with the consideration of the interaction between both the evolving universe and the observer, a tendency Rogers terms “interrelatedness” (p. 133).

Corcoran (2009) also frames the study of ontology as a refutation of what he terms “first-nature” psychology (p. 3). For Corcoran, first-nature refers to accounts of psychological phenomena that neglect ontology in preference for epistemological concerns. According to Corcoran, such research whilst presented as objective, neglects the import of intersubjectivity on the co-creation of individual's experience and researcher’s interpretation of that experience. The cost for psychology is impaired ethical and relational grounding, the what and why of the discipline. Holquist (1990) concurs arguing that ontology is always relational and always, “not just an event, but an event that is shared.” (p. 25).

Whilst the study of first-nature accounts of psychology is fascinating, and facilitates our understanding of how we as machines work, without an exploration of ontology we can never understand that which lifts us beyond our physical components to explore the metaphysical, that which gives us life. Corcoran (2010) suggests that the ongoing, and powerful evolution and growth of humanity is minimised as a result. Gergen (1991) and Fox, Prilleltensky, and Austin (2009) concur with the arguments of Corcoran suggesting that a focus on first-nature psychology actually hinders the process of humanity's movement towards wellness and wholeness. Corcoran, and Rogers (1995) argue that ontological approaches to the human condition are more effective in achieving this aim.

An interesting link can be made here with the work of Oliver (2004) who argues that inability to speak about our experience, or lack of vocabulary to give that adequate voice is indicative of oppression. She suggests that women, are one societal group who lack the language or appropriate forums to speak about the diversity and depth of their experience resulting in an effectual “oppression on the psyche” (p. xvi). Further, she suggests that such oppression manifests as physical impairments labelled pathological, citing Freud as the forefather of such interpretations. For Oliver, this way of (first-nature) thinking has infiltrated
all areas of how we collectively view development and the subsequent interpretation of another’s experience.

1.4 My Personal Circumstances and my Data Analysis

Before I move into introducing the topic, and logic of my thesis in full, I will provide a brief autobiography as it pertains to my research. This is as an acknowledgement that within the qualitative research community, there are many who think that the hermeneutic of how we as researchers help create our results requires an account of ourselves, over and above the methodological rationale and clarification of the processes of validating interpretations (Willig, 2013).

There are good reasons why we might reflect on our own circumstances and desires in the process of research. Few now argue that research is not shaped by the ideas, theories, needs and wishes of the researcher and their contexts. In practical terms such reflection can be used, as a process of interrogating any interpretations gleaned from data. That is, within the analysis of my data, I needed to overtly employ a process ensuring I searched for alternatives and counter-instances to my initial interpretations, modifying, rejecting, and substantiating results through that procedure. In this way I ensured I was not just reading into the data, or cherry-picking for ideas convenient to my own thinking.

What such reflection can be compared against is a widely held belief that reflecting during qualitative research needs to entail a selective autobiography as part of the production of knowledge. For example, the fact that I am not a practicing psychologist, while those interviewed were, may impact on the type of data thrown up (Silverman, 2000). Similarly, the fact that I have studied psychology, and had an obvious interest in the practice of the discipline (evidenced by my research question). However, whilst there may be another thesis investigating the impact of my being, or not being a clinician on the production of findings of significance, this thesis is concerned with examining the responses of those interviewed and the relationship between what was said, with organisational context, including requirements from professional bodies.
Instead, the critical perspective leading to my interest in studying this particular microcosm was gained during my years studying to be a psychologist (whilst not yet being one). During that process, I became increasingly intrigued with varied inadequacies (as I saw it) within the discipline, such that the spiritual, relational, and psycho-social seemed largely ignored, in favour of the metaphor, man-the-machine. Additionally, as I successfully jumped over the varying hurdles necessary, I watched with a level of incredulousness, as individuals I felt would have been incredible practitioners fell by the wayside (because they couldn’t quite ‘get’ statistics, or if they could, not at a distinction level). People who I felt (subjectively) to drip with the wisdom of life experience, who were able to build rapport with others with practiced ease, who were comfortable in their-own-skin, and in whose presence I could well imagine, someone in pain would find comfort. And yet, the discipline of psychology, which I believed to be about facilitating wellness and recovery, did not want them! What then did it want? And what were those people like? And was that a profession I really wanted entry into after all?

Thus, I decided to enter into the study of what practitioners do do in the face of complexities of current discourses. The following thesis, actively seeks to step outside what can be made known using first-nature accounts, to delve deeply into the nature of experience, as articulated by registered, and practicing Australian psychologists.
Chapter 1

Diagnosing the Profession

1.1 Introduction
Since its formal inception in 1944, marked by the inaugural meeting of the Australian branch of the British Psychological Society (Cooke, 2000), Australian psychology has experienced the ongoing trials, tribulations and political maneuverings of a fledgling discipline seeking to cement its place in society as both a high status profession, and a science (Cooke; O’Neil, 1987; Shakow, 1965). Pivotal informant to this task is the philosophical and educational framework provided by the scientist-practitioner, or Boulder model of pedagogy (e.g. Australian Psychology Accreditation Council [APAC], 2010, 2014a; Australian Psychological Society [APS], 2013). The express aim of this pedagogy is to shift psychology from a space of “rudimentary [scientific] knowledge” into “being a science” (Shakow, p. 353) through the process of privileging knowledge generated by research, which it becomes the practitioner’s role to apply. Consequently, the pedagogy ossifies the assumption that “a scientific area belongs ultimately to its investigators, not to its practitioners” (Shakow, p. 354), and application of knowledge so generated becomes best practice. Yet despite the paradigm’s legislated uptake (APAC; APS), its 60 plus years of influence within Western psychology (e.g. Raimy, 1950), “gold standard” status within Australian and more broadly, Western clinical psychology (Bradley, 2009; Page, 1996), no formal evaluation of the model in terms of its impact on endorsed, and currently practicing clinicians, has been conducted. Using core tenets of Hollway and Jefferson’s Free Association Narrative and Interview Method (FANI, 2013), and concepts employed by organisational psychology (e.g. Diamond & Allcorn, 2009), and delineated by Klein (1997), my thesis provides an initial evaluation.

How clinicians experience working within the scientist-practitioner frame provides insight into the flow-on thinking which is allowed, encouraged, and perceived to be required by the profession of psychology and society more broadly. Chatwin (1988) penned the story of the Aboriginal Songlines stretching across Australia and evidence of the creation story, the singing into existence of the Australian landforms and people. C.S. Lewis (2001) invokes comparable
imagery in his work “The Magician’s Nephew,” as the great lion Aslan, sings the new world of Narnia into being. In psychology, how practitioners understand and thereby enact their practice, metaphorically articulates the Songlines, or landscape of the Australian psyche (Thomas, 2003). Clinician enactment of psychology informs the ontological space in which our mental health or un-health unfolds, impacting directly on the experience of mental unwellness, available and funded treatment options, and ultimately the pathway to wellness individually and collectively (Corcoran, 2009; Slade & Longden, 2015). As reminder, I use the term *ontology* here to denote assumptions around what can be known about the world (Willig, 2013), and in the context of this thesis, what it is that the practice of psychology is seeking to move its clients towards. In short, what does it mean to Be a person, and to be well, and what are the best practice processes via which this can be facilitated and researched?

With mental illness projected to be the second highest contributor to the burden of disease by 2030 (Who, 2011) an understanding of this experience, and answers to some of these questions, may be crucial to facilitating wellness within the Australian, and more broadly Western population. Additionally, an ethical psychology needs to consider the flow-on of the Songlines it is singing into existence. The experience of registered, practicing psychologists provides one microcosm in which to explore this space. I will begin by providing an overview of the scientist-practitioner model, before moving onto explicating key terms, and describing the current state of play within Australian psychology.

### 1.2 Boulder, and the Scientist-Practitioner Model

The Boulder, or scientist-practitioner model is the “single most important statement of training philosophy in clinical psychology” (Stricker, 2000, p. 253) and as such, is the dominant learning, and practice paradigm within formalised psychology. I use the term “formalised psychology” to describe psychology as it is understood, promoted and enforced within Australia by regulatory bodies and associations such as the APS, APAC, Australian Health Practitioner Agency (AHPRA), and Psychology Board of Australia (PsyBA), and legitimised by the Health Practitioner Regulation National Law Act 2009. Individuals can not legally call themselves a psychologist without formal approval under the
processes developed by these bodies. I will briefly explain the roles and interrelationships between these parties in section 1.3 of this chapter.

The Boulder model paradigm requires that psychological students who enter the discipline seeking to become clinicians, must also be trained as researchers. The flow-on expectation is that due to this training, clinicians will be more inclined to both use the findings of published research in their practice, and conduct and publish their own research, such that all of their assumptions are tested by the rigor of science (Frank, 1984). This technical-rational approach to pedagogy, with its flow-on to practice, “treats professional competence as the application of privileged knowledge to instrumental problems of practice” (Schön, 1987, p. xi), and assumes problems faced by practitioners are generic. Additionally, it assumes all problems are “resolvable, at least in principle, by reference to the facts [upon which] professional knowledge rests” (Schön, p. 36). Within this frame, the skilled professional is one who draws on the “professionally sanctioned”, “accurate models” and “powerful techniques”, produced by science. This approach is viewed as providing all that is necessary for the varied client presentations the therapist may see in their career (Schön, p. 218). I will expand on this idea further in chapter two.

Psychology’s version of the model has its origins in a report written by Shakow (American Psychological Association Committee on Training in Clinical Psychology, 1947), exploring how best to train clinical psychologists. Recommendations from this report were used to inform discussions at the American Psychological Association’s conference, held at Boulder, Colorado, in 1949 (Raimy, 1950), and from which the model received its name. Shakow’s (1965) original intention was for psychology to “implement a few experimental training programs in clinical psychology in which internships would be included as an integral part” (p, 354). However, Shakow (1965) argues that what began as “a period of slow and careful experimentation, that might have provided [psychology with] an opportunity to learn what was desirable and necessary in clinical training” (p. 354), was usurped by the onset of World War II, and “demands [supported by substantive funding] for psychological services from the Veterans Administration and the Public Health Service” (p. 354) in the USA. Thus instead of applying “slow and careful experimentation”, prior to its overarching implementation, the scientist-practitioner model was endorsed,
without formal evaluation, by the APA, as the preferred training model for therapists (Chang, Leeb, & Hargreaves, 2008). This decision has since been mirrored within contemporary Australian psychology (e.g. APAC, 2014a).

A number of researchers have explored elements of the Boulder model since its uptake. For example, one thematic based, meta-analysis by Chang, Lee, and Hargreaves (2008), uses 10 published articles to explore the changing role of psychology, and suggests that the Boulder model has not evolved to reflect associated societal change, or change within the professional practice of psychology. These researchers suggest that the idea that any individual can divide their time equally between research and practice is unlikely, and they question whether “the aptitude and motivation for engaging in research is...necessarily compatible with the aptitude and motivation for applied clinical work” (p. 270). Indeed, research exploring the relationship between the individual’s expressed preference for research versus practice (e.g. Beutler, Williams, Wakefield, & Entwistle, 1995) finds that clinicians do not divide their time equally, if at all between research and practice and that “a form of dissonance [exists] between what their training model has told them is required of them and the realities they face once they are qualified and begin their professional careers” (Chang et al., p. 271). Moreover, in a study of 24 graduate students’ perceptions of the model, Aspenson and Gersh (1993) found the model effectively forced students whose aptitude and interest was in practicing, to also develop the skill sets necessary to research, with the intent that they would then research and publish. However, according to Milne and Paxton (1998) “the modal frequency of publication amongst clinical psychologists is zero” (p. 221). The age of many of these references, relative to 2016 is notable. The apparent lack of research exploring the experience of registered clinicians required to practice in the Boulder model frame is the focus of this thesis, and something I will address directly in chapter two.

Despite these initial rumblings against the efficacy of the Boulder model, and lack of a formal evaluation, the model is both utilised and legislated for within Australian psychology. I will unpack this positioning in greater detail during this, and subsequent chapters, particularly chapter two. Prior to beginning that exploration, I will outline the role of pivotal stakeholders and regulatory bodies in Australian psychology. I will then outline the logistics and legalities of becoming a psychologist in Australia. Whilst my thesis is not
directly about how students experience studying within the discourse created by
the Boulder model, this information is important for understanding some of the
flow-on effects created by the scientist-practitioner model within Australian
psychology. Additionally, I will later argue that the findings of my research, have
direct implications for the recruitment, training and supervision provided to, and
required of, incumbents to this role. I will then pull this information together into
a final paragraph, providing evidence of the substantive influence of the Boulder
model within Australian psychology. In providing this information concerning the
experience of students created by the Boulder model, I am continuing the
process of demonstrating the need for, and relevancy of both my particular
piece of research, and chosen methodology. However, I will begin with some
key definitions.

1.3 Definitions

The work of endorsed agencies within psychology, is
“empowered” (AHPRA, 2012, p. 2) by the Health Practitioner Regulation
National Law, which “came into force on 1 July 2010 in all States and Territories
except Western Australia” (p. 2). The Law seeks to oversee both initial and
ongoing registration of various health professionals, including psychologists.
Thus it is illegal to practice as a self-described psychologist without having done
a named, accredited and registered degree in psychology. A primary stated
aim of the Law is to protect the public, and ensure that “only health practitioners
who are suitably trained and qualified” to practice, are legally allowed to do so
(p. 3). The “objectives and guiding principles” (p. 3) of the Law “apply equally to
all those exercising functions under” it. However, other entities such as, for
example, those who facilitate retreats purporting to provide treatment for
addiction (e.g. The Bay Retreat, 2016), or providers of cosmetic surgery (ABC,
2015), are not bound buy such legal requirement.

1.3.2-Australian Health Practitioner Agency: AHPRA.
AHPRA are the legally endorsed body “responsible for regulating the
health professions” (AHPRA, 2016, para 2). AHPRA's “primary role [is] to
protect the public [and] set standards and policies that all registered health
practitioners (including psychologists) must meet.” In addition, each Board that
exists under AHPRA, enters into a “health profession agreement...which sets out the fees payable by health practitioners, the annual budget of the Board and the services provided by AHPRA” (para 2).

1.3.3-Psychology Board Australia: PsyBA.

The role of the PsyBA is to register psychologists and provisional psychologists, establish guidelines, codes and standards for the profession, manage any complaints made against individual psychologists, assess psychological training obtained outside of Australia, and to approve “accreditation standards and accredited courses of study” (PsyBA, 2016a, para 2). Whilst APAC (2016), develop standards and ensure they are being adhered to by various organisations, under the Law. The “final decision on whether the accredited programs of study are approved for the purposes of registration” (p. 5) belongs to the PsyBA.

1.3.4-Australian Psychology Accreditation Council: APAC.

APAC is the “independent not-for-profit quality and standards organisation, appointed as an external accreditation entity under the Health Practitioner Regulation National Law Act 2009” (APAC, 2016, para 1). The Board of APAC is made up in equal parts, by nominees representative of the APS, PsyBA, and Heads of Departments and Schools in Psychology Association (HODSPA; APAC, 2014b). APAC is responsible for outlining the training and educational requirements through which an individual becomes a psychologist, and as approved by the PsyBA. APAC ensures educational providers are adhering to these standards, and determines whether any overseas training is equivalent. APAC’s overarching mission is to ensure that psychologists are sufficiently regulated to “protect the public” (2016, para 2).

1.3.5-Australian Psychological Society: APS.

The APS is one of the professional organisations within Australia, which focuses on psychology (APS, 2016). Whilst there are other, much younger professional bodies of direct relevance to the practice of psychology, e.g. the Australian Association of Psychologists Inc (AAPI, 2016), the APS currently holds the largest membership, and arguably has the most influence. This is evidenced for example by its presence on the APAC Board. In a very real
sense, these bodies dictate what can be, and what is, the process of becoming (and continuing to be) a psychological practitioner, and to a lesser extent, who in society can become one.

1.3.6-Pathways to registration within Australian psychology.

Within Australian psychology, there are currently three legal study pathways, whose successful completion results in registration. These are the 4+2, and 5+1 internship programs, and an accredited professional degree (PsyBA, 2016b). I will expand on the latter in the next section. Common to all three programs is a four year undergraduate degree or equivalent (these four years can be made up of a three year behavioral science/psychology degree and a one year diploma year including a major research project, an honours year, or alternatively, a non-psychology degree, a graduate diploma in psychology and a one year postgraduate diploma). The two postgraduate years of the 4+2 internship program can be completed over two years full-time or four years part-time “under supervision that enables the individual to gain the supervised practice experience necessary to become eligible to apply for General registration as a psychologist” (PsyBA, 2016c, para 1). The two postgraduate years of the 5+1 internship program:

Refer to the fifth year of a five year sequence of accredited tertiary study comprising coursework and practical placements, followed by a sixth year (one year full-time or equivalent part-time) supervised practice internship approved by the Psychology Board of Australia. (PsyBA, 2016d, para 1)

Heated discussion exists around these two pathways because limited internships are available, and reporting requirements may be experienced as onerous by both the student, and supervising agency (Palmer, 2015). For example, within the two internship years of the 4+2 program, students are required to participate in 1114 direct client-contact hours, 1670 client-related activities, 176 supervisory hours, and 120 professional development hours (PsyBA, 2015). There are few, if any, paid positions available to facilitate this pathway, placing students in a bind as to how to support themselves while seeking registration. Additionally, students are generally expected to pay for their weekly supervision (two hours per week for a full-time load, and charged at around $150 per hour. Relationships Australia calculate the cost of supervising
a psychology intern at $17,000 per annum (APS, 2012). Students with dependents are virtually prevented from entering this registration pathway unless they have a partner, or other person, willing (and financially able) to support them through the process.

The final accredited professional degree pathway:

Involves completion of an accredited postgraduate degree offered by coursework at minimally a fifth and sixth year of study such as a Masters degree (the standard higher degree pathway) or Doctorate (the doctoral higher degree pathway) while registered as a provisional psychologist. Completion of an accredited postgraduate degree satisfies the requirement under the National Law and the General registration standard to complete a period of supervised practice required to become eligible to apply for General registration as a psychologist.

Accredited postgraduate degrees generally comprise coursework, practical placements and a research thesis. (PsyBA, 2016e, para 1)

This pathway is also the site of marked contention, because psychologists with a clinical masters are more likely to be referred to by for example the NRMA or other insurance companies (AAPI, 2012). They also have greater access to a diverse range of jobs (e.g. APS Matters; and job search engines such as Trovit and My Career) and can access a substantially higher government rebate of $122.15 per session (typically one hour) compared to all other psychologists who can only claim $83.25 per session back from medicare under the Better Access scheme.

1.4 The Scientist-Practitioner Model in Australian Psychology

Under the umbrella created by the interaction between these varied bodies, and overarched by the Health Practitioner National Law (2009) (APAC, 2014c), the scientist-practitioner model is expressly legislated for within Australian psychology. For example, APAC’s (2014a) accreditation standard for programs of study in psychology requires “all programs of study offered” to “teach psychology as a science-based discipline drawing on an evidence-based approach...based on the Scientist-Practitioner model” (p. 8). However, debate exists regarding the equity of balance afforded to the component parts of the scientist-practitioner couplet within psychology, and whether in fact a dichotomy exists which preferences knowledge generated by one arm of knowing, over the
other (e.g. Bradley 2009). In my next section, I will seek to unpack that debate, beginning with an exploration of how science is understood by Australian psychology. In providing this information, I will begin the process of explicating the impact of this discourse, both on those who practice and the broader profession.

1.5 Science and Practice within Formalised Psychology Defined

Within psychology, the term science has increasingly been equated with empiricism, which is taken as the best means to satisfy “the need for certain knowledge” (Bradley, 2005, p. 4). Central to empiricism, is the assumption that it provides practice with irrefutable “facts” (Gillies, 2009, para 2) to apply within therapy. Within formalised psychology, the word is used analogously with evidence-based, and refers to knowledge generated by certain privileged forms of research (APAC, 2014a). It should be noted that psychology’s view of science has also been challenged over the decades (e.g. AAPI, 2012; John, 1984), and may not reflect the more holistic, philosophical understandings employed by other health-based disciplines (Page, 1996), or recognise the “misappropriation [of research agendas by] vested interests, [particularly the] “drug and medical devices industries” (Greenhalgh, Howick, Maskrey, 2014, p. 1). However, a definitional debate beyond how science is presented by formalised psychology is not the role of this thesis.

Within formalised psychology, the type of research viewed as most likely to produce a solid evidence-base reflects, in part, guidelines provided by the National Health and Medical Research Council (NHMRC) (1998). These guidelines specifically privilege evidence generated by the “systematic review of all relevant randomised controlled trials” (RCTs; p. 56), and to a slightly lesser extent “comparative studies [with] concurrent, [or] historical controls” (p. 56). The relevance of that knowledge is informed by recency of publication, and the expectation that it be published in “high quality peer-reviewed scientific journals of international standing” (APAC, 2014a, p. 8). The APS presents the application of knowledge generated within this frame as “best practice for Australian psychological service delivery” (APS, 2010, p. 1).

In contrast, the term practice within formalised psychology, is presented as the therapist’s capacity to apply the certain knowledge base generated by science, as delineated above (Shakow, 1965). Within this positioning, it is
assumed that this form of science (defined above), and not practice (or any other source of understanding), provides the best knowledge necessary for the therapist’s efficacious response to varied client presentations. Problematic for the *practice* of psychology is (a) that practice may not be best conceived as the application of knowledge generated by randomised controlled clinical trials (b) that the exploration of practice does not easily lend itself to the research methodologies embraced by psychology’s preferred image of science, and endorsed as “best [research] practice” (APS, 2010), (c) that what is presented as certain knowledge, may not be, or may not always be, in fact certain, and may not necessarily be relevant to the individual that the clinician is working with at any one time, and (d) that knowledge which is generated by practice, may be of inherent use to the purpose of practice. I will expand on these assertions in chapter two. However, unable to generate this privileged form of evidence, research into practice-based knowledge is less likely to attract government funding, because such sponsorship “quite reasonably requires the use of treatment interventions that are considered to be evidence-based as a means of discerning the allocation of funding” (APS, 2010, p. 2). Furthermore, research into practice-generated knowledge is also less likely to be published, and as a result, is less likely to be given legitimacy by formalised psychology. The result is something of a Catch-22; a circular privileging of knowledge generated by empiricist science, which ensures that practice based knowledge remains inaccessible to best practice.

Additionally, the clinician is required to override any promptings derived from their own practical experience in order to “reduce subjective bias and subject inferences, and to be cognizant of the dangers of reliance on intuitive thinking” (APS, 2013, p. 9). Imbued as they may be with uncertainty, the clinician’s own subjectivity, and intuition, along with the hard-won lessons of their experience, are presented as inimical to their professional work as psychologists, instead of being sources upon which the therapist may legitimately draw. This is in contrast to evidence from other health professions such as medicine or nursing, where intuition may be presented as a component part of good practice (Benner, 1984; Benner, Tanner, & Chesla, 2009; Greenhalgh, 2002). This is what I will call “the primary contradiction of psychological practice”.

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A further thorn for psychological practice is that apart from an expectation to apply scientifically generated knowledge, there exists no overarching, contemporaneous, and endorsed theory of practice upon which clinicians may legitimately draw. Substantive theories of practice developed within other disciplines, such as nursing, architecture or teaching, are not accessible to psychologists, as these theories place an overt value on the disciplined use of judgment, personal experience, subjectivity, reflection, and intuition (none of which are encompassed by formalised psychology’s definition of what constitutes an evidence-base). Confusingly, within these other disciplines’ theories of practice, the practitioner who has mastered the art of reflective judgment and informed intuition is viewed as having reached the zenith of professional development (e.g Benner, 1984; Benner et al., 2009). In contrast, Australian clinicians, whose practice is regulated by the framework provided by formalised psychology, are effectively left in the space of having to make it up, as they interact with clients whose presentations and responses may not conform to findings from one, if any, published randomised controlled trial (Greenhalgh, 1998).

1.6 Additional Sources of Contradiction for the Practitioner within the Scientist-Practitioner model

Additional sources of contradiction for the practitioner operating within the frame provided by the Boulder model, may be inferred by unpacking the attributions afforded to the scientist versus the practitioner. John (1986) argues that “the scientist” role model is employed by psychology as a socialisation agent. He cites the work of Liam Hudson (1972) who observed that:

In the course of three years, the students’ perception of psychology is stood on its head. They enter expecting to study a subject that is humane, and emerge convinced that it is a science. That such a feat of inculcation is possible is remarkable in itself. And it should scarcely surprise us if it leaves behind a residue of dissatisfaction. (p. 85)

Integral with John’s delineation of what constitutes a scientist, is his identification of a scientist’s capacity to embrace objectivity, which John (1986) argues, “calls for the splitting of cognition and affect” (p. 232). As a result, the unilateral embrace of science as the means for practicing psychology, does not
provide an adequate framework for the clinician to deal with the moral, ethical, and subjective similarities and/or differences between practitioners and clients, or acknowledge psychology’s ethical aim of “promoting human welfare” (John, 1984, p. 159). For John, this latter task “calls for the exercise of moral judgement [which he argues] by their [scientific] training, [psychologists are] unprepared [for, and indeed] have been taught to avoid” (p. 159). In contrast, research pertaining to what constitutes the effective practitioner calls for the embrace of affect (Rogers, 1995), capacity to value and respond to the subjective presentation of each client (Greenhalgh, 2002; Rogers; Yalom, 1980), and the ability to create “informal theory” (Rolfe, 1997, p. 95). I will explore these ideas further, in the next section.

Additional sources of tension within the profession may be unearthed by considering the contradiction between formalised psychology’s portrayal of science as producing objectivity, versus what it actually achieves within pivotal, foundational areas of psychological study, such as mental illness aetiology. Kendler (2005) suggests that despite years of study, science has not been able to identify with certainty, what the absolute causes of any one mental illness are, or even whether mental illnesses exist, or instead have been socially created, as was the case for homosexuality (McNally, 2011). Additionally, Kendler argues that we are unable to articulate with certainty, the mechanisms through which the symptoms of psychopathology manifest neurologically (e.g. hallucination). Moreover, key theoretical strategies put forward by formalised psychology as best practice, such as Cognitive Behavioral Therapy (CBT), are unable to define in an objective manner, core concepts encapsulated within their frame, and instead have to resort to the use of subjective, and not clearly defined terms (e.g. dysfunctional thinking). In fact, psychology is not clearly and unequivocally able to articulate what its practice seeks to achieve, what its clinicians are seeking to move their clients towards, or even what it means to Be a person (Corcoran, 2009).

Moreover, theoretical tension exists as different schools of thought seemingly provide equally plausible, yet largely contradictory, evidence-based rationales for pivotal psychological phenomenon. For example research supports the varied discourses of psychopathology as being caused by biomedical dysfunction (McNally, 2011), social, and income inequity in Western countries (Wilkinson & Pickett, 2010), and the flow-on of oppression (Fanon,
2005; Oliver, 2004). Additionally, financial tension exists around formalised psychology’s differentiation between clinically trained, versus alternatively trained, practitioners. Faced with these conflicted theories, what do practitioners do? Through my research I seek to explore how they exist within this space.

1.7 Theories of Practice in Western Thought

The notion of learning from experience, is not anathema to Western thinking. Aristotle coined the term *phronesis* to describe “knowledge that addresses the concrete situation rather than the gaseous universal” (Bradley, 2009, p. 12). Pivotal to this form of understanding, is the individual’s capacity “to grasp an infinite variety of circumstances” (p. 12), and it “presupposes a direction of the will – i.e. moral being” (Gadamer, 1991, p. 21-22). Phronesis thinking requires moral action. It cannot be split into theory versus application, measurable by capacity to prove, or apply a predetermined response to any one situation, as is implied, for example by the scientist-practitioner frame. Instead, the individual’s actions are used to determine whether, in the case of psychology, a clinician has become, or is becoming experienced or not (Bradley). Bleiker (2003) terms this deliberate intent agency, presenting it as the antithesis of application, or just doing what you are told. For Bleiker, agency requires the individual to both act on, and influence, their environment.

Within the disciplines of nursing and teaching, the process of becoming experienced is intimately entwined with the individual’s capacity for reflexivity. Reflexivity here is defined as the clinician’s ability to “construct informal theory out of practice, apply that theory back into practice, and reflexively modify the theory as a result of the changed clinical situation” (Rolfe, 1997, p. 93). The generation of informal theory is thus an enmeshed, circular process, “contained in practice by definition, because without it practice is merely random and uncoordinated activity...informal theory is similarly, by definition, generated from practice” (Rolfe, p. 95). Furthermore, the interrelationship between informal theory development, and practice, facilitated by reflexivity, results in the flattening of a knowledge hierarchy. This privileges knowledge generated by randomised controlled trials, thereby “closing the theory-practice gap” (Rolfe, p. 96). According to Benner (1984), the value of such a reflexive practitioner to their profession is that “each expert [clinician] has his/her own situation
repertoire of paradigm cases which is unique to him/her, and which constitutes a body of personal knowledge which is very different from public, academic knowledge” (Rolfe, p. 93).

Moreover, experienced practitioners “have come to grips with the culturally avoided or unchartered and can open ways of being and ways of coping for the patient and the family” (Benner, 1982, p. 407). Benner (1982), and Benner et al. (2009), further argue that it is the clinician’s capacity for processing experience in a reflexive manner, which differentiates the novice from the expert. For both Benner (1982), and Gadamer (1991), “experience is not the mere passage of time or longevity; it is the refinement of preconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theory” (p. 407). Moreover, whilst both theory and evidence as defined by formalised psychology, “offer what can be made explicit and formalized”, “clinical practice is always more complex and presents many more realities than can be captured by theory alone” (Benner, 1982, p. 407).

Viewed from this frame, for the discipline of psychology, science and practice are contradictory and almost incompatible terms. Indeed, as explicated previously, uncertainty, in the form of intuition and subjectivity, seems so threatening to the broader system of formalised psychology, they have been legislated out of what practitioners are allowed to do.

### 1.8 Induction into the Scientist-Practitioner Dichotomy

Along with the overarching aims of the Boulder model introduced previously, the existence of a dichotomy between component parts of the scientist-practitioner model is evidenced at a number of levels within the education of Australian psychologists. Of primary interest is the absence of any practical component woven into and through the first three years of study required to become a practitioner. Initial exposure to the practical application of the theories learned, does not occur until the honours, or fourth year, or possibly never. Furthermore, in Australia, when this exposure does occur, it normally has nothing to do with any analogue of clinical practice. Rather, in adherence with APAC (2014a) requirements, the student is required to design and conduct an original research project, whose method and findings are evaluated through the medium of a written thesis.
Student may sometimes be allowed to select from quantitative versus qualitative methodologies. However, quantitative theses have historically been and still are (in some Australian Schools of Psychology) either compulsory or prioritized. This is arguably because the former approach is more closely aligned with a scientific way of thinking, as defined previously, whereas qualitative research may be construed as the subjective exploration of experience (Hollway & Jefferson, 2013). Subjectivity here may be understood as a changing space of “significant personal content [imbued with] uncertainty” (Bradley, 2005, p. 5), and informed by potentially “conflictual...[and] unconscious...forces” (Hollway & Jefferson, location 1015 of 4956).

According to the Australian College of Applied Psychology (ACAP, 2016) the fourth year in psychology provides “students with advanced education and training in the core psychology graduate attributes” (para 1). That preparation involves developing:

Advanced theoretical and empirical knowledge in some of the core research areas of the discipline; knowledge of the theoretical and empirical bases underpinning the development of psychological assessments; knowledge of the theoretical and empirical bases underpinning evidence-based approaches to psychological intervention; understanding and explaining how the science and practice of psychology is influenced by social, historical, professional and cultural contexts and also how psychological practice in turn may affect those contexts. (ACAP, 2016, para 2)

Thus, despite research indicating that no one individual can be a scientist-practitioner (e.g. Chang et al., 2008), in order to achieve an Honours degree in Psychology, which ACAP claims suitably “prepares students for either a research or a practice career path in psychology” (2016, para 3), the prospective practitioner is required to undertake an extensive research component. In contrast, there is no comparable requirement for students to demonstrate a developing skill set, and a capacity to work directly with clients. Instead of learning how to learn from experience, in keeping with the tenets of the scientist-practitioner model, the would-be clinician learns about research and the application of published techniques. Indeed due to the competitive nature of psychology, some students may never even have the opportunity to flex their practice muscles as it were, prior to starting to earn their keep as (supervised) practitioners. This means that many students will have had no
opportunity to determine their compatibility with this profession as it unfolds at
the interface of interaction with a client. The underlying assumption is that
those who excel at research, will correspondingly be good at practice.
Conversely, those who excel at practice may never get to discover or exercise
their gifts within the pale of formalised psychology.

This leads to a further contradiction because the practice of psychology,
as opposed to its research, is what the majority of psychologists do. It is
certainly the reason why many potential students seek to enter the profession
(Pachana, O'Donovan, & Helmes, 2006). Furthermore, research suggests the
existence of temporal stability between the preferences with which an individual
enters into the study of psychology (i.e. research or practice), and what they are
doing in reality, ten years later (Zachar & Leong, 2000). Thus the student who
enters into the study of psychology with an aim to be a practitioner, is, upon
graduation, likely to seek registration as a practitioner, as opposed to entering
into a career orientated towards research and publication.

This is not to say that knowledge gained from randomised controlled
trials and applied within psychology is not of value. Yet knowledge generated in
this way, does not necessarily acknowledge the non-absolute relativity of the
resultant theory or approaches. Nor does it acknowledge the variance in
responses, or the existence of outliers, which are often absorbed or made to
disappear by the statistical representation of the results. Furthermore, such,
un-tampered with knowledge may never be published (Greenhalgh, 2014).
Thus the individual facing the clinician within the therapeutic space may not
conform to any population described in published peer-reviewed journals.
Furthermore, in assuming that each client will conform to published
presentations, practitioners may in fact be obfuscating their capacity to attend to
the presentness of exactly what it is their clients are presenting with.

Of additional importance from an ethical perspective, is that evidence
exists that the most unwell people, who may have experienced extreme trauma
and abuse, may not always be included in empirical trials due to the extremity
or singularity of their presentations. When they are included, it tends to be
assumed in the research that they can never become, or are highly unlikely to
ever become, well (e.g. Jääskeläinen et., 2013; Slade & Longden, 2015). Yet
research or thinking which sits outside what is made available by empirically
supported trials, may provide effective treatment avenues for the therapist. For
example, such research provides evidence that recovery is not a linear process, and may be heavily influenced by subjective factors (Lavin & Ryan, 2012; Morrison, et al., 2013), by relationships including the therapeutic alliance (Baldwin et al., 2007; Blatt et al., 1995; Moran, et al., 2014; Okiishi et al., 2003; Roos & Werbart, 2013; Schön, Denhov, & Topor, 2009), or may occur without any professional intervention (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Thus, what may constitute alternate effective treatment methodologies for this group, becomes inaccessible to the clinician trained under the auspice of formalised psychology, rendering the profession potentially unable to adequately deal with the most unwell in our communities.

This leads to the slightly bizarre situation within which the practice of psychology by the very discipline containing it, is given minimal consideration in any holistic manner, save to the fond hope expressed by its regulators that its practitioners’ applications reflect results from randomised controlled trials carried out on varied populations, none of which may be specifically represented within the room which a particular client/clinician may inhabit. Thus, with no clearly explicated, theorised framework (save to draw on evidence), what do practitioners do when faced with clients who do not conform to some preexisting norm defined by existing published research? How do practitioners problem-solve within the therapeutic space? Using qualitative methodologies, and through the exploration of experience, I seek to explore these issues in my research.

Why should formalised psychology appear to preference one type of knowledge base over another, when both would appear to be beneficial to the effective practice of psychology? Faced with this apparent contradiction, how can the discipline of psychology seek to understand this phenomenon giving consideration to theory, and from there explore the implications of this privileging both to practitioners, and the broader profession? Using the main tenets of Hollway and Jefferson’s Free Association Narrative and Interview Method (FANI, 2013), and concepts delineated by Klein (1997) and employed by organisational psychology (e.g Diamond & Allcorn, 2009), I endeavor to find out how practitioners in psychology might cope psychologically with such contradiction, and how they experience practice in Australia, within the space created by the Boulder model.
Chapter 2

How do Practitioners Experience Themselves as Clinicians within the Boulder Model Frame?

2.1 Introduction

To explore the questions I raised in chapter one, I will now outline research which evaluates and unpacks how the space created by the Boulder model is experienced by psychological practitioners. I will compare and contrast findings from that research with research which describes what the role of Australian practitioners is. During that comparison, I will ask the question: does the Boulder model adequately provide clinicians with the tools they experience as necessary for the successful execution of their role, or do they also draw on and value other sources? Additionally I will unpack how formalised psychology’s methodologies for marrying science with practice, i.e. evidence-based practice works in this frame. I will then compare formalised psychology’s practice-as-application, with alternate conceptualisations of practice available to the discipline, both historically, in the form of Aristotle’s argument for the existence of two types of knowledge, and currently, in the form of theories of practice drawn from the professions of nursing, and more recently, medicine. Finally, I will explore whether a contradiction does in fact exist for our psychological practitioners as they seek to work within the space created by formalised psychology, and what further research is required to understand the impact of the Boulder discourse on the therapist.

2.2 Evaluation of the Boulder Model, and how Practitioners of Psychology Experience Working within its Frame

Contrary to what one might anticipate, there currently exists no systematic, objective, comprehensive evaluation of the Boulder model in Western psychology. What is available, is an eclectic selection of articles, themed as either pro or anti the Boulder frame, stretching from its commencement informed by Shakrow in the 1950s (e.g. APA Committee on Training in Clinical Psychology, 1947; Raimy, 1950; Shakow, 1965), to the present (e.g. Aspenson & Gersh, 1993; Change et al., 2008; Gelso, 1993; Leube, Radcliffe, Callands, Green, & Thorn, 2007; Milne & Paxton, 1998;
These articles are primarily philosophical in nature, utilising thought experiments or systematic logical forms as opposed to directly presenting and analysing the clinician’s experience. For example, Page (1996) argues that “the term scientist is so devoid of meaning that for an individual, a training program, or a professional society to profess allegiance to the scientist-practitioner model is gratuitous” (p. 103). Additionally for Page, psychology ignores the many philosophical faces of science in favor of empiricism. Page outlines some of the various thought stages science has moved through, and in some cases moved on from, such as induction, falsification, and in the case of Popper, something “approaching, but never reaching truth” (p. 104). Page then calls for psychology to acknowledge the inherent “philosophical...diversity” (p. 106) of science.

Using a similar argument, John (1998) purports that the primary thrust of the Boulder model is to “enable a particular group of psychologists to position themselves as the elect voice of psychological authority” (p. 24). This sentiment has been echoed more recently by the AAPI (2012). In a response to John’s assertions, Cotton (1998) argues that if psychology wants to be viewed seriously, then it needs to play the scientist-practitioner game, and as I stated in chapter one, Stricker (2000) claims that “the scientist–practitioner model is the single most important statement of training philosophy in clinical psychology” (p. 253). Thus it is the views of the considered academic, as opposed to the experience of the practicing clinician that are more visible in the published debate.

Researchers who have sought to directly capture the experience of the therapist, generally through the use of survey, oftentimes target the student practitioner, who is not yet eligible to seek full registration. For example, the results of VanderVeen et al’s. (2012) assessment of 653 clinical psychological graduate students indicated that whilst they had been trained in the scientist-practitioner model, and felt confident to implement its associated principles in their practice, “one third of students reported that they rarely use science-based decisions when informing clients of the clinical services they will be providing” (p. 1048). The research also highlights the temporal stability of motivations leading an individual into psychology (practice versus research). For example the findings of a 10-year longitudinal study carried out by Zachar
and Leong (2000) showed that students who went into the study of psychology with an aim to practice, did not then decide to become researchers as a result of their education within the Boulder model frame. Another avenue of research within this space focusses on course content for endorsed training programs, and whether it conforms to the requirements of the scientist-practitioner model (e.g. Pachana, et al., 2006). What is remarkable within all of this postulating, is that research explicitly exploring the voice of the established practitioner, and their experience within this frame, is notably quiet.

Tyler and Clark (1987) surveyed graduates of American clinical training programs who are all required to complete a PhD, and who had then moved into either academia or practice. Their aim was to explore whether “the Boulder balance of scientific and professional training serve each group equally well” or whether “this model is better suited to the professional role of the academic psychologist?” (p. 384). Whilst their findings were not definitive, they argue that the Boulder pedagogy is more supportive of the needs of researchers then practitioners, although only 20% of students go on to research while 60% students go on to practice. Additionally, Tyler and Clark advocate for more research to explore the relevance of teaching all psychologists using the Boulder philosophy.

An interesting aspect of the American process is their inclusion of “match day” which is an internship process that “bridges the gap between graduate training and entrance into the professional world [and]...is also a requirement” for accreditation by the American Psychological Association (Callahan, Hogan, Klonoff, & Collins, 2014). Whilst Callaghan, et al. argue for the veracity of the Boulder pedagogy, they also state that “there are no published or known existing studies examining whether theoretically derived competencies map onto the achievement-centered academic variables captured on the...Application for Psychology Internships (AAPI)” (p. 69). They then argue that

We do not yet have enough information about the presence or strength of association among clinical or professional competencies and AAPI variables. One step toward progressing this much-needed area of inquiry is to determine which variables from the existing AAPI are associated with matching. This approach may facilitate developing preliminary corresponding benchmarks within training programs to assist students in
their development of needed competencies prior to applying for internship. (p. 69)

However, these researchers seem to fail to question whether the assumptions inherent in the testing point, i.e. the AAPI are problematic from the outset, or whether they constitute an irrefutable truth upon which further assumptions can be built and claimed. Additional confusion is added, as these researchers also claim that based on their research, using a sample of $n = 601$, the greatest predictor of an internship match, was the number of interviews obtained by the student, with six being presented as a bare minimum. Furthermore they identify the influence of personality factors (as opposed to a capacity to marry both practice and research) on match day outcomes, positing that “research indicates that applicant personality, as reflected by Big Five personality traits, is important in both obtaining interviews and in interview performance. Applicants who were more extraverted and conscientious were invited for more follow up interviews” (p. 69). If this is the case, it would seem that personality variables as opposed to learning within the pedagogy provided by Boulder, are predictive of the likelihood of gaining a match and therefore access to the next rung necessary to become a practicing clinician in the American setting. Additionally, these researchers explored the experience of students who have not yet shifted into the space of full registration, which is in contrast to what I seek to do in my research.

As outlined in chapter one, the aim of the Boulder model is that practitioners should be trained as scientists first, and practitioners second. The assumption is that practitioners will both participate in the creation of research throughout their professional lives, and employ treatments which have been found to be efficacious (using for example, randomised controlled trials) with their clients. Yet even staunch advocates of the model state that despite this aim:

Contrary to what we have told ourselves through the years about the primacy of the Boulder model for clinical training and practice, few clinicians undertake research or, for that matter, even read about it. The infrequency with which clinical practitioners utilize clinical research, an issue ever since Hans Eysenck (1952) published his initial evaluation of the effects of psychotherapy almost 50 years ago, continues to be a disappointment and an embarrassment to the discipline. (Nathan, 2000, p. 250)
Therapists who refuse to take up the main tenets of the Boulder model, and apply research findings to their practice, are variously given many names (none particularly flattering) by the pro-Boulder camp. Such names include “quasi-scientific psychologists” (Long & Hollin, 1997, p. 77), and “poets,” whose “belief [is] that imaginative insight and mysteriously privileged sensibility can tell us all the answers that are truly worthy of being sought or being known”, (Medawar, 1984, p. 60), and who also believe in a “concept of truthfulness that belongs essentially to imaginative literature” (p. 58).

In stark contrast, Nel, Pezzolesi, and Stott (2012) found that 357 surveyed members of the Division of Clinical Psychology of Britain predominantly believed that “they learnt mainly through doing and by observing others’ clinical practice” (p. 1058) as opposed to applying the findings of published journal articles. Intriguing to this research is that

It is the first known study of its kind in the United Kingdom to specifically focus on the views of anyone who has completed their clinical psychology training, rather than educators who are delivering training. This is an important perspective, because those who are qualified clinical psychologists are in a unique position to judge what learning methods and activities during training have actually equipped them to be fit for practice in the settings that they are, or have been, working in. (p. 1059)

This claim is supported in part by Callaghan et al. (2014), who cite the existence of only “18 publications [from] empirical studies” exploring the veracity of the Boulder paradigm (p. 81). In criticising these publications, they state that “none of them specifically tested whether an interaction effect was observable between science and practice on any outcome” (p. 81).

Within Australia, to date, no comparable capture of practitioners’ experience has been conducted. Thus, lacking insight into the practitioner’s experience of working within the Boulder frame as provided within a research frame, by needs we must turn to alternative sources as we seek to unmask how the scientist-practitioner model is experienced by our clinicians. One avenue is through reverse engineering what is required of the therapist role. Through that process we can compare the tools we might reasonably expect a practitioner to require in their role, with the tools they are provided with by the Boulder model paradigm.
2.3 What is the Therapist's Role? Application, Evidence-Based Practice, Expertise, and becoming Experienced

Again, inconsistent with what one might expect, a clear-cut definition of what the therapist's role is within Australia, is not available (e.g. APS, 2010; vs Rogers, 1995; vs AAPI, 2012; vs Corcoran, 2009). As outlined in chapter one, within formalised psychology the therapist's role is defined as the ability to apply evidence-based knowledge published in peer-reviewed scholarly journals, whilst avoiding the use of subjectivity and intuition. Within formalised psychology, this approach is oftentimes termed “evidence-based psychological practice”, which is defined by the American Psychological Association (APA, 2005), and reproduced by the APS (2010) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 3). However, what remains unclear for the practitioner, is what precisely formalised psychology means by “expertise,” the processes by which the individual becomes experienced, and whether something other than knowing about and applying published theory and therapy is necessary to get there. In documenting the experiences of clinicians, such expertise can be examined.

Some clarity regarding formalised psychology’s understanding of expertise is provided by the APS (2010) who state, that “using evidence-based psychological interventions in practice...requires a complex combination of relational and technical skills” (p. 5). Here it appears that expertise is understood as both being “relational” and having “technical skills.” “Being relational” may be interpreted as awareness of “patient characteristics, culture, and preferences”. Having “technical skills” in context may be understood as the capacity to “apply” evidence-based knowledge published in peer-reviewed journals. Yet according to the APS, application also needs to be viewed as “more than...mechanistic adherence to well-researched intervention strategies” (p. 5). What is meant by “more than” remains unclear, as the APS also states that “for comprehensive evidence-based health care, the scientific method remains the best tool for systematic observation and for identifying which interventions are effective for whom under what circumstances” (p. 5). Viewed collectively, and in context, it seems that formalised psychology views expertise as being aware of a diversity of published techniques, and knowing who will benefit most from “which intervention”. Moreover, the assumption
seems to be that you are either a therapist, or you are not. No formalised, graded, and developmental career trajectory exists along which registered psychologists may make the nuanced shift from novice through to expert.

Additional insight into how expertise is understood within formalised psychology may be gleaned by considering the current hierarchy within psychology which distinguishes between clinically trained, and alternatively trained practitioners. As discussed in chapter one, greater status in psychology is very specifically afforded to those with additional academic training, in the form of clinical masters, or doctoral degrees. Moreover, according to the PsyBA (2016f, para. 3), this additional academic, as opposed to practical training, and associated endorsement is not “based on experience derived during the course of the professional career,” but is derived from the completion of, and presumably demonstrated awareness of specific evidence-based, published empirical trials. Thus a practitioner with 20 plus years of experience, including publications, and demonstrated success with clients, is placed in the position of professional “subservience” to a recent graduate of a clinical masters or doctorate program, and at the very least will be financially discriminated against under the Better Access Scheme, and may not even receive the referrals necessary for receiving work within this system (AAPI, 2012). So too, a student following the more practically rigorous 4+2, or 5+1 pathways. Thus whilst the talk is there, in the form of evidence-based practices in psychology, the legislation, training and financial remuneration favors those with on-paper greater capacity to apply knowledge generated by, for example, randomised controlled trials, and a reasonable conclusion is that being or becoming experienced and doing best practice therapy, equates to the same.

In contrast to this positioning Bradley (2009) presents experience, defined here as the “capacity for solving problems in unique circumstances” (p. 1), as the “crucial [component of] professional practice” (p. 1) and necessary for maturation in practice-orientated professions such as teaching, nursing, and psychology. For Bradley, inherent in any curriculum (understood here as both introductory and life-long), is an expectation for the student, or maturing registered clinician, to demonstrate problem solving within varied and increasingly complex settings, embedded within a frame which then facilitates reflection. Such garnering of experience, is provided for in the form of regular practicums, each of increasing difficulty, with assessment tasks geared towards
the creation of tangible resources for use within the space of practice, and
active reflection on what does or does not work, why that may be the case, and
possible ways of generating better outcomes in future, comparable scenarios.
Experience gleaned from each practicum or client presentation, is then used to
inform the next practicum or client presentation, usually in an alternate setting,
and so on and so on. By needs then, practical experience becomes more then
something which just happens. Rather it becomes a process which shifts
experience from a happening into a resource, a developing wisdom which can
be applied to the next experience or happening and its outcomes learned from.
Inherent in this process is “reflexive analysis and discussion of [clinician and
client] values and interests” (Flyvbjerg, 2001, location 143 of 5218).

Historically, this conceptualising of moving practice into experience, may
be traced back to the thinking of Aristotle. Aristotle argued for the existence of
two types of knowledge; episteme and phronesis. Episteme is understood here
as “analytical, scientific knowledge” (Flyvbjerg, 2001 location 128 of 5218), and
is the type of knowledge currently favored, and legislated for in formalised
psychology. Phronesis translates as practical wisdom or prudence, and “is
most important because it is that activity by which instrumental rationality is
balanced by value-rationality,” and “such balancing is crucial to the sustained
happiness of the citizens in any society” (Flyvbjerg, location 161 of 5218).
Moreover, Aristotle’s notion of phronesis introduces an ethical and situational
element to knowledge generation, and a “true state, reasoned, and capable of
action with regard to things that are good or bad for man” (Aristotle, trans.
1976). Thus, phronesis becomes “the relationship you have to society when
you act” (Flyvbjerg, location 1120 of 5218), and through virtue of being an act,
“phronesis goes beyond both analytical, scientific...know-how” and instead
“involves judgments and decisions made in the manner of a virtuoso social and
political actor” (Flyvbjerg location 131 of 5218).

Hand-in-hand with this “cradle-to-grave” educational frame are rich
theories of practice and learning, such as Dreyfus and Dreyfus’s (1980) model,
Benner’s (1982; 1984) and Benner et al’s. (2009) insight into the stages of
nursing practice, and Green’s work around professional practice (2009a;
2009b). All of these authors actively seek to provide an avenue for shifting
practice, or an experience, into an evolving resource set, which is unique to the
individual, and able to inform their behavior in their next experience.
Particularly influential outside of psychology, is Schön’s (1987) concept of the reflective practitioner.

2.4 The Reflective Practitioner

Schön (1987) labels the two theories of practice outlined above as technical rationality, and reflection-in-action. He effectively pits them against each other, and provides the metaphor of the highground versus the low and swampy ground to differentiate between the two. The high ground equates to theory and best practice within an epistemological frame of “technical rationality” (p. 3), which “treats professional competence as the application of privileged knowledge to instrumental problems of practice” (Schön, 1987, p. xi). Conversely, the low and swampy ground equates to the reality of being in the room with the individual, faced with their “problems of...human concern” (p. 3), a space which by needs requires a capacity to “handle situations that are uncertain, unique and (at times filled with) conflict” (p.16). Conflict here can be, for example, different world-views, personalities, belief sets, moral values, or experience, none of which may be countenanced in the high ground, as it works in the space of absolutes. Regardless, it is these nebulous presentations which form a regular component of the kinds of issues faced by therapists (e.g. Reik, 1983; Rogers, 1995; Yalom, 1980, 2002). Schön then asks the question; within a technical-rational frame, what do practitioners do when the problems they face are not “resolvable...by reference to the facts” (p. 36).

As foil to this dilemma, Schön (1987), provides the model of the reflective practitioner. Schön defines reflective practice as “thinking [about] what you are doing while you are doing it” (p. xi), and he argues that it is necessary for practitioners as they approach “situations of uncertainty, uniqueness, and conflict” (p. xi). The concept of reflection, when applied to practice, provides the tool via which experience, or doing, is shifted into a developing wisdom. For Schön, reflection-in-practice is necessary as practice throws up “indeterminate zones” (p. 6), or unique situations, which cannot be solved via the literal application or overlay of “the canons of technical rationality” (p. 6). More specifically, reflection-in-action arises when, for example, a client presentation involves an element of surprise, a glitch in the matrix, or presents in a way we are not immediately (if at all) familiar with. That is, “something fails to meet our expectations” (p.26). For Schön, the element of surprise requires
the practitioner to reflect, and change course, or, at the very least explore alternatives. The clinician can then respond to this surprise by ignoring it, or they can stop for pause and reflect on what has/is happening, and identify factors integral to bringing about the desired outcome. Based on this process, the clinician can then change their behavior in keeping with their developing understanding of the situation at hand. Schön terms this “reflection-in-action” (p. 26), or “on-the-spot experimentation” (p. 28). Each reflected moment and associated response, leads to another moment which may or may not “fail to meet our expectations.” The process continues such that we move towards a solution or a space of no surprises (for the moment). The process is messy, and occurs in Schön’s swamplands as opposed to the clean space of technical rationality which again assumes that problems faced by practitioners are generic. However, according to Schön, knowledge thus gained can then be applied to the next novel situation.

Building on both Schön (1987) and Benner’s (1982, 1984) work, Rolfe (1997) articulates this process as informal theory creation, or problem solving. Rolfe states that the practitioner uses their:

- Personal knowledge to construct an informal theory about the situation they find themselves faced with, hypothesize about the possible outcomes of applying that theory, test out their hypotheses in practice, reflect on the changes that this produces, respond to those changed by modifying their theory, test their new hypotheses, and so on in a reflective cycle. (p. 95)

Moreover, the process creates clinicians, each with their own unique “repertoire of paradigm cases...which constitutes a body of personal knowledge...very different from public academic knowledge” (p. 93). My research seeks to explore this space in part. However, for a detailed account of documentation supporting this model, refer to the work of Benner (1982, 1984), and Benner et al. (2009) in full.

Benner (1982), and Benner et al. (2009) provide an example of how experience shifts into resource, through the process of reflecting-on-practice, highlighting the nursing profession. Like Bradley (2009), Benner defines experience as more than “the mere passage of time or longevity; it is the refinement of preconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theory” (p.
Nurses regularly deal with clients, or their relatives, who may have no prior experience dealing with what they are faced with in the hospital setting, for example “illness, pain, disfigurement, death, and even birth” (p. 406). Indeed, it “makes little sense for the lay person to personally prepare in advance for the many possible illness experiences” (p. 406), as they may or may not encounter them in their lifetime. In contrast, due to the nature of their profession, nurses:

Through their education and experience, develop and observe many ways to understand and cope with illness, as well as many ways of experiencing illness, suffering pain, death and birth. Nurses offer avenues of understanding, increased control, acceptance, and even triumph in the midst of what, for the patient, is a foreign, unchartered experience. (Benner, p. 406)

Moreover, “nurses, in their practice, by the way they approach a wound or the way they talk about recovery from a surgery, offer ways of understanding and avenues of acceptance” (p. 407), none of which can be learned from theory alone. For Benner,

Experience, in addition to formal education preparation, is required to develop this competency since it is impossible to learn ways of being and coping with an illness solely by concept or theorem. A deep understanding of the situation is required before one acquires a repertoire of ways of being and coping with a particular illness experience. (p. 406)

As with nurses, experienced and effective psychologists by needs “have come to grips with the culturally avoided or unchartered and can open ways of being and ways of coping for the patient and the family” (Benner, 1982, p. 407). For example, Roos and Werbart (2013) “reviewed [44] empirical studies [published between January 2000 and June 2011] with a wide range of methodological approaches, both those directly addressing questions of dropout rates in relation to therapist, relationship or process factors, and those including some of these variables in the analysis” (p. 396). An inherent assumption was that clients who remained in therapy, were more likely to achieve their wellness goals then those who did not. Of particular interest in this study was that, unlike previous research, which focuses on client factors impacting therapy dropout, Roos and Werbart deliberately sought to delineate therapist factors contributing to the same, as it is these factors which are "under
investigated” (p. 385) in the scholarly literature. Moreover, this is despite the fact that prior research provides evidence that the therapist is pivotal in determining therapeutic outcome (Baldwin, Wampold, & Imel, 2007; Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Okiishi, Lambert, Nielsen, & Ogles, 2003). Additionally, available research supports the assumption that “better outcomes as well as lower dropout rates are related to...[the clinician’s] experience, flexibility in relation to treatment manuals, [capacity to] accommodate...clients’ specific problems, [and their own personal] training and...psychotherapy” (Roos & Werbert, 2013, p. 395).

From their work, Roos and Werbart (2015) drew the conclusion that “therapists’ experience, training and skills, together with providing [their clients with] concrete support and being emotionally supportive” (p. 394) served as protective factors against client dropout. Moreover, lower drop out rates were related to therapists being more experienced, irrespective of type of therapy delivered. As a result of this work, Roos et al. put forward the hypothesis that “therapists become more responsive and focused on the relationship as they move beyond their years of basic training.” (p. 413). Further, to facilitate retention, they posit “therapists need enhanced skills in building and repairing the therapeutic relationship” (p. 394).

With consideration of Aristotle’s view of knowledge, and Schön (1997), Benner’s (1982, 1984), and Benner et al’s. (2009) alternate ways of learning from practice, the question for psychology becomes what types of problems is the therapist likely to encounter within their rooms with their clients, and which theories of practice are most effective at facilitating problem solving within that space? Moreover, what do clinicians present as underpinning their practice process, and within which theories of practice does that experience sit? Fundamentally, the question stands as; does the therapist only operate within the space of episteme, as formalised psychology would currently have us believe, or do they operate also in the space of phronesis? To explore this notion further, I will look at assumptions embedded within the epistemic understanding of practice, asking whether they are potentially problematic for the therapist.
2.5 Does a Contradiction Exist? Problems with Epistemic Knowledge in Practice

Epistemic, or science-generated knowledge has as one of its base-line assumptions that generalised results of published randomised controlled trials, and population studies, easily translate from the pages of a journal to any one individual’s presentation. However, this is not necessarily the case. For example, Greenhalgh (1998) states:

In particle physics, the scientific truths (laws) derived from empirical observation about the behaviour of gases fail to hold when applied to single molecules. Similarly (but for different reasons), the ‘truths’ established by empirical observation of populations in randomised controlled trials and cohort studies cannot be mechanistically applied to individual patients or episodes of illness, whose behaviour is irremediably contextual and (seemingly) idiosyncratic. In large research trials, the individual trial participant’s unique and many-dimensional experience is expressed as (say) a single dot on a scatter plot, to which apply the mathematical tools to produce a story about the sample as a whole. The generalisable truth that we seek to glean from research trials pertains to the sample’s (and, it is hoped, the population’s) story, not the individual trial participants’ stories. (p. 251)

Such population studies provide patterns which may be useful in assessing varied client presentations. However, as explicated in chapter one, the individual presenting before any one clinician may not conform to the findings of any published results, and instead may be an outlier, or a unique presentation, the treatment for which has not yet, nor may ever be published.

Moreover, within psychology, there may be competing theories and evidence regarding how to treat any one presentation, with comparable efficacy results obtainable for both. For example Mohr et al. (2005) conducted a randomised controlled trial comparing a “16-week T-CBT (telephone administered CBT) program” with “16 weeks of telephone-administered supportive emotion-focused therapy” (p. 1007). Their research had a data set of \( n = 127 \), with seven participants dropping out during the course of the study. Additionally, the work included a 12 month follow up. Using the Hamilton Depression Rating scale, both treatments were found to be equally efficacious at immediate and 12 month follow-up.
2.6 Summary

In this chapter, I have demonstrated that contradiction exists for the therapist required to practice in the legislated Boulder model paradigm. I began by outlining research seeking to evaluate and understand how the space created by the Boulder model is experienced by psychological practitioners, and I highlighted the lack of research exploring how practitioners (as opposed to students or universities) navigate this expectation. Next I unravelled how formalised psychology’s methodology for marrying science with practice, known as evidence-based practice, lacks clarity and does not provide clinicians with sufficient strategies to make the nuanced shift from novice through to expert. I then compared formalised psychology’s practice-as-application, with alternate conceptualisations of practice, available to the discipline both historically, in the form of Aristotle’s view of knowledge, and currently, in the form of theories of practice drawn from for example the profession of nursing, and more recently medicine which do provide that scaffolding. Finally I demonstrated that a contradiction exists for our psychological practitioners, as they seek to work within the space created by formalised psychology, and that further research is required to understand the impact of the Boulder model on the therapist. I will now move to an exploration of what that research might look like, and what could constitute an effective methodological frame.
Chapter 3

Methodology

3.1 Introduction

In order to examine the questions posed in chapters one and two, a method of collecting and analysing interview data is needed, which allows for practitioners to explore their subjective experience of working within the Boulder model frame. Over the last 30 years, research traditions regarding how best to explore subjectivity have evolved, and current thinking presents qualitative methodologies as providing a suitable avenue for researchers to explore the “quality and texture of experience” as opposed to “identifying cause-effect relationships” (Willig, 2013, p. 8). However, rather than positioning qualitative versus quantitative approaches as inimical to each other, they can be used to inform cycles of research. Qualitative methodologies can provide insight into the diversity of experience occurring within an identified population, necessary for the creation of new theory and hypotheses (Eisenhardt & Graebner, 2007). In addition, the results of qualitative research can be used to identify and inform the kinds of questions that a quantitative researcher might then seek to ask. As I have shown in chapters one and two, we are presently “in the dark” as to how Australian therapists experience the practice of psychology within the Boulder model frame, how they position themselves within legislated expectations, and whether they find the resultant Songline helps or hinders their perceived role. Thus, whilst quantitative methods such as surveys and likert scales may be used to determine the prevalence of an experience, these are limited and less useful in accessing answers as to what that experience is.

3.2 Social Constructionism, and Hollway and Jefferson’s Theory of the Defended Subject

Due to the “created” nature of the Boulder model paradigm in which Australian psychologists are generally required to work (refer to chapters one and two), we have an identifiable population whose experience characteristics can be explored qualitatively through interviews. Social constructionism becomes a suitable epistemological frame within which to commence a formal investigation (Gergen, 1973, 1985; Willig, 2013). Gergen argues that the
experience of the individual is informed by the social, cultural, and historical forces acting in on them. In focusing on how these forces are experienced by this population, we are well placed to evaluate the questions of this thesis, as presented in chapters one and two. Consequently, in my research, I will be mapping and analysing how individuals construct themselves in amongst the discourses that are socially and theoretically available to them. My analysis recognises that social self-construction reflects both subjects' access to, and adaptation of, socially-provided discourses and practices and the intersubjective dynamics of the interviews themselves.

As this research is aimed at exploring the individual's experience of contradiction, participants' subjectivity needs to be theorised. One way of theorising the subjective impact of formalised psychology's privileging of science-generated, as opposed to practice-generated knowledge on clinicians, is with consideration of psychoanalytical theories of anxiety (Hollway & Jefferson, 2013; Klein, 1997; Laplanche & Pontalis, 1988). According to psychoanalytical thought, each individual is in possession of a “dynamic unconscious that defends against anxiety [which] significantly influences people’s actions, lives and relations” (Hollway & Jefferson, p. 17). Hollway and Jefferson call that individual “the defended subject” (location 350 of 4956) and argue that informed insight into that person’s experience requires explication of the defense mechanisms they employ as they interact with, and respond to, challenges posed by the external world. The primary aim of such defense is to allow the individual to manage anxiety-producing events such that they do not “become (or remain) pathogenic” (Laplanche & Pontalis, location 208 of 13238). According to Hollway and Jefferson, if we are able to understand how a person, in this case a psychological practitioner, is deploying defense mechanisms as they deal with the world, we are better able to understand how they are both interpreting, and experiencing that world.

One example of a defense against anxiety, is the concept of splitting, which stems from Kleinian thought, and is based on observational research carried out on the feeding child and extended to the functioning of workers in institutions, such as nurses in hospitals (Menzies, 1960). From a young age, the child learns to identify the breast (or bottle) as a source of both pleasure (when it is felt as “good”, as the child’s suckling desires are met), and discomfort (when it is felt as “bad”, as the child’s suckling desires are not met).
The dual nature of the unitary object (i.e. its capacity to be felt as both good and bad) can create an experience of anxiety for the child, particularly if they are unable to predict or control when the desired object (i.e. breast/bottle) will be good, or bad.

Within Kleinian thought, the child’s capacity to manage resultant anxiety manifests in two ways. Either toddlers are able to view the object (e.g. their mother) as being unified, and thus being by turns both good and bad, or they instead view her as unilaterally good or bad. Klein presents the former capability, as a sophisticated response to anxiety attributed to objects which can be felt as simultaneously good and bad. She terms this position, the depressive, or rational position. Klein terms the lack of this capacity, the schizoid effective, or irrational position, and presents this response as a more draconian, less sophisticated means of managing anxiety. Here the child is unable to view the one object as possessing both good and bad qualities, and instead treats the object as split into two. However, both mechanisms have as their aim the reduction of tension resulting from anxiety, such that the idea, or object, is able to exist for the person, and no longer cause internal tension or “unpleasurable affect” (Laplanche & Pontalis, 1988, location 3507 of 13238).

3.3 The Primary Contradiction

Viewed from this angle, we may gain some insight into how practitioners cope psychologically with the primary contradiction between (a) being a good professional as they have been taught (i.e. being a scientist applying research-based knowledge to their clients) and (b) being a good professional as they have learnt through their experience in relationship with their clients and peers, and through their reflection on the same, and resulting in, for example, developing insight, practical knowledge, and professional judgment or phronesis (refer chapter two).

3.4 The Current Study

For this research, subjectivity will be theorised using Hollway and Jefferson’s (2007) defended subject, giving consideration to Kleinian notions of splitting and anxiety defense. Integral to this theory of subjectivity within the epistemological framework of social constructionism, are considerations of discourse created by historical, cultural, and linguistic factors, each serving to
inform the subjective experience of the individual, and manifesting as the practice of psychology in Australia (Gergen, 1973, 1985; Willig, 2013). Further, the influence of the psychosocial space will be recognised, a concept denoting the complex interplay between the “inner” world of the individual and the “external” world, acknowledging psychic and social simultaneity (Clarke, 2006; Hollway & Jefferson, 2007). Consideration will also be given to induction and the possibility of generating new theory informed by in-depth analysis of qualitative interviews as advocated for by Eisenhardt and Graebner (2007). These researchers argue that theory generated in this way is particularly powerful because it grows out of practice generated vignettes, and is “accurate, interesting and testable” (p. 26). Consequently, they advocate that an inductive approach to qualitative research helps to bridge the gap between quantitative and qualitative data collection, providing an avenue for experiential knowledge to be shifted into the space traditionally inhabited by epistemic knowledge. With consideration of the topic of this thesis, such an approach is particularly useful.

The outlined approach which I employ in my study, is in contrast to much existing research into practitioners’ experience, which is seemingly focussed on very specific topic areas such as how practitioners navigate sexual attraction with clients (Giovazolias & Davis, 2001), or their thoughts on the efficacy of the Better Access Scheme (Pirkis et al., 2010). Such research does not explicate the epistemological and ontological underpinnings of the practice of Australian psychology, paradox, resultant discourse and the experience of practitioners within that. Consequently, clinicians have access to a limited research framework in which to explore the resultant impact on subjectivity and practice. Furthermore, psychology has access to little information with which to explore the current pragmatics of mental wellness facilitation. The current study seeks to at least partly address this deficit.

Given my theoretical interest in experience and paradox, and for the reasons outlined above, a qualitative approach will be employed, with participants being interviewed regarding their experience of contradictory discourse within their practice. As the data collection method will primarily be via interviews, a theory of subjectivity needs to be articulated, in order to provide a framework within which to explore the research data obtained from each individual, and to inform interpretation. Moreover, through this study, I seek to explicate the experience of paradox within the practice of Australian
psychology, a theory embedded in beliefs that participants will “tell-it-like-it-is” (Hollway & Jefferson, 2013, p. 3) is likely to prove insufficient to interpret the data. As stated previously in this chapter, Hollway and Jefferson suggest that interviewees will seek to avoid presenting themselves in a contradictory light and instead seek to provide coherent accounts of themselves. Consequently, this study will employ Hollway and Jefferson’s theory of the defended subject, as it provides a theoretical framework within which to explore both paradox, and resulting anxiety. These researchers state “in our theory of the defended subject...the crucial motivation for investment in particular discourses is the need to defend oneself against feelings of anxiety” (p. 54). Moreover, their theory both recognises the intersubjective space, and provides a reflexive frame in which to work, as the interviewer is also defending against anxiety. Hollway and Jefferson comment that “the impressions we have about each other are not derived simply from the ‘real’ relationship...what we say and do in the interaction will be mediated by internal fantasies which derive from our histories of significant relationships...often accessible only through our feelings and not through conscious awareness” (p. 42).

3.4.1 Collective biography.

In addition to interviews, a collective biography will be conducted with a small group of practitioners (Davies & Gannon, 2006). Collective biographies allow the researcher to explore discourses inherent in a common experience such as being a practicing psychologist, through a shared building on, and over each other’s heard stories. The approach, also highlights that we are not individuals whose experience is created in a vacuum. Rather we are socially created beings. Correspondingly, whilst our biography is about an individual, it is created through the social process (Bradley, 2005). Thus, according to Davies and Gannon, recall of our biography can be facilitated by a group process. The procedure for the collective biography is described in section 3.4.6.

3.4.2 Participants.

In order to more accurately capture how practitioners, as opposed to students or provisional psychologists, experience working within the Boulder model frame, my research recruited currently practicing clinicians, registered
with the PsyBA. Through word-of-mouth and “snowballing” (where people interviewed, introduce the researcher to someone they know that may be interested in participating), I was able to recruit seven psychologists for one-on-one interviews, and three for a collective biography. Clinicians were from a variety of cultural backgrounds, however all were fluent in English. Clinicians resided in various locations across Australia, and expressed an affiliation with varied philosophical and theoretical practice-positionings. Please refer to Table One, for therapist demographics. Each therapist was interviewed once, with resulting transcripts read a minimum of four times for the purpose of analysis. Each interview, and the collective biography was audio-recorded and transcribed in its entirety.

Ethics approval was granted by the Human Research Ethics Committee at Charles Sturt University (Appendix A) and all participants were treated according to the ethical guidelines of the Australian Psychological Society (APS, 2007). Written consent (Appendix A) was sought from participants after they had read and understood the details of the research outlined in the Information Sheet (Appendix A). This process ensured that participants were aware of the process they were entering into, and how that information might be used, albeit in de-identified form.

3.4.3 Demographic information.

Demographic information emerged spontaneously throughout the interview. Where necessary additional questions were asked to elicit this information. A profile “snapshot” of each participant is viewable in Table 1. Of note here is that participants were drawn from varied locations across Australia, including WA, and country and urban NSW. However, specifics beyond that have been removed to safeguard their anonymity.

Table 1
Demographic Data of Participants

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Cultural Background</th>
<th>Practice years at interview</th>
<th>Status</th>
<th>Int/ CB</th>
<th>Medium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phoebe Bee Berbee</td>
<td>36</td>
<td>Anglo Australian</td>
<td>6</td>
<td>Clin Psych</td>
<td>Int</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Age</td>
<td>Cultural Background</td>
<td>Practice years at interview</td>
<td>Status</td>
<td>Int/ CB</td>
<td>Medium</td>
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<td>------------</td>
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<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td>Annette</td>
<td>58</td>
<td>Anglo Australian</td>
<td>38</td>
<td>Clin Psych</td>
<td>Int</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Michelle</td>
<td>36</td>
<td>Anglo Australian</td>
<td>5</td>
<td>Reg</td>
<td>Int</td>
<td>Phone</td>
</tr>
<tr>
<td>Anna</td>
<td>61</td>
<td>Greek Australian</td>
<td>25</td>
<td>Clin Psych</td>
<td>Int</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Captain</td>
<td>54</td>
<td>Withheld for anonymity</td>
<td>33</td>
<td>Clin Psych</td>
<td>Int</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Dukie</td>
<td>47*</td>
<td>Anglo Australian</td>
<td>17</td>
<td>Clin Psych</td>
<td>Int</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Johannes</td>
<td>58</td>
<td>European</td>
<td>23</td>
<td>Clin Psych</td>
<td>Int</td>
<td>Skype</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>37</td>
<td>Anglo Australian</td>
<td>7</td>
<td>Clin Psych</td>
<td>CB</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Ted</td>
<td>48</td>
<td>Anglo Australian</td>
<td>24</td>
<td>Clin Psych</td>
<td>CB</td>
<td>face-to-face</td>
</tr>
<tr>
<td>Callitump</td>
<td>42</td>
<td>Anglo Australian</td>
<td>18</td>
<td>Reg</td>
<td>CB</td>
<td>face-to-face</td>
</tr>
</tbody>
</table>

**NB:** “Int: refers to Interview; “Reg” refers to fully registered, but without a clinical psychology speciality; “Withheld” for the purpose of anonymity.

**NB:** Registration commenced in 1981, so a number of these clinicians were practicing well before then.

* Approximate age

### 3.4.4 Procedure for the interviews.

Prospective participants were contacted via phone or email and invited to participate in an audio-recorded interview regarding their experience of navigating contradiction in the practice of psychology. A mutually suitable venue and time was determined. Due to distance, Michelle was interviewed over the phone, and Johannes was interviewed via Skype. Rapport was established prior to recording through casual conversation and through, for example, a brief discussion around the shared experience of studying psychology. However as the researcher’s role is different to that of a friend or therapist, this style of communication shifted into the asking of open-ended
questions as outlined, and in keeping with Hollway and Jefferson’s methodology (2013). As previously discussed, inherent in this positioning, is the idea that participants may not tell-it-like-it-is. Consequently, what is said needs to be interpreted by the interviewer, with consideration given to the varied contexts created by the participant in society, and what is thrown up by the participant-researcher interaction. The fact that I had studied psychology, and was now doing a PhD within that discipline, along with my gender, age, and the fact that I am a mother of two children, all play into the data that was produced within each interview. For example, Michelle and I had a shared experience of the length of studying psychology evidenced in the following interaction

J: Yep okay, yeah it’s a long study cycle, psychology (laughter)  
M: it is...  
J: What are you doing..[this was a question relating to her doctoral studies]  
M: It’s a lifetime of training.

In addition we had a shared experience of doctoral training—which further contributed to the rapport created (Stopford, 2004).

On the other hand, Johannes, who was a number of years older than me, and whom I had previously met in academic circles—wherein he is higher up the food chain, and who I perceived to have quite different viewpoints around psychological practice, may be viewed as seeking to calm my nerves at the start of our interview. Whilst I attempted to “dive straight into it,” he sought to participate in some “small talk” as evidenced in the following excerpt from our interview

J: Can you see me okay?  
Jx: Yes, I can see you okay  
J: Yep. Well thank you very much for giving up your  
Jx: You’re sitting in a big place.  
J: A big place?  
Jx: Yeah  
J: Yeah, we just had our house renovated, so we have a very high roof.  
Jx: (Laughs), very good, very good.  
J: Thank thank you for agreeing to um...to give some of your time and um let me you interview you. I appreciate it, it’s very kind of you. Have you had a busy day or are you...  
Jx: Ohw I had two weeks holidays, I was in [country] just came back ahh Sunday, so yes.
This co-creation of research, does not invalidate what is said. Rather the resulting interactions are the stuff of which qualitative research is made. It is the analysis of what is co-produced which provides insight into the discourses, and grit, from which society is crafted (Davies & Gannon, 2006; Hollway & Jefferson, 2013; Stopford, 2004). Additionally, it is the co-creation of data, which lends itself to both my chosen epistemological and methodological frame as previously outlined.

Information regarding the nature of the interview, and the aims and purpose of the research were discussed. Furthermore, the information sheet outlining these details was provided to, and read by the prospective participant (Appendix A). In addition, signed consent was sought and given (Appendix A).

Each interview involved asking a single open-ended question at its commencement. However, whilst the intent behind this question remained constant across interviews, the question itself became more refined. For example, in my first interview which was with Phoebe Bee Burbee, I asked her to share her experience of

Expectations, and assumptions and judgments I guess that are placed upon you as a practicing psychologist by differing groups, so whether that’s media, or your clients, or yourself, or um........um...you know the psychology board, or AHPRA, or any of those. What sort of shapes your sense of yourself as a psychologist, and a practicing psychologist?

Whereas with my final interview, which was with Johannes, following a long discussion around demographic details, and his personal study pathway, I asked him to share “an example from [his] practice that has stood out for [him] um in terms of ........being quite a powerful experience”. This was a seamless way into the same area of questioning given he had already mentioned some of the terms used in my initial question above.

At the commencement of each interview, I also outlined how I would conduct the interview, and how I would use silence to allow the interviewee space to reflect. This is in keeping with the interview technique of Hollway and Jefferson (2013). I also advised participants that they were free to stop the interview at any time if they felt distressed. In the event that distress was evident, I was prepared to contact one of my supervisors Dr Jane Selby who is a registered and practicing clinical psychologist for guidance.
During the interviews, clarifying questions were asked as required to facilitate narrative, using the language of the participants (Hollway & Jefferson, 2013; Mauthner, 2002; Slater, 2007). For example when interviewing Captain, he began speaking about projection, in amongst commenting on the relative sophistication of Melbourne versus Sydney. Instead of interrupting him from what seemed like a digression from what I wanted to hear about, I waited until there was a suitable pause in his speech, and then using the words and terminology he had injected into the interview, I asked him to speak about projection. This interaction is evidenced in the following interview excerpt. The dotted line is used to indicate the relative length of the pause which occurred prior to my asking my question.

C: .....Melbourne is a much more sophisticated place then Sydney (J:mm) I think for those reasons.................................................................
J: ahhhh................mmm........(C: so that’s a Sydney psyche for you)
that’s a Sydney psyche for you....you just made, well you made quite a few comments then (C: yes)..you sort of said, you talked about, oh, you made the comment about seeing what people project onto you, would you be happy to talk a bit more about that?
C: Absolutely, absolutely.

If necessary, additional biographic and demographic data was sought, to facilitate placing the interviewee in a time and place influenced by the psycho-social space (Hollway & Jefferson; Mauthner). This approach facilitates reflexive understanding of the intersubjective space co-created between researcher and participant as outlined previously (Bradley, 2005; Hollway & Jefferson, Slater).

Each interview went for a minimum of one hour, with most lasting between one and a half, to two hours. In the event of any of the participants evidencing distress during the course of the interviews, I was prepared to gently ask them if they wished to continue and remind them they were free to terminate at any time. However, none of my participants gave me any evidence of distress, and in fact they seemed to enjoy the audiened time for uninterrupted reflection on their experience, as evidenced by the easy flow of, and duration of the interviews.
3.4.5 Procedure for the collective biography.

The three participants for the collective biography were recruited in a manner comparable to that used to recruit the interviewees. However, instead of a one-on-one scenario, participants met at a pre-determined central location. As “payment” for their time, they requested that I provide them with a home-cooked meal, which I did. As consequent, the collective biography was quite relaxed, however Davies and Gannon (2006) present their own use of this methodology in a similar vein, at times involving their participants in weekend retreats.

Following an outline of the process, the three participants were invited to reflect on “an experience they had had that had shaped their understanding of really good psychological practice”. This experience did not need to be linear, and could include smells, tastes, feelings, impressions, textures etc. Participants were then given around 20 minutes to reflect on that experience, either writing it down verbatim, or in note form, which they then spoke to. As per the one-on-one interviews, the clinicians were then invited to share, in an uninterrupted manner, their experiences and reflections in response to the stimulus question. After hearing all of the stories, participants were then given another 20 or so minutes to expand on their initial stories, or comment on the stories of others. Again, this was done individually, and in silence, prior to each participant then sharing the second capture with the full group. Following on from this second stage, the group moved into a general discussion around their experience and perception of the practice of psychology in Australia. Please refer to Appendix B for a copy of the tool I used for this component of the research.

3.5 Data Analysis

Formal analysis began at the point of transcription, which was not outsourced. Recordings were made on a SONY hand-held recorder, allowing for play-back at half speed. It was this speed which was used during the transcription stage, as my typing skills allowed me to (almost) keep up with the words of my participants. Thus, I was immersed in the language, intonation and voices of each interview for a second time, following the interviews themselves. There was a surrealist quality to this process, as I found myself dreaming the words of my interviewees each night, and hearing their voices in my head.
during the day. Even now, I still have auditory flashbacks to that process. However, that approach, also seemed to facilitate analysis, and I was able to jot down thoughts, impressions, and questions in the morning when I woke, or (what seemed the status quo for most of my phd study) during the early hours of the morning, when I was unable to return to sleep without first writing things down. Additionally, I maintained close contact with my supervisors during this time, checking in with them around my interpretations, and impressions, or inklings.

The transcript style I used was verbatim, with dots (...) indicating relative length of pauses used by participants. With the exception of the use of dots to denote an approximation of silence, this style is in keeping with that used by Hollway and Jefferson (2013).

Following on from the creation of transcripts, the interviews were analysed using Hollway and Jefferson’s (2013) concept of the defended subject, giving consideration to Klein’s (1997) notion of splitting outlined previously. More specifically, the transcripts were read multiple times to identify key themes, slippages, ambiguities, contradictions, what was not said, metaphors used, images drawn on, and use of the language of ‘should’. Brown and Gilligan (1992) suggest “should” is indicative of discourse, societal expectations, assumptions, and judgments which are external to the individual but which weigh in on their experiencing.

I also sought to pull out, from each individual interview, and the collective biography, evidence of manifestos, value for the ontology of Being, the relevance of agency to the facilitation of wellness, personal beliefs, key terms injected into the interviews by clinicians, and how they defined them.

Moreover, as stated previously analysis focussed on areas of ambiguity and contradiction, made knowable through Hollway and Jefferson’s (2007) theory of the defended subject. Byres (2010) argues that ambiguity and contradiction “are not only present in mathematics [they are] essential...and imply the existence of multiple, conflicting frames of reference...that give rise to new...ideas” (p. 23). Nucci (2008) argues for the worth of exploring these effectual glitches in the matrix, precisely because they highlight “disruptions to normalcy that need to be repaired or suppressed” (p. vii). Furthermore, it is the associated experience of discomfort, which forces the individual to align themselves consciously or not, with a subject position of subservience,
concurrence or resistance. Nucci suggests resistance is essential for ongoing evolution and growth at the individual, social, and indirectly professional level. However, subservience is linked with oppression, and concurrence is linked with the maintenance of the status quo (Oliver, 2004). It is acknowledged here that more than one position may be occupied simultaneously. Alternatively, the participant may shift between a number of positionings, which is also evidence of contradiction and ambiguity (Nucci, 2008; Oliver, 2004).

More specifically this involved a process of writing copious notes on each interview, with each reading. At one point (which lasted for approximately three months), I became obsessed with the metaphors the clinicians were using. During this phase of my analysis, I read widely around metaphor and language, and sought to categorise emerging metaphoric themes. However, in discussions with my supervisors, it became apparent that I was 'losing my way'.

Then followed a period of extreme writer’s block, where I struggled with finding meaning in what I had read. However, this period ended, when my supervisor’s requested I go through my interviews yet again, and (informed by my already copious notes and existing impressions) write anew my ideas about what was emerging. From here, I spent literally days writing an extensive analysis of each interview, ensuring that I included the direct evidence (i.e. the quotes) from each interview which led me to this impression, and supported my interpretation. From here, my data chapters began to emerge in their (at that time) very raw form. This process of analysis, took nigh on one year. The completion of the data chapters, in the form bound in this thesis, and following that process, took close to another two years.

Implications for current psychological practice and theory were drawn out. In addition, consideration was given to the psychosocial and intersubjective space existing between and within researcher and interviewee (Bradley, 2005; Hollway & Jefferson, 2013; Slater, 2007). Reflexivity was thematised at all levels of the data analysis. Additionally, when analysing tapes, it was recognised that the language was co-produced. Hence, the interviewer's language was analysed as rigorously as that of he interviewees' (or group), where appropriate.

Of note here, is that as someone critical of formalised psychology, I needed to take care that I was avoiding ‘cherry picking’ statements to confirm my impressions. To minimise this likelihood, and to provide assurance to my
reader that my interpretations are reasonable, I have provided examples of extensive quotes from each of my participants, along with a thorough ‘unpacking’ of each to justify the conclusions and interpretations I have made. For example when Ted says “I don’t refer, and have not referred to a... normal clinical psychologist in 23 years...it feels like abuse.” (p. 83), it seemed he meant it as a criticism of formalised psychology. On reading his transcript for counter-examples of such criticism, it also seemed that he acknowledges that he simultaneously benefits from the institution, as he gets paid for working in this role “because I am one [a psychologist]” (p. 82). This contributed to developing and substantiating one of the central themes of the thesis, that is, that practitioners have competing ideas about their discipline. I will now fully discuss my results.
Chapter 4

The Othering of a Profession: Clinicians who Explicate their Practice as Contrary

4.1 Introduction

When I first embarked on my interviews, I felt there was just one primary question to be explored: would practitioners show any evidence of being affected by the contradiction that Schön (1987) and Bradley (2009) have suggested compromises psychologists trained under the aegis of the Boulder model? And if practitioners experience this contradiction, how are they affected? However, as I commenced the initial analysis of my data, what began to emerge was the sense that clinicians were speaking about their practice of psychology in different terms to how they understood they were meant to practice. It was also different to the types of practice they perceived as being rewarded, primarily from a financial perspective, but also relationally from peers and from the establishment of formalised psychology. In this sense, clinicians were experiencing themselves, and their modes of psychological practice, as almost alien to what they understood their profession to both be, and require of them.

Dipping back into the scholarly literature in order to better understand this phenomenon, I found that the separation or distancing of self from a perceived requirement to behave in particular ways, already had a name - “othering” (e.g. Henry, 2003; Laplanche, 2005; Miller, 2008; Rief, 2009; Robbins, 2014). Within this literature, othering allows an individual to both distance themselves from a reality which they may not feel resonates with them, and in some instances create a new reality which does. However, it also creates a space from which anyone perceived as “deviating from the standard” can be controlled or punished in subtle ways (Mullin-Jackson, 2009, p. 1). Using Kleinian terms, what or who is othered, can then be viewed dichotomously as good or bad, or simultaneously as both (Spillius, 2007).

Due to the synergies between my analysis of what the clinicians I was interviewing were experiencing, and this terminology, I decided to employ the term othering to describe psychologist’s experience of an externally imposed expectation to practice in a particular, and for them undesirable way. However,
it occurred to me that the experience of othering may also be viewed from the perspective of the dominant discourse created by formalised psychology (outlined in chapters one and two), such that the individual's alternate practice modes may be positioned by the establishment as good or bad, or simultaneously as both. With reference to my methodological chapter, it is the latter positioning, which according to Klein, may open up pathways for maturation and growth, as the individual, or organisation, is able to “tolerate [concurrent] contradiction” (Spillius, 2007, location 4311 of 5714).

As I moved through my analysis, such thinking raised additional questions for me. Do Australian clinicians experience themselves and formalised psychology in this way? Does formalised psychology view its clinicians in this way? And if this is the case, what is the evidence, and what are the implications for the practice of psychology?

Consequently, in this chapter I seek to explore whether clinicians may characterise an othered psychology, whether they portray themselves as working in a way that differs from this characterisation, and whether such positioning represents attempts to navigate the larger contradictions in which their profession is embroiled.

Within this chapter, I will organise my discussions around the entirety of each interviewee's experience, as opposed to using a more thematic/conceptual approach, which I will employ in later chapters. Conceptual organisation requires jumping back and forth between the perceptions of different interviewees, which in this instance seems to impair the flow of idea presentation.

In the first section, I will provide evidence for the perception of an othered psychology as a formal requirement to practice using an evidenced-based frame, and presented as synonymous with CBT. Sections two and onwards explore the perceived professional consequences of this positioning for the client, the clinician, and the broader discipline of psychology.

4.2 An Experience of Othered Psychology: The Case of Phoebe

I will begin my discussion with a focus on the experience of Phoebe, a 36-year-old, self-employed, female, clinical psychologist. She describes herself as having a full-time load, consisting of 20-22 client hours per week. From the
outset, Phoebe articulates an experience of external pressure to conform to a short-term CBT framework. She comments:

I feel I have a pressure to work in a CBT framework, and I feel that pressure from AHPRA, the Australian Psychological Society and also from insurance companies that I might do work for and also because of Medicare. So all these different bodies suggest that you should work in a short-term way, and using structured methods [J: yep] believing that structured methods are preferable.

The word “pressure” suggests Phoebe experiences the expectation to “work in a CBT framework” as an unpleasant, restrictive requirement, at odds with her preferred practice mode which is “probably closer to psychodynamic,” reflective of her “belief that real change does take time.” Her verbal colocation of “short-term...structured methods” and the word “believing” in reference to “these different bodies,” suggests she views this requirement as being based on an unsubstantiated preference, even bias from “these different bodies” who favor “short-term...structured methods.” This is in contrast to her own belief that “real change does take time” and effective practice requires “developing a very strong therapeutic relationship based on empathy, warmth, unconditional positive regard, and using at some point the therapeutic relationship to create change.” Phoebe’s inclusion of the word “does” in tandem with “takes time,” is unnecessary for meaning, and can be viewed as a tool for emphasis. That she experiences a need to reiterate, supports the view that Phoebe understands her approach as being contrary to what is required by formalised psychology.

Additionally, by suggesting that “change” occurs at “some point” within the developing “therapeutic relationship,” she contrasts her approach which “takes time,” with “short-term...structured methods.” Hinted in her verbalisation of “some point” is that the “point” of “change” may be different for each client, and each created “therapeutic relationship.” Phoebe’s postulations regarding her clinical approach then, seem at odds with an expectation to practice in a “short-term” “structured” way. In the context of the interviews, Phoebe may be understood as employing the word “structure” as a synonym for CBT.

Phoebe locates the pressure to conform to short term therapeutic practices such as CBT in the edicts and documented expectations of regulatory bodies:
Overt, it's documented, it's in stuff that you can read on the web, it's up in guidelines, um, when you work for these bodies, you have to work in a particular way. They're the rules, that the government only funds through Medicare, structured approaches, Ummm..yeah. [J: Yep, ok]. Same with NRMA, or insurance, it's all very clear how they intend you to work.

Here Phoebe presents a picture of psychology as “overtly” prescriptive, and lacking flexibility; “you have to work in a particular way.” By stating “they’re the rules,” Phoebe frames her choice to work in a different way, as a contravention. Through her matter-of-fact tone, and use of the words “overt” and “documented” she hints at the idea that professional autonomy has been repositioned from residing with the psychologist, to now being the jurisdiction of “these bodies” who put their expectations “on the web” and write “documents” and “guidelines” which collectively make it “very clear how they intend you to work.” Phoebe’s choice of the word “intend,” in co-location with the phrase “very clear” (expressed with emphasis), suggests she perceives that a level of force exists behind that requirement. The word “intend” implies a negative consequence for non-adherence, and creates the sense of minimal room for movement being allowed a clinician preferring alternate modes of practice. This interpretation is also supported by Phoebe’s comments that only those practitioners or approaches which acquiesce to the “rules” are “funded” and supported by both “government” and established psychological structures, represented here as “these bodies,” including “Medicare” “NRMA” and “insurance” companies.

Phoebe expresses the “pressure to work,” “using a structured method,” as contrary to the “way that” she “feels comfortable with,” and requiring some level of resistance. She comments

In terms of how I ...manage the expectations I feel are placed on me, versus how I want to work, um.........................I, I work in the way that I feel comfortable with, which is the psychodynamic way.........................um...don't pay too much attention to the pressure to work............ahh using a structured method......and write my reports in a way that suggests that perhaps I'm toeing the line, um, but since my clients do healthily improve, within good timeframes, it doesn't bother me that I'm not obeying the rules as such.
Whilst stating that she doesn’t “pay too much attention” to the pressure to work in a particular way, she contradicts herself to some extent, by stating that her reports do “toe the line.” So at the very least, the system seems to be experienced by this practitioner as sufficiently stringent to require a level of deceit for clinicians such as her who practice in a way different to short-term therapy.

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

After that evening I came to feel like I’d done something wrong, so perhaps this is a thing that comes up quite a bit. When it’s triggered, I can come to feel like I’m doing something wrong, versus other times of feeling that I’m solidly doing something right.

When I sought clarification around this from Phoebe, I reiterated her words, in keeping with Hollway and Jefferson’s (2013) interview technique, stating “So the times that you feel that you’re doing something wrong are......,” she responded by saying:

Only in the context of being with a psychologist who works differently to me [J: yep], I think it’s probably reflective of............um......what’s happening in psychology broadly though at the moment in terms of um...........the massive voice around CBT and, as supported by the APS, and government, and .........................and it’s almost criminal the idea of doing anything different.

Here it appears that Phoebe perceives professional peers, who “work differently” from her (and presumable use CBT, she presents her sense of “doing something wrong” as “reflective” of “psychology’s broader”, and “massive voice around CBT”), feel a level of entitlement, supported by professional and political bodies (the “broader” “psychology”, “supported by the APS, and government”), to critique her “different” approach, and provide censure. Her almost immediate use of the word “criminal” may be interpreted as Phoebe experiencing this as a highly unpleasant experience, with implied overtones of separation from the fold, and again punishment, metered out on those who practice in a “different” way. Indeed punishment in this scenario, seems
understood by Phoebe as provided by her colleague “who works differently from [her],” but in a manner “supported by the APS, and government.” Additionally, her use of the word “massive” to describe the “voice around CBT” suggests Phoebe experiences herself as part of a minority in psychology. However, the hint of scorn in her tone supports the hypothesis that she views this other perspective with a level of disdain.

Whilst Phoebe suggests that she doesn’t “feel” like she is doing anything “wrong” in terms of working within her psychodynamic framework, she seeks to justify her position to me using an unorthodox (not necessarily evidence-based), three-tiered justification system, which I will term triangulation. I would like to acknowledge here that I am effectively borrowing this term from both qualitative research and therapeutic practice. Within research, the term is used to denote “the use of more than one method in order to mobilize multiple sources of evidence” (Willig, 2013, p. 37). Phoebe posits she is “giving the clients what they need” and that

The proof’s in the pudding, that um...the doctors keep on referring so they must be happy with the work, um...so even if they’re aware that I don’t follow .......ah, CBT or short-term methods, doesn’t seem to be a problem.

Phoebe reflects further on her experience commenting

I probably am a rebel in the context of being um a clinical psychologist working in this way, so I get all the advantages of the clinical rebate without working within that frame [J: yeah yeah] um, but I don’t feel rebellious because I feel like my approach is right..I don’t feel like I’m doing anything wrong. I think I’m giving the clients what they need.

Here she simultaneously acknowledges that whilst she does not internally acquiesce to structural demands by compromising her therapy, she benefits financially from the arrangement, not because she literally “toes the line,” but because she has the necessary qualification and can “write [her] reports in a way that suggests that perhaps” she is conforming to the demands of the othered psychology. Phoebe appears to justify the validity of this stance with the comment that her approach “feel(s)...right.” This reference to her feelings as being an arbiter of her professional behavior seems to be mirrored in her
comments regarding her thoughts on what constitutes good therapeutic practice, thereby further justifying her position.

Phoebe presents her therapy (which “Doctors keep on referring” clients for, and through which her “clients do healthily improve, within good timeframes”) as “all about...words..and ........particular meanings of words...selected for a particular reason, based on a particular feeling or nuance.” Additionally for Phoebe, underlying her client’s “symptoms...seems to be an issue of emotional regulation...they can’t manage their emotions, or they’re blocked to their emotion, or they experience too much emotion.” Conversely, bad therapeutic practice, such as CBT neglects “feelings,” and although it “might work for six months...in six months’ time, they [the clients] find themselves back in the same place, ‘cos the feelings behind the problems have never been addressed.” Thus, as outlined previously, whilst Phoebe appears to experience a level of deceit in relation to how she presents herself as a practitioner to regulatory bodies (e.g. she “toes-the-line” with her reports), she has a clear understanding of the efficacy of her own practice, which she presents as being superior to “the expectations” she feels “are placed on” her. Phoebe’s approach addresses “feelings,” and works for more than “six months” because “the feelings behind the problems” have “been addressed.” Moreover, in the aforementioned quote regarding being a “rebel,” Phoebe, repeatedly uses “I.” Despite “pressure,” a “massive voice” supported by “the APS and government,” and a sense of “criminality” attached to “working differently,” Phoebe here appears to both take responsibility for her decision, and view herself as suitably able to determine what is, or is not good practice. The edicts of professional and/or political bodies do not feature, or are sufficiently curtailed by Phoebe to not “seem to be a problem.”

Phoebe appears able to arrive at this point, where her experience of contradiction does not seem “to be a problem” through a complex process of splitting (Klein, 1997) and resistance (Nucci, 2008). Phoebe clearly identifies what is expected of her practice approach—an expectation well supported by the literature, as outlined in chapters one and two. In response, she articulates a conscious decision to behave and practice in an alternate manner of her own choosing. Yet despite the seeming incompatibility between the “expectations” Phoebe feels “are placed” on her, “versus how” she “wants to work,” she still draws on her training in the sense that her practice decisions are informed by
an evidence-base. What is different is that Phoebe does not define evidence-based practice as referring to the application of knowledge generated by randomised controlled trials and endorsed as best practice by formalised psychology (APS, 2010). Rather, she understands evidence-based as referring to triangulation. This apparent definitional, yet (for her) justified splitting allows Phoebe to continue practicing within the profession of psychology despite her practice approach being at odds with legislated requirements. Additionally Phoebe’s behavior here may be viewed as an act of conscious resistance (Nucci) as she seeks to disrupt what is considered normal and best practice. However, from a psychological perspective, Phoebe, may be viewed as managing her experience of professional difficulties very well, even though they may be painful. In this instance, Kleinian splitting, minimises the pain of the dilemma.

To continue the discussion, I will now move to an exploration of Anna’s encounters with the practice of psychology. In doing this, I will provide evidence that clinicians may have experienced othering as a gradual process, or a shift which has occurred over time, albeit in their working lifespan. This gradual shift may be understood as influencing professional choices made by the therapist. Highlighted in these vignettes, is the need for formalised psychology to explore how homogenous it would like the profession to be, or to become, and whether there is value in maintaining career path diversity. In using the word homogenous, I am drawing on the evidence provided by Phoebe’s experience (outlined previously), of an expectation to apply an evidence-base understood as a singular entity, i.e. CBT, and Anna’s experience which I outline in the next section. Anna’s experience of an othered psychology is presented as both historical and contemporaneous, informed by her extensive years of practice (25 years).

4.3 Othered Psychology Experienced as a Pressure to Conform: The Case of Anna

Anna presents her experience of an othered psychology, imposed by formalised psychology, in a slightly different manner to Phoebe. Anna is a 61-year-old, self-employed, female, clinical psychologist, with a part-time practice. Anna describes the current state of psychology as a “big schism,” “occurring um between general psychologists and the clinical psychologists, and the other
post grad psychs who aren’t being recognised, in terms of the Medicare stuff.” However, whilst the end product has been a “big schism,” for Anna, its development has a history, spanning decades. She comments, that whilst “[she] did [her] clinical training back in 19, 1990” she was aware even then that “clinical psychs [were] favored.” This is in contrast to her sense that “everyone sort of seemed surprised, you know,” that this was now the case. Her use of the word “favored” suggests that Anna, like Phoebe views this discrepancy as being based on institutional bias.

Anna presents the “big schism” in psychology as “causing...hardship” for practitioners who do not work within its frame, and as “favoring” those who do, which Anna presents primarily as the “clinical psychologists.” Anna articulates that acquiescence to the clinical frame is necessary for “keeping up,” and that it is “better career-wise,” because ultimately it is “more highly regarded.” Conversely, Anna says “hardship” is experienced by “general psychologists...and the other post grad psychs who aren’t being recognised, in terms of the Medicare stuff.” Here, “hardship” appears to be understood by Anna as both financial “in terms of the Medicare stuff” (videlicet differential pay scales) and in terms of status, namely that clinical psychologists are “more highly regarded.” Exactly who has made this decree is presented as an esoteric, albeit divisive (suggested by her choice of the word “schism”), generic force which “was always there.” Anna here may be understood as presenting psychology as a split profession, a concept I will explore further.

Anna speaks of how her perception that clinically trained psychologists were “favored...back in 1990,” influenced her decision regarding “what to do for post grad.” She states, “[I] thought, oh no, you know, it’s probably going to be better career-wise if I do have the clinical ‘cos even then there seemed to have been um......a ....a. um...realisation that that was ........more ...highly regarded.” Anna presents this “realisation” as being in contrast with her then work focus, which at the time, was “organisational psych...with TAFE.” However, it seems Anna experienced the pressure to “have the clinical” as sufficiently powerful to shift her career path “otherwise you weren’t going to be um......you know in in ....keeping up, you know [J: yep] and have the expertise.” Anna reflects on that choice, commenting, “I’m also so so grateful that I chose clinical rather than organisational, although that might have taken me down another path, but I don’t think I would have enjoyed it as much.” What is unclear here is whether
her “enjoyment” was informed by remaining “within the fold” as it were, thereby allowing her access to, for example, the greater financial rewards and status that working as a clinician offer, as opposed to being required to operate on the fringe. Having chosen the more “highly regarded” career path, Anna, to all outward appearances, operates within the “favored” elements of the “schism.” Additionally, with her spoken emphasis on the phrase “even then,” Anna may be interpreted as understanding the expectation to practice within this frame as an even greater force now then it was “then...back in 1990.”

As the interview progresses, Anna talks about the “boom years of psychology” in the “late 60s and early 70s” where she was exposed to “the best of all possible worlds...all the bright minds, and all the you know, the different attitudes, whereas now you only get what you get at CSU or what you get at Macquarie, you don’t get, you know everybody’s perspective.” Anna appears to find the access to intellectual and theoretical diversity of training that used to be available to psychology, inspiring and exciting. Furthermore, she states, “I got a really good grounding in counseling skills, and that I think...has held me in good stead.” It appears for Anna, psychology was better in the “60s and early 70s” when “everybody’s perspective,” and “grounding in counseling skills” was available. The converse implication is that diversity within contemporary psychology, has been replaced by only some people’s “perspective,” a de-emphasis on “counseling skills,” and a shift towards homogeneity and standardisation of what constitutes the endorsed practice-base.

Yet despite having chosen the more “highly regarded” career path and thereby operating within the “favored” elements of the “schism,” Anna provides evidence that she still experiences her practice as alternative to the edicts of formalised psychology. She can be seen as having her sense of professional competence and judgment undermined. As evidence of this claim, Anna describes her approach as “A mish-mash, and [she doesn’t] know whether to be embarrassed about that or not.” Later in the interview, Anna provides some insight into her experience of “embarrassment,” presenting it as coming from outside her. She states; “some people think it ("sticking to a model and doing it perfectly") is important, and that’s when I think I say I’m a bit embarrassed.” Yet Anna expresses a sense of conflict around what she perceives is expected of her versus how much she “should” allow her experience to inform her practice. Despite being a practitioner who has enjoyed professional longevity, she states:
I don’t know anymore.................how ....................you know whether you
should be sticking to a model and doing it........perfectly.....um............or
whether.............experience actually shows you that.........................it
doesn’t matter what model you use, what’s important is that you relate
effectively with the client, and that they have a good experience, and that
they are finding insights into what’s happening for them.

Here Anna appears to express a juxtaposition between her experience of
effective practice, which tells her one thing, and “other people” who according to
Anna, expect you to “stick to a model and do it........perfectly.” Moreover, with
her use of the word “should,” according to Brown and Gilligan (1992), Anna
may be understood as referring to a moral voice in psychology, experienced as
both external to her, and requiring her to practice in a mode at odds with both
her preference (which is a “mish-mash”) and what her “experience” has “shown”
her. As with Phoebe, Anna appears to experience her alternate practice
approach as denigrated and devalued by the mainstream, an approach
requiring a level of apology. On the one hand Anna’s “experience” “shows” her,
that “it doesn’t matter what model you use,” but on the other hand, “some
people,” who seemingly have sufficient influence over Anna to make her feel
“embarrassed,” “think it [what model you use] is important.” However, Anna
appears able to override that embarrassment by her use of triangulation, that is,
how her belief regarding “what’s important” (in therapeutic practice) interacts
with her perception that her clients are having a “good experience” (with her),
and that her process is facilitating their “finding insights into what’s happening
for them.” She states:

I keep ........getting referrals and I keep getting .......you know
word-of-mouth stuff, and um..........yes, so ..........it’s ...at least the
people I see, seem to be okay with it. The ones that don’t like the style,
maybe don’t come back, I dunno, but I don’t even have that many of that,
so...it um......it’s fine.

Anna, (like Phoebe) seems to use triangulation, in tandem with her “experience”
to determine “what’s important” in the effectual practice of psychology as
opposed to drawing on “other people’s” expectation that she “stick to a model
and do it........perfectly.”
Additional evidence of Anna’s encounter with an othered psychology exists in her later reflection on the influence of formalised psychology on her practice. Anna simultaneously justifies to me her self-described, “pragmatic,” non “purist” approach, in comparison to what she terms, “real psychology.” Anna speaks of external structures such as Medicare whose influence she experiences as an expectation to diagnose using DSM defined categories, for legal and funding purposes. She comments on their (e.g. Medicare’s) need to “be able to tick boxes,” to “justify,” “you know they’re spending public money.” Yet, Anna posits that “it’s not going to change......what my clinical work will be with a client.” The sense is that she will give them what they want as required. If “they want a label, they can have a label,” but with the amendment “as long as that label is not going to be damaging for the individual.” With this statement, despite her anxiety as to whether to be “embarrassed or not” regarding her “mish-mash” approach, Anna seeks to firmly retain autonomy regarding which therapeutic approach she will implement, and with whom.

Anna’s account provides us with further insight into the experience of contradiction and othering in psychology, perceived here as a requirement to conform. Anna speaks of how historical pressure to acquiesce to an expectation to practice in a particular way, that was “more highly regarded” “even then....back in 1990,” prompted her to change her original practice choice from organisational to clinical. Through this decision, Anna may be interpreted as having subsumed her personal desires and beliefs around what works and what does not work, thereby allowing herself to operate within the “favored” elements of the “schism.” The suggestion is that psychology is split between a space of practice conformity (“sticking to a model and doing it perfectly”), and practice as informed by triangulation. Correspondingly for Anna, there appears to be a loss of psychology’s intellectual property, and professional wisdom, as exposure to “all the best and brightest” is replaced by the requirement to “stick to a model and do it perfectly.” As Anna speaks of her professional development over time, she presents her current practice approach as no longer operating from a space of conformity. Instead, Anna presents her practice as being a “mish-mash,” which whilst causing her some “embarrassment” she keeps doing, as, using triangulation, she can see results.

By way of contrast, I will now continue my argument by focussing on some of the perceived professional consequences of an othered psychology,
both to the clinician and the broader discipline of psychology, as viewed through the lens provided by Captain. In particular, he forwards othered psychology as legitimating the promotion of clinician self-interest at the expense of colleagues, and creating a professional (non evidenced-based) hierarchy which fosters derision and a further split within the profession.

4.4 Othered Psychology, Experienced as Promoting Self-Interest, and Facilitating an Unsubstantiated Professional Hierarchy: The Case of Captain

Another psychologist I interviewed was Captain, a 54-year-old, self-employed, male, clinical psychologist with 33 years practice experience. He describes himself as having a full-time load. Captain talks about the “war...in APS between clinical psychologists and non-clinical psychologists, saying that it’s around money.” Captain presents this “war” as comparable to the historical delineation between psychiatry and psychology, with the medical title of “doctor” in his recollections, easily trumping qualifications gained within the latter degree.

Captain defines the “entirely arbitrary” differentiation between registered and clinical practitioners, as being based on self interest and varied “belief systems.” He presents this differentiation as being unrelated to “science” (conversely suggesting that this is how it is presented to the profession), and instead, as a reflection of the fact that (according to him), “we can’t stand to be with people who don’t share our, um belief systems.” He presents the case of “let’s say CBT” in contrast to “psychodynamic psychotherapy,” arguing that practitioners who subscribe to one point of view are “not going to criticise the methodology” of articles which support their team. He comments that “we’re not really interested in empirical outcomes,” “you just want to know whether your team is winning.” With these statements, Captain appears to refer to a predilection within psychology (he uses the all encompassing pronoun “we”) which seeks to present itself as informed by “empirical outcomes,” when in fact (according to Captain), it is actually informed by inter-group (“team”) rivalry, based on “belief systems,” which are riddled with “prejudice,” and motivated by “self interest.” For Captain, this state of affairs for Captain is the antithesis of “empiricism.” The suggestion is that this split within
the profession is not based on evidence even though it is presented as though it is.

In addition, Captain constructs an experience of psychology in which clinicians such as himself, are provided professional and political permission to afford themselves higher status relative to non-clinically endorsed peers. His vignette provides an illustration of a divisive element within the profession. He states:

I find myself acting with the same sort of smugness around people who don’t have medicare rebates, as psychiatrists used to do with me...cos you know, you might have a psychiatry colleague who might also be a psychotherapist, but at a particular point they’ll say oh yes yes, we’re doctors...and that’s what I do with people who call themselves psychotherapists, at a particular point, or out loud...like, ‘yes but you’re not ...there’s a reason why we have Medicare and you don’t.’

On the one hand, Captain claims that different knowledge bases do not have merit, stating the debate is “entirely arbitrary,” and driven by people who “dress that up as something other than self-interest [laughs]” driven by a desire for more “money.” Yet he concurrently comments, “as a clinical psychologist I naturally take the side of people who say ‘Well we’re special, we should be paid more money.’” Here, we have some account of what is perceived by some therapists as being behind the schism experienced by Captain and others within the discipline.

In my next section I will discuss how the requirement to practice psychology in a particular way can mean that clinicians experience themselves or their colleagues, as ignoring the “gut” (a term Michelle injects into the interview space) of what they perceive is going on. To illustrate this claim, I will draw on evidence gained from the collective biography (whose method is outlined in chapter three), which I conducted with Callithump, Ted, and Elizabeth. I will illustrate how practitioners may experience othered psychology as negatively impacting on the efficacy of client outcomes. Additionally, I will explore the impact of timeframes imposed by short-term therapies, on how practice is evaluated. These insights are important as they point to the nub of what the (contested) practice of psychology is about i.e. the facilitation of wellness (Corcoran, 2009), informed by Aristotle's construction of phronesis versus the application of knowledge generated by science. Furthermore, they
highlight the impact that the requirement to adhere to time parameters, has on some clinicians. I will explore these notions further in chapter five, using the experiences of Michelle.

4.5 Othered Psychology and the Client: The Case of Ted, Elizabeth, and Callithump

Ted is a 48-year-old, male clinical psychologist with 24 years professional experience. He describes his practice as targeting modest to severe mental health conditions, including borderline personality disorder. Elizabeth is a 37-year-old, self-employed, female, clinical psychologist with seven years professional experience. She describes herself as having a full-time load, consisting of 20-22 client hours in Sydney’s Inner West. Her target population consists mainly of adults with depression and anxiety, and includes gay, lesbian, bisexual and transgendered communities. Callithump is a 42-year-old, male, psychologist with 18 years professional experience. He describes himself as having a generalist private practice.

Consistent with previous sections, Callithump and Ted refer to how clinicians are effectively forced into embracing those therapies which “fit into 10 sessions” (i.e. CBT). They present this expectation as resulting in formalised psychology’s neglect of approaches (however efficacious) which do not fit within this imposed timeframe. For example, during a discussion around the Hearing Voices Network (HVN, Hornstein, 2009), based initially in the UK, and viewed by these practitioners as “an exciting direction” (understood here as innovative, legitimate therapy), Callithump comments; “there’s nothing there that fits into 10 sessions, or 12 last year...so why would you [formalised psychology, and practitioners who embrace othered psychology] study it [the HVN], because it’s not going to make anyone any money.” Consistent with Captain’s views on the importance of money, Ted responds by highlighting “it’s [the HVN] being run by consumers,” and further caricatures the HVN’s political and structural rejection by formalised psychology, with such statements as

T: Ohhh they’re [the HVN] not a member of the APS!!!! what are they doing [laughs uproariously] how dare they?!!! They’re not even registered you know
C: It’s terrible...how could they [the consumer-run HVN] possibly know anything?!!
Here, Ted and Callithump, may be interpreted as presenting formalised psychology as screening, and even censoring practice approaches which do not fit into its specified time frame (“10 sessions, or 12 last year”). Additionally, by highlighting their perception that rejection of this approach by formalised psychology is, at least in part, informed by the fact that the creators of the HVN are “consumers” who are “not members of the APS” and are “not even registered,” Ted and Callithump, (like Captain above), provide additional evidence for the existence of a hierarchy within the discipline which preferences formalised psychological knowledge, over anything else—particularly the client’s lived experience. This hierarchy may be understood as favoring knowledge created within the frame of formalised psychology (i.e. CBT), and which “fits into 10 sessions, or 12 last year.” Moreover, with the use of the phrase “how dare they?!!!” Ted and Callithump suggest that knowledge/practice approaches created by, for example, “consumers” are scorned by formalised psychology.

For Ted, the current state of psychology is presented as a conflict between what he professionally gets paid for, “because I am one [a psychologist]”, and his “embarrassment” around this. Why Ted finds psychology “embarrassing” is elaborated in the following analysis. He comments “I don’t call myself a psychologist anymore, I tend to call myself a psychotherapist, because I find it embarrassing now, the whole area [E:mm] [laughs] the profession [has] just become an embarrassment at some level.” Ted seems to find the professional space provided by the label of psychotherapist as less restrictive, less “embarrassing,” and able to produce good client outcomes. Conversely, the label of psychologist requires him to ignore the experience of, for example “consumers” (because it is not evidence-based), and work within timeframes dictated from a space external to the profession. Davies (2003) terms this phenomenon “new managerialism” (p. 90), which is “characterised by the removal of the locus of power from the knowledge of practising professionals to auditors, policy-makers and statisticians none of whom need to know anything about the profession in question” (p. 91).

Yet, like Phoebe, Ted recognises that whilst this is his stance (that psychology has become an “embarrassment”), at another level he benefits from working within that system. He states; “I still accept a pay cheque because I am
one, so in some ways that’s a bit...bit weird, but it’s become an embarrassment, I think, the way it’s heading.” It appears that Ted almost experiences the co-existence of two psychologies, one so “embarrassing” that he selects an alternate label for his role (i.e. “psychotherapist”), and one which allows him still to be paid “because [he is] one (a psychologist)”.

Ted further articulates an apparent resistance to his experience of expected practice, which he presents as being embraced by the majority. He states; “I don’t refer, and have not referred to a... normal clinical psychologist in 23 years...it feels like abuse.” Callithump concurs, stating that to do so actually “feels unethical.” Elizabeth does not even feel the need to put words to her response, she just laughs. Here Ted may be understood as almost participating in an internalised professional split, on the one hand he is paid to be a psychologist, on the other hand, psychology does not produce practitioners worthy of referring too. Yet the system has produced both him and the other members of the collective biography, who he speaks to with respect, and in the case of Callithump, even admiration.

As justification for his (Ted's) reticence to refer to “normal clinical psychologists,” Ted talks about his experience of working with clients who have had “unbelievably bad, traumatic” experiences in “hospital...and with other treatment providers,” stating; “you often spend the first year [of therapy] working those through.” To illustrate, he provides the example of one of his female clients who:

Had seen six clinical psychologists under Medicare in the last couple of years, who had not, even though she told them about her child sexual abuse history, all six of them said that we’re not going to focus on that, we’re going to focus on this....anxiety [E: and your present day circumstances] we’re talking six, one after another.

Here Ted expresses a belief that traumatic experience (he mentions his client’s “child sexual abuse history”), is implicit to the creation of mental distress. The problem for him, and his clients, is that other clinicians, supported by structured expectation (e.g. he is meant to refer suicidal clients onto psychiatrists for drug therapy), do not share this view. Lacking suitable therapy options to deal with the client’s presenting problem; such clinicians force their clients to receive therapy which they have not asked for, because it fits into a CBT framework.
Alternatively, Ted may be understood here, as perceiving that “clinical psychologists under Medicare” feel a need to fit their client’s therapy into known categories such as “anxiety,” where treatment may be carried out within a short-term frame, as opposed to focusing on the real problem which for Ted, is the “sexual abuse history.” Elizabeth and Callithump concur, suggesting mainstream clinicians fit their patients to therapy, as opposed to providing them with something that works. Callithump presents this primarily as CBT, satirizing this approach with his statement “we don’t have any sheets that will change the past.”

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

Ted talks about the impact on the individual of both Clozapine and what he views as a misdiagnosis of schizophrenia versus “a very extreme childhood sexual abuse history, which no-one has asked about, no-one’s listened to, no-one believes.” He states:

Her entire life has been wasted.......um on this terrible drug, and .....she’s had no relationships, no work, no life essentially for [time] while she’s been treated like an invalid which is how schizophrenics get treated um, meanwhile, she’s not schizophrenic at all.
Here, Ted posits the belief that his client’s “entire life” has been “wasted” on “shit” practice, where the client is forced into a therapy, including the prescription of drugs, as opposed to being asked in the first instance about her “trauma history.” What is interesting here is that a strong evidence-base exists to support Ted’s claim of a direct relation between an experience of psychosis or schizophrenia, and childhood abuse and trauma (e.g. Hornstein, 2009; Slade & Longden, 2015). The biomedical model positions mental illness as residing within the individual, as opposed to being socially constructed. Formalised psychology may be viewed as splitting off any evidence that does not adhere to this model, positioning such evidence as being bad. And all of this is constructed as impugning an othered psychology which is “crap”.

Ted, Callithump and Elizabeth seem able to continue working with confidence within the space created by othered psychology (understood here as formalised psychology), demonstrating the experience of good and bad, splitting. Their splitting off from the edicts of formalised psychology is evidenced by their use of black, derisive humor, and expressed scorn around what othered psychology offers—both to the clinician and to the client. Their shared viewpoint, evidenced by their completing each others’ sentences, concurrence with statements made, and shared laughter, may be viewed as a mechanism for absolving any guilt they may feel for practicing in a way contrary to how they understand they are required to. Indeed this camaraderie may be viewed as supporting a guerilla-style response, or as resistance to the perceived requirements of formalised psychology (Nucci, 2008).

4.6 Discussion

In this chapter, I have used data from a number of interviews to illustrate clinicians’ experience of a psychology, which is other to themselves, and their preferred mode of practice. Within the theoretical frame provided by Hollway and Jefferson (2013), and in the context of this research, othered psychology may be understood as that psychology (as perceived by the individual) which minimises their capacity to embrace a professionally-agent subject position. It concurrently works against, or calls into question the individual’s belief systems and professional observations, and is experienced as imposed. Hollway and Jefferson’s theory, with the inclusion of Kleinian (1997) notions of splitting, predicts that individuals who experience anxiety or emotional discomfort within
a particular discourse will seek out alternative discourses which minimise “anxiety and therefore support identity” (p. 21). Within this chapter, I have provided illustrations of clinicians who do this, presenting two psychologies; one which they articulate as being restrictive and undermining, and another, which is their alternate, and according to them, superior version. This latter version is more consistent with their professed belief systems and feelings, and they seek to justify it via triangulation, as outlined previously.

Additionally with reference to Captain’s experience, and giving consideration to Hollway and Jefferson’s theory of the defended subject, one can argue that the profession of psychology is defending against its own anxiety, motivated by perceptions of what constitutes status (financial reward for the provision of scientifically derived therapies). On the one hand, the discipline presents best practice as being the application of knowledge generated by science, and published in peer-reviewed journals. On the other hand, the decision to split the profession along training lines informed by the scientist-practitioner model, draws on “prejudice,” motivated by “self interest.” Captain presents this split as comparable to what occurred historically between psychology and psychiatry. Thus psychiatry, embedded as it is in medicine, is afforded greater status than psychology. Similarly, within psychology, clinically trained psychologists are afforded greater status than alternatively trained psychologists (refer chapter one).

Cooke (2000) presents psychology’s attempts at improving professional status, as informing movement towards regulation. Victoria led the trend in 1966, using the rhetoric of both controlling the rise of Scientology’s version of psychology, and more generally policing the practice of psychology. Cooke further explores the rationale for registration, citing its origins in the belief by psychologists “that psychological techniques were superior to...‘quack’ alternatives and could not be used appropriately without proper training” (p. 183). The PsyBA, responsible for national regulation of the psychological profession, professes comparable sentiments citing their primary aim as “protecting the public” (AHPRA, 2016b).

Yet, regulation did not occur without some level of debate. The politician, Laurie Brereton, in 1983, questioned whether psychologists were primarily concerned with protecting the interests of the public, or with placing themselves in a position to receive medical and other benefits for services rendered (Cooke,
Moreover, the then Minister complained that cases of malpractice in psychology within Australia were “several years old and generally based on anecdotal evidence” (Cooke, p. 184). The AAPI (2012) also questions whether either altruism or science is behind psychology’s (particularly clinical “specialists”) political maneuvering. The AAPI suggests that recent agitation for increased regulation of psychological practice and registration is the attempt by varying academics whose 

Agenda over the past decade has clearly been to try and force the government to increase funding for university-based clinical masters courses by increasing the pressure upon psychologists to gain such qualifications—despite the lack of scientific evidence that a clinical master’s degree improves the quality of practice delivery. (AAPI, 2012, para 16)

Regardless of debate, regulation was gradually adopted by each Australian State and Territory. The circle was completed in 2009, with the passing of the Health Practitioner Regulation National Law.

However, with reference to the sentiments presented by Ted, Callithump, and Elizabeth around the diagnosis and treatment of sexual abuse presented earlier in this chapter, whether the expressed aims of registration (i.e. “protecting the public”) are being met, appears to be a contested space. Even more concerning than this, is the implied allegation that clinicians are inadequately trained to respond to this presentation (i.e. sexual abuse) on behalf of their client. Yet minimal evidence exists within the collective biography of any of the trio whistle blowing on colleagues, and lodging a complaint on behalf of their client with the PsyBA (the body responsible for “protecting the public,” previously stated). However, at the time of the interviews, this was not an avenue of questioning which I sought to clarify. Additionally, whether Ted in particular was telling-it-like-it-is, or whether he and the others involved in the collective biography were seeking to tell me what they thought I might like to hear cannot be known. However, near the end of the collective biography, having explained to them briefly the research of Wilkinson and Pickett (2010), I asked the trio the following question “I was just wondering what you might think about that sort of research, that suggests that mental illness is caused by inequity in a .............”. However, they did not give me the response that I would like to have heard, namely concurrence. Instead, whilst they were courteous to
my viewpoint, Ted responded “I dunno, it’s possible, that that’s part of it, but I wouldn’t think it’s the whole...” He then proceeded to tell me about his alternate point of view.

Explored in this chapter, and as predicted by the theoretical frame provided by Hollway and Jefferson (2013), if practitioners are experiencing the discourses available in psychology as anxiety-creating, evidenced by their word choices, derisive humor, justification via triangulation and othering of psychology, then to minimise their anxiety, and support their identity, they have to find or create alternate versions. Within the discipline of psychology, for practitioners, this may mean the creation of alternate discourses pertaining to, for example, the aetiology of mental illness, what is good practice, what is the purpose of therapy, and the practicalities of achieving the desired outcomes and applying good practice within the therapeutic space. I will explicate these possibilities in my following chapters. However returning to a Kleinian perspective, the question now arises, is this response good, or bad, or both?

4.7 Summary

In this chapter I have provided evidence that in contrast with the legislated requirement for therapists to apply scientifically generated knowledge, practitioners’ preferred therapeutic approach, may arise out of influences which are not necessarily evidence-based as prescribed by the APS. Instead of drawing on evidence created by aggregate data, inferential statistics, and/or randomised controlled trials, therapists may seek to justify their (not necessarily evidence-based) approach to me by suggesting that doctors keep referring to them, that their clients keep getting better, and that they, the practitioner are able to observe the positive results of their approach within the therapeutic setting. I term this form of three-tiered justification for the unorthodox way clinical practice may be grounded, triangulation. However, whilst clinicians may present their practice as effectual, and themselves as professionally autonomous, they may also refer to the existence of an othered psychology. I have defined othered psychology as that psychology experienced by the practitioner as an externally imposed expectation to practice in a particular, and for them undesirable way. Primarily othered psychology is presented as an expectation by formalised psychology, to practice within an evidence-based frame, understood as being synonymous with CBT. In keeping with a social
constructionist perspective, this experience by practitioners can be viewed as arising from the organisational and intellectual trends I have described in chapters one and two.

Additionally, othered psychology may be presented by some participants as a divisive force existing between those who practice in accordance with its expectations i.e. who work within the dictates of the scientist-practitioner model (and practice CBT), and those who do not. The external expectation to practice within this model, is presented as being imposed on the individual by formalised psychology (defined in chapter one). However, clinicians working within the frame of othered psychology, may also be experienced as imposing this expectation on their colleagues who do not so work. Therapists may present this imposed experience as reflective of a prejudiced, professional stratum, or hierarchy created by the auspice of formalised psychology, which facilitates for some psychologists, an apparent entitlement to sanction peers who they perceive are not practicing accordingly. The motivation behind the imposition of othered psychology onto clinicians, is sometimes presented by the clinicians I interviewed as stemming from a desire by some elements within the profession, to facilitate their personal financial gain, as opposed to emerging from an objective, evidence-based discussion. Additionally, practitioners may position othered psychology as obfuscating their professional role and capacity to facilitate effective treatment outcomes for their clients.

Further to these findings, clinicians also articulate an experience of anxiety resulting from their decision to practice in a manner counter to how they understand they are expected to by the othered psychology (irrespective of years of practical experience, or the existence of a substantive evidence-base for their preferred approach/es). Practitioners may also express concern at their perception, that formalised psychology is moving away from the embrace of diverse practice approaches and towards requiring therapeutic homogeneity.

As introduced in chapter three, I argue that one of the ways clinicians manage the impact of conflicting ideas and approaches within contemporary Australian psychology, is through the use of Kleinian notions of splitting between good and bad. What is good is experienced as their own practice, often justified through the process of triangulation, and what is bad is perceived as separate to, or other to themselves. The consequences of such splitting are illustrated by the interviewees in varied form, including directing scorn and
disdain toward formalised psychology, seeking to justify themselves to me (an individual with no formalised therapeutic experience in psychology), expressing discomfort, unease or a sense of being tarnished, articulating a feeling of being judged (and found wanting) by other psychologists and the broader profession, identifying a need to conform, experiencing a sense of professional sanction to behave in self-serving ways and at the expense of their peers, and in seeking to distance themselves from the profession.

In this chapter, I have demonstrated the existence of an othered, and at times, imposed psychology, under which clinicians are required to work, and which may be in contrast to how they want to work. This raises questions around how clinicians then manage to work within the discourse created by formalised psychology’s assumption that application of published techniques is best practice for service delivery. Additional questions are raised around what techniques therapists may use in preference, how these techniques and/or theories may be created, and whether any clinician does actually do what formalised psychology asks, namely to use any one published technique in its unadulterated or pure form? I will explore these conundrum in chapter five, and beyond.
5.1 Introduction

As I continued my exploration into how clinicians navigate the expectation to apply formalised psychology’s best practice principles to their practice, it became increasingly clear that even those therapists who presented themselves to me as aligned with a particular mode of practice, primarily CBT, did not necessarily use that approach in its pure form. In using the phrase “pure form” I am referring to how that approach is presented in the scholarly literature created by randomised clinical trial research, and presented by formalised psychology as best practice (refer to chapters one and two). For example, the Australian Association for Cognitive and Behaviour Therapy (2016, para 1) highlights that the use of CBT involves requiring the client to “practice in between sessions,” and to complete “tasks” or “homework.” Similarly, the APS (Kazantzis, 2013) identifies several core principles of CBT including “concentrating on the here-and-now” (para 4), use of “homework” (para 5), educating the client around CBT, “use of Socratic dialogue” (para 7), translation of the client’s “problems...into a series of clear and specific goals for therapy” (para 8), and for the number of provided sessions to be “time-limited” as “agreed upon at the beginning of therapy” (para 9). Therapy which does not conform to these principles, is arguably no longer the CBT which has been “extensively investigated in rigorous clinical trials and has empirical support” (Australian Association for Cognitive and Behaviour Therapy).

I found it fascinating that the clinicians I interviewed, whilst describing themselves as practicing using a particular therapeutic form, during their interviews, provided me with evidence that they did not in fact adhere religiously to how that approach was presented empirically in the literature. As a result, they were arguably not actually practicing scientifically nor using best practice interventions as defined by formalised psychology. What then did they do? And why did they not conform religiously to methodologies which science had demonstrated were efficacious, and which their discipline legislates that they enact? In addition, as analysis of my interview data evolved, whilst some clinicians presented as adhering to formalised psychology’s practice guidelines,
I found evidence that some other therapists used empirically supported treatments such as CBT as just one of the therapies they kept in their clinical bag. However, they also reported drawing on many other practice modes, which cannot necessarily be described as evidence-based or best practice using the rationale provided by formalised psychology. Why would some clinicians present themselves as drawing on many resources, which are not necessarily evidence-based? And was there merit in working in this way?

In this chapter I will further explore what clinicians understand as equating to formalised psychology’s best practice, whether they experience this as helpful to their practice, and whether they actually provide best practice in its pure form, and if not, what do they do? I will begin this chapter with a focus on Annette, whose experience provides further evidence that best practice may be understood by therapists as being synonymous with CBT.

5.2 The Othering of a Science: Clinician’s Experience

5.2.1 CBT experienced by clinicians as synonymous with formalised psychology’s understanding of evidence-based practice.

Annette, at the time of interview, was a 58-year-old, self-employed, female, clinical psychologist, of Anglo descent, with 38 years practice experience. Annette describes herself as having a full-time load. Whilst talking about the content of workshops that she organises for “colleagues about various things,” Annette laughs as she states that, as a result of “the requirements that we have,” some of that content is “evidence-based.” This is immediately followed by the comment “so lots of it is CBT,” which seems to imply that Annette understands the “evidence-based” practice “required” of her, and other psychologists (her use of the collective “we”) is “CBT.” However, within the context of this interview, Annette’s laughter does not seem to be disparaging of “evidence-based” therapies (i.e. “CBT”). Rather, it seems indicative of a sense of irony at the weight given to this “required” approach, when she views others as also “valuable.” She posits, “but also, um we get people to come and talk about……….anything that we think would be really valuable….we’ve had, you know, art therapy, and music therapy, and psychoanalytic therapy.” Thus, instead of indiscriminately accepting “the requirements,” placed on her and her “colleagues,” Annette, and those she associates with, seek out “anything” they interpret as “really valuable” to their
practice, as suitable material for their “workshops.” It is interesting to note here that neither art nor music therapy are included on the Australian Psychological Society’s (2010) listing of what treatments constitute best practice in psychology, yet they are viewed by Annette, and apparently others (she refers to “we”) as “really valuable”.

Annette further talks about CBT as “not the be all and end all. [J: yeah] It’s not the only, well it’s not the only therapy that’s evidence-based, even though it’s touted as really being that way.” Annette places CBT within the historical framework of her own professional development, commenting; “CBT didn’t exist when I went through university.” However, Annette does not present this as a lack. Rather, she views this as an “advantage” which resulted in her “having been taught other ways first.” Hinted at here is the idea that Annette perceives the current “touting” of “CBT” as the only “therapy” with an “evidence base,” as resulting in disadvantage (as opposed to “advantage”) for contemporaneously trained clinicians correspondingly exposed to fewer theoretical options. For this practitioner, varied methods all inform “who [she is] as a psychologist now,” and CBT is just “one of the things [she has] in [her] bag”. More specifically, Annette delineates her use of CBT stating, “I don’t use CBT with DID [dissociative identity disordered] clients. They’re too smart for me anyway, they’d run rings around CBT...but it’s very very useful stuff in terms of managing anxiety and depression.” Like some practitioners, outlined, in chapter four, Annette may be understood as drawing on differing theory and practice approaches, not because they are “required” of her, but because over time, she has found them to be “really valuable” in working with specific client populations. Here Annette raises a question as to how well a theory such as “CBT” generalises across different client groups. Whilst this “required” approach may be effective with presentations of “anxiety and depression,” from Annette’s perspective, it is ineffectual with her “DID clients,” because “they’re too smart.” Instead, Annette seems to value access to diverse strategies with which to work with her clients, and which inform “who [she is] as a psychologist now.” This process of adding to her “bag,” seems by Annette to be linked to her maturation, and her evolution as a therapist, a claim I will explore in greater detail in chapter nine.
5.2.2-Lack of familiarity with other “orientations.”

Conversely, 36-year-old, self-employed Michelle, expresses an inability to speak about “orientations” other than “a theoretical framework of cognitive behavior therapy” informed by “the biopsychosocial model,” “because I don’t think I’m really familiar with other orientations, and ways of doing things.” This lack of familiarity with alternate forms of practice is in stark contrast to for example Annette who practices, and actively educates herself and peers, around techniques other to what is “required” because she views them as “really valuable.” One interpretation of this apparent disparity may be that Michelle is both chronologically and professionally younger than Annette. Annette presents herself as having received her initial psychological training prior to the “requirement” to practice using “CBT,” “which didn’t exist” when she “went through university.” Conversely Michelle was educated in a time when CBT existed, and was regarded as the gold standard for treatment. Alternatively, Michelle’s apparent favoring of “a theoretical framework of cognitive behavior therapy” in contrast to Annette’s viewing CBT as just “one of the things I have in my bag,” may reflect the application of triangulation (a concept introduced in chapter four) by both professionals. Michelle articulates her client group as primarily consisting of “anxiety and depression” referrals. A substantial body of research exists, which supports the efficacy of CBT when used with this population group. However, this is still a contested space. For example, refer Pilgrim (2011). In contrast to Michelle, Annette presents her client population as more diverse, and including one group “DID clients,” who “run rings around CBT.” It may be that practitioners faced with diverse client populations are forced to draw from many and varied sources to facilitate efficacious outcomes for and with their clients.

Nevertheless, ongoing education seems to be integral to Michelle’s work ethic. When speaking about her internship process she shares

I’d come across issues I hadn’t dealt with before [J:mm] and so I would have to go home and read [J: yeah] and...buy books, and accumulate knowledge in various ways [J; yeah] and do a lot of research there all the while doing some sort of formal treatment, without knowing exactly what I was dealing with.
Michelle appears to simultaneously present herself as “unfamiliar” with “other orientations” whilst being forced to “read,” “accumulate knowledge in various ways” and “do a lot of research” to effectively “treat” her clients. What is unclear here, is why Michelle only “accumulated knowledge” which reinforced her “theoretical framework of cognitive behavior therapy,” thereby rendering her “unfamiliar” with “other orientations.” One interpretation may be that Michelle feels constrained “under the general health system” to “provide” her clients with “sufficient strategies” within the “6-12 sessions, or 10 sessions now.” Consequently, she turns to “cognitive behavior therapy” which presents as being able to work effectively within a short-term frame, as opposed to other therapeutic options.

As evidence for this interpretation, Michelle speaks about the consequences of providing therapy within a set time frame. Despite her professed embrace of the “theoretical framework of cognitive behavior therapy” informed by the “biopsychosocial medical model” which arguably sits well within the frame defined as othered psychology, and which I outlined in chapter four, Michelle seems more constrained in her practice approach than, for example, Phoebe. As discussed in chapter four, Phoebe feels able to work in a manner consistent with her belief systems, only “toeing the line” when it comes to writing reports. However, Michelle seems compelled in “most instances,” to very quickly identify if she is going to “go beyond that 10-12 sessions.” The implication seems to be, that therapies which do go beyond 10-12 sessions are synonymous with incompetence. Furthermore, Michelle’s professional identity, and evaluation of therapeutic approaches applied within her rooms, appears to be entangled with her need to provide “sufficient strategies” for her clients to “manage effectively in those 6-12 sessions, or 10 sessions.” If Michelle is able to provide therapy within a 10-12 session timeframe, she has “done good.” Conversely, if she cannot, she feels compelled to re-evaluate the efficacy (or not) of her practice approach. With reference to Hollway and Jefferson’s (2013) defended subject, and Klein’s (1997) notions of splitting, Michelle may be understood here as defending against incompetence (her own and others), using time as a measure. Additionally, she may be viewed as experiencing almost a third presence within the room with her as she works with her clients, which inform how she views her practice, and pivots within it.
However, during the interview, Michelle hints at an interest in, or an awareness of something else, which she terms “the gut of what’s going on [for her clients]”. She presents this as being converse to the “very high level, cognitive level, cerebral level”, “reactions” which “psychologists” “tend to” focus on, thereby “distancing [themselves]” from the “gut of what’s going on,” which is the “intense emotion.” One interpretation here is that CBT-practicing Michelle may experience her training in this evidence-based practice approach, as being insufficient for dealing with “intense emotion” which is in fact what she is required, at times, to do in therapy. As Michelle speaks about these concepts, she appears to struggle to find words with which to present her thoughts. When I ask her to “talk a bit more about...the very core of being human,” a concept she injects into the interview, she begins by saying “yeah, well, so I can’t think exactly myself what I’m meaning by that...” Additionally, Michelle repeats herself, uses long pauses between disjointed phrases, restates words, and finally seeks acknowledgement from me asking “does that make sense?” Furthermore, the language she employs to articulate her thoughts may be regarded as more colloquial, more confused, and less professional, than her listing of what is her practice, which I will outline in the following paragraph. For example, she states that “we [psychologists] think through emotions a lot to ahh, a lot and um.............do it at a very um.......................think think think about reactions that are very high level, cognitive level, cerebral level.”

In contrast, Michelle’s articulation of what is her practice, presents as scripted and pre-determined, with minimal use of pause. This is suggestive of an ease of accessing associated concepts with which to explicate her meaning and experience. She clearly delineates her process to me, presenting this in almost check-list form which she describes as a “comprehensive assessment,” and including “biological factors,” “symptoms,” “family history of mental health issues,” “previous history of mental health issues,” “biological factors that might be an issue,” “current situation,” “social situation” the contribution of “role modeling,” “workplace,” “stress,” and “protective factors that may be present.”

In placing a spotlight on the vignettes provided by Annette and Michelle, I have illustrated that clinicians may experience CBT as being an insufficient tool to meet the complex needs of their clients. However, they may simultaneously view the technique as useful to have in their bag. Moreover, the idea that CBT itself has grown out of, or morphed from other theories is hinted at. This is a
concept I will explore further, using the experience of Annette and Anna. Additionally, through the experience of Michelle, I have provided evidence that even though CBT may not provide clinicians with sufficient language to describe or explore the “gut” of what is going on, they may feel conscripted into using the technique in order, to enable their therapy to fit into Medicare’s time restraints. This sense may extend to therapists who, in seeking to find effective ways of responding to their varied client presentations, may continue to seek out approaches which conform to the requirements of short term time restraints. As a result, they may not then have the language to speak about alternate methodologies, which may in fact be more useful for what they are facing. This interpretation is hinted at, as Michelle whilst knowing about CBT, concurrently verbally stumbles as she attempts to “reach” for alternate ways of describing and responding to the “gut” of what she perceives evolves out of her practical experience.

I will now further my discussion with a shift into the experiences of practitioners who suggest that the use of an evidence-based practice approach, understood as CBT, is not only an insufficient tool, but that it works to obfuscate what is effective therapy. At the very least, as illustrated in the experience of Michelle (outlined previously), the actual doing of practice, may give rise to a suspicion that more than what is made available, by for example CBT, is required if the therapist is to be able to target the “gut of what’s going on” for the client. In doing this, I will provide evidence that practice, understood as the application of knowledge generated by science, is a contested space (or may become one-as is hinted at by the experience of Michelle) for some clinicians with substantive years of experience at the coal face, and indeed is viewed by some clinicians as the antithesis to what they are seeking to achieve with their clients. The question is then raised; does the experience of psychology’s clinicians provide evidence for the need for a legitimated theory of practice, which goes beyond the application of knowledge generated according to NHMRC guidelines? Additionally, do the experiences of clinicians evidence that ingredients exist, which are necessary for the facilitation of wellness, but which sit outside what formalised psychology’s version of science is able to produce? In the next section, I will explore these ideas through the lens provided by Ted, Elizabeth, and Callithump. As a reminder, this trio participated in the collective biography (outlined in chapter three).
5.2.3-CBT: Shifting the locus of control and beclouding effective therapy.

Callithump, Elizabeth and Ted have a scathingly contemptuous discussion regarding their experience of an evidence-based practice approach, as it pertains to the use of CBT. Their contempt is evidenced by their choice of words, dark, and at times riotous laughter, use of sneering sarcasm, impersonations of othered psychology, and tone of voice. Here they may be seen as using these mechanisms, whose efficacy seems magnified by the group’s consensus, to resist, and defend against the expectations of formalised or othered psychology, with which they disagree vehemently. My assumption of their shared agreement around this, is supported by their nods, vocalisations, interruptions, uptake of each other’s language choice in their own dialogue, and completion of each other’s sentences, which occurs throughout the second phase of the collective biography.

During their discussion, Callithump presents CBT as the clinician’s “prepackaged response...to to whatever [is] the first little bit that comes out” of therapy, and questions whether “that...prepackaged response might remotely [T:yees] um....address...you have panic attacks do you, ohww I've got a great 6 week program for panic attacks.” In context, Callithump may be construed as equating a “prepackaged,” “6 week program” with external expectations to practice within a short-term, CBT frame. His use of the phrase “the first little bit that comes out,” and his rhetorical statement “that their prepackaged response might remotely...address,” with the hinted unspoken addition of “the client’s real issues,” supports an interpretation that this forms the “antithesis” [T] of “good psychological practice” [J/E]. Conversely, “good psychological practice” is created by responding to later bigger “bits that come out” of the “co-created” [T], therapeutic “connection” [C/T/E]).

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

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After I commented that “there’s a DSM-5 diagnosis for that, being resistant to therapy” (formally termed “nonadherence to medical treatment” American Psychiatric Association, 2013, p. 726), the following interaction ensued:

T: Is there?
J: There is....patients who are resistant to therapy
E: Laughs uproariously
J: It’s in there
T: Oh, in there
E: That’s hilarious
C: Oh for fucks sake

Callithump then interjects with

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

In an even more scathing comment, Callithump states, “resistant to the therapy you want to give them [group laughter]. They’re resistant to the therapy that you want to give them.” Here he appears to suggest, that a flexible, creative and intuitive clinician, who is responsive to the individual needs of each client, is intrinsic to good therapy. Callithump goes on to suggest that such practitioners do not emerge from “clinical masters program[s]” with their focus on CBT. Instead, graduates from such programs seek to fit their clients into a preconceived diagnosis and treatment plan (“the therapy that they want to give them”), an interpretation further evidenced by his emphasis on the words “they’re” and “you.” Within this paradigm for Callithump, if therapy does not work, it is because the client is “resistant,” as opposed to the clinician and more broadly othered psychology, needing to reflect on the efficacy or not of their treatment process. The trio’s perception of such training appears to be that it facilitates the embrace of evidence-based practice approaches which form the “antithesis” of what constitutes “good practice” in psychology. As a reminder, “good practice” for this trio is informed by the client, and “co-created” [T] within the “therapeutic relationship” [E]. I will explicate these claims further in chapter seven. The shared hilarity from the room, suggests a black delight in Callithump’s ridicule of othered psychology, and agreement with his sentiment.
Callithump also questions the validity or usefulness of evidence-based practices which have been deemed as such, based on statistically significant findings in randomised controlled trials. He comments:

You can’t apply the same technology to two different people and expect to get it’ll, if you do it to 100 people, it’ll average out, and you know 55% of them will get better, and you’ll go, ace that’s what we’re looking for...that’s that’s that’s an improvement...it’s the first thing, you’re right] but it doesn’t...what about the other 45%?

In context here, Callithump appears to position formalised psychology as requiring “pre-packaged” responses to treatment, suggesting almost a fear of uncertainty within the therapeutic space. He provides the metaphor of “a flowchart, with little yes, no, nos.” Yet, in contrast, Callithump presents the lack of access to “sheets that will change the past,” or that will change the client’s “thinking” as almost necessary for an efficacious process. He argues the therapeutic alliance is always about working with “different patients,” “different therapists” and “different histories,” and “what worked for you,” can be “experienced in a totally different way” by someone else. Yet Callithump mitigates this by suggesting that the main tenets, or philosophy of one therapy can transfer across to other patients, for example, “trying to find a common language with somebody” which “resonates for them.” The “difference” for Callithump is that, in “good practice,” even if a clinician does apply a “technique” with a client, they do not then continually position themselves as the expert, or remain rigid in their interpretation. Instead, they “go on to accept the feedback” from the client and “listen to what happens afterwards.” If the technique works it is not “because you know, I read the right page on the text book.” Conversely, if it does not work, it is not “because they’re just being resistant [today], and I’ll try it again next week [when they may no longer be].”

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

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

5.2.4-Summary.

In this section, I have demonstrated that clinicians can other their experience of an externally imposed expectation to practice using evidence-based practice approaches, which are understood by formalised psychology (erroneously, according to some of the practitioners highlighted within this chapter) as equating to CBT. They may do this using varied mechanisms, including resistance and splitting off, or by separating themselves and their preferred practice approaches from how they understand they are expected to practice by formalised psychology, namely by employing CBT. Whilst some practitioners view CBT as a tool which they can pull out of their bag, they may not view the therapy as being effective with all client presentations. Awareness of other therapeutic options then becomes necessary to facilitate desirable outcomes for the client. However, alternate therapies referred to as effective, may not be presented as best practice by, for example, the APS (2010). In contrast to this positioning of what constitutes best practice, some clinicians may present having access to a diversity of practice-approaches as being beneficial to their professional development, and necessary for facilitating their client’s health.

As presented in chapter four, I have provided evidence that triangulation (a clinician’s use of their beliefs and feelings, in interaction with continued doctor referrals, and observations regarding client improvement) is used by some practitioners to determine what is or is not useful therapy, as opposed to them drawing on the results of randomised controlled trials in accordance with expectations from formalised psychology. Here clinicians use triangulation to critique the application of NHMRC-style treatment approaches (particularly CBT), and present these as being insufficient for their needs at the coal face. Additionally, whilst some practitioners may articulate a lack of awareness of methodologies alternate to CBT and NHMRC-style approaches, they may concurrently express a valuing of concepts external to their practice of CBT, but struggle to adequately express these ideas.

Clinicians may express a valuing of ongoing education, yet only draw on those resources which re-affirm the philosophical stance perpetuated by
othered psychology. Finally, some practitioners present CBT as the antithesis of what constitutes good practice within psychology. CBT may be viewed as a prepackaged, scripted response to a client’s presentations, resulting in brittle, inflexible responses to the client by the clinician. Additionally, the clinician in this paradigm is viewed as being the expert, and if treatment does not work, the client is positioned as being at fault. Conversely, good practice is viewed as the therapeutic response co-created by client and clinician within the therapeutic relationship, with associated technique flexibility informed by that interaction. I will explore this assertion further in chapter seven. Additionally, the perception by some clinicians is that CBT is what is taught to trainee clinicians during clinical masters programs, resulting in a virtual beclouding of the graduate’s professional vision, and capacity to respond to the real needs of the client in any meaningful way.

During this section, I have provided evidence to support my argument that the experience of an othered psychology, for practitioners, may extend to an othering, or splitting off of psychological techniques, presented as best practice by formalised psychology, but which are at odds with their preferred approaches. Using triangulation, therapists may identify the need to look to alternate therapeutic options to facilitate recovery for their clients.

I will now explore how clinicians may respond in practice to their experience that CBT is not a panacea for the varied client presentations they may encounter in the therapeutic space. I will illustrate that one mechanism psychologists employ, is to use evidence-based practice approaches as a platform to guide, as opposed to dictate how they will work. For example, they may take the main tenets, or component parts of existing theories as they understand them, and shift and change these into something new, using inspiration from multiple sources, which may not include randomised controlled trials or processes which are able to be defined as evidence-based, as espoused by formalised psychology. In providing this information I will demonstrate that clinicians may experience practices endorsed by formalised psychology, not as discrete truths, but as themselves an evolution out of something already or previously in existence.
5.3 The Morphing of a Science: Clinicians’ Experience of Change within Evidence-Based Practice

5.3.1—“Old things in new language.”

As outlined in section 2.1.1 of this chapter, during her interview, Annette makes reference to her perception of a push within psychology “requiring” the use of evidence-based practice approaches, understood as “CBT.” Her resumé is diverse and extensive, including work stints within government, academia and private practice, and within the legal and health systems. Further, she has held numerous and ongoing teaching and supervisory roles. The sense I gained from her during our time together, was that due to her longevity within the profession, and obvious competence, as evidenced by her current, and prior work history, she has lived through many different psychological “fads,” taking it all in her stride. Annette comments “most new theories are old things in new language.” However, she later mitigates this comment somewhat by suggesting she was being “a bit cynical” and that “sometimes, within that, even though a lot of it is new names, there’s a creative way [in that of] dealing with [client presentations].” Here it seems that for Annette, the value of new theories, even if they appear to be “old things in new language,” is to open up “new” ways of thinking about “old things.” Collectively, for Annette, they become “one of the things [she has] in [her] bag,” informing “who [she is] as a psychologist now.”

One example taken from our interview, which supports this interpretation is Annette’s application of the “serenity prayer”\(^2\) in her practice, the content of which “informs a lot of [her] CBT stuff.” Within context, Annette may be understood as using the “serenity prayer” as a metaphoric tool with which to better understand the application of CBT within her practice. Whilst there is some debate regarding the origins of the prayer, general agreement exists that it was authored by theologian Reinhold Niebuhr, around 1943 (National Catholic Reporter, 2008), well before the origins of Beck’s Rational Emotive Therapy, and subsequent evolution into what today is termed CBT (National Association of Cognitive-Behavioral Therapy, 2008). Additionally, a search of the Beck Institute website (2014a), yields no results for the “serenity prayer.” Yet Annette articulates her use of this arguably non evidence-based practice approach, as “informing a lot of [her] CBT stuff.” Thus Annette may be construed as applying

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\(^2\) “God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference” (National Catholic Reporter, 2008).
ideas external to the pure form of the therapy, in this case CBT, thereby metamorphosing that approach into something still recognisable, yet no longer the evidence-based practice approach tested using randomised controlled trials, promulgated in peer-reviewed journals, and expected by formalised psychology. It has evolved, however subtle that evolution may be. I will term this phenomenon “morphing” which is a word that Michelle interjects into our interview, and which I will discuss later in this chapter.

Anna (61-year-old, self-employed, clinical psychologist) too, talks about new therapies which have “the same overall principles,” and “the same processes...just different words and maybe....a little bit different style.” As an example, she describes mindfulness “it’s almost like they’ve discovered mindfulness [J: yep] but it was there [in the past], it just wasn’t called mindfulness, it was called you know relaxation training or something.” Anna also speaks of “emotion focused therapy” positing “I can’t see that that’s different either to........the sort of Gestalt principles and the self-centered client stuff that we did back in the you know the 70s.” For Anna, it is the resultant “overlap” between therapies that “makes it hard.....now....to....just.............stick to one thing because........um..........................’cos they are all relevant, but they are all similar.” Here Anna may be depicted as valuing diversity in therapy: “they are all relevant,” whilst questioning any real difference between them “they are all similar.” Her use of the word “they” suggests Anna understands relevant therapies to be diverse, certainly too many to list in full, and “overlapping” as opposed to discrete entities. This interpretation is in keeping with evidence provided in chapter four, where Anna describes her approach as a “mish-mash.” Further, Anna seems to experience an expectation to “stick to the one thing,” which she posits is “hard” because of the apparent lack of real differentiation between therapies. However, Anna suggests that despite this expectation, she does “do her own thing.”

As vignette to doing “her own thing,” Anna explicates her experience with CBT: “I don’t actually have a problem with CBT, maybe because ......I do my own thing with it...like [J: yeah...okay] I don’t, I’m not...can’t cope with giving people homework.” However, according to Judith Beck (2010) from the Beck Institute, a defining component of CBT is that the therapist “sets an agenda, discusses homework, sends clients home with notes (regarding with the client needs to remember during the week) and asks for feedback at virtually every
Clinicians who do not engage in such behavior are not “really practicing CBT” (para 6). Yet, Anna, presents herself as doing CBT, albeit in her own way. This clinician may be interpreted as achieving the self-perception that she is doing CBT, again through the use of morphing. She leaves out those aspects of the therapy which she “can’t cope with,” and retains those aspects she finds useful within her practice. Anna comments that “[she] still talk[s] about .....you know.....cognitive.......things.” However, instead of being informed by any one evidence-based practice approach in its “pure” form, Anna is informed by “what seems necessary at that moment,” rather than having to “you know go through rigid steps.” She describes “rigidly applying stuff” as “quite alien [to her],” and something “[she] can’t do.” However, she also appears to feel a need to justify her lack of “discipline” (said with a laugh), commenting: “yet, if I look at what I’ve done with somebody over a year....I’ve actually touched on......all the aspects [of what I’m expected to do].”

5.3.2-The morphing of theory.

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

Phoebebe uses similar language to Anna, as she comments:
I don’t feel myself consciously using theory when I work with my clients [J: yep] um, I think perhaps I am, and it’s just kind of a bit of a mish-mash inside me now.

The clinician elucidates this comment with her statement “how I work...just feels very......innate now, and fluid. Comfortable.” Additionally Phoebe presents her practice as “an idea that’s developed over time around how I work based on who I am.” Here Phoebe appears to concur with statements made by both Michelle and Anna, who describe how a broad range of influences combine together to form “a mish-mash inside.” In chapter seven, I will expand on Phoebe’s articulation of influences, including autobiographical, which according to her, have shaped her as a therapist. Again, whilst the main tenets of evidence-based approaches remain relatively obvious, morphing has also occurred, such that the pure form of that evidence-based practice approach no longer exists.

Michelle also alludes to an experience of morphing inherent to her therapeutic application of an evidence-based practice. As a reminder, Michelle “practices from a theoretical framework of cognitive behavior therapy,” “but [she’s] taken so much from the biopsychosocial model.” As the interview unfolds, Michelle talks about the impact of “starting to supervise...intern psychologists” on her practice process. She presents this experience as “causing [her] to reflect a lot on whether [she] learned that [particular therapy], and how helpful was that in the learning and [does she] ever use that, or [is she] just making shit up (laughs).” Michelle comments: “I find that these types of things tend to morph over time where it’s hard to know [where your practice process stems from].” She goes on to say that whilst “you might develop a bit of a formal education about things,” “the actual learning of how to apply that goes on ........on a practical basis with clients when they come into the room.”

Like Anna, Michelle appears to understand the application of theory within the therapeutic space, as a fluid coming together involving a “definite” “evolution of what is a legitimate strategy for the next patient.” For Michelle, this process may be interpreted as requiring constant “reflection on what works and what doesn’t,” because even when “the integration of both the training and the practice” seems to “work with a particular person,” it “might not work” with the next. Here it seems, that whilst Michelle’s overall practice is informed by CBT, it no longer remains in its pure form. This interpretation is evidenced by
the way she uses the phrase “a definite evolution” to describe her practice
development, and the way that she has concurrently “taken so much from the
biopsychosocial model.” We may infer from this that Michelle informs her CBT
practice with tenets of the “biopsychosocial model.” However, the
biopsychosocial model does not form part of CBT, practiced in its pure form as
delineated by, for example, the Beck Institute website or online training modules
provided by the APS (2011a, 2011b). Instead the biopsychosocial model was
forwarded by Engel (1977), as a “challenge for biomedicine” (p. 129) as
opposed to reflecting any attempt to make a contribution to CBT. One
reasonable interpretation then, is that Michelle’s CBT practice has also
“morphed” away from CBT into something new, informed by the
“biopsychosocial model,” and resulting in a “definite evolution.”

Continuing the discussion around morphing, I will re-introduce Captain
whose interview provides evidence for the existence of “morphing” as it occurs
very specifically within a therapeutic approach. As a reminder, Captain is 54-
years-old. Captain, outlines his practice shift from “classical psychoanalytic
psychotherapy, which is very verbal” to “intensive short term dynamic
psychotherapy [ISTDP]” which is “almost entirely biological.” Captain presents
himself as having completed his undergraduate Honours program at one
University, his clinical “Masters at (another) Uni,” “then back at [the first
university] for a PhD.” He also did his “psychoanalytical” studies with “(a
particular individual).” However, as his professional experience deepened,
Captain presents himself as moving away from his training in “classical
psychoanalytical psychotherapy” towards “intensive short term dynamic
psychotherapy.”

ISTDP was developed by Davanloo during the 1970s, and is an
approach “informed by traditional psychoanalytic theory, but modified with the
explicit goal of engaging highly resistant patients and avoiding prolonged and
often interminable courses of exploratory therapy” (Town, Abbass, & Bernier,
2013, p. 91). Captain explicates his experience of the approach, stating:

Everything that happens in a room becomes really really........super
important [J:mm] um........................transference............as in the room
when you know, eye contact avoidance starts to happen, and intensive
psychotherapy you pick it up straight away, you don’t let it go for six
sessions...you work it out on the spot, and the person will go ahhhhh
hhaaaaa...you’re right [J:mm] it’s very much a ...you’re looking for a biological signal...you’re not looking for the verbal ones...and that’s the biggest challenge for those of us who’ve been doing the traditional stuff to learn, looking at the...non-verbal cues.

Captain’s reasons for making his therapeutic shift are not clearly explicated within our interview. However, viewed from an ontological framework of social constructionism (Gergen, 1985), hinted at here, is the idea that Captain has been influenced by expectations to practice using short-term therapies. Evidence for this interpretation includes his perception that “science” presents “CBT” as the approach psychologists “should all be doing” despite “just just just just just huge!” evidence for alternate approaches such as “psychodynamic psychotherapy” which he professionally favors. Captain’s embrace of ISTDP may be interpreted as his way of managing both his experience of an expectation to practice using CBT, and his professed preference for “psychodynamic psychotherapy.” However, instead of individually morphing his practice of traditional psychodynamic psychotherapy, he has found a therapy where that morphing has already occurred. This allows him to legitimise his current approach, whilst continuing to work within the clime of othered psychology as outlined in chapter four. Additionally, he stresses the “biological” nature of ISTDP. This may be understood as Captain defending against an experience of being required to think of psychopathology in those terms. In the previously mentioned quote, Captain also comments that “you don’t let it go for six sessions,” and he emphasizes the immediacy of his current approach: “you pick it up [non-verbal cues] straight away.” This provides further evidence for this interpretation. For Captain, there is a hint that, being aware of a developing atmosphere in psychology inclusive of biology and short-term therapies, he has sought to morph these into his preferred approach influenced by “psychodynamic psychotherapy.”

I will now move to an exploration of influences, additional to those already highlighted within this chapter, which practitioners may draw from to inform and morph their therapeutic approach. These approaches, may also be understood as stemming from sources not covered by formalised psychology’s definition of what constitutes an evidence-based practice approach. I will begin this discussion by introducing Dukie.
5.3.3-Alternate influences.

Dukie is a 48-year-old, self-employed, female, clinical psychologist, with 17 years practice experience at the time of interview. She presents her preferred approach as favoring “mindfulness.” During her interview, Dukie suggests that she uses herself as a “guinea pig” in combination with “reflecting on what it is to be human” to determine the efficacy or not of her approaches. She states, that whilst there is not “anything [she’s] come across really that [makes her] think, gees, that’s dodgy, or that’s really not helpful,” the “psychological practice” Dukie uses needs to “resonate” with her, be consistent with her “values” and help her become “the human being [she] wants to be.” However, Dukie laughs a little at her logic here stating “of course I only do courses that interest me anyway [laughs] [J: ah yeah]....you know, so it’s a skewed up sample.”

Instead of using an evidence-based practice approach as required by formalised psychology, to determine what is good practice, Dukie articulates her use of “anything...that assists [her]......in being.......the human being [she] wants to be, to live by [her] values, to live a rich and meaningful life, ahhh, is useful, and [she] doesn’t really draw the line.......[she] doesn’t really find a line there between ways that do and ways that don’t.” Here it appears that Dukie’s practice approach is informed by her self-tested understanding, of “what it means to be human,” and the processes involved in becoming that. This clinician appears to practice, not in alignment with a specific evidence-based practice approach, but rather from a particular world view, or ontological frame, informed by how she understands “being human,” Dukie may be interpreted here as having a clear idea of what she is seeking to move her clients towards, (“being the human being [they] want to be”) as opposed to facilitating the prevention of symptoms. This latter positioning is more in keeping with discourse promulgated by for example, DSM-5 (American Psychiatric Association, 2013), or the Beck institute which presents the “goals of cognitive therapy” as being to “help individuals achieve a remission of their disorder and to prevent relapse” (2014b, para 1). One construction of Dukie’s approach is that she draws meaning from psychological discourse influenced by philosophy, and exploration of the ontological question of what it means to Be (e.g. Etchells, 1969; Fromm, 1987; Heidegger, 1993; Tillich, 1980). However, to this
approach, she morphs “biomedical” components such as “sending people for
blood tests,” “the story of buddha,” “meditation” and “mindfulness.”

5.3.4-Summary.
In this section I have provided evidence that clinicians can take the main
tenets, or component parts of existing theories, as they understand them, and
shift and change them into something new by using inspiration from multiple
sources, which are not necessarily evidence-based, as defined previously.
Some clinicians articulate an experience of being required to practice using
evidence-based therapies, with evidence-based being understood as equating
to CBT. However, they may present this as erroneous. New theories may be
presented as variations on existing approaches, with their benefit being viewed
as their capacity to facilitate new ways of looking at old problems or
presentations, through the introduction of new language. As opposed to
retaining a discrete identity, diverse therapies acquired by a therapist over the
years of their practice may be experienced as becoming enmeshed, mixing in
together, and collectively informing how the clinician practices within therapy.
Consequently therapies in their pure form, undergo a virtual metamorphosis into
something still recognisable, yet no longer the evidence-based practice
approach tested using randomised controlled trials and promulgated in peer-
reviewed journals and by formalised psychology. The therapy, in its application
and interaction with the individual therapist, has evolved—however subtle that
evolution may be. I have termed this phenomenon “morphing,” using a word
Michelle interjects into our interview. Additional influences to this occurrence
may include the practitioner’s ontological frame, how they define wellness, and
what it is they say they are seeking to move their clients towards. I will
explicate these influences further in chapter seven.

5.4 Discussion and Chapter Summary
As outlined previously, Australian formalised psychology requires
clinicians to practice using evidence-based practice approaches, primarily
determined by results of randomised controlled trials and reported in peer-
reviewed journals. Using the approach outlined by the NHMRC (1998), the APS
(2010) have identified 14 evidence-based practice interventions applicable to 26
mental disorders. CBT is one of those approaches. However, in this chapter,
and in chapter four, I have shown that practitioners can experience an expectation to practice primarily using CBT. Furthermore this therapy is presented by some practitioners as being touted by formalised psychology, as the only evidence-based practice approach. However, I have provided evidence in this, and other chapters, that some clinicians view neither CBT, nor other therapies which may be defined as evidence-based (using NHMRC (1988) guidelines, endorsed by the APS (2010) and presented as constituting best practice), as best practice, or at least as the only form of best practice. Instead, clinicians may be depicted as valuing access to a diverse range of practice options, even presenting this as necessary to facilitating wellness outcomes for their clients, and for professional development. It is noteworthy that both CBT and long-term psychodynamic psychotherapy are included amongst the 14 evidence-based practice approaches highlighted by the APS (2010). Yet some practitioners are particularly derisive in their expressed sentiment regarding the former approach. Moreover, despite the inclusion of 14 evidence-based practice approaches on the APS (2010) list, clinicians may find it difficult to speak of therapies other than CBT.

Collectively, this information may be viewed as evidence for the ongoing existence of two discourses in psychology which have been inherited from psychiatry, namely the “biomedical” and “psychoanalytical” discourse (Luhrmann, 2001). Alternatively, the discourses may be viewed as reminiscent of the historical struggle existing in Australian psychology as it shifted from a focus on philosophy and an interest in questions of the soul, to a focus on being a “science” (Cooke, 2000; O’Neil, 1987).

According to O’Neil (1987) and Cooke (2000) Australian psychology had its roots in the discipline of philosophy, and more specifically Scottish philosophy. Formal studying commenced at various academic institutions between 1881 and 1913, as lecturers and then professors were appointed responsible for covering areas such as “mental and moral philosophy” (O’Neill, p. 2). However, even in these early stages, psychology began to distinguish itself as a discipline separate to philosophy, increasingly embracing research techniques and terminologies developed within a natural science discourse such as analysis, classification and observation (Cooke). Concurrent to this discourse shift was the continuation of psychological study into “the three great objects of speculation—the human soul, the material world and God” (Laurie, 2000).
1902). For at least one Australian university in 1916, psychological study included among other things, “soul, memory, fatigue, attention, association, thought” (O’Neil, p. 16).

As stated in chapter one, Corcoran (2009), argues that the discipline of psychology, or perhaps more accurately academic psychology has moved away from an interest in the study of the soul, and the ontological question of Being to a focus on “first nature” (p. 3) accounts of people’s experiencing. For Corcoran, first-nature refers to accounts of psychological phenomena that neglect ontology in preference for epistemological concerns. Yet even as late as 1995, influential psychological practitioners such as Carl Rogers argued for the import of this discourse to the facilitation of wellness in the individual (1995).

Conversely, the question is raised as to whether there is a contemporaneous ontological and epistemological struggle occurring between some clinicians and their perception of how they are “required” to practice, and their professional preference. If this is the case, it may be beneficial for the discipline of psychology to bring light to this debate, and use it as an impetus to explore how applied psychology can think about the world, and what we can then know about both mental illness and wellness. These are questions which evidence-based practice approaches determined using randomised controlled trials are inept to answer. However, if the discipline of psychology, which arguably interacts at the coal face of humans’ mental suffering and associated experiences of mental pain, is unwilling or unable to tease out these issues, to which applied discipline do we turn? By allowing the co-existence of varying pathways, perhaps psychology is holding open doors which may allow entrance into rooms where such contemplation may occur.

One insight that may be taken from this interpretation is that within the practice of Australian psychology, collectively both pathways have merit, even if that may not be the stance taken by any one clinician or governing body. Philosophical psychology may facilitate language around ontological and existential questions regarding the nature of Being and purpose, (Corcoran, 2009; Yalom, 2002), and the study of the soul (Yalom, 2002), which a practitioner like Michelle appears to struggle to express. This may be termed phronesis as introduced in chapter two. Scientific psychology, or epistemic knowledge, may facilitate language around discrete tool-sets, which may be applicable within the therapeutic setting. Alternatively the latter described
psychology may provide early career practitioners with concrete approaches to employ within therapy, until they enjoy the experience of a “flowing in” or “mishmash” of varying therapies, which are triangulated and morphed, to inform “who they are as a psychologist,” and what their therapeutic approach is over time.

Additionally, I have illustrated, that whilst formalised psychology advocates the use of evidence-based practice approaches which have been tested using randomised controlled trials, the pure forms of resultant therapies, may not be what practitioners are using in the field, irrespective of how these practitioners may label themselves. Instead, some clinicians may be construed as either morphing pure forms of a therapy, using many and varied inspirations as muse to this process, or they may be construed as enmeshing their ontological and epistemological frameworks with their insight into what it is they are seeking to move their client’s towards. Moreover, in contrast to formalised psychology’s privileging of knowledge generated by the science arm of the Boulder model duality, in this chapter I have provided evidence that it may in fact be in the space of practice that new knowledge is created, or at the very least evolves. This way of thinking effectively flips the status quo of psychology on its head, with the process of practice and not science becoming the gold standard against which best practice is measured.

In order to further my exploration of the contested nature of what constitutes an effectual evidence-base for the practice of psychology, I will now move to a discussion exploring how practitioners understand the aetiology of mental illness within the frame provided by formalised psychology. As highlighted in my use of the Songlines metaphor, how mental illness is understood by a community (or practitioner, or formalised psychology) impacts directly on the experience of mental unwellness, available treatment options, and ultimately the pathway to wellness individually and collectively (Corcoran, 2009). For example, if we understand psychopathology as individualised, biomedical dysfunction, we treat the individual and medicate. However, understood as the result of, for example, financial and social inequity, we respond with social justice initiatives and political activism. With mental illness projected to be the second highest contributor to the burden of disease by 2030 (Who, 2011), an understanding of this experience may be crucial to the facilitation of wellness within the Australian, and more broadly, the Western population.
Chapter 6

One Truth or Many? Clinicians and Metaphoric Diversity: The case of the Aetiology of Mental Illness

6.1 Introduction

Having found that clinicians may shift and change, and morph empirical theory into something new within their practice approaches, and that they may value access to a range of tools to use in therapy, rather than use one or two approaches, I began to wonder whether this phenomenon would also apply to how they viewed and spoke about mental illness aetiology, and the cause of mental distress. Would clinicians look to one explanation of psychopathology, or to many? Would they speak about aetiology in its pure form, or morph that also, adding in their own belief sets and insights drawn from experience?

As outlined in chapter one, formalised psychology seems to advocate for mental illness aetiology to be understood as biological dysfunction (Kagan, 2012; McNally, 2012; Slade & Longden, 2015). Diagnosis and treatment target the individual, and aetiology is viewed as stemming from a genetic predisposition, triggered by external factors such as stress (Comer, 2007; Leader, 2011). The Department of Health Australia (2012) states that “people with a mental illness need the same understanding and support given to people with a physical illness. A mental illness is no different” (p. 3). However, as I outlined in my opening chapter, theoretical aetiologies of mental illness within the peer-reviewed literature are diverse, incongruous, and may be in contrast with aetiology being understood as individualised, biological dysfunction (Kagan; McNally). For example, psychopathology may be explicated as: stemming from social/political policy and/or income inequity (Wilkinson & Pickett, 2010); or as compounded by the complex interplay between historical, cultural and social factors (Foucault, 1965; McNally); or as the natural expression of an oppressed psyche (Fanon, 2005; Oliver, 2004). Whilst an in-depth discussion of varied aetiologies of psychopathology is beyond the scope of this thesis, suffice to say it is a contested space.

What then would the clinicians I interviewed do? Would they concur with the notion of psychopathology being understood as biological dysfunction triggered by factors such as stress, or would they dip into varied theory, and
weave and morph? Would their verbalised beliefs around psychopathology be consistent within their interviews, or would they sometimes hold seemingly incompatible explanations? And how would they justify their positioning to me? Would they also use triangulation here, or would they employ different methods for determining what to them, seems efficacious, and useful to their therapeutic practice? In the following chapter I seek to explore these questions, giving consideration to how clinicians speak about psychopathology and the cause or causes of mental illness.

I will begin with an analysis of the evidence provided by Johannes. I will illustrate how, in contrast with the edicts of formalised psychology, practitioners who may operate within this frame, can hold contradictory views around mental illness aetiology. I will provide initial evidence that a singular view of psychopathology may be experienced as insufficient for the purposes of therapy, and that it can be experienced by the therapist as leading them to an effectual dead-end. Instead, to facilitate pathways along which the clinician may work with their client, the practitioner may draw on varied conceptualisations—a phenomenon I will term “application of metaphoric diversity.” I will provide evidence that clinicians may then “throw” each metaphor into the therapy, and test for its usefulness using the client/clinician synergy. If one does not work, they may seek to create another metaphor in collaboration with their client, or draw out another possibility from their “bag.” In this way, practitioners may be viewed as testing for the veracity of each songline or metaphor they are injecting into, or which arises out of the therapy. If the flow-on of the Songline seems to facilitate wellness and recovery, or at the very least, a desirable outcome for their client as tested over time by triangulation, the Songline is reinforced and expanded on. If not, another songline, or metaphor by needs is searched for. I will term this process, “phronesis thinking,” a concept I will expand on shortly.

In providing this evidence I will build on the concepts of morphing and triangulation introduced in chapters four and five. Morphing involves the evolution of a theory or approach within the space of practice, such that something new, or at the very least a variant is created. Metaphoric diversity is the use of varied theories of practice, or aetiologies of psychopathology, which may or may not be contradictory, to inform what happens, or can happen in the therapeutic space. Both constructs are tested by the client/clinician synergy,
using triangulation. However, using the process of phronesis thinking, metaphorical diversity may enjoy a more instantaneous feedback system. Viewed in this way and from within the space of therapy, it is the client/clinician synergy (as opposed to capacity to apply published techniques) which forms the ultimate arbiter of what does or does not constitute effective therapy. This finding is in direct contrast to how formalised psychology portrays best practice.

6.2 The Nomenclature of Mental Illness Aetiology, a Practitioner’s Perspective

6.2.1 Aetiology understood using both the nomenclature of past and present, and of individual biological dysfunction.

Johannes is a 58-year-old, male, clinical psychologist, of European descent. He describes himself as having a full-time load working in psychology, which includes a part-time therapeutic practice. Johannes, categorises his practice “as eclectic with a focus on CBT.” Here, and in the context of the interview, Johannes may be understood as operating from within the conceptual frame explicated by formalised psychology. However, this therapist also articulates a professional leaning towards “psychodynamic” approaches. Johannes defines CBT as “basically the here and now,” and “psychodynamic really looks at...pre...here and now,” “in a person’s past and in front of a person’s experience from the past into the here and now.” One interpretation of these statements is that Johannes understands mental illness as stemming from both historical and contemporaneous circumstances. He suggests that “consideration” of both influences is “important...for the long term effectiveness of any treatment one does.” However, the present must be dealt with first, ensuring that “the person’s suitably stable” prior to “addressing” “issues that relate, to how the past links to the present.” Thus for Johannes, his approach may be interpreted as CBT, which deals with the “here and now,” informed by a psychodynamic influence which looks at the past, the “pre here and now.” Moreover, his practice response may be viewed as being enmeshed with his conceptualisation of psychopathology.

Johannes suggests that “it’s the clients themselves,” who then bring up “any issues in their lives, and how they see that...it relates to the here and now.” It is also the client who, “empowered” by the clinician, then articulates “the connection” between their experiential history, and current symptomology.
When “the connection between present and past” has been established, “the next step will be how to manage that better.” As vignette, Johannes talks about a client who in the “work situation” experienced “some issues that really got her down and got her a a anxious, got her depressed, and got her to the state where she [was] wanting to withdraw from that work environment.” His initial response was to talk with her about “the here and now issues,” and from there look “at what happened in [her] past? Where similar situations might have arisen.” Within this scenario, his client purported to have had a “very domineering” father such that “whenever she had...interaction with a particular person at work, it reminded her actually, subconsciously of her father and the feelings she had.” Johannes’ response was to explore “how to deal” with that. He stated that “cos the father was still alive,” “the ideal would have been for her to confront this head on, but we used the two chair technique.” The two chair technique is used to allow an individual to split themselves, and seat their component parts in two separate chairs. They are then encouraged by the therapist to take turns talking to their different selves (Greenberg, 2010). The result for the client was increased “tolerance,” and she “didn’t take things too personally, because it was not that important any more.”

Here Johannes may be understood as attributing the causes of mental illness to a number of factors. For example, he highlights his client’s “very domineering” father, which is suggestive of a relational component to his theory. Johannes also mentions the “subconscious” and “feelings.” Additionally, using the two chair technique, he seems to work with his client to identify the existences of behavioral patterns, informed by early experiences. In this instance, Johannes presents these as stemming from his client’s inter-relation with the “domineering father,” which the work scenario recreates. Having identified how the past (represented by childhood patterns of relating with the “domineering father”) interacts with the present (represented by the “interaction” with the “particular person at work”), Johannes is able to work with his client to increase her “tolerance.” By “tolerance,” Johannes may be understood as referring to his client’s capacity to re-arrange what she will allow to cause her angst: “it was not that important [for her] any more.”

Whilst these approaches may be seen to be at odds with each other, as outlined in my opening section, the clinician may be viewed as using phronesis thinking to test the veracity of varied metaphors arising out of the therapeutic
interaction. Drawing on feedback from this reflection, Johannes seems then able to pivot and change his approach until the point is reached where the cause of his client’s angst becomes “not that important anymore.”

Conversely, Johannes also likens the aetiology of mental illness, particularly schizophrenia, to “electric circuits within the brain, [where] there’s some circuiting that went wrong [J: yeah]....biologically speaking.” He simultaneously articulates, that this statement is a belief, commenting: “that is probably a better way to to explain, and it’s probably more likely anyhow [J: yeah] than the other stuff.” “The other stuff” may be interpreted as a reference to my earlier comment during our interview, about a TED talk by a person diagnosed with schizophrenia (Longden, 2013). This person came to perceive her voices as “another way that her self was trying to speak,” which is a view in keeping with the positioning of the aetiology of mental illness by for example, the consumer run, Hearing Voices Network (Hornstein, 2009). Johannes suggests that he does not concur with this understanding, commenting: “oh, I mean, that’s her perception,” and that whilst he “would validate, I would acknowledge that, and say yes this is what you’re experiencing,” he would simultaneously challenge such a client on their “interpretation” of “the voices,” positing “we may have to talk a little bit more about that.” He forwards the idea that this “leap into her own experience” may result in her “putting herself down,” whereas “explaining a little bit about the brain, and the electric circuits within the brain” is “probably a better way to explain” the “possible cause of these voices.”

Here Johannes may be interpreted as presenting his “biological” explanation for schizophrenia, as alternate to that provided by his client. He suggests his explanation is “probably a better way...to explain” the “cause of these voices.” Conversely, he presents linking schizophrenic “voices” with “emotional stuff” as a less helpful conceptualisation.

By linking the client’s experience of “voices” with “the emotional stuff,” Johannes may be interpreted as equating “her perception” with “emotional experience,” which contributes to her psychopathology. Additionally, he suggests her “leap into her own experience” may result in her “putting herself down.” Conversely he suggests that a “biological” explanation is “more likely,” and expresses a need to “shift” the client, “a little bit away” from the “emotional experience, and keep that as separate,” “because otherwise, these voices will always trigger the emotional stuff.” Instead, for Johannes, “the possible cause
of these voices” may be viewed “as more a biological development [J: yeah] that went wrong.” The clinician provides the metaphor of “an albino having red eyes,” “so something went wrong biologically, and that’s what happened to you.”

However, whilst these conceptualisations regarding the causes of mental illness (here-and-now versus previous experience, versus relational, versus subconscious, versus genetic) seem contradictory, if we understand such theories as being metaphoric tools rather than truths, their disparity begins to make sense. For example, if Johannes were to apply a biomedical understanding to the presentation of his first client, that positioning does not automatically open up the therapeutic pathways for the client/clinician synergy to explore which the past/present positioning is presented as facilitating. Interestingly, the same logic does not necessarily flow over to the vignette of the client with schizophrenia. By positioning the psychopathology of this disorder as akin to “an albino having red eyes,” Johannes leaves minimal room for therapeutic approaches apart from medication. However, Johannes mitigates this confusion somewhat with his later statement

I mean the thing is with schizophrenia, is really looking at insight, how much insight a person has got. If the person has got very little insight in what’s happening to them, then treatment is very difficult [J:mm] but if the person has got a degree of insight, then one might be able to work on that.

For Johannes, within the experience of schizophrenia, treatment options depend on “how much insight a person has got.” Consequently he may be seen to draw on yet another metaphor for psychopathology, namely the client’s capacity (or not) for insight. In providing this metaphor, Johannes opens up an alternate Songline along which he can potentially move his client. No longer restricted to treatment only involving medication (which the genetic Songline facilitates), Johannes is now able to work with a client who presents with schizophrenia through exploring and expanding on their capacity for “insight.”

In this section I have illustrated that even those practitioners who subscribe to the aetiological understanding of mental illness supported by formalised psychology, may experience confusion as they seek to shake that understanding down into an effective tool for use with clients in the therapeutic space. This is consistent with my evolving argument, which is informed by
evidence, that epistemic knowledge, provides the clinician with an insufficiency of legitimate tools with which to work. Instead, the process of phronesis and access to metaphoric diversity is implicated as pivotal. Evidence of the importance of phronesis may be drawn from the fact that some practitioners (for example, Johannes above, and Annette below) morph theories around psychopathology such that these theories reflect their perceptions of what is happening in the therapeutic space with and for their client, rather than being scientifically validated.

In the next section, using the experience of Annette, I will provide further evidence to support the claim that morphing, and metaphoric diversity are by-products or component parts of what some therapists cast as good therapy. Moreover, clinicians employ phronesis thinking as they both act on, and respond to their interpretation of the Songlines created within the client/clinician synergy.

6.3 Aetiology Understood Using the Nomenclature of Biology, and Consequence of Horrific Childhood Experiences: The Framing of Therapy

As a reminder, Annette is a 58-year-old, self-employed, clinical psychologist with 38 years practice experience. At the time of interview, Annette has a full-time load. Annette appears to equate mental illness with psychosis and “no perception of the world that is real, so everything is paranoid.” It is this client population, and those who have “what [she] would call biological [depression], like some postnatal depression, or where there’s a whole family history” who Annette may encourage to seek medication. For Annette, medication is used during the psychosis, “so that, they [the clients] have better concentrations...and mental capacity” and because nothing else “is going to work while someone’s psychotic.” She provides the vignette:

I had one guy here, walking up and down...........ranting um............and I just sat here calmly and sort of talked to him about ‘Gee, you know, it seems like you’re feeling distressed, I know you’re not taking any medication, but I wonder if this, the medication would help you concentrate a little bit better, so you can go and get your money back...’ which is what he was ranting about, and you know just talked him down.

Whilst Annette is able to “talk” her patient “down,” she argues that clients in this state cannot be helped by any therapy “you know Cognitive Behavior
Therapy, um, Acceptance and Commitment Therapy, any therapy that you’d like to try is not going to work while someone’s psychotic.” Instead, medication is required. Annette does not leave her comment here. Instead, she seeks to unpack exactly what it is about psychosis which can “destroy you,” targeting impaired “capacity to relate to other people” and even “reality.” Through this process of phronesis thinking, Annette provides additional evidence for the clinician’s need for metaphoric diversity. Moreover, the concept is expanded on, as Annette uses phronesis thinking to embed the metaphors she is using back into a theory (one which may be described as morphed, as opposed to reflecting any theory in its pure form—refer to chapter four), which she seeks to articulate to me thereby providing a purpose or frame for her resultant therapy. That frame then becomes a more sophisticated test point against which the clinician can check in with, or use as the test point for the metaphors she is injecting into the therapeutic space. Furthermore, I provide evidence that Annette uses this frame to channel some client presentations into one line of therapy, and others into another.

Annette rejects the notion of psychotic behavior being “learned.” For Annette, “someone who’s got psychosis needs medical treatment” and the therapist can “help them after that.” However, it seems to be only “psychosis,” or “where there’s a whole family history,” which Annette appears to label “mental illness,” and equate with a “biological” psychopathology. She comments, “I think a lot of the people that I get referred from doctors are not mentally unwell, you wouldn’t categorise them as having mental illness if it wasn’t in there [the DSM].” Additionally Annette delineates between for example, her “DID (Dissociative Identity Disorder) clients” who she does not view as “mentally ill,” unless that experience is coupled with being “psychotic.” Instead Annette describes such presentations as “a state of Being.” However, once medication has been used to help the client “relate to other people” and “reality,” the psychologist is able to “help them after that.” This suggests that Annette believes change is possible for this client, once their presumed chemical imbalance has been addressed via medication.

“Bi-polar” disorder is also viewed by Annette as having a “biologically based” psychotic component, requiring “medication.” The justification for this statement seems to be around the manifest contradiction between the individuals’ experience, and their reality:
So you’re in the depths of despair, even though your life’s quite happy, you know, happy in the sense that you’ve got all that you need, or you’re elated, and doing bizarre things, like spending all your money on whatever, you don’t have any control over that.

Annette contrasts these “biologically based” experiences, with “GP referred,” “anxiety and depression” which she describes as “lighter relief.” For Annette, this latter presentation does not require medication, because it can be more “easily” treated with, for example, education around “stress management...the physiology of anxiety...the biology of anxiety” and via this process, the therapist can “change their [the client’s] whole existence in fairly predictable ways.”

Conversely, Annette also speaks about mental illness aetiology as it pertains to “sexual abuse histories” and “child abuse.” For Annette, a causal relationship appears to exist between the experience of sexual abuse and symptomology manifesting as “dissociation.” “I ...um ....see a lot of women..and men..but mostly women, who’ve had sexual abuse histories, and...that’s led to an interest in dissociative disorders.” Annette contends that psychology generally is ill-informed regarding sexual abuse as an antecedent to dissociation she states that “many of the clients I see as adults, really should have been picked up sooner um, in terms of their abuse histories.”

Annette maintains that “dissociation...is used as a way of coping with...horrific childhood experiences.” The clinician describes dissociation as the process of placing “experiences in little boxes, so their sad feelings are one person, and their angry feelings are another person.” Annette presents this coping mechanism as a natural response to dealing with extreme “trauma,” and a response to be admired: “it’s fascinating that they are able to do that, with what’s happened to them, you’d think they’d be locked up in a psych ward screaming, or having killed themselves.” For Annette, integral to the compartmentalising process is the separation of “their host if you’d like to call it that, the person who fronts them,” from the rest of their “parts.” This technique allows “the body” or “host”, to “go through life without...........that experience.” Whilst this is not seen to be an ideal scenario, because “they lose time, if another part takes over,” it does allow them to “get through a lot of things” such as “mothering” and facilitates some capacity for employment.
Here Annette seems to employ an aetiological understanding which opens up a Songline or therapeutic avenue inclusive of hope and the possibility of healing for her clients, specifically her “DID” clients. By positioning the cause of their symptoms in “horrific childhood experiences,” “sexual abuse” and “trauma,” Annette effectively removes their Being, or who they are, from the cause of her client’s symptoms. Instead she blames their experience. Conversely, if Annette applied her genetic understanding to this client group’s presentation, she would be forced, in some ways, to view their compartmentalisation and varied personalities as fixed entities, allowing minimal room to facilitate growth or change. The concept of change and the capacity for agency, as being ingredients required on the pathway to wellness, will be delineated more rigorously in chapter seven.

In context, these vignettes, provide evidence that some clinicians use phronesis thinking, to morph conflicting aetiological theories which they may have been subjected to, into something which is instrumental to their practice, and the facilitation of recovery. The motivator of this pivot seems to be a grasping for metaphors, or tools which generate testable options within the therapeutic space, as opposed to creating road blocks. If aetiology is only understood in terms of biomedical positioning, as seen in the example of Johannes, limited therapeutic pathways are opened up for the therapist to work within. However, the morphing of that thinking, opens up corresponding pathways down which the clinician may facilitate movement for their clients. This way of working, can be likened to a lean start up (Ries, 2011), which argues that when we do not know what an end product will look like, or needs to be, or even how to get there, we need to avoid “making complex plans that are based on a lot of assumptions” (location 297 of 4069). Instead, working in such a space requires idea agility and a capacity to “make constant adjustments” based on a “feedback loop” (location 297 of 4069). Depending on what that information throws up, the individual either pivots—meaning you shift and change your thinking to accommodate the new knowledge that you have obtained—or you persevere, and continue on the same path. Integral to the idea of a lean start up, is a vision, which can be likened to the therapist’s and client’s shared belief sets around what it is that will facilitate wellness, and an associated recovery journey for them. “Every setback” then becomes “an opportunity for learning how to get” to that point, or closer to that point (location
Within this way of thinking, the end result, or vision is what pulls the entrepreneur or therapist along. Getting there, requires a constant dance.

Even in the instances where both Johannes and Annette suggest that some experiences are genetic, and sit within a biomedical understanding of psychopathology, their flow-on discussion around their behavior sits in contrast with that, or at the very least suggests they believe something else is at play—even if they do not state this with any clarity. Johannes shifts from his albino metaphor, to suggesting that how clients respond is about “insight,” and Annette, who suggests that clients in a florid state require medication, is able to “just talk then down.”

6.4 Aetiology Understood Using the Nomenclature of Biophysiology, Genetics, and Situation

In this section, I will demonstrate how access to metaphoric diversity allows clinicians to pivot within the therapeutic space and in the client/clinician synergy. The point is not how they understand, in this instance psychopathology, the point is that they are seeking to find a space from which change for the client can occur. In chapter seven, I will further expand on the idea of opening up opportunities for change. The testing point for whether the clinician continues on with a particular Songline, is whether it opens up, or closes wellness, recovery, or change pathways for the client. I will now return to the experience of 61-year-old Anna, a self-employed, clinical psychologist, with a part-time practice, who describes her practice approach as a “mish-mash.” In doing this, I will provide additional evidence that the use of metaphor provides practitioners with conceptual tools necessary for pivoting, and an associated capacity to facilitate movement as opposed to stagnation for their clients. Correspondingly I will illustrate that practitioners may experience reservation as to the absolute truth of the biomedical positioning of mental illness aetiology.

For Anna, individuals whose “world’s perfect” yet who have “severe depressive illness” are instances of “the bio.....physiological...thing of of mental health...and mental illness.” “Schizophrenia is a perfect example of that.” For Anna, schizophrenia is a “predisposition,” “and there’s probably some...gene somewhere there.” She tentatively suggests that “mmaybe some environmental thing might trigger it,” and then more decisively states “but I think it is a a .biological problem (J:mmm) biochemical problem.” Anna likens “severe
mental illness” such as “schizophrenia” to “the way that you get diabetes,” justifying this metaphor with the rhetorical question “why does somebody have diabetes as a child or as a baby, you know, they haven’t done anything, they’ve just got the genetic bits there that makes it happen.”

Yet Anna suggests that whilst some mental illness can be a “genetic thing,” other symptoms are “just purely situational, and anybody under those circumstances” would respond in a similar vein. For Anna, “when they’re [the client] in the florid psychotic state, there is nothing I don’t think anyone can do there except get their symptoms under control...you know through medication for instance.” She further delineates between her experience of treating clients who she believes have a mental illness due to genetic factors, and her experience of those who she believes have a mental illness due to situational factors, stating “that’s a different flavor treatment I think to your, general run-of-the-mill you know, people that come, certainly to private practice.” This is suggestive of the rarity of such an extreme experience. Anna further clarifies her experience by commenting that people with “schizophrenia” have to be “stablised” via medication prior to effective “treatment.”

Anna differentiates between “personality disordered people” and those who are “depressed and anxious.” Whilst she views both as being “stuck in how they view the world, the former are “so stuck,” that “that.......it’s not.....they’re not so easy ...............to help.................move ......through it.” Thus mental illness appears to be understood as a lack of capacity for growth and forward momentum. Anna presents the cause of this stasis as “early experiences that they’ve never addressed, or because of current....environmental stresses.” Additionally, Anna blames:

Traumatic ........childhoods......um......you know either because they’ve been...you know physically, or sexually abused, or verbally abused, or neglected, or they’ve witnessed you know, alcoholic fathers, and fights and you know, all that.

However, when asked to talk about being “mad,” a word Anna injects into the interview, the clinician speaks of “clients who ........who lose it you know,” However, even at this more extreme end of symptomology, she pulls causation back to external circumstances and her client’s interaction with that, “it’s a
defense mechanism” whose aim is “to protect” the afflicted individual. She states

They get psychotic episodes because of the stress, you know they get so depressed, and ...things just get so big...that they ..do end up with psychotic symptoms, and um...............and then that frightens them. And I just find, if you can again, just explain you know, this is what's happening, it's just got all too big, and so yeah, this is happening, it's a defense mechanism, it's to protect you so that you don't have to deal with all this stuff you don't like.

Here mental illness aetiology appears to be understood by Anna as being almost an expected linear equation. Her clients experience “stress,” and they respond with “psychotic episodes” or “depression” because the “stress” has become too “big.” Given the “stress,” their response is to be expected, and is a “defense mechanism” employed to “protect them.” This presentation seems at odds with Anna’s previously discussed positionings regarding, for example, schizophrenia. Yet like Johannes, insight into this apparent oscillation between psychopathological theories may be gleaned from a consideration of Anna's main treatment tenets. These seem to be aimed at facilitating “change” for her client through the process of helping their “understanding of the processes [underpinning their experience] that actually empower them to do the next thing which is you know, take control.” As long as Anna is able to facilitate “change” for her client, how she positions mental illness aetiology, is in some ways irrelevant.

This exploration into Anna’s positioning of aetiology, provides further evidence that the clinicians’ embrace of theory may be influenced by the therapeutic options that this way of thinking opens up to them. Additionally, some therapists favor theories which position causation outside of the individual and thereby allow the clinician to work with the client to promote their capacity to be agent in their own change. This suggests that what metaphors the clinician may draw on in their therapy may be informed not just by the client/clinician synergy, but by an end point, or a belief set that the clinician holds relating to the purpose of therapy. For example, Anna uses the phrases “empowerment,” “change,” and “take control.” In looking at how practitioners such as Anna talk about their therapeutic choices, i.e. they shift and change to facilitate treatment pathways for their client, we are provided with evidence as to
how clinicians both view and experience requirements to work in the Boulder model frame. The question now is raised, do clinicians pull metaphor out of the air, and throw “whatever” into therapy, or is there method to their madness?

6.5 Aetiology Understood Using the Nomenclature of Biology Versus Reflecting on the Holistic Picture

In this section, I will demonstrate that metaphoric diversity is not created at whim, instead, more experienced clinicians may be understood as pulling together metaphors to form comprehensive theory reflective of what it is they are seeking to move their clients towards. Whilst Annette’s and Anna’s experience introduce this phenomena to this chapter, the reflections of Dukie add nuance. As a reminder, Dukie is a 48-year-old, self-employed, female, clinical psychologist, who favors the use of “mindfulness.” Vignettes taken from Dukie’s interview, in context, provide evidence that some practitioners may screen their use of metaphoric diversity, using their own vision of what it is that they are seeking to move their clients towards. I will demonstrate that the exploration of metaphoric diversity within therapy, is not generated at whim, but rather it may be informed by the ontological frame within which the therapist identifies their work, or to use the language being generated by this research, a form of philosophical triangulation. By this I mean, that the clinician uses phronesis thinking, i.e. they test out metaphors or rationales behind the cause of their client’s presentation, and see what therapeutic avenues these open up. Metaphors or rationales leading to dead-ends are by needs discarded, and replaced with an alternate positioning, which opens up avenues through which the client and clinician can move towards the endgame, or purpose of the therapy. The endgame or purpose of the therapy, is determined, at least in part, by how some therapists understand the facilitation of wellness or recovery. As in the case of Johannes, for some clinicians, the endgame equates to symptom reduction through, for example, facilitating increased “tolerance.” For Dukie, the endgame equates to how best to be human. Factors which may influence how the clinician determines what is, or is not a useful endgame are explored further in chapter seven. What is important here, is not the commonality (or not) of the experience of my participants. Rather it is that part of the job description of psychological practitioners is having to move their clients towards something, which as outlined in chapters one and two, is not yet clearly defined by the
profession. In exploring how some clinicians speak about navigating this experience, we go some way further towards understanding what the professional development needs of therapists may be, and how we might more clearly define exactly what it is psychologists do.

Dukie suggests that mental illness can have a biomedical component to it. As part of her process, particularly for “people struggling with anxiety,” she “generally send[s] people for blood tests” with “a couple of GPs” who work “In an alternatively psychiatric way, within the mainstream medical system. So they’ll test for levels of zinc, levels of um...you know the Bs and all those things, and um....................and............find out if people are leeching all these goodies through their urine.” Those afflicted are then “put on these really amazing vitamins,” and whilst this is not a panacea “it really supports...most people.”

Dukie views her “openness” to “most......ways of working,” and interest in the “biomedical field” as consistent with her overarching approach, which she labels “holistic.” She explicates her meaning by commenting “I think we’re very complex beings, and we’re you know, we’re both, we’re all of the above, our genetics, our emotional experience, our, you know, upbringing, you, all of those things contribute to who we are, or how we experience being human.” Thus whilst Dukie presents her practice as favoring “mindfulness” approaches which employ for example “meditation,” she finds a value in simultaneously drawing on insight from other positionings, because we are “very complex beings,” and she presents this as part of an “holistic” picture.

Dukie provides some insight into her understanding of aetiology as stemming from an “holistic” space. She posits, “I find myself open to most .....ways of working even though my preferred way ......um..........................I mean the way I work is by using myself as a guinea pig, and [by] reflecting on what it is to be human.” It would appear, that Dukie views practices alternate to her own, as also contributing to her “preferred way.” She posits “anything.....that......I’m in a position to learn about that assists me......in being.......the human being I want to be, to live by my values, to live a rich and meaningful life, ahhh, is useful, and I don’t really draw the line.” This “drive” towards holistic interconnectedness appears to be particularly pronounced for Dukie in that she uses herself as a “guinea pig,” reflects on “what it means to be a human,” talks about becoming the “human being [she wants] to be,” living “by [her] values,” and living a “rich and meaningful life.” Furthermore by stating that
these are her aims, and in combination with viewing herself as a “guinea pig,”
Dukie clearly delineates what she is trying to achieve as a practitioner, and what
the purpose of therapy is. She also explicates the ontology of Being, and how,
for her, this is integral to the process of therapy. Thus Dukie may be interpreted
as seeking to integrate her aetiological understandings, with her preferred
practice approaches and philosophical stance.

As introduced in chapter one, and woven throughout this chapter what
we are observing here, is evidence of phronesis thinking being used as an
integral component of therapy. As a reminder, Aristotle coined the term
phronesis to describe “knowledge that addresses the concrete situation rather
than the gaseous universal” (Bradley, 2009, p. 12). Pivotal to this form of
understanding, is the individual’s capacity “to grasp an infinite variety of
circumstances” (p. 12), and it “presupposes a direction of the will – i.e. moral
being” (Gadamer, 1991, p. 21-22). Here, the therapist, is drawing on multiple
conceptual and theoretical metaphors, applying them within therapy, and
pivoting, or persevering depending on what is being seen, via triangulation, to
be effective for the client. However, in the case of Dukie, her vision, or
articulated endgame is clearly explicated, potentially allowing her greater
expertise in determining which metaphors to use or not use within her sessions.
This is in contrast to, for example, Michelle (as discussed in chapter five), who
is relatively new to the practice of psychology, and who can be seen to be still
finding her way.

I will now return to the experiences of the collective biography trio.
Through their data, I will illustrate how clinicians, in drawing on metaphoric
diversity, may present their therapy as benefitting from remaining open to
possibility. For these clinicians, to not remain open results in an effectual killing
off of what could be a workable therapeutic Songline. However, I will
simultaneously illustrate a layer of contradiction. Whilst on the one hand, the
trio present themselves as remaining open to possibility, on the other hand, as
outlined in chapters four and five, they reject the edicts of othered psychology
out of hand. Insight into this discrepancy is provided, as Ted, Elizabeth, and
Callithump argue that some positionings (i.e. the positioning condoned by
formalised psychology) effectively lead to therapeutic dead ends, within which a
client cannot be saved. In addition, the trio also use their understanding of
metaphoric diversity, to explore the Songlines created by various positioning on
the broader society. In unpacking this evidence, I will illustrate that some clinicians may experience the endgame for their clients as being influenced by a societal, as opposed to an individual feedback loop. This information highlights that some therapists view the role of psychology as potentially sitting beyond a focus on the individual as argued for by formalised psychology. Instead society may also be viewed as implicit in what is any one client’s presentation.

6.6 Aetiology Understood Using the Nomenclature of Inequity and Complex PTSD

Ted appears to position “the serious end of the mental illness spectrum,” as a “type of inequality,” triggered by “complex PTSD [post traumatic stress disorder]” caused by “extreme abuse” which impacts on the individuals’ capacity to “thrive and exist.” He comments, “the whole serious end could be summarised in one thing, it’s complex PTSD, every single one of them, whether it’s bipolar, schizophrenia, schizoaffective, that’s the serious end. Now the inequality there is extreme abuse from the time of birth.” Here Ted may be construed as seeking to provide an holistic explanation for what is psychopathology. He argues “the whole serious end could be summarised” as “complex PTSD.”

Yet, Ted also provides evidence that he concurrently questions the purpose of defining psychopathology. He states that “psychology potentially is just sort of focussing on the wrong things.” As foil, he suggests the discipline of psychology needs to “refocus on what matters, which is basically what’s required for the human organism to have the best possible chance of thriving...then we could have a huge impact.” He suggests psychology’s failure to focus on “what matters” is due to the profession being “stuck in some...some reactive nonsense. We’re just following psychiatry down the toilet. I mean psychiatrists no longer believe their own crap...and what’s psychology doing? Following it blindly.” Here for Ted, mental illness aetiology appears to require a consideration by formalised psychology, of what Songlines its positionings are singing into existence for clients. With credence given to the “wrong” aetiologies and philosophical approaches, psychology focusses “on the wrong things,” and is “following psychiatry down the toilet.” Conversely, by focussing on “inequality,” understood by Ted as “extreme abuse from the time of birth”
which requires people to “retreat” into their “imagination,” therapeutic opportunities are created which allow “a living organism” to “thrive and exist.”

Like other practitioners outlined within this chapter Ted may be construed here as using his definitions of psychopathology in a comparable way to a tool set. Ted then adds to his bag those tools (understood within this thesis as a developing metaphor set), which focus “on the [right] things” and open up treatment pathways at the individual and collective level. Conversely, those tools which “follow psychiatry down the toilet” are rejected.

Additional evidence for this interpretation may be found in Ted’s later statements where he presents current understandings of mental illness as a “worldwide,” “neoliberal push.”

To make everything about the individual.............that the individual is.....nearly everything's on the individual...so how you process everything is your fault [C: yep] what you experienced, your income is your fault, you know, your problems are your fault, everything’s in you.

Callithump’s “yep” suggests his agreement. Ted articulates his perception that this viewpoint has been formalised in documents such as “a recovery model in mental health,” “embraced” by “Australia.” For Ted, this is all about the “‘individual journey” in inverted commas,” “but the actual motivation behind the support is it’s going to save money.” Additionally, Ted may be construed as interpreting this positioning as absolving society of any moral responsibility for the experience of the individual. He posits, “now its all up to the client and not up to the community.” He presents this as almost a crime with the potential for “someone’s true trauma” to be “twisted into being a personal pathology,” a positioning which does not necessarily open up treatment options for the clinician.

As the collective biography progresses, Callithump, Ted, and Elizabeth share an interaction which provides insight into their understanding of what mental illness is and how to treat it while simultaneously critiquing the status quo of “mainstream psychology,” particularly “CBT.”

C: If you reduce somebody's story to a collection of symptoms to be treated, you kill the story, and if you kill the story you kill the person
T: You kill the person [E:mm] which is that's right
C: It's who, it's not what are you treating, it's who are you treating
Callithump likens this approach to “a medical model idea.” His comments suggest that for him at least, this way of conceptualising both mental illness, and its interaction within the individual, are anathema to wellness.

It’s about there’s a virus in this person, and we have to kill the virus, and we’ll give them antibiotics because it kills the virus...the person is just the carrier of the disease, they’re they’re sort of incidental to the process, and you you apply that to um...people’s emotional lives...that’s what you’re doing to people’s emotional lives, to their psychological life, like...their psychological life is some sort of parasitic um...[E:hmm] inhabitant, and the person that you’re speaking to is just the carrier of that...that’s fucked up [T: laughs].

Here, Callithump may also be interpreted as seeking to find metaphors for mental illness aetiology which open up treatment pathways for his clients. For Callithump, the “medical model idea” which treats the individual as “the carrier of the disease,” and positions psychopathology as a “virus,” “kills the story of the person.” For Callithump, such an approach effectively blockers the client from considering the implications of their experiencing, to their “emotional lives” and their “story.” Conversely, wellness requires access to diverse aetiological understandings which do not do this.

6.7 Summary

In this section, I have demonstrated that clinical practitioners position the aetiology of mental illness in varied, and at times conflicting ways, and express these using diverse nomenclature and metaphor. Therapists may describe psychopathology as stemming from, for example: individual biological dysfunction; severe trauma; dysfunctional relationships; biopsychosocial causes; cognitive distortions; or an interaction between past and present experience. I have demonstrated that at times, therapists dance across competing aetiological understandings within their practice. The purpose of this may be interpreted as being the clinician’s attempt to find a conceptual positioning, or metaphor for their client’s presentation, which facilitates therapeutic pathways, or Songlines for exploration within the therapeutic relationship. Practitioners who make reference to a biomedical or biological discourse with its flow-on treatment responses necessitating medication, seem
to also require access to alternate or nuanced explications, which more readily open up treatment pathways, alternate to medicalisation. Other clinicians may seek to bring cohesion to the entirety of their theoretical and practical understandings, as they create an almost “world theory” of what is their Psychology. I will now move to a discussion of the implications of this evidence for psychological practice and theory.

6.8 Discussion and Chapter Summary

Within this chapter, I have used data from a number of interviews to illustrate that whilst formalised psychology seems to largely ignore psychopathology positioned as other to biological dysfunction, stemming from a genetic predisposition, and triggered by external factors such as stress (APA, 2000; Comer, 2007; Leader, 2011; McNally, 2011), some practitioners appear to embrace diverse, and at times contradictory discourses surrounding this. For example, I have provided evidence that clinicians may speak about the aetiology of mental illness in terms of individual biological dysfunction; severe trauma; dysfunctional relationships; biopsychosocial causes; cognitive distortions; an interaction between past and present experience; or as an inability to function.

Yet as outlined in chapters one and two, the nomenclature and associated metaphor employed by a discipline articulates how we conceptualise within that space and consequently act, facilitating some paradigmatic avenues, whilst discouraging others. Across a number of disciplines, diversity within this space is highlighted as being the conceptual crux to human creativity (Feldman; Gruber & Bodeker, 2005; Leary, 1990; McFague, 1982; Pepper, 1942; Warren, 1971). Lakoff and Johnson (1980) and Leary (1990) argue all scientific understanding is esoteric in nature, a positioning they label “metaphoric.” Lacking absolute explanations of the aetiology of mental illness as evidenced by contradictory aetiological research (e.g. Kagan, 2012; Kendler, 2005; Wilkinson & Pickett, 2010), clinicians by needs draw on diversity of language and metaphor in an attempt to bring insight to that “which can never be dealt with directly” (McFague, 1982, location 451 of 3354) and to articulate “the great unknowns” (location 292 of 3354). As introduced in this chapter, I term the capacity to do this, phronesis thinking. More specifically, within this chapter I have provided evidence that clinicians may draw on varying, and at times
contradictory understandings of psychopathology as they seek to articulate their experience of practice to me. Whilst on-the-face-of-it their conceptualisations may present as disparate, the underlying intent seems to be a grasping for aetiological understandings which open up potential treatment Songlines for exploration within the therapeutic space, thereby creating the possibility for change. “Change” will be discussed more fully in the following chapter. However, of note here, is that faced with formalised psychology’s lack of a clearly articulated purpose to the practice of psychology, other than application (refer to chapters one and two), the word change is used in place of anything more definitive.

However, the resulting confound may be viewed as a gift, as the inherent clash between different positionings, facilitates metaphor creation, exploration of alternate Songlines, and may even open up the pathway towards paradigmatic change (Gergen, 1990; Lakoff & Johnson, 1980; Pepper, 1942). Additionally, this interpretation sits well within the epistemological framework provided by social constructionism (Gergen, 1985). At the very least, an ethical psychology needs to consider the flow-on impact of its conceptualisations to both practitioners and those afflicted, and to facilitate different streams of experiential and theoretical thought necessary for discipline growth.
Chapter 7

Beyond Application: Subjectivity and Intuition: An Exploration of Factors which may Influence how the Clinician Determines what is, or is not useful to the Therapeutic Endgame

7.1 Introduction

My curiosity became increasingly piqued. Some clinicians were presenting their practice as being contrary to how they understood they were meant to practice, justifying this to me through the use of triangulation. If they were morphing pure forms of therapy into something new, but no longer quite that therapy reported on in the empirical journals. If they were drawing on many and varied ideas to open up Songlines along which to move their clients using metaphoric diversity and phronesis thinking. How were they navigating formalised psychology’s decree to “reduce subjective bias and subject inferences, and to be cognizant of the dangers of reliance on intuitive thinking” (APS, 2013, p. 9)? Would clinicians experience subjectivity and intuition as “dangerous” resources to be avoided? Or would they, as Greenhalgh (1999), Schön (1987), Benner (1984), Bradley (2009), and Dreyfus and Dreyfus (1980) argue, draw on these as a matter of course, and as important tools to enhance the efficacy of their work (refer to chapters one and two)?

In this chapter, I will continue to open up the vast, and in Australian psychology, unexplored field which is the study of how psychologists practice. In presenting this evidence, I will demonstrate that within the real world of practice, therapeutic pedagogy, as defined by formalised psychology, provides insufficient and contradictory direction to psychologists seeking to do what they may understand to be their job. Even more than this, I will illustrate the existence of a comprehensive, sophisticated, evolving theory of practice, developed by psychological clinicians through their practice. The evidence shows how this enmeshed, metaphoric, phronesis thinking and subjective approach to practice can be drawn on more comprehensively by therapists, than the currently endorsed avenues of practice can be. The edicts of formalised psychology and the current framing of the scientist-practitioner model, faces the dilemma of whether to position the wisdom and insights
obtained by clinicians immersed in practice as inherently valuable, or to continue to view this as “quasi-scientific” (Long & Hollins, 1997, p. 77), and a “disappointment and an embarrassment to the discipline” (Nathan, 2000, p. 250).

In the first section I will show how clinicians may describe varied, and non-scientific elements as informing their practice. These include, for example, their own and their client’s personal experiences and autobiography. In addition, I will provide evidence that clinicians may draw on resources in direct contrast with what is allowed for by the endorsed knowledge generation mechanisms of formalised psychology. More specifically, some clinicians may rely on (even if it is not consciously acknowledged), vigilance for clinical minutiae, and intuition, particularly in cases of clients presenting with extreme trauma. In the second section, I will explore how clinicians articulate the process of becoming well and how they may ascertain what they understand to be necessary to facilitate that process.

I will begin my discussion with a focus on Annette. Using her experience I will illustrate how some clinicians may reflect on their own experience, and inject learnings from this back into the therapy they provide for their clients. From there I will move to the case of Captain, who credences his autobiography as opening up a Songline allowing him to work effectively with a very specific client population. In exploring these vignettes, I will provide evidence that the therapy provided by practitioners, can be (heavily) influenced by non-scientific factors.

7.2 The Clinician within Treatment: A Practitioner’s Perspective

7.2.1-The role of personal experience and autobiography.

Annette, who as a reminder is a 58-year-old, self-employed, clinical psychologist, with a full-time load, speaks of her therapeutic process as being informed by her personal experience of having to deal with emotional discomfort caused by, for example, people criticising her. She suggests the process she employs to move past this discomfort is to explore whether “the cap fits or not,” stating “that’s the way that I tend to deal with things.” Here, Annette may be construed as being open to criticisms from a place external to herself, whilst retaining her autonomy within that. She explores whether “the cap fits.” It is implied that if the “cap” does “fit,” then she can implement behavioral change,
and if it doesn’t she can ignore it. Annette suggests she uses her experience, which allows her “to deal with things,” as inspiration for her therapeutic approach, commenting “I get my clients to do that too.” Innate to this approach is Annette’s valuing of “choice,” “choosing what we can change, and what we can’t.” Annette links “choice” to action, challenging her clients “about taking on what other people impose. If there is some truth about it, what are you going to do about it? And if there’s not, how are you going to repel those statements?” She provides the vignette of a domestic violence situation where:

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

Here, Annette may be understood as linking “choice” with agency, defined as a deliberate acting in on a relational system or dynamic (Bleiker, 2003). Annette uses the terms “change,” “react” and “options,” and orientates those towards the individual she is seeing in her rooms, by stating “you can change...you.” Framed within Kleinian thinking, this positioning, forms a twofold purpose. On the one hand it pushes into the open, or conscious, what is being defended against or split off from the individual. That is, the client and clinician articulate what is happening. On the other hand, it shifts the individual into a space of deliberate action, which in this example includes resistance to that which has been split off, namely the domestic violence situation. The elements of “choice,” “acceptance,” “change,” and correspondingly, options, are intrinsic to this process. Here then, there is also a fling back to the idea of phronesis thinking and the use of metaphoric diversity introduced in my last chapter. For Annette, the facilitation of wellness and recovery (in this instance) necessarily requires these four ingredients. Moreover her process is directly informed by her own experience which has taught her how to “deal with things,” and it is this phronesis thinking, as opposed to a listing of academic articles read, which she applies.

Captain too, identifies an interaction between the personal experience of the therapist and treatment efficacy. However, unlike Annette, he appears to link this more directly with his autobiographical experience of having grown up “mixed race” in an Asian country and “not really belonging to a tribe.” Captain
suggests this life experience, placed him in situations where, unsure of his ethnicity, those around him would make assumptions about him, and, according to Captain, would “project” those assumptions onto him, but ultimately view him as alien/different to themselves. As evidence he states:

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

Captain elucidates this claim further with the statement, “you are whoever people think you are.” In context, this may be interpreted to mean that Captain has found it difficult to develop a solid sense of his own identity, as consequent to the varied external assumptions “projected” onto him by by others. Yet it is exactly because of this experience, and the implied “work” Captain has had to do to process being “whoever people think you are” which appears to enable his claim that he “work[s] very well with people who project, paranoid people.” Put simply, Captain has been on the receiving end.

Captain presents his experience of growing up “mixed race” as contributing to his being able to “study it [paranoid projection] first hand” and explore “how some of these [paranoid projection] things work,” “cos [he’s] able to actually sit there and try and work out what's actually going on.” Whilst some may view the capacity to “work out what's actually going on” as inherent to the role of the psychologist, the difference here is that Captain’s “first hand” experience of “projection,” facilitates his working with this “very very difficult” client group “at the extreme end” who you “avoid eye contact with,” “out on the street.” Captain explicates his claims by suggesting his clients, at times “completely....misunderstand what [he’s] trying to do.” His “job” as therapist, then becomes a process of “work[ing] out how the misunderstanding happened, and correct[ing] it.” He suggests this is “very very difficult with people who are as you say, in projection, people who are in a paranoid state.” More specifically, when in therapy with his paranoid clientele, Captain is “working very very hard to bring their wall down.” He suggests “their wall” is a response to “one or two things,” including “aggressive feelings which most people are uncomfortable with, and “emotional closeness.” His professional response is to work “very
very hard to look at the resistance to those two areas, and work on it on the spot.” Integral to that process is that

   Everything that happens in a room becomes really really........super important [J:mm] um..................transference.............as in the room when you know, eye contact avoidance starts to happen, and intensive psychotherapy you pick it up straight away.

   Captain defines “psychotherapy” as being “almost like” clients giving, “personal responses to...questions.” Yet the process itself is not streamlined. Captain describes some of his clients whose “defense system is so harsh,” and “punitive,” that he “draws back” for “self protection,” “because you [the therapist] don’t want to be hurt, squashed, rejected.” It is plausible here, that an experience of “rejection” reminds Captain of his childhood experiences growing up mixed race,” having a “flexible identification” and “not really belonging to a tribe.” Captain has first-hand experience of alienation, which simultaneously allows him to “work very well with paranoid people” whilst making him susceptible to being “hurt, squashed, [and] rejected.”

   For Captain, the result is a therapeutic bind, because by responding in this manner, his own emotional response may overshadow his client’s and “you’re not going to even get to the defense system of the patient.” Captain describes this as “the ghost in the room, my pain,” and that “in any psychotherapy encounter which looks like two people, there’s at least three people, [the client], the therapist, and the therapist’s pain.” Whilst his “pain” may be understood as stemming from his childhood experiences, Captain presents a need for psychologists to deal with their own “pain” in order to create a space for dealing with “the defense system of the patient.” Thus for Captain, whilst his autobiographical experience both informs, and obstructs his process, this duality facilitates his capacity to work effectively with his particular client population because he has both had the experience, and done the work to deal with his “pain.” Viewed from a Kleinian perspective, Captain is able to hold this divide or split in suspension, such that both can co-exist, albeit at a cost.

   Captain describes this process, for clinicians like himself, as “an occupational hazard,” “a very interesting double edge sword” because for Captain, “it requires someone with a problem, to discover that problem, and enunciate it,” but that comes at a cost. Here we see evidence that Captain
views his unpleasant experience, of having growing up “mixed race,” as providing him insight into paranoid projection. He states that “it requires someone with a problem, to discover that problem and enunciate it.” In using the word “enunciate,” Captain implies that having the problem is not sufficient to generate insight into possible solutions to it. Instead, enough thought needs to have gone into what solutions may exist, and how to access them, to allow an individual, in this case the therapist, to “enunciate” exactly what the problem is. His inclusion of “in psychology” suggests he does not view this phenomenon as being isolated to him. Rather it is a generic “double edge sword” for practitioners. Captain references this way of thinking in part, to a book he has read by “Robert Skynner” and “John Cleese” (1997), stating:

The match is very very specific between your childhood emotional task and the type of psychotherapist ahh that you become [J: that you become] So, is it very surprising that my area that I’m most interested in is........very very very heavily defended..paranoid people.

Here, Captain may be understood as very deliberately shifting his own experience of “pain” into something which becomes useful, even fertile. He presents himself as being able to do the “emotional” work such that what was a blocker, or defense mechanism for him as a child due to his experience of “not really belonging to a tribe,” becomes a poignant ingredient of his therapy. Moreover, it is this experience, in tandem with the “emotional” work, which actively opens up his capacity to work with “very very very heavily defended..paranoid people.” With this vignette, I have illustrated that Captain at least, views his experience, as opposed to anything else, as integral to his capacity to be the “psychotherapist ahh that [he has] become.”

In this section, I have provided evidence to illustrate my developing argument that therapists are influenced by factors which sit outside of epistemic thinking, and which they inject into their clinical work. For example, as outlined above, Captain is able to work with a complex clinical population, namely “defended paranoid people,” because through his experience he has been (and perhaps still is) one himself. Beyond that, he presents himself as having done the “emotional” work necessary for him to “enunciate” what that is (i.e. he is able to name the beast) for and with his clients, and from there move with them into problem solving mode.
In my next section, I will return to vignettes provided by Dukie, illustrating how she draws on constructs which do not easily, if at all, lend themselves to validation or discovery using scientific inquiry. Dukie uses these un-scientific constructs to articulate how she facilitates becoming, and remaining well, both for herself and her clients. This evidence is in contrast with Captain who does not necessarily present himself as being well. Rather, he is able to help his clients due to his insight into what has been the shared outcome of their respective experiences, namely paranoid projection. Dukie, on the other hand, is able to help her clients by using those processes which allow her to be well, in terms of how she understands that. Additionally, for Dukie, it is not necessary for her to have had an experience in order to help her clients. Rather it is her capacity to relate to the feelings that any particular experience throws up.

7.2.1-Working with me” to enable “working with people,” and introducing “compassion,” “permission,” and the process of informed empathy.

To reiterate, Dukie is a 48-year-old, self-employed clinical psychologist, with 17 years practice experience, and whose practice approach is informed by Buddhism and “mindfulness.” Dukie talks about her role in making people well, as beginning with her. She states, “I think the only way I can really work with people is to work with me.” However, for Dukie “work[ing] with me” is a twofold process. Firstly, she identifies her own need to be “well,” “because I’m only going to be as helpful as I am well,” and unless she is “well,” “whatever method [she uses on the client] is not going to be helpful.” It is interesting to stop for a moment and contrast these claims by Dukie with the experience of Captain, portrayed previously. Captain suggests that it is because of his difficult experience growing up “mixed race” that he is able to work with his client population of defended, paranoid people. Yet Dukie suggests it is because she is “well” that she is able to work with her client population. However, whilst the immediate comparison seems contradictory, more careful analysis suggests that for both clinicians, wellness begets wellness. Whilst Captain has had an ongoing experience of alienation growing up “mixed race,” “it requires someone with a problem, to discover that problem, and enunciate it.” Captain’s life experience requires him to deal with his “pain” and “the ghost in the room,” and thereby facilitate wellness for his clients. Conversely, Dukie believes she is able
to employ her capacity for empathy, which arises out of her philosophical belief set to achieve a comparable aim. I will expand on this claim shortly.

In keeping with her view of herself as a “guinea-pig,” (outlined in chapter six), Dukie uses her “personal experience” of “a real connection [with] and a sense of efficacy” around “what [therapy she’s] speaking about,” as antecedent for what constitutes effectual therapy. Dukie articulates a level of frustration around the complexity of this process, commenting “I can’t have a personal experience of everything.” However, to explicate her meaning, she provides the vignette of “people that [she finds] very difficult to relate to,” whose way of “behaving is not something [she’s] experienced.” Dukie navigates this seeming contradiction, by relating to the emotion behind the experience, as opposed to the experience per se, commenting, “what I can always bring it back to is the fact that they’re distressed [J: yes] and that is a very shared experience.” She provides the specific example of “road rage,” commenting that it is “just my luck, it’s [her experience of anger] never manifested” as “anger at all on the road.” Yet Dukie “certainly know[s] what it is to be angry,” “and [she] knows what it is to feel....injustice,” which is how she understands people experience road rage; “they experience a genuine sense of injustice.” Dukie articulates that this approach works “even with someone with a really marked personality disorder,” where she “bring[s] it back to the fact that their anxiety is so extreme...and their trauma .....is is so extreme you know” that she asks herself, “what would that be like?”

Dukie may be understood here as seeking to describe both how she understands, and uses the empathy construct in therapy. In context, for Dukie, empathy is a tool which allows her to interpret her client’s experience through a process of finding common ground. In this case, Dukie is able to equate her client’s emotional response back to their “shared experience,” which, in this instance, is “distress.” The associated process allows her to avoid “get[ting] caught up in the labeling of you know, us and, me and them, because I don’t, I don’t think that’s helpful at all.” Dukie describes this capacity for informed empathy as “compassion” and likens it to “having a cup of tea with the pain,” “holding your own hand,” “that very gentle being with,” “not trying to alter it in any way,” “curiosity” as opposed to “interrogation,” and as “respectful, intelligent, kind,” but “not indulgent.” Viewed from a Kleinian perspective, like Annette, Dukie (in collaboration) is forcing whatever is split off or other to her
clients, out into the open. However, for Dukie, this forcing involves a holding in suspension—a three dimensional positioning, allowing a “curious” circling.

Dukie remarks that her clients can “get really worried” if they have previously equated “car[ing] for themselves” with “self pity,” and “indulgence.” In contrast, Dukie describes the “fine line between self pity and compassion,” as the capacity to “connect.” “Compassion does not separate me from you.” Additionally Dukie explicates her capacity for “compassion,” as being “the most helpful thing” to her therapeutic approach and as “the hall mark” of “mindfulness.” This necessitates regular meditation on the behalf of the practitioner, which for Dukie, is “the best way to get in to know yourself.” She states, “I can only be compassionate if I’m compassionate to myself. I can only know their suffering if I know my own. I mean that’s my position.”

Permission also features in Dukie’s therapeutic approach: “You know one of my big jobs, and through talking, is to help people get themselves.” Here she appears to equate cause-and-effect with the client’s presenting symptomology, suggesting that people naturally, “of course” behave in certain ways, and feel certain things, given particular circumstances. As part of the process of “people getting themselves,” Dukie encourages her clients to “have an image of the person you want to be,” and seek to become that person. The clinician presents this aim as having a level of commonality between people: “you know, most people I find have very similar values, it’s how closely we live by them, that’s the difference you know.” The converse implication is that people who do not live “closely” by their “values,” are those who require “help” to “get themselves.”

Dukie explicates the consequences of not “getting” yourself as an experience of “pain” and “suffering,” which can result in feelings of “self pity.” She comments “it’s completely understandable in the situation,” but “it’s just it’s not helpful,” “it’s not going to move me [to a new, and better place]...it’s not going to heal me.” Instead “helping” people to “get themselves” involves Dukie working with her clients to “get the opening happening,” with a converse implication being that “not getting yourself” involves a closing off. She asks herself, “what are [the] things I can do in my life that assist that [opening to happen]?” The answer is informed by what has worked for her in her self-positioning as a “guinea-pig” (refer to chapter six), and may be understood as “whatever the medicine,” as long as it “attends to the wound.” Here, Dukie
advocates for the need for time to build “trust that what [she’s] saying might, might have some um, currency” with her clients. Additionally, her clients need to “acknowledge that what [they’ve] been doing isn’t working.” Instead “we’ve got to go towards the wound...in a different way.” Permission and forgiveness appear to feature here, as she states, “even if we slip into self pity, we then don’t beat ourselves up!” She likens that response to the person who “fall[s] over and graze[s] their knee and then hit[s] it with some sort of weapon!”

Dukie talks about “suffering” in her “line of work” as the “main um reason people come,” and that “once they feel that they can hold their own suffering, and understand it,” “they don’t need to come anymore.” “Coming to terms with........................the inevitability ..........of suffering is part of the human condition.” For Dukie, mental illness as a defined concept seems largely irrelevant to her therapy. Instead, it is people’s emotional responses, manifesting in “suffering,” which she seeks to address. The clinician comments, “accepting that suffering is an inevitable part of being human” facilitates the individual’s capacity to “hold their...suffering,” because “we get less shocked when it happens.” She presents “Western cultures,” “particularly,” as having “this expectation that everything ...is going to be easy and........um........................run smoothly” and “it’s peculiar because...um............there’s no evidence for that [laughs] model [J: yeah]......it flies in the face of the hard evidence.” Instead, for Dukie, “suffering” is “inevitable.”

In providing this evidence, I have illustrated how clinicians may draw extensively on constructs which do not easily, if at all, lend themselves to validation or discovery using scientific inquiry. Instead, Dukie may be viewed as drawing extensively on that which is uncertain, subjective, and esoteric—none of which are endorsed or discoverable using the evidence-based frame provided by formalised psychology. However as outlined above, Dukie uses such terms continuously throughout her interview. Moreover, for Dukie, such constructs form both the reasons why people come to therapy (e.g. “suffering”), and open up the path through which she is then able to facilitate them to become the person they want to be, which for her seems to be equated with the purpose of effectual therapy.

I will now shift to an exploration of the experience of clinicians who may be construed as highlighting the importance of “vigilance for clinical minutiae,”
within their therapeutic approach. I use the term vigilance for clinical minutiae to describe a phenomena introduced by some of my interview participants whereby they notice something isn't quite right. Whilst the therapist may not consciously be aware of why they think this is the case, the impression prompts them to further action to explore what is an effectual glitch in the matrix. I will provide support for this claim shortly. However, the evidence that this is indeed what some clinicians do, is in stark contrast to the legislated requirement by formalised psychology that practitioners should “reduce subjective bias and subject inferences, and be cognizant of the dangers of reliance on intuitive thinking” (APS, 2013, p. 9). Whilst a number of practitioners allude to participating in such behavior, I will begin with the voice of Johannes. Due to his expressed alignment with the edicts of formalised psychology, his case is particularly interesting. Whilst on the one hand, Johannes subscribes to this frame, on the other hand, I will provide evidence that he draws on intuition as a matter of course. Consequent to this positioning is whether use of intuition is, as formalised psychology claims, a “danger” or whether it may be a pivotal tool that allows clinicians to do their job. As a reminder, Johannes is a 58-year-old, male, clinical psychologist, of European descent. He describes himself as having a full-time load working in psychology, which includes a part-time therapeutic practice operating in country New South Wales. Johannes, categorises his practice “as eclectic with a focus on CBT.”

### 7.3 Intuition: Vigilance for Clinical Minutiae

Insight into how Johannes understands effective treatment, which for him is “tailored to the individual,” may be gleaned from his vignette of “a person,” “referred by their GP for memory problems.” Prior to determining which “approach” to take with his client, Johannes conducted an “assessment,” which involved “looking at the stability of the here and now, and then moving from there to events in the past that may have contributed to the issues of the here and now.” During the process of his “assessment” he discovered that “this person [hadn’t had] a blood test for a while.” Having had the tests “it [became] evident that she had a thyroid under-function,” “so basically with a little pill,” her “memory...improved.” It appears here that for Johannes, “tailoring to the individual” is about looking for the glitches in the matrix, the gaps which emerge during the “assessment” and which hold a question mark over them.
Exploration of these glitches then provides insight into potential pathways to explore within therapy, even if nothing comes of them. For Johannes, this information comes from “the assessment......and the information you have from your client...and then the other thing's also to discuss with the client, the objectives he or she has in terms of treatment outcome.” He comments, “another person might not have thought about that.” Additionally, Johannes presents this as being very important to his process, and that “another person,” perhaps:

Would have given the whole gamut of things, found out their memory is defective, and maybe said the person's starting, starting to have Alzheimer's or something like that [J: yeah yeah] which would have been dreadful [J: yep] ah, just the the psychological ah impact of that on the person.

For Johannes, it appears that his capacity to attend to clinical minutiae, as opposed to testing for “the whole gamut of things,” is integral to his effectual therapeutic process. Indeed, it is this capacity, which Johannes presents as setting him apart, and above another clinician who “would have given the whole gamut of things,” and erroneously diagnosed the person as having “Alzheimer's or something like that.” Paradoxically, it is this latter approach of giving the “whole gamut of things,” as opposed to “tailoring to the individual” which may be understood as being more 'scientific' because it provides clear evidence, using scholarly reviewed tools, that an individual does or does not have one condition or another. In contrast, “tailoring to the individual,” on the face of it, seems to lean more towards a valuing of subjectivity.

Regardless, something in the interview with the client, stops Johannes, and stays his hand. Instead of continuing down the path of absolute knowledge, Johannes considers that his client had not had a “blood test in a while.” For Johannes, this information, in context, became sufficiently important to encourage his ensuing follow up, which ultimately resulted in his client’s diagnosis of “thyroid under-function.” Whilst this latter response also involves an evidence-based treatment in the form of a blood test, getting there appears to have required an intuitive leap, which Johannes, but not necessarily another clinician (according to him), was able to make.
I will now return to the experience of Anna. Through further exploration of the content of her interview, I will provide greater insight into the use of intuition and the attendance to clinical minutiae used by some practitioners within the therapeutic space.

Like Johannes, 61-year-old, self-employed, clinical psychologist, Anna, talks about the importance of clinical vigilance for minutiae. She comments, “we’re in such a privileged position...you can’t.......you know you can’t ............be complacent when people walk in because...you actually can miss something.” She explicates this statement with a client chronicle: “she was just down, and...a good friend had moved away about five years ago, and so she was, you know...sort of at a loose end...just feeling a bit despondent.” As part of her process, Anna “gave her [client a Young’s] schema questionnaire...and she filled it in, and there was nothing [untoward], and everything was very balanced” except “there was one [question], where she scored, she actually gave herself three, which is more true than untrue...I carry secrets, you know I’ve got secrets that people don’t know about.” Yet with this questionnaire, “we only really look at fives and sixes and maybe fours,” so “there [wasn’t evidence of] distorting, maladaptive thought patterns from the past,”

But I just commented on it..I said, oh you know this is the only one that was a three...and ...this is after seeing her for four, five times...and she says....oh I......yeah I remember that, I don’t know if I should say anything, but my brother.......sexually assaulted me you know when I was seven or eight or something, and so then all these issues came up.

Anna describes this discovery as “sheer luck” or maybe “fortune,” “cos I would have normally, like if I’d just looked at the numbers, I would have dismissed it.”

When psychometrics are used, caution is advised against “conveyor-belt” responses. Therefore, within this frame, Anna correctly noticed the outlier in the context of the client’s other responses. This is actually what you should do when using psychometric tests. Yet, like the example provided by Johannes above, both practitioners proffer the sense that they have enacted a therapeutic practice contrary to what they perceive other practitioners may do.

Returning to Annette’s experience, this practitioner also alludes to the concept of vigilance to clinical minutiae as informing her practice approach, stating, “I mean, as psychologists, you come across things, when you think, this
is not quite right." She provides the vignette of a client presenting with panic attacks:

She couldn’t move, she couldn’t speak...and I’m going, I’ve not heard that before in my 36 years of psychology, [J: did she have epilepsy?] and you know, ...no she didn’t have epilepsy, she talked about it, and when I was talking to her the following, I think I saw her two or three times, when I was talking to her I thought, mmm, I wonder if there’s any bi-polar here. So I went through all the bi-polar symptoms, ‘Ohhhh’ she said, ‘that’s exactly how I experience things.’

Subsequent to this interaction, Annette talked about her ensuing insight:

When she left I went ‘Ohww, I’m sure I’ve seen something about catatonia with bi-polar’, so I got out my DSM-IV, and it talked about catatonia, bi-polar with catatonia [J:mm], and the catatonia is not being able to speak, not being able to move your muscles and so forth.

Annette, Anna, and Johannes’s vigilance for clinical minutiae may be understood by some as indicative of good practice (Greenhalgh, 2002; Reik, 1983), and even necessary within the vignettes provided, for circumventing a level of calamity. However, as already stated, the edicts of formalised psychology do not easily create a space where such uncertain phenomena may be learnt about, explored, honed, or validated. The net result may be an experience of othered psychology even by, for example, Johannes, who of all the clinicians I interviewed, most notably sits within its outlined frame.

In this section, I have provided evidence that clinicians may draw on something almost inexplicable as they articulate noticing that something is not quite right with their clients. It is the capacity to do this, which may be presented as differentiating between best practice, and potentially “dreadful” consequences. I will now return to the experience of Ted. Using evidence from his interview, I will demonstrate that even if clinicians subscribe to the edicts of formalised psychology (which I have demonstrated throughout this thesis Ted does not), they are not provided with any legitimate tools on which to draw when faced with a client whose experience, being so extreme, has not yet been (and may never be) captured in a randomised controlled trial.

Ted also talks about the importance of being vigilant for clinical minutiae when dealing with clients at “the really extreme end of,” for example, “some women’s experiences as children.” He employs the nomenclature of “pure
intuition.” Ted shares a story of being faced with the “most severely traumatised person [he’s] ever come across, and [he’s] worked with severely traumatised people for many years um, but ah, this was beyond.” Ted presents “pure intuition” as the capacity for originality “I came up with ideas that I would never never have read about, never.” He suggests the ideas “just came out of nowhere, from the relationship I think, from......what was required, and a lot of it, you wouldn’t read about.” Ted’s use of the word “relationship” suggests he experiences intuition as growing out of a developing understanding and interaction between him and his clients.

Elizabeth presents how intuition is valued, as being indicative of “the whole question of [therapy as] art versus science.” Thus she likens its use (or not) to a conscious choice informed by bias or preference. Her insinuation is that formalised, or othered psychology prefers “science,” whilst she prefers “art.” She comments:

The idea of therapy as an art, and I think that’s something that’s little spoken of these days [Mmmm] it’s all about therapy as a science [T:mm].....but I think this area of therapy being an art is the area where it’s all at.

Elizabeth explicates her meaning here by equating therapy as “art,” as being “where it’s all at,” and as the place where “good changes,” for “the client” are “to be made.” For Elizabeth, “art,” is when the clinician is “drawing on intuition, imagery, language, feeling, rather than a prescribed idea of you know..what works with what.” I will expand on the use of intuition, and the positioning of therapy as “art,” further in chapter nine as I explore clinician creativity within the therapeutic space.

7.4 Summary

In this section, I have provided evidence that practitioners may attribute their interest and expertise in working with specific client populations, to their own life history. The “work” required to process resultant “pain” in this scenario is presented as both hindering and promoting treatment efficacy. Clinicians may describe themselves as “guinea-pigs,” determining what is effectual therapy through first testing approaches on themselves. Integral to this process, is ensuring that they, the therapist are “well.” When faced with clients
of diverse experiencing, clinicians may distill the underlying emotion from the event, to facilitate their empathetic response. This distillation may be termed “compassion.”

Clinicians may apply the nomenclature of “change” to the process of facilitating an evolution which forms the antithesis of “being stuck.” Permission, compassion, transparency, hope, and forgiveness are viewed by some as influencing therapeutic outcome, with clinical vigilance for minutiae, described by some as intuition, presented as necessary to healing, particularly in cases involving extreme trauma.

7.5 Discussion and Chapter Summary

Against the backdrop of formalised psychology which favors evidence-based practice, I have provided evidence that clinical practitioners may look elsewhere for guidance regarding how to treat their clients. Some clinicians may look to their personal history to inform their practice focus, others may determine practice efficacy, not because the practice is endorsed, but rather because it works on them. Practitioners may present the aim of their treatment as being to minimise their client’s presenting pain, with this aim being facilitated by their giving permission to the client to feel as they do, given their experience. Some clinicians present intuition, or clinical vigilance for minutiae as necessary in order to identify what the problem is, and how it might best be dealt with. The findings from this chapter have implications for both what is endorsed by formalised psychology, and the processes via which new clinicians are made.

Within Australia, evidence-based responses to the diagnosis and treatment of mental illness have risen in popularity such that the current push within academic institutions responsible for the training of prospective psychological clinicians favors related approaches, primarily CBT (e.g. RMIT, 2016; Sydney University, 2016). Acceptance into these courses is highly competitive and predominantly based on demonstrated academic capacity. For example, preference is awarded to students with First Class Honours, and/or scholarly publications (e.g. Macquarie University, 2016). In this chapter, I have used data from a number of interviews to illustrate that whilst formalised psychology argues for, and in some cases dictates the use of evidence-based practice approaches (particularly CBT), as determined largely by published results of randomised controlled trials, clinical practitioners may look elsewhere
for insight into how to treat their clients. As first point of call, some clinicians present their interpreted personal histories as crux to their practice, with the inference being that if it works for them, it may work for their clients. At the very least, the navigation of childhood experiences may be viewed as channelling them into the lines of work they now inhabit, and as enhancing their capacity to understand and respond to clients with related presentations. In context, this suggestion raises a question around the process of becoming a therapist and what elements should be involved in the selection process. One possibility alternate to the current process, is that the discipline of psychology may benefit from seeking to attract prospective practitioners from diverse backgrounds to commence psychological studies. By encouraging diversity, a flow-on of efficacious treatments/therapeutic relationships targeting specific client populations may be ensured.

Additionally, within formalised psychology, intuition is presented as paradoxical, even irrelevant to effective, evidence-based treatment. For example, using the search engine integrated within the APS website, a search for articles referencing “intuition” yields “0” results (2014a), whereas a search for “evidence-based practice” yields “177” (2014b). Yet, in this chapter, I have provided evidence that practitioners identify vigilance for clinical minutiae as necessary for treatment efficacy, particularly in cases where the client has experienced severe trauma. For some, this capacity is viewed as pinpointing the space from which healing may commence. Conversely, researchers such as Charman (2005) state that “the consistent message [regarding what constitutes an evidence-based practice approach] has been that best practice is determined by research evidence derived from comparing contrasting treatments” (para 1), and that these treatments are then “operationalised in treatment manuals” (para 2). My question here is, for practitioners such as Tim who profess to working with the “most severely traumatised” people, what does a clinician do within the evidence-based practice paradigm? Which evidence-based practice do they turn to, which has dealt with a large cohort of severely traumatised people, such that a designated treatment has been identified, evaluated, proven to be effective, and written up in a manual? Within this research, I provide evidence that faced with such circumstances, clinicians do not appear to turn to evidence-based practice for guidance. Instead, they may be interpreted as turning to the unique skill sets they bring to the therapy
session, and the interaction of that skill set with the client within the therapeutic setting. Furthermore, they may concurrently use symptomology to highlight a need for change, and treatment avenues via which that change may occur. Appropriate responses to that presentation are presented as manyfold, and not necessarily reflective of the 14 evidence-based practice interventions applicable to 26 mental disorders endorsed by the APS (2010).

Additionally, within the evidence-based practice paradigm, minimal research is carried out in relation to for example, what wellness is, or what it means to be a person. This paradigm also fails to clearly delineate precisely what the practice of psychology is seeking to move clients towards. Yet, I have provided evidence that some practitioners seek to articulate answers to exactly those questions as a matter of course. For example, they may apply the nomenclature of “change” to the process of becoming well, with hope, permission, compassion, and transparency facilitating this shift. They may explicate change as being the process which helps their clients become unstuck. The therapeutic relationship is articulated by some clinicians as being the key to this process. The therapeutic relationship is explicated as a microcosm of real-world interactions, and as a tool for diagnosis, teaching and exploration. Practitioner history may be presented as informing that process. With consideration of these findings, academic institutions may benefit from shifting their selection process for prospective psychological practitioners from an academic focus to one which seeks out diversity of experience, a capacity to articulate and reflect on that experience, and an ability to develop rapport. I will now move into chapter eight, within which I will explore how clinicians speak about some of the difficulties of being a therapist, and the ways in which they manage any resultant problems.
Chapter 8

Emotional Difficulties of Practice: Self Care, Signposts, and the when and why of Peer Supervision

8.1 Introduction

Having demonstrated in chapter seven, that clinicians may draw on subjectivity and intuition as a matter of course, and that their preferred therapeutic approaches and choice of client group may be informed by their personal experiences, I began to wonder, how did clinicians look after themselves? In drawing on their own resources in such an intimate, and at times deliberate manner, how did they allow themselves to refuel? How did they protect themselves from the fall out of what seemed to me to be a continual giving to others? And how were therapists looking after themselves, when in the words of Captain, every psychotherapy encounter includes a “ghost in the room,” namely the therapist’s “pain?” And if despite what formalised psychology sets down as best practice, clinicians are drawing on themselves in such an intimate, subjective, and personal manner, how else might they be using their arguably un-scientific responses to their client and to therapy, to inform their practice?

Formalised psychology requires psychologists to complete a “minimum of 10 hours” peer consultation “each year focused on the psychologist’s own practice” following an “educational rationale” (PsyBA, 2010, p. 3) which is largely “self directed” (p. 1). However, as outlined in chapter one, best practice in this regard equates to the application of epistemic knowledge. Within this frame, supervision or peer consultation arguably then becomes a mechanism to ensure that clinicians are applying the findings of research to their practice as opposed to, for example, drawing on their subjective experience. Yet, I have provided evidence that therapists may look to subjective experience to inform their practice. How then do they experience supervision? And who do they seek supervision from? Is it from experts in published theoretical knowledge, or is it from those whose wisdom equates more with the Aristotelian concept of phronesis outlined in chapter two?

In this chapter, I will explore how therapists articulate self-care within the space created by the Boulder model frame. I will also highlight signposts they
may use to indicate their professional need to seek support in managing the client they are facing. I will provide evidence that in contrast to the edicts of formalised psychology (as already outlined), clinicians, working as they do in a space of uncertainty, may use their feelings as a litmus or "canary-in-the-mind" test for what is going on for them within the therapeutic space, as the client’s experience unfolds before and with them. In addition I will expand on the “turn-to-self” approach (explored in chapter seven) which is used by some clinicians as they quite deliberately draw on their subjective experience and emotional responses, as they work with their clients. These findings build on one of the primary themes of my thesis, which is that clinicians may draw on subjectivity as a matter of course to inform many components of their therapy. At the very least I will demonstrate the likely impossibility that a therapist may always be self contained, and follow the rules of clinical practice.

8.2 Difficulties of Practice: Self as “Barometer,” a Double-Edged Sword

During the course of the interviews, as clinicians reflected on their practice, and spoke about their experience of therapy, some of them raised issues regarding the emotional cost of being a psychologist and dealing daily with people who have “come to you in pain” (Phoebe), or who are seeking help navigating the fall out of “experiences” at “the extreme end” (Ted). Dukie speaks specifically of the impact her clients’ emotional states can have on her, particularly when she feels one of her clients is “really angry with me...I hate it, ohwwwww I just struggle.” Dukie’s sentiments can be appreciated at face value. Her tone of voice, choice of words, and extended groan “ohwwwww” provide testament to this assertion. However, whilst she “hates it,” Dukie suggests that if she is able to inject her feelings back into the therapy in a “transparent” way, the result can be both informative, and necessary to useful outcomes. The clinician describes this as a process of her “just talking about what’s actually going on in the room, within [her], within what [she] see[s] happening to the person,” with her client. Her use of the word “just” suggests Dukie views this as a fairly mainstream, almost perfunctory component of her therapy, arising out of her verbalising to her client “what’s actually going on in the room.”

As vignette, Dukie narrates the story of a long-term female client who was “being bullied...at work,” a situation which had been “going on for years.”
Dukie relates how during the course of therapy, she questioned her client “outright” regarding her choice to remain within the situation causing her stress, asking “you’ve been abused all your life, how long are you going to put up with this?” “Transparency” here required Dukie to “just say it,” “what was going on,” “the way that [she] saw it”. However, whilst Dukie suggests her use of such “transparent” techniques result in good outcomes for her clients, getting there may not feel at all pleasant for Dukie. In this scenario, Dukie’s client “dared to take leave” from her workplace, which “really took a lot of courage.” In response though, Dukie shares that her client was both “terrified” and from there “furious with [her] because [she] pushed her”, into doing something which “was going against the grain for her.”

However, continuing on with her “transparent” process, Dukie relates sharing with her client the emotional fall out of that ire on her. Dukie recalls telling her client:

I’m really struggling here because I feel you’re so angry with me, and she’s [the client] not a person that expresses it openly [laughs] [J: yeah] and she was able to say “yes, I’m really angry with you, I want it to be your fault”, she said, “but you know, that’s the kid me, and the grown up knows it’s not”.

For Dukie, it seems that difficulties within the therapeutic relationship, experienced in this instance as her client “being really angry” with her, which Dukie “hates,” are integral to the process of facilitating change. As a result of this interaction, Dukie’s client is able to differentiate between her “kid” response which is to be “angry” with Dukie for suggesting she leave her workplace, and her “grown up” response, which takes responsibility for her own decision-making process. In context, this realisation appears to be presented by Dukie as being indicative of growth, specifically, the client is viewed as undergoing a maturation process as she moves from a “kid” response to that of a “grown up.” However, the underpinning catalyst for client change here, may be interpreted as Dukie’s courage to “just say,” “what was going on in their relationship,” “the way I saw it,” informed by her own emotional response of “struggle” and “hating” the feeling that her client was angry with her.

Dukie shares an additional anecdote, further highlighting how an experience of emotional discomfort for the clinician may be used as impetus for
facilitating positive change for the client. Within this scenario, Dukie articulates greater difficulty in transforming heavier aspects of therapy into a positive outcome for both herself and her client. However it is in this instance, that Dukie ultimately seeks outside support for both herself and her client. Dukie speaks of “two clients that were suicidal” one of whom “was emailing me constantly telling me that she wasn’t coping [with her life], and wanting to suicide.” During this extended interaction with her client, Dukie reports finding herself “not functioning in such a healthy way.” Yet again, she appears to reflect on that experience and use it to inform her self-awareness and to increase her capacity to maintain her equilibrium. From there, she was able to channel that new awareness back into her therapeutic practice. This is reflective of her way of working which, as stated previously is to “use [herself] as a guinea pig” and “reflect on what it is to be human.”

Dukie presents her own emotional response, in this case “anxiety,” as “a great barometer” indicative of her “not functioning in such a healthy way.” Furthermore, Dukie views her emotional response as symptomatic of her not “drawing very good [professional] boundaries” with the client who is emailing her. However, whilst Dukie’s emotional response may be interpreted as “a great barometer” signaling her need for external support in dealing with her client, as outlined previously, it is this clash which may also precipitate change for the client, or at the very least, be used as a tool to that end. Through the application of transparency and despite (or maybe because of) her own “anxiety,” Dukie suggests that within the relationship, she was able to “trigger” something for her client which facilitated a movement towards health. Dukie shares an ensuing conversation where she tells her client of her difficulty in coping with the client’s emails:

Hearing about you wanting to kill yourself every day, I care very much about you, you matter a lot to me”, and it was too much for me. I was not able to hold it, “I need help. I need other people to help me support you”...and then I let the cat out...it was an accident, I wasn’t intending, “I’ve actually stopped sleeping” [laughter].......and that was the thing that triggered her...it was perfect...she said, “Ohw, D.....really?” She rang me back and she said......“I’m not angry with you, I understand why you did it....I need to contain myself more...you weren’t seeing that after I emailed you each time, it made me feel better [J: yeah]. you know, I know I need to find other ways.
Intrinsic to this exchange, seems to be Dukie’s verbal articulation of her “care” for her client, a sentiment further supported by her seeking support such that she could better “hold” her client’s suffering, and thereby continue to “support” her.

8.3 Summary

In this section, I have provided evidence which demonstrates that emotional difficulties, which the therapist experiences at a personal level and which he or she attributes to arising from the client/clinician interaction and the client’s pain, are integral to the practice of psychology. Practitioners may present the resultant rub as being necessary for successful therapeutic outcomes, or at the very least, as creating an opportunity, whereby change for the client can occur. Clinicians may facilitate change here through the use of “transparency” which is understood as informed reflection by the therapist with the client around what is happening in the therapeutic space, both within the client and the clinician, and between them. A practitioner’s experience of anger being directed at them by their client, and their own discomfort caused by this experience, may be one catalyst for such therapeutic interaction. The resultant process, whilst presented as beneficial, may not be presented as a pleasant experience for the therapist. In providing this evidence, I have demonstrated that clinicians may use their emotional responses in therapy as a litmus test, or canary-in-the-mind warning that something is not quite right with their clients, or that an explicit, “outright” response is required by them to propel the client into making changes. They may then use that emotional response to inform future discussions with their client. In so touching on the demands on clinicians’ own feelings, I have addressed why clinicians feel they require self care, and identified ways they may seek to cherish themselves whilst working in a profession which deals with emotional “pain.”

I have provided evidence that therapists may also use their embodied, emotional, or felt responses as an indicator that something is not quite right with themselves, or how they are responding to their client’s experiencing. Here then, emotions may be viewed as highlighting a need for the clinician to draw on support from sources external to themselves, in the form of, for example, peer supervision. In illustrating this I have demonstrated that a theory of practice within psychology may require elements beyond application of
NHMRC-style research, as clinicians seek to maintain their energy and capacity to work within the space of other people’s pain, and to determine when it is they need to seek additional support for themselves.

I will use the following section to expand on this and the canary-in-the-mind metaphor mentioned previously. More specifically, I will expand on how clinicians may use their emotions as an indicator that they need to draw on resources external to themselves, in the form of peer supervision, to facilitate their continued work with a particular client. In looking at how practitioners talk about supervision, we are provided with evidence for what clinicians may seek supervision for, and what are the signposts for them, which indicate their need for it. As stated in the introduction of this chapter, whilst formalised psychology requires that therapists receive a minimum of 10 hours peer supervision annually, the reasons for this are presented in an indeterminate way. For example, no formal direction is provided as to when to seek supervision, or what warning signs indicate supervision may be needed. Instead, in keeping with the premise that best practice equates to published epistemic knowledge, a positioning which assumes the clinician’s experience adds little value to therapy, therapists are required to perfunctorily demonstrate they have participated in 10 hours of peer-supervision, as opposed to knowing when and why they need to seek it, or how their experience may indicate this necessity. In contrast, in this chapter, I demonstrate why some clinicians may seek supervision, and how they may draw on their embodied, and subjective response to know when this would be useful. In providing this illustration, meaningful purpose is attached to a requirement. Additionally, I demonstrate that for some clinicians this need is highly subjective, as indicated by emotions which start to act up. Again, epistemic knowledge does not provide sufficient tools by which to learn more about or to explore this space of uncertainty. Instead phronesis thinking, which privileges subjectivity, is required.

8.4 Self Care Strategies, and Emotional Responses used as the Clinician’s Canary-in-the-Mind Test for their own Mental State

During the course of the interview, Annette muses on why “psychology is stressful to work in” and how she copes “with the strain.” Annette talks about taking on “some responsibility for other people’s lives” due to being “empathetic” which she views as a “fortunate” attribute for the effective clinician. Indeed, this
capacity to “experience some of the ah....feelings that they have” is perceived as valuable, and even a necessary part of the therapeutic process. Annette refers to this phenomenon as “transference” stating “when I get stressed for them, that this is a transference of their feelings on me, so I am then able to turn that around and say this is what they are feeling to some extent.” However, she also acknowledges that

You hear horrific experiences, particularly with trial and child abuse, and dissociative disorder in particular, they’ve usually had tortuous experience you might say, um, it is very difficult to hear people talk about that.

Annette provides us with some insight into how she is able to navigate her “difficulty” in “hearing people talk about” “horrendous experiences” and from there, move her clients towards a place of wellness. She states, “the way that I deal with that, is to concentrate really hard during that [therapy], on how to help them through that.....rather than concentrating on the actual experience itself.” One interpretation here, is that Annette views forward momentum as being efficacious to mental health for both client and clinician. She argues for moving “through,” as opposed to “concentrating on” the “actual experience.” The existence of a goal, albeit esoteric, which Annette is seeking to move her clients towards, is hinted at. Furthermore, Annette’s focus on moving “through” the “actual experience,” as opposed to “concentrating on the actual experience,” seems necessary in maintaining the clinician’s personal equilibrium. As additional evidence for this claim, Annette expressed her “surprise” during one case when she “became upset reading what happened to that child” such that she had difficulty writing “the report [she] had to write.” Annette describes her “upset” response as “an unusual experience for [her].” It would seem here, that having a goal, and a known (effectual) process to employ with clients, provides one component of emotional support for clinicians. When that is experienced as being hampered by the clinician, “supervision” can be drawn, on “you know in half an hour,” to help “sort through that stuff.” Annette may also be construed here as articulating tolerance for her client’s pain, thereby demonstrating containment of the emotion produced by knowledge of their “tortuous experience,” and also that she is able to co-exist with that information whilst exploring with them, the possibility of a different future.
Annette also describes ways of protecting herself from the full force of client distress, through the use of “compartmentalising.” Annette uses the language of putting aspects of the therapeutic relationship (either the client’s experience, or how the clinician responds emotionally to that, or both) “away in the filing cabinet, both literally and metaphorically.” However, whilst Annette speaks of “compartmentalising” her client’s experience, she does not seem to mean this as being “ambivalence” on her part. Rather her self-management informs the sorts of defenses and techniques she is then able to share with her clients, a capacity which, for her, facilitates rapport. For example, Annette comments on her openness to the dissociative diagnosis stating:

I’ve always talked in terms of parts, you know how you’d say, oh part of me feels angry, and the other part feels happy, oh I can see that part of you wants to do this, but there’s a part of you that’s holding you back [J:mm, yeah] it’s that language. That language is really helpful in terms of [J: yeah] bringing out dissociation [J: mmm mmm]. For most of us that just means I’m ambivalent, but for those who actually have separate parts, [J:mm] they recognise then that they can actually talk about that, which is interesting.

Moreover, Annette highlights her propensity to work in this manner, using the language of “parts,” “compartments” and “filing” things away, as essential to her mental health “I mean otherwise you’d go nuts wouldn’t you (J:mm). If you held all that pain in your head.” Here the clinician here comes across as ordinarily human, which is a vision of the psychologist that is absent from formalised psychology. In addition, their humanness, or subjectivity, can be used as an important aspect of good clinical practice.

Paralleling clinician use of sidelining emotions as part of therapy, Annette points out the benefits of having a practice separate to your home, which she has not always done in her working life, she also demonstrates the use of humor as a self-care strategy. Annette suggests that keeping work, physically separate from home can help create boundaries which facilitate “being able to turn off [J: yeah] after work.” The alternative is a situation where “you never leave work, and you never leave home.”

I had one client who was a dissociative disorder, who used to scream when she was reliving experiences that she’d had as a child, so I would
Annette's capacity to tell humorous stories around her clients, and their shared experience, provides some insight into how she seems able to work from home with a client who "screams" as she relives "horrific" "experiences that she’d had as a child." My laughter during her story, is indicative of the entertaining manner in which Annette narrated seemingly incongruous experiences throughout our interview. However, Annette’s capacity to laugh at some of her interactions with her clients seemed infused with a genuine love and admiration for them, as opposed to being disparaging in any way. This was evidenced by her tone of voice, animation, choice of words, and demeanor as she spoke about them. Her use of humor, and her ability to laugh in the face of her client’s sometimes “torturous” experiences, seems to be used as another self-coping, deflective mechanism to avoid going “nuts” holding “all that pain in [her] head.”

Annette highlights the value of deliberately addressing her own needs in order to render her associated “distress [at her client’s experiencing] bearable.” The therapist speaks of her deliberate restriction on how many of certain types of clients she allows herself to work with. For example, with her dissociative work, she sees “usually no more than two or three at a time, cos they’re pretty exhausting.” However, having stated this, the clinician moves on to describe the symbiotic nature of the relationship, as they simultaneously “give a lot back to [her] as well.” I will describe this phenomenon further in chapter nine.

Other strategies used by those interviewed include the use of meditation. Dukie highlights the role of meditation, to both her practice, and her capacity for self-care as a human being. She has an established routine which has “become a very important daily part of [her] life.” Dukie meditates “whenever [she feels]...any emotional discomfort, or...[she’s] having any emotional struggle,” it is her “first medicine.” During therapy, “even if [she is] sitting, talking to someone” if she feels she is “struggling,” “[she’ll] be very conscious of [her] breath going in.” Here Dukie appears to reiterate the importance of her Self to the therapeutic process, “because I’m only going to be as helpful as I am well.” Dukie also presents meditation as a “set of things you can do to settle yourself,” “particularly around anger.”
Dukie speaks of clients who “shoot an arrow” when they “start to feel uncomfortable,” as a “defense mechanism.” With clients such as these, she talks of caring for herself via the use of “mindfulness”: “I just reflect on the fact that I’m struggling, I talk to myself [laughs] and thinks, jeez I’m having a hard time, this is a tough session, just breathe.” The clinician distinguishes here between “how much of it’s my stuff and how much of it’s their stuff,” “cos sometimes your own stuff does get triggered, and [she’d] just hold that as best [as she could] and care for [her]self, and then be as a present as possible [J: yeah yeah] um.....with what’s going on.” From there, Dukie will “talk to someone else about it, meditate, do all the stuff that [she] needs to do....about the fact that [she’s] struggling.”

For Johannes, self care appears to involve, at least in part, “know[ing] very much areas I like to work in, and areas I don’t like to work in.” He relates this to “custody cases” where he only really works “on the fringes because [he doesn’t] really like them much.” He explicates his emotional response by stating:

The child irrespective of the decision is always the victim [J: yeah] the child is voiceless more or less, even so they have their own lawyer, things like that, but really they’re voiceless [J: yeah] and they’re suffering immensely, so that’s why I have stayed very much away, away from working ah..with children.

With respect to those instances where he “unexpectedly” gets a job he is uncomfortable with, Johannes states, “you do your best job...but ah.....if you can avoid it, I refer onto other people.” Instead Johannes states his preference for working “with people who have a mental health problem.”

However, for Ted, part of his self-care, as outlined in chapters four and five, may be understood as involving his deliberate separation from the broader profession of psychology as he views it. As outlaid previously, during the collective biography, he comments

I don’t call myself a psychologist anymore, I tend to call myself a psychotherapist, because I find it embarrassing now, the whole area [E:mm] [laughs] the profession is just become an embarrassment at some level.
8.5 Summary

In this section I have provided evidence that therapists may respond emotionally to the presentations of their clients, and use that subjective response to inform their therapeutic approach. However, this approach, may come at a cost, and can require practitioners to employ diverse strategies to support any emotional fall out. Some practitioners may seek to keep the physical premises of their work-place separate to their home. Additionally, therapists may employ humor; making jokes about patients, or creating characterised names of certain types of patients they may see. However, humor seems to be employed in a respectful manner, and is used more as a pressure valve, than to indicate any disrespect for the client. Indeed, practitioners spoke about their clients in tones, and using words suggestive of a deep admiration and agape love for those they worked with.

Some practitioners reported, restricting their intake of those client types that they viewed as more exhausting to work with, whilst acknowledging a two-way interaction between client and clinician in terms of shared benefits of therapy. I expand on this idea further in chapter nine. Some practitioners present “transference” between client and clinician as necessitating practitioner employment of self-care strategies. When working with clients who have had particularly horrendous experiences, some therapists suggested that how they positioned the aims of therapy facilitated the maintenance of their own equilibrium and their capacity to continue working. Furthermore, the ability to “compartmentalise,” and put things “away,” was viewed by some as necessary to maintain practice efficacy. Some practitioners may advocate for the use of meditation, as a daily behavior to minimise clinician stress and maintain emotional health. Alternatively, therapists may present their emotional discomfort as stemming directly from the practice expectations of a formalised psychology that they view as being contrary to their preferred mode.

Having explored emotional signposts that clinicians may use to indicate their need for external support, I will now illustrate how therapists may experience peer supervision, the specific benefits they may ascribe to it, and who they may seek supervision from. I will also highlight the lack of awareness clinicians may have about how peers outside of their self-created peer-supervision circle, may work. In providing these illustrations, I will expand on my thesis which privileges phronesis thinking and subjectivity, and I will provide
an initial practice-informed justification to support formalised psychology’s peer supervision requirements.

8.6 Peer Consultation: A Practitioner Perspective

Annette expresses her valuing of formalised psychology’s peer supervision requirements “even though it’s irritating at times, in terms of number of hours etc.” She presents the vignette of having to deal with a particularly difficult case involving an abused child, who was ultimately murdered. She comments:

The statement of facts was really explicit, [J:mm] and what happened to this very young child was...horrrific......and went over an extended period of time...and it just...yeah, it was just one of those things.

Finding herself unable to “move on” with what she was doing “because [she] found a block, in being able to manage the case,” a “three quarter hour supervision, let [her] sort through the issues.” Annette states “I just talked to [name] and I just explained to her what the situation was.” Annette suggests “I suppose it was all that emotion, anger, you know, you’d like to swear at the guy [who abused and murdered the child] rather than write about him.” From here, the process became her supervisor helping her unpack that experience and realise that her “report was really about the living children, and their safety and protection,” as opposed to having to reprimand the offender, “so she [her supervisor] was able to talk me around in that way, and it lifted.” Annette highlights the similarity between such a supervision session and the client/clinician interaction, positing, “it was a really good experience for me cos I thought, well that’s what we do for clients... when we do that therapeutic process with them and help them sort through stuff.”

In the past, Annette had “only sought supervision on a casual, when I needed it basis.” However, she experiences the current supervision requirements as forcing her to “talk about [her client] issues,” and hear “other people’s cases.” With consideration of some of the findings of this current research, it is interesting that Annette is not forced to hear just anyone’s “issues” and “cases.” Instead, she shares regular supervision with two clinicians who she has known for numerous years, opened a practice with, feels she can ring at any time, and who it would also seem are her friends.
Whilst Annette appears to value the professional opinion of her peers, she also draws on the insights of her non-clinician husband, stating:

He’s outside the field, but he’s very psychologically minded, so I can go home and go sfwhehhhboooooo to him, [J: yeah] and he will listen, and often if I’m puzzling something over, he can come up...like lay people can often do [J: yeah] and then come up with....well that’s obvious, you know.

On the one hand, Annette’s valuing of her husband’s opinion around psychological matters seems completely logical due to the nature of the marriage relationship. However, this is a practitioner with over 30 years of clinical experience, and her consideration of opinions outside the profession seems at odds with the professional requirements that supervision be administered by other psychological professionals. Furthermore, she suggests that “lay people” “can often,” have greater clarity around psychological matters then practitioners themselves, suggestive of an opinion that professional support can come from many sources. Annette may also be understood here as experiencing some aspects of therapy as being almost explosive in their need to be shared, or unpacked, she employs the nonsense word-sound “sfwhehhhboooooo.” Moreover, there is a sense that some of what is shared in the therapeutic space, needs to be “sfwhehhhboooooo” to get it out of the clinician, and into an external, more distant space where it can be circled, and as in the case of a “puzzle,” be solved.

Annette also talks about the value of supervision for “omaintaining [her] own emotional health.” She appears to not quite know how to articulate what it is that supervision does for a clinician, oscillating between “sense of worth...oh no that’s not the right word,” and “emotional health.” Again, her use of the word “sfwhehhhboooooo” to express what she at times needs help with, lends itself to the interpretation of a slightly intangible milieu around what supervision is. Regardless, Annette reiterates her sense of the value of compulsory supervision, “because psychologists often are very busy people.” Busyness, and a level of selflessness, seem to be viewed by her as being integral to the profession because practitioners are required to manage clients in “crisis.” “You book them [clients in crisis] in, and you cancel going to whatever you were going to that was going to be for you.”
During the course of the interviews, I was surprised to be asked by a number of my participants, about what other practitioners had said, and how they had talked about their experience as therapists. My assumption was that supervision, and ongoing professional development requirements, would provide clinicians with ready access to varied experiences of practice. Yet this did not seem to necessarily be the case. After Phoebe had commented a number of times, that her preferred mode of practice differed to CBT and short-term therapies, I asked Phoebe to elaborate on how her work contrasted with that of someone who was “toeing the line,” and using CBT. Her reply to me was: “Oh golly, I guess I only have an imagining of how another therapist works, not having been in a therapy room with them.” Another therapist, Michelle, commented to me that for her:

It’s always been interesting to think I wonder how other psychologists practice in their rooms, because I’ve never actually had much of a chance, except in my internship to actually see other people.....practicing...and to get a contrast with how I practice.

Dukie asks “Are people similar?...I’m always curious about how other people practice psychology, I’m sure I practice quite differently.” These were all registered psychologists, with numerous years clinical practice under their belt. Yet based on these comments, and within the context of our interviews, they apparently had limited awareness of how their practice process compared and contrasted with that of their peers. With consideration of the evolving findings of this research, my question here is; what is formalised psychology using supervision for? Is its purpose to facilitate education regarding diverse practice, or is its primary role to effectively “allow” clinicians to remain in a space of comfort and homogeneity regarding what their clinical practice is via participation in supervision with like-minded professionals? At the very least, I think such questions need to be pushed out into the open so that the collective of psychologists can debate the varying merits of different approaches and ensuing Songlines.

I will now return to the experience of Phoebe, who presents the mandated need for supervision as facilitating her capacity to continue working as she would like to, which is other to how she is required to work by formalised psychology. In providing this evidence, I will demonstrate that supervision may
be used by clinicians to maintain their status quo. My point is not whether this is good or bad, but rather that for some clinicians, this is the case. In keeping with my thesis, an ethical psychology needs to consider the Songline flow-on of what it is singing into existence, and in this case, what the role of supervision could be.

As outlined in chapter four, Phoebe presents formalised psychology as being other to both her preferred practice mode, and what to her, is effective therapy. However, she presents the mandated need for supervision (which ironically, is mandated by one of the professional bodies she implicates in perpetuating that experience of othering) as facilitating her professional mental health. Mandated supervision provides Phoebe with a legitimate mechanism which actively supports her alternate mode of practice. For Phoebe, “surrounding” herself with “like minded individuals,” including her “peer supervision group” consisting of “three others that all work in the same way” enables her to slough off any feeling that she is a “rebel.” Additionally, she works “with psychotherapists mainly, and counsellors...so [J: yeah] so I feel like I’m pretty much in step with them.” This is in contrast to how she positions herself within the dinner party vignette, explicated in chapter four, where she felt herself to be “doing something wrong,” “in the context of being with a psychologist who works differently to [her].”

Dukie presents supervision as necessary for dealing with clients “that [she] really doesn’t like...really press buttons.” Additionally she tries to “reflect upon what it is about that person that really erks [her],” stating “generally it’s when they’re really disconnecting.” However, supervision does not feature heavily in her interview. Instead she seems to give greater precedent to her world view, “using [her]self as a guinea pig, and reflecting on what it is to be human” in combination with “meditation.” Johannes presents supervision as a valuable commodity, necessary because “nobody’s perfect,” and the process can shine “new light, [and] different perspectives” on the problem at hand, which can then be “work[ed into] the intervention you do with a client.”

As one means of counteracting the influence of the “most difficult patients” who “get in under your skin and disturb you,” Captain talks about his convening of a group of psychological professionals who meet to process exactly that experience (the name of the group style has been omitted to maintain anonymity). Through their combined “struggling” with the case, the
practitioner is able to “get some insight into it” and the “next time we see the
patient, the patient’s not going to get under your skin.” Additionally he has
instigated a “study group for people in Sydney” with a specific interest in
another form of therapy (omitted to maintain anonymity). Captain presents this
latter group as being contrary to group supervision experiences that he
participated in, “in the old days,” which involved meeting with “your supervisor”
sometimes within a group setting. You would go “shit, what am I going to
present, and you [would] present, some fragment of a piece of work, and then
make it up as you go along, try[ing] to make yourself look as good as possible.”

As a response to this dilemma, with his new supervisory group “you show
a video.” For Captain, the benefit of this approach is that with video “there’s just
no bullshit.....just no lie, it’s your video, and if it’s a video of a guy struggling,
then you’re going to get some help from that struggling.” He likens this
approach to:

The apprenticeship model, where you know, if you’re a boot maker,
no-ones gonna say to you, now share with me what your experience was
with your last boot....they’ll say, bring it in, they’ll say “No mate, your
stitching’s wrong” [J: yeah yeah] you do it like this. And with video, you
can actually do that [J: yeah] um....so that’s really good use of
technology.

It is interesting here to contrast Captain’s approach to supervision and his use
of technology, with questions posed by some of the other therapists I
interviewed (and mentioned previously in this chapter), who wondered about the
practice modes of their peers. Using Captain’s “apprenticeship model,” if the
“stitching’s wrong,” “then you’re going to get some help.” Additionally, Captain
suggests that he is only able to be so exposed with his peers in his “middle to
late career” as it is “only, now [he’s] confident to really show [his] work to other
people.” However, Captain appears to attribute his perception that he’s
“actually getting a lot more supervision, then [he] ever got when [he] was
young,” not to external expectations to undertake supervision, but rather to his
feeling sufficiently “confident to really show [his] work to other people.” For
Captain, at a pragmatic level, this degree of supervision efficacy “can only be
done with video because.......there’ll be a person [J:mm] in your room on video
that [your] supervisor can see.” He provides me with a narrative sketch to
demonstrate the effectiveness of video, particularly as he immerses himself in, and learns about, a new technique.

I had this person come in and he [my supervisor] goes ‘she’s very paranoid, she’s projecting on’...and you go ‘no, look at all the lovely things she says’. [My supervisor then asks] ‘Do you notice how she comes into the room? she puts her bag down, does not turn sideways to you, doing this...oh okay, do you notice where her eyes are?’ [J:mm] yeah [J: yeah] so so this is my my big learning curve for me now.

Additionally here, there is the sense that supervision, using video and thereby allowing detailed feedback on actual practice, has re-energised Captain as a clinician. He is provided with new ways of thinking about and enacting his practice, and concrete ways of doing this. In short, he is provided with a challenge, which is articulated by Captain as being a “big learning curve.” Within the context of his interview, his embrace of this approach is in keeping with his verbalisation around what constitutes “evidence,” and what is “scientific objectivity.” Again for Captain, video allows for “no bullshit,” and “no lie.”

Captain also talks about the value of supervision in dealing with difficult clients, stating that, “you know you’re getting the [metaphoric] crap beat out of you.” He articulates the need to deal with this scenario promptly “before you start to kind of get stuck into that position of being beaten up by a patient, and feeling like you’re a loser or whatever.” For Captain, supervision then becomes a process where:

Someone will say ‘Well the patients’ defense system is this’...and you’re not........getting to that....and you go ‘Ahhh’ then you’ve got something useful to do the following week [J: yeah yeah] which is to help the patient rather than be worrying about yourself.

Here he reiterates the double role of therapy, in raising issues for both the client and clinician, which the latter needs to be able to put aside or deal with separately in order to “help the patient.”

Callithump, Ted, and Elizabeth also discuss supervision as part of the collective biography. At times they appear to equate supervision with undergoing their own therapy, assumedly this is because they practice within a psychodynamic way, which traditionally requires the therapist to undergo their own therapy as part of the ongoing education process. Both Ted and Elizabeth
speak about supervisions they have had, which have shaped their practice. Elizabeth stated, “I have reflected on bad experiences that I’ve had as a guide to what hasn’t been good, and therefore [I know] what is good.” As vignette exemplifying bad supervision, Elizabeth shares around a “therapy that [she] began when [she] was a student um.............and recently married, and starting a masters, and pregnant with [her] first baby, and terribly stressed around a range of issues.” She posits her therapist’s “response to this was” to give her a “series of handouts to manage [her] stress,” which she “didn’t find useful at all, and so the therapy didn’t last.” Additionally she shares the story of a:

Couples therapy, also a negative experience, um..................that was negative because of um.............my experience of the therapist jumping in with solutions, um, before she’d really heard the whole story, and so what that told me was that importance of really understanding the client’s material, before anything is really offered in response.

Ted, Elizabeth, and Callithump, like Phoebe, present themselves as working in a way contrary to how they are expected to practice, as portrayed in chapter four. Yet during our interview, Elizabeth at least, presents her supervisions as influential in shaping her current practice modes, particularly as she was going through the necessary motions required to “become a clinical psychologist.” Elizabeth identifies “two things...as useful,” articulating these as “the supervisor’s hope and belief in [her] capacity for transformation” and “his lack of anxiety about [her] process.” For Elizabeth then it seems that supervision historically provided her with concrete examples of what not to do, and conversely what works.

8.7 Summary

In this section I have provided evidence demonstrating how some clinicians position supervision as making a valuable contribution both to their professional health, and their capacity to practice. Supervision may be presented as helping the practitioner position a therapy session/client in different ways, thereby facilitating forward momentum as opposed to stasis. However, some therapists seem to engage in supervision with professional colleagues having comparable viewpoints to their own. Thus, supervision may be viewed as a vehicle for reinforcing the psychologist's current belief sets and
theoretical-practical frames. This appears to be irrespective of whether that belief set/theoretical-practical frame is viewed by the clinician as comparable with, or contrary to how they understand they are expected to practice by formalised psychology. Additionally, some psychologists may present supervision provided informally by people not endorsed by the PsyBA to take on that role, as being very helpful, and at times, providing greater clarity than supervision provided by those who are endorsed.

Yet, whilst all practitioners are required to partake in supervision, some may express a lack of awareness regarding what occurs within the therapeutic spaces created by other clinicians. Captain presents video as foil to this conundrum. For him, video is re-energising because it ensures supervision is effectual in that it responds to what is, as opposed to what the clinician may want to present. Some practitioners present supervision as being useful for rethinking difficult clients, but they present their own self-reflection and self-care practice as being of more use to maintaining their emotional equilibrium. However, as outlined in the previous section, lack of emotional equilibrium, or clinician discomfort, was presented by some practitioners as a tool to facilitate wellness, or at the very least a positive shift within the therapeutic setting.

### 8.8 Discussion and Chapter Summary

In this chapter, I have provided evidence that some clinicians may at times experience emotional discomfort in their work as psychologists. The management of this necessitates, or at least benefits from, accessing external support in the form of supervision, as regulated by the PsyBA. Discomfort was presented as stemming from varied sources. These included client anger at the clinician, a conflict between a mind versus feeling dichotomy, mismanagement of boundaries with, for example, suicidal clients, or a sense that the clinician was practicing in a manner contrary to how they understood they were expected to by formalised psychology. However, the process of dealing with such discomfort was presented as being advantageous to therapy. Reasons for this included helping the therapist feel more in control of subsequent sessions with that patient through catalysing efficacious client/clinician interaction, or through providing sanctioned access to like-minded peers. Indeed clinicians appeared to access supervision from sources compatible with their professional leanings, thereby reinforcing their current belief sets/theoretical-practical frames. Thus,
maintaining the status quo in terms of how clinicians practice and think about their practice, may be a hidden curriculum of regulated supervision. Giving consideration to the developing findings of this thesis, professional growth and clinician creativity, may be facilitated through requiring clinicians to have a certain number of annual CPD hours in supervision with practitioners working within an ontological/theoretical frame at odds with their own, thereby forcing them to reflect in different ways about issues they face within the therapeutic space. Furthermore, as raised within this chapter, clinicians expressed a lack of awareness regarding the practice modes of their peers. Through the inclusion of video supervision sessions, this lack can be addressed whilst simultaneously allowing greater adherence to an apprenticeship model of training. One practitioner suggested that supervision was beneficial because it was presented to his supervision group in visual format. The prior articulated assumption was that early career clinicians may seek to present themselves to their supervisory group or mentor in the most competent manner possible, as opposed to presenting their practice “warts and all,” which allows for pertinent feedback and the facilitating of professional development in a potentially more potent manner. Thus, regulated supervision may benefit from requiring clinicians to record difficult sessions, with the ensuing supervision focussed on that visual record as its stimulus for discussion and reflection.

Additional sources of therapist support, articulated as being valuable by interviewed clinicians, or inferred by me, included the use of humor in thinking about challenging clients or client presentations, and conversations with laypeople, which assumedly occur in adherence with the code of ethics, thereby retaining client confidentiality. Practitioners may benefit from the inclusion, in the supervisory regulations, or training around the use of humor to diffuse negative client/clinician interactions and to minimise practitioner stress. However, care would need to be taken in any pilot programs, as some types of conflict were presented by practitioners as facilitating their client’s movement towards wellness, when handled in a particular manner. Clinicians may also benefit from the findings of pilot groups exploring the benefits (or not) of regulation such that therapists may seek supervision from sources not directly related to psychological practice. Again, in keeping with findings within this thesis, such a pilot could include accessing a broad array of health
professionals, giving consideration to diverse metaphors they employ, and how their use in therapy may facilitate wellness outcomes.
9.1 Introduction

As I began to wind up the process of analysing my data, I began to wonder—if some clinicians use their subjective experience as a matter of course in their therapeutic practice, and they morph theory and test it using triangulation. If their practice is being informed by the Aristotelean concept of phronesis, and if they are using metaphoric diversity to open up possible wellness Songlines for their clients, what do they learn by enacting this process? What insights do they glean into the nitty gritty of how therapy works, what it means to be a person, what wellness is, and what the purpose of therapy is? What I find intriguing is that these are the kinds of questions which psychology has historically sought to answer (refer to chapter five), and which some key thinkers in mental health, still seek to explore (e.g. Corcoran, 2009; Rogers, 1995; Yalom, 1980, 2002). Moreover, I have provided evidence that as they seek to fulfill what they understand is their role, some clinicians may look to and speak about these issues, and position them as the “gut” of what therapy is about.

In looking at how practitioners speak about these things, we are provided with evidence as to how they may navigate the contradiction between best practice equated to application of epistemic knowledge, versus best practice involving at the very least, legitimated platforms upon which to explore the existential, esoteric, and indefinable-the questions of the soul. As I outlined in chapter three, through the use of inductive qualitative interview and analysis techniques involving a deep exploration of the corresponding case studies, my thesis goes some way to providing evidence necessary to inform a new practice-generated theory for Australian (and potentially Western) psychology. In bringing light to bear on this conundrum, I have provided insight into how we can better train our therapists and extend their capacity.

In this chapter, I will begin my discussion with an exploration into clinicians’ experiences of what I will term “gestalt.” I would like to acknowledge here that I am effectively borrowing this term from both the German, and the work of Wertheimer, who founded Gestalt psychology. The concept is based on
the idea that there is a “whole that is more than the sum of its parts” (Hollway & Jefferson, 2013, location 1044 of 4956). In using this term, I seek to capture the phenomenon whereby psychologists, having injected their insight and wisdom (which may or may not be evidence-based) into a therapy session, experience a throw back arising out of the therapeutic relationship, and out of which upon reflection, new insight and wisdom may grow both personally and/or professionally. Using the words of Annette, whilst clinical practice can be “pretty exhausting,” the clients “give a lot back...as well.” In providing this evidence, I will continue my thesis which argues that the expectation to apply published knowledge, and techniques provides an insufficiently broad professional, theoretical, technical, and existential spectrum along which clinicians may grow. Additionally it provides insufficient freedom to facilitate effective clinician responses to unique client presentations. The consequence of this positioning is the identification of a need to develop a more sophisticated theory of practice for psychology, which privileges, and legitimates the wisdom generated by reflexive practice.

9.2 Gestalt: Clinician Self Discovery within the Therapeutic Space

During the previous chapter, some of the more difficult professional synergies arising from the practice of psychology were explored. These included, suicidal patients, inadequate retention of professional boundaries, and the importance of feelings as signposts indicating a need for the clinician to seek external support. Yet, over the course of the interviews, some clinicians illustrated how a positive coaction between therapist and client can result in personal insight for the therapy provider. Michelle, who as a reminder, operates from a theoretical framework of cognitive behavior therapy informed by “the biopsychosocial model,” speaks of this experience as a “daily” “evolution.” She states, “practicing psychology is a huge part um...plays a huge role in who I am as an individual, and what I think it is to be a, to be a person.” Michelle suggests that resultant insight is informed by “seeing humans at their most vulnerable,” and this interaction happens with “pretty much every single person [she has] sit in front of [her].” As vignette she talks about a client whom she “might be speaking with...about relationship issues... and [she thinks] okay, so, what you’re talking about is...and [she wonders] how that applies to [her] own life.” Michelle presents her capacity to distill practicalities necessary for being
“a better human, and a more understanding human, and a more empathy...empathic human” from her “wonderment” (understood here as reflection) at her client’s experience, and as a process of “continually reflecting on [her] own life.” It seems for Michelle, there is a synergy arising out of her relationship with the client, which manifests as personal and professional growth for her. Michelle presents this process as arising from “reflecting” on the experiences of “vulnerable” people, and re-injecting the resultant insight back into her own experience or “life,” thereby becoming a “better human.” Insights such as this are not made available via the application of epistemic ontology. Rather, they require clinicians to descend into the murky swamplands of Schön’s (1987) reflexive practice (refer to chapter two), as they wrestle with the “gut” of therapy (Michelle).

Arguably, there is a metaphysical component to these concepts, which Michelle seeks to express. However, as outlined in chapter five, a contradiction exists between Michelle’s professed embrace of the “theoretical framework of cognitive behavior therapy” informed by the “biopsychosocial model” and her articulation of positionings more in keeping with psychology’s philosophical origins. Michelle’s confusion is made more apparent as over the course of the interview, she appears to shift from speaking about her client’s ailments “from a theoretical framework of cognitive behavior therapy” informed by “the biopsychosocial model,” to presenting them as a form of “narrative” or “story.” She comments:

So I’m a real believer in that, well we do need a bit of a narrative to...a way of being able to ......see our lives as a story, and being able to position ourselves as part of that story in a particular point in time...and so [J: yeah] use of words can be really helpful.........for that [J: yes]....this is a map of this stage in my life, and this is what went on for me, and this is how I keep going at it, and actually being helpful to me in terms of being able to move past this, as I can look at that as being a stage of my life which happened.

Whether her shift reflects a well thought out positioning, or whether it is in response to my interaction with her, is unclear. Regardless there is quite a mismatch between operating as a CBT therapist, and describing what it means to be human as being the “gut” of therapy.
As discussed during chapter five, CBT does not seek to define what it means to be a human or what the practice of psychology is seeking to move clients towards (save perhaps symptom alleviation). Nor does CBT seek, in any overt manner, to explore metaphysical concerns. Additionally, CBT does not attempt to delineate, in any reproducible manner, what is meant by key concepts (to its frame) such as “dysfunction.” Such an attempt would make available a conceptual lattice informing all the concerns raised here. Yet the CBT informed practitioner, Michelle, still seeks to articulate some of these concepts, even presenting them as “core.” Could it be that Michelle is seeking to express what her practice may be teaching her, namely that techniques in isolation, whilst useful, need to be embedded within an existential purpose or direction and an understanding of what it is to be human, if they are to impact the “gut” of what is going on? Whether or not this is in fact the case is in some ways irrelevant. What is pertinent is that Michelle gives voice to that which, as stated above is in direct conflict with the edicts of formalised psychology. This is despite presenting herself as conforming to that frame (i.e. she describes herself as primarily operating from an evidence-based approach). However, as outlined in chapter five, for Michelle, this way of thinking is in process as she struggles to express what is, for her, the “core” of therapy.

The notion of understanding the human in relationship, rather than in isolation, appears to be woven into Michelle’s concept of being a “better human.” She comments:

I feel that in every interaction I have with another person, that it encourages me to strive more.....or recognise when I’m perhaps behaving in a way that perhaps isn’t so helpful in my relationships, or in my life, to prompt me to make a greater effort.

Michelle seems to pull her insight, informed by “every interaction” she has “with another person” back into her own experience. Using that entangled learning she is able to “knot” new concepts into and through her own experience of, for example, “relationships” creating something new, and more robust. This approach may hearken back to a need for a private ontology, “prompt[ing]” Michelle “to make a greater effort,” and “reminding” her, “on a daily basis” of “what we are...at the very core.”
Here, I have provided evidence that clinicians may learn from the experiences of their clients, and inject those learnings back into their own life. Furthermore, this learning may be positioned as an attempt to capture the esoteric nature of what it means to Be, which may be presented (albeit indirectly) as the “gut” of therapy. This way of thinking and speaking about psychology, is in direct contrast to the Songlines made available by formalised psychology’s best practice.

I will now return to the practice of 48-year-old, self-employed Dukie, who as a reminder favors “mindfulness.” Whilst Michelle speaks of injecting learnings from the therapeutic alliance back into her own life and relationships, Dukie speaks of injecting her learnings about what it means to be a human, back into the therapeutic space. As outlined in chapter seven, Dukie’s learnings seem to arise out of both her philosophical beliefs, and her “work” as a psychologist. Additionally, Dukie refers to the consequence of injecting back into the therapy the “wrong” learnings, defined here as those which “get in the way,” and which may be more reflective of the clinician’s own “stuff,” rather than what the client needs.

Dukie presents her “work” as providing her with “the opportunity to learn how to care about human beings...without getting in the way so much,” a process which she “loves.” Dukie appears to position the curriculum for her ongoing education concerning what it means to be human, as being co-created by the client/clinician interaction within the therapeutic space. It may be inferred that the content of that curriculum includes the apparent oxymoron of Dukie’s simultaneous presence and absence in therapy. Her absence, or not “getting in the way,” may be construed as the clinician keeping her “stuff” out of the therapeutic space. Dukie states “I just try to keep my focus on them, what’s going to be helpful [for] them”. Additionally she discusses the impact of inappropriate disclosure on her part for her client “I watch people, and I can see if I’ve brought something up, and I can see what they’re doing with it, it’s like, oh no, you know I wish I could...turn the clock back.” Conversely, being present within therapy, may be interpreted, at least in part, as Dukie contributing “what’s going going to be helpful [for] them [her clients]”. This is informed by the diversity of her experience, using herself as a “guinea pig,” and exploring what it is, that helps her become “the human being [she] wants to be.” Again this process seems to be informed by a feedback system between client and
clinician, which is underlaid by a process of ongoing reflection, and in Dukie’s case, facilitated by meditation.

Dukie differentiates between her “work” and her “life,” and whilst she “knows her work is part of her life,” she is able to “turn” to her “job” which “frees her.” Here it appears that it is within her work as a psychologist, that Dukie is able to learn about things which she views as valuable, including how to become “the human being [she] wants to be.” Alternatively, it is the capacity to do this (i.e. reflect on what it means to be human and develop strategies which facilitate becoming that), which defines what the role of the psychologist is for her. As further evidence for this interpretation, Dukie talks about “coming to therapy” as being a “spiritual process,” and a “long process,” “affecting [her] as a human being.” She states, “most people,” “want to come for a long time.” Dukie speaks of therapy as being a “bonding experience” and that her clients express thinking of her “as a replacement mother,” for the therapeutic duration. The clinician presents “learning to trust another human being and and then..learning to be in relationship with a person in the way they want to be in relationship with people” as part of the reason for the length of her therapy. Based on this experience with her, they are able to then “take it [their learnings about relationships] out into the world.” For Dukie, integral to the success of this relationship is her clients “actually having someone genuinely care about them.” Dukie explicates her meaning as she describes using her relationship with her client as a microcosm of the relationships they have “out in the world.” If she is able to clearly articulate to her client what her experience of, and emotional response to them is within the therapeutic space, then they (client and clinician) are provided with concrete material to work with, in the form of relational and communicational problems to be solved.

9.3 Summary

In this section I have provided evidence that clinicians may use insights gleaned from the therapeutic alliance, for both their personal and professional development. I have drawn on the term gestalt to describe this phenomenon. Clinicians may also simultaneously present their personal learnings as contributing to improved therapeutic outcomes for their clients. In this way, they may be construed as re-injecting their learning back into the therapeutic recipe, using themselves as a conduit. The process benefits both client and clinician,
and a growth cycle is perpetuated. The process may be likened to the mother/child relationship. This way of learning about therapy and influencing it is in contrast to how formalised psychology defines best practice.

I will now move to a discussion around how some clinicians position their experience of creativity within the therapeutic space. In doing this, I will provide additional evidence that clinicians may, as a matter of course, draw on knowledge generated from outside what is made available to them by an epistemic ontology. Furthermore, they may present the education they have received within psychology as almost needing to be unlearned if they are to develop as therapists.

9.4 Clinician Creativity within the Therapeutic Space

By asking Phoebe to “talk about [her] experience of creativity in [her] workplace, or in the therapy that [she] provides.” I raised the possibility of the existence of creativity within the therapeutic space. Additionally, this question opened up ways of exploring how practitioners may actually experience their work, against a backdrop of “rigid rules” and how they articulate forms of creativity which may be central to developing good practice-based techniques. Phoebe did not appear to experience any discomfort from my asking this question. Nor did she demonstrate any sense that such a question was out of place within the framework of our interview. Indeed, her immediate and unhesitating response that “this is a work in progress,” suggests that improvisation is a concept that she grapples with as a matter of course within her practice. From here, it is intriguing that her ensuing response was neither about her current practice, nor directly about creativity in any particularly positive sense. Instead, Phoebe reflected on her participation in a Masters in Psychology degree and her resultant perception of the course’s overemphasis on rule adherence. Phoebe may be interpreted as presenting this experience as being almost foil to her professional creativity and one which, according to her, required years of distancing from prior to her being able to incorporate creativity into her practice in any powerful way. Alternatively, it may be that Phoebe was forced to teach herself methods of incorporating creativity into her practice approach because these were not part of the formal curriculum of her masters program.
It should be noted here that Phoebe does not present her Masters training as "all bad". Discussions around her "identity as a psychologist" were articulated as ongoingly helpful to both her thinking and the positioning of herself as a psychological practitioner. Additionally, whilst Phoebe may be interpreted as articulating to me that she experienced generic rules as oppressive, the rules that she viewed as pertaining to ethics and to right and wrong ways of conduct were positioned as something to be embraced. It is plausible, that adhering to ethical rules may facilitate an experience of professional freedom for the practitioner through the delineation of clear, professionally and/or socially sanctioned boundaries, whilst technical “rules” and the you must do this of practice, may be positioned as being debilitating and "rigid.” Phoebe comments:

I think that creativity wasn’t encouraged instead um......a very closely obeying the rules seemed to be encouraged, particularly rules around ethics which I do believe in. Rules around how to work with clients that felt very rigid, and ...which gave me at first a.......fear of doing things wrong, um............and a fear to go outside the boundaries.......to the extent that you know I guess when I first started working I felt I can’t have coffee or tea in the therapy room, can’t have water, you know all these rules.

In associating formalised psychology with non-creativity, Phoebe’s comments alert us to how formalised psychology as described in chapters one and two, and further explicated in chapter four, may defend itself against a loss of centralised control. This lack of control may be construed as manifesting in, for example, clinicians responding creatively and unpredictably to varied client presentations. Conversely, control may be viewed as clinicians predictably responding to pre-determined ideas about how mental unwellness presents. Whilst these ideas are not directly mentioned in the preceding quote by Phoebe they are an impression threaded throughout her interview. In some ways, fledgling practitioners are also regarded as being incompetent, and even likely to behave in inappropriate ways, unless appropriate (and “rigid”) guidance is provided.

Given the emerging findings of this thesis, it is plausible that the level of control, expressed here as an ambience “encouraging...a very close obeying of the rules,” is a natural flow-on effect of the psychology created by the Boulder
model frame, which practitioners are required to adhere to. Conversely, it may be the result of lecturing academics failing to separate their personal biases regarding what constitutes best practice, from the guidelines provided within the Code of Ethics (APS, 2007). Rather than appreciating this level of control, or presenting it as providing her with a valued support framework, Phoebe illustrates how this mix within which practitioners eke out their professional identities, may undermine and curtail her professional creativity. She felt a “fear to go outside the boundaries.” Furthermore, she felt positioned as lacking competence, and unable to even have a drink with her “in the therapy room,” during client sessions.

Yet despite her observations about the impact of her formal training on her practice efficacy, Phoebe seems to place a high value on clinician creativity, presenting this as integral to practitioner growth, effectual operation of the therapeutic space, and even as a catalyst for the facilitation of wellness for her clients. She has come to conceptualise her training as a counter to what she does in the present, and equates her perception of increasing professional creativity with her longevity as a practitioner. Phoebe suggests this is not an easy skill-set/approach to achieve/learn. I will expand on this claim in the next section.

9.5 Creativity Equated with use of “Language and Metaphor,” “Pictures,” and “Fantasy”

As the interview progresses, Phoebe comments:

Only maybe 10 years in, 11 years in, am I beginning to get a feel for what it would mean to be sort of creative in the workplace, and at this point it’s around language and metaphor, and...using the words to kind of.................paint pictures, um...talk of fantasies, um..............................yeah...so it’s all around words I guess.

Here, Phoebe correlates creativity in her practice with the use of “language and metaphor,” presenting the capacity to manipulate words as legitimate, and even indicative of advanced therapeutic practice. She suggests that “only maybe 10 years in, 11 years in” is she starting to “get a feel” for what being “creative” as a psychologist might mean. Additionally, she suggests that her insight shows her
there is more to be learned in the realm of being “creative in the workplace.” This is evidence by her use of the words “at this point.”

Lacking the rigidity of rules discussed previously, metaphor and language appear to provide Phoebe with a vehicle to invent, explore, and create within her practice, and with her clients. However, when I asked her to talk more about these ideas, her response was, in her words “rambling.” This was consistent with her earlier sense that creativity within her practice was a “work in progress.” Her response is also in keeping with an interpretation of the data, wherein creativity has not been an overt part of Phoebe’s formalised psychological education. Despite presenting as highly articulate, and reflective, Phoebe’s thinking around clinician creativity is “rambling” and “in progress.” In so struggling, Phoebe illustrates how, through the edicts of formalised psychology, clinicians may not be provided with an enriching, complex set of discourses relevant to human interest and the therapeutic process in particular.

Phoebe’s reiteration of the importance of feeling, is consistent with her aforementioned approach to therapy (see chapter four). How she feels about what the client is sharing with her, forms an important part of therapy. Combined with clinician creativity, expressed here in the form of “language and metaphor,” Phoebe appears to use these tools (i.e. feelings and metaphors) as a “feed back” system regarding what is transpiring in a therapy. Considering the content of this chapter, metaphor here may be viewed as a client/clinician co-created tool which is used by Phoebe to check-in with her client regarding the accuracy of her perception of the gestalt that is taking place, both for the client and the clinician. Phoebe states:

My approach is all about um...........words..and ........particular meanings of words, and the idea that no word is used accidentally....either by the client, or even ......by myself, I mean it’s all...they’re all selected for a particular reason, based on a particular feeling or nuance, or........and.......so the client’s choice of word is...interesting, and able to be explored, and I guess the words that I choose in response, are equally chosen specifically.

Phoebe further explicates her use of language, metaphor, and “feedback” systems within therapy, by commenting that whilst she is “with a client,” “[she’s] not only listening to the words on the surface, but [she’s] also trying to build an [informed] picture [around what is/has happened for/to them].” For Phoebe, this
equates to “an idea” she may have which is “more than [what] they may be saying” to her. This “idea” may “pop into” Phoebe’s “mind” in the form of “images.” For example, she states, “I might get an image of shame” seeing “my client...sort of hanging their head, and sort of walking away shyly or something.” Phoebe will then “translate the image” for her client, and “put words to it...‘it sounds like you’re really feeling shame today,’ something like that.” For Phoebe, even if her “idea” is incorrect, it doesn’t matter, instead she views everything that comes up in the therapeutic space as “grist for the mill.”

In this section, I have provided evidence that therapists as a matter of course, may draw on resources which sit outside what is made available to them by the edicts of formalised psychology. They may present these resources as being all about language and metaphor, the use of which facilitates their capacity to be creative. Additionally, they may present everything that goes into the therapy as a potential space of learning, such that even what may be viewed as a “mistake” can be transformed into “grist for the mill.” Moreover, they may present the compulsory training they have received, which allows them to legally call themselves a psychologist, as having impaired their capacity to develop such tools or to even be aware of their efficacy.

I will now return to the experience of Ted and Callithump, and explore their positioning of creativity within the clinical setting. Their vignettes provide insight into how some clinicians view what the practice of psychology is. Rather than being a static, “cookie cutter” industry, where discrete approaches translate unproblematically to varied client presentations, psychological practice is presented as a constantly evolving, intangible entity.

9.6 Therapy as “Art”

Ted speaks about therapy as “an art form in a way..it evolves...bit like an art form [laughs] blank canvas, and you never know where it’s going to end.” Here he reiterates his belief that therapy is not a static process but rather, it involves responding to the unique circumstances and experiences explicated by his clients. Additionally, for Ted, creativity is not a process occurring in a vacuum. Rather, it grows out of the therapeutic relationship. As introduced in chapter seven, where I explore clinician use of intuition and vigilance for clinical minutiae, Ted comments that having worked with “the extreme end of.....some women’s experiences as children...............the really extreme end of it,” at times
he is forced to trust his “pure intuition” and do and say “things [he’s] never thought of before.” Ted suggests, that faced with such unchartered experience, the clinician is required to “come up with ideas that [they] would never never have read about, never.” He presents this experience as “just hanging on for dear life sometimes, Ahhhh,.......by the fingernails.”

Unlike Phoebe, Ted may be understood as acknowledging that his education has facilitated his capacity to work with clients at “the really extreme end” of “some women’s experience,” requiring the use of “pure intuition.” However, the education that he speaks about is not that which was required by formalised psychology. Rather, it grew out of participating in his own therapy. Following a “kind of...breakdown,” Ted was referred to “someone to help [him] explore deeper issues.” He presents this experience as pivotal to his ensuing psychological practice, commenting, “at that point I was a bit of a behaviorist,” and prior to this he had “never heard of,” “deeper issues.” Ted presents his personal therapy “exploring deeper issues” as “life changing,” “I just leaped on that,” “drank it in” and it “was the first hope I’d ever had.” This therapy was something that Ted “connected with” and that for him, “made perfect sense.”

Additionally, Ted suggests this alliance was helpful due to his therapist’s capacity to “see through [his] annoying parts” to what was “beneath” and to what was a “more genuine part of [him].” Furthermore, it taught him about “connection, both to [his] own feelings, and to others and the feelings of others.” It also taught him that “feelings matter, and the rational takes a huge back-step.”

Ted describes how cases at “the really extreme end” occur rarely within therapy, and due to that rarity, they lack therapeutic precedent. As such, they are unlikely to have an article published about how best to deal with them. Thus some kind of creative leap must be made by the clinician if any form of healing is to be facilitated for the client. Ted comments, “I felt like I knew through my training what to hang onto in a way, which is thank god for that.” As described in this chapter, what he as a therapist needs to “hang onto” in dealing with some clients, is exploration of “deeper issues,” valuing “feelings” and holding onto the “hope” that your client can, and will improve. Ted states, “no matter how they [his clients] are, how psychotic or whatever, I have hope, and it works.” He attributes this belief to his professed capacity to heal “a lot of people that [other] people thought were unhealable.” Additionally, he appears to receive affirmation for his use of creativity and intuition from his client’s
improvement but “that’s it, only at the end.” For Ted, further reinforcement of his approach appears to come from his later application of some of his “ideas that [he] would never never have read about, never,” to the presentations of other clients. Ted posits that whilst he still has “question marks over some of the stuff [he] did,” this is mitigated by “other clients” also at “the severe end, and it’s helped them as well.” It is important to remember here that Ted’s client group is “at the extreme end,” and includes “the most dysfunctional people in the community,” who have experienced severe and ongoing abuse and trauma, as opposed to more mainstream clients presenting with, for example, agoraphobia or depression. Within this scenario, it does not seem impossible that Ted, at times, is required to think on his feet. According to his description of how he works, the experience of Ted illustrates the possibility and probability of how new approaches are first conceived, i.e. within work with marginal or extreme cases or under-researched populations.

9.7 The Value of Stories

Callithump talks about the value of “stories” to his therapeutic process. He articulates “stories” as being “not just stuff that’s happened to somebody.” Instead stories have “life” and “colour,” “they have feeling, they have emotion,” which “is just as important, if not more important than events, then then sequence.” Here Callithump seems to suggest that all of these factors inform his sense of what has contributed to where his client is at, and they provide him with insight into the process through which healing can happen. Part of his insight into this process involves the “co-creation” (Ted) of “imagery” tools for use within the session. For Callithump, imagery may be understood as being created “as [he] listen to people’s stories.” Whilst his clients speak, Callithump suggests he “sees things” (understood in context as inferring meaning, as opposed to an experience of a vision), and that his client’s words can “evoke images that you can come back to,” and “that that there’s something there, something that’s created, that’s that’s living, and alive, or it seems to be so [T:mm] in your conversation with somebody.” Here Callithump appears to be drawing on multiple senses to uncover information, or impressions which may be instructive within the therapeutic frame. Callithump articulates his agenda of searching with his clients to find “common words, common images, common ideas which will resonate for them.” In context, his use of the word “common”
means shared understanding between client and clinician, as opposed to meaning everyday. Callithump suggests “common” (or shared) understandings grow out of “listening to (his clients) speak, and in listening to the language that they use” and which then “occur” to him as “ideas.”

Callithump shares an experience of working with a:

Lady that I’ve been seeing for about three years, who.............grew up with um.............a a mother with largely untreated schizophrenia, and a father who was very absent, and unresponsive...um and [she] escaped home at age 18.......ahh into the arms of an extremely abusive, physically and emotionally abusive bloke, and was eventually able to sort of leave him.

Callithump suggests that one of the “dynamics,” created by this experience, manifested for his client “in her interpersonal relationships,” leaving her with a need to “please everyone to keep herself safe.” In the process, Callithump presents his client as having lost “her own sense of what was important to her, and what she would like, and what she wanted.” According to Callithump, for this woman healing began “just in talking with her over a period of time.” Together, they “came up with” the “metaphor...of her own internal compass........that she had a compass, and it pointed in a particular direction.” Callithump’s client was then able to apply that “metaphor,” which they “refer back to...almost every session”, to her own experience. Callithump’s client used the metaphor to “step out of the role of doing what everyone else wanted” and instead “see where,” “her own internal compass,” would “lead her.” For Callithump, this “metaphor,” was not one he had “used with anybody else...but it was something that fit for her, that fitted for her.” In response to Callithump’s sharing, Ted interjects into the conversation, “co-created I guess,” to which Callithump responds “I guess that’s kind of the idea (T: yees) that you come up with somebody, in that shared space (E: mm).”

Ted also talks of “get[ting] images,” which can be “very strong,” when “listening to someone in extreme trauma.” Ted presents these images as being at times “pretty much........what what she [his client’s] experienced,” describing them as “almost like a type of prescience in a way.” Callithump suggests it is “something that’s communicated,” which “sparks something in you.” For Ted, it is “at some subliminal level.” Intriguingly, Ted, Callithump and Elizabeth suggest that this “prescience” (Ted), “sparks” (Callithump), “images”
which “resonate with what the client is communicating” (Elizabeth), and “have to be taken seriously” (Ted)—but do not always need to be discussed with the client. Ted comments, “it’s just something that I’ve got to hold, for the client.” According to Ted, this allows his clients to “know [he] believes them,” when they share their stories of horror. Elizabeth suggests that this process only occurs “in the context of a good connection.” Thus according to these therapists, intuitive creativity becomes essential for therapy, and an indicator of its efficacy.

Such experience may be construed by some as being the “stuff of therapy” (e.g Benner, 1982; 1984; Reik, 1983; Rogers, 1995). However, the point here is that this kind of knowing about and responding to the world, sits outside what is made available and legitimated to the therapist by the edicts of formalised psychology. Yet for clinicians such as Callithump and Ted, such knowing and responding to the world is presented as the “gut” of therapy. There is no hesitation as they speak about these things, their conceptualisations are well thought out, and clearly articulated. Moreover, within the collective biography, this sense, seems to be shared, as they nod and “mmm” their agreements, finish each others points, and input their own comparable stories into the interview space. However, as outlined in chapter four, it is such clinicians who experience themselves as operating outside the fold endorsed by formalised psychology. As stated in chapter seven, the dilemma faced by the edicts of formalised psychology, and the current framing of the scientist-practitioner model, is whether to position the “wisdom” and insights obtained by such clinicians, immersed as they are in practice, as inherently valuable, or to continue to view this as “quasi-scientific” (Long & Hollins, 1997, p. 77), and a “disappointment and an embarrassment to the discipline” (Nathan, 2000, p. 250).

9.8 Summary

In this section I have provided evidence that within the disciplinary context of working as a practitioner within the Boulder model frame, clinicians can respond to their perception of its inadequacy by privileging creativity within their practice approaches. Creativity may be understood as being a clinician’s capacity to work in a non-scripted manner, informed by what the therapy session throws up. Formalised psychological training may be presented by some practitioners as obfuscating a clinician’s capacity to work in this manner,
replacing the facilitation of creative practice with the ability to follow rigidly applied rules. This may be interpreted as stemming from a mainstream fascination with evidence-based practice approaches which are informed by the hypothetico-deductive paradigm (Stainton Rogers, 2003). Feelings may be used by therapists as an indicator of the importance of a moment in therapy, and this may be accentuated at times by the concurrent occurrence of metaphors or visual images pertaining to the client’s presentation. These insights may then be “fed-back” to the client, to determine the legitimacy of interpretation. Even if they are incorrect, these insights and interpretations provide “grist for the mill.” Such insights are viewed by some clinicians as being “co-created” by the client/clinician synergy. Open ended therapeutic tools viewed as facilitating this process include the use of metaphor, stories, images, and words. Some practitioners may speak of working with client populations whose experiencing is so extreme, limited data exists pertaining to effective treatment options. In such scenarios, clinicians are forced to think on their feet, and draw on tools, such as those mentioned previously. Such tools are separate to evidence-based practice approaches in their pure form. Indeed, it is conceivable that for client presentations at the extreme end, treatments in their pure form do not yet, and may never exist. These findings point towards the need to expand on how best practice in psychology, or even simply practice in psychology is understood and defined. Additionally, informed by this data, formalised psychology may be better situated to provide for the initial, and ongoing education, training and developmental needs of both its acolytes and its masters.

9.9 Discussion and Chapter Summary

In this chapter, I have provided evidence that psychologists may position diverse factors as contributing to their professional maturation, and even necessary to it. These factors may be in addition to, or completely separate from what is currently endorsed by formalised psychology. Of particular importance is what I term gestalt, which is insight that is co-created within the therapeutic space by the interaction between the client and the clinician. Additionally, therapists may present a capacity for creativity, as being necessary for the facilitation of wellness, with the use of it being indicative of clinician growth. Creativity is defined here as the clinician’s ability to work in a non-
scripted manner, informed by what the therapy session throws up, or as their ability to respond to novel (to them) presentations. Open ended therapeutic tools viewed as facilitating this process include metaphor, stories, images, words, feelings, and the hope or belief the client can, and will improve. It is these factors which some clinicians may present as influencing how their therapy works and hence, how they believe they improve as therapists. This is in direct contrast to adhering unequivocally to an epistemic approach which formalised psychology presents as best practice. I will now move into my concluding section, in which I will provide a summation of the contents of the chapters, and draw out implications for the practice of Australian psychology.
Chapter 10

Conclusion: Mapping the Songlines of Australian psychology: What is, and What Could be

10.1 The Current Songline

The scientist-practitioner, or Boulder model is the dominant philosophical, education, and training pedagogy for Australian, and more broadly, Western clinical psychology. Within Australia, this model is legislated for by the Health Practitioner National Law (2009) (APAC, 2014b), and adherence to its frame is enforced by what I have termed formalised psychology, which consists of key psychological bodies including APRA, PsyBA, APAC and the APS. For example, APAC’s (2014a) accreditation standard for programs of study in psychology requires that “all programs of study offered” draw on “an evidence-based approach...based on the Scientist-Practitioner model” (p. 8). It is these bodies who dictate the process of becoming and remaining a psychologist, and to a lesser extent, who in society can be one.

As presented in chapter one, within the scientist-practitioner dyad, knowledge generated by science is privileged over knowledge generated by practice. For example, within formalised psychology, the type of research presented as most likely to produce a solid evidence-base reflects, in part, guidelines provided by the National Health and Medical Research Council (1998). These guidelines specifically privilege evidence generated by “systematic review of all relevant randomised controlled trials” (p. 56), and to a slightly lesser extent “comparative studies” with “concurrent,” or “historical controls” (p. 56). The relevance of that knowledge is informed by the recency of publication, and the expectation that it be published in “high quality peer-reviewed scientific journals of international standing” (APAC, 2014a, p. 8). The APS presents the application of knowledge generated within this frame as “best practice for Australian psychological service delivery” (APS, 2010, p. 1). This means, that according to formalised psychology, best practice is equated to the application of published techniques and there exists no need to invest time and money into developing a comprehensive and endorsed practice-generated theory of practice for psychology.
Moreover, the development of a comprehensive theory of practice seems to be viewed by the profession of psychology as a backwards step. For example, O’Neil (1987) argues that the shift of Australian psychology towards becoming a profession, was supported primarily by younger psychologists (including himself) who “had little patience with philosophical analysis and speculation and strongly preferred conclusions drawn from experimental, psychometric or other observational studies” (p. 77). Cooke (2000) comments that this deliberate schism with philosophy facilitated psychology’s development as both a discipline and a profession. Within this discourse, it is assumed that there are no inherently valuable lessons to be learned from clinicians’ (or clients’) experiences, as generated within therapy sessions, nor that if collected, this information could be used to build a scaffolding, and later a suite of tools and insights which clinicians could draw on to inform, and enhance their work.

However, as I outlined in chapters one and two, despite this legislated positioning by formalised psychology, there has been no Australian research to date expressly exploring the impact of this discourse on registered and practicing psychological clinicians. The result is what I have termed the primary contradiction for those who practice the discipline, namely, how do they navigate conflict between the legislated expectation to (a) be a good professional as they have been taught (i.e. being a scientist applying research-based knowledge to their clients) and (b) being a good professional as they have learnt, or are learning through their experience. Within this convoluted space, the focus of my research was on what contemporary registered psychologists experience, and how their experiences interact with pragmatics and theory.

With mental illness projected to be the second highest contributor to the burden of disease by 2030 (Who, 2011) an understanding of this experience may be crucial to the facilitation of wellness within the Australian and more broadly, the Western population. Clinician enactment of psychology informs the space in which our mental health or un-health unfolds, and it impacts directly on the experience of mental unwellness, the availability and funding of treatment options, and ultimately on the pathway to wellness individually and collectively (Corcoran, 2009). Metaphorically, this experience articulates some of the Songlines or landscapes of the Australian psyche, and an ethical psychology needs to consider the flow-on of the Songlines it is singing into existence.
To examine this question, I drew on qualitative methodologies. More specifically, I conducted my research within the epistemological frame of social constructionism (Gergen, 1985; Willig, 2013). Additionally, I theorised about participants’ subjectivity using psychoanalytical theories of anxiety (Hollway & Jefferson, 2013; Klein, 1997; Laplanche & Pontalis, 1988), the defended subject (Hollway & Jefferson), and Kleinian notions of splitting (Klein, 1997). I interviewed seven clinicians using one-on-one interviews, and I conducted one collective biography consisting of three therapists (Davies & Gannon, 2006). Consideration was given throughout to the co-creation of data, reflexivity, the psycho-social space (Bradley, 2005), and the possibility of creating new theory using a process of induction. Eisenhardt and Graebner (2007) argue that the analysis of data thrown up by in-depth qualitative interviews can be used to generate new theory. Additionally, because such theory arises out of practice generated vignettes, it is “accurate, interesting and testable” (p. 26).

10.2 Formalised Psychology's Response to the Primary Contradiction:
Evidence-Based Practice

As I outlined in chapters one and two, a contradiction exists within the best practice discourse promulgated by formalised psychology. On the one hand best practice is equated to the use of scientifically tested approaches, while on the other hand, the discipline argues for the use of evidence-based practice in psychology. This positioning seems to be in response to the extensive research base which provides evidence for the importance of the therapeutic alliance and clinicians’ personal attributes to the outcomes of therapy (e.g. Baldwin, Wampold, & Imel, 2007; Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Okiishi, Lambert, Nielsen, & Ogles, 2003; Roos & Werbart, 2013). It is also possibly a response to the need of clinicians to give status and recognition to the learning that happens in the therapeutic space. This sentiment has been expressed by groups such as the AAPI (2012). Alternatively, this positioning may hearken back to psychology’s roots in philosophy, and an interest in questions of the soul, which are not answerable by scientific methods (Cooke, 2000; Yalom, 2002).

However, as I argued in chapter two, whilst rhetoric exists around the use of evidence-based practice in psychology, best practice within this scenario is still equated to the application of scientifically generated knowledge.
Embedded in this positioning is the assumption that what is captured by research, tests what it claims to test for, readily flips over into the space of the clinic, and is the ingredient that brings about healthy therapeutic change. It is also assumed that it is the therapist’s capacity to apply this research, as opposed to any influence of personal attributes, belief-sets, or experience, which is the key to therapeutic success.

Furthermore, Australian legislation, training and financial remuneration for the profession, favors those with a greater on-paper capacity to apply knowledge generated by, for example, randomised controlled trials. The PsyBA (2016f, para. 3) states that endorsement as a clinician is not “based on experience derived during the course of the professional career.” Instead, it is derived from the completion of, and presumably demonstrated awareness of, specific evidence-based published empirical trials. Thus, a practitioner with 20 plus years of experience, including publications and demonstrated success with clients, is placed in the position of professional “subservience” to a recent graduate of a clinical masters or doctorate program, and at the very least will be financially discriminated against under the Better Access Scheme, and may not even receive the referrals necessary for receiving work within this system (AAPI, 2012). A reasonable conclusion is that being or becoming experienced and doing best practice therapy, equates to the same thing. Consequently, the registered practitioner is provided with no formalised and legitimated pathway along which they may make the nuanced shift from novice through to expert, as the perception seems to be that there is no need. Moreover, they are provided with no endorsed avenues via which to shift their practice-generated understandings into the legitimated mainstream and thereby provide avenues through which to build on the practice-generated findings of others.

As I outlined in chapter two, formalised psychology’s approach is in contrast to professions such as nursing, and increasingly medicine, where being a practitioner requires gaining of experience, albeit in tandem with an awareness of theory, and an increasing capacity to “solve problems in unique circumstances” (Bradley, 2009, p. 1). Additionally, as I have illustrated throughout my thesis, the current stance taken by formalised psychology, which requires a blanket approach to client presentations, is in stark contrast to the individual value clinicians may say they bring to each therapeutic encounter. It is also in contrast to how they may say they practice, or how they understand
they need to practice (as opposed to how they are required to practice) in order to facilitate wellness outcomes for their clients. Thus, my thesis provides an initial, and I would argue, a more comprehensive insight into practice then does formalised psychology’s assumption that best practice equates to the application of pre-identified, published, research approaches.

10.3 An Alternate Songline: Aristotle’s View of Knowledge, and Schön’s Reflective Practitioner

As I argued in chapter two, the thinking that practice generated knowledge, i.e. experience, has a valuable contribution to make to practice, education, and ways of being in the world, may be traced back to the thinking of Aristotle. Aristotle argued for the existence of two types of knowledge episteme, and phronesis. Episteme, the type of knowledge currently favored, and legislated for by formalised psychology, is defined as “analytical, scientific knowledge” (Flyvbjerg, location 128 of 5218). Conversely, phronesis translates as practical wisdom or prudence, and introduces an ethical and situational element to knowledge generation.

Schön (1987) respectively terms episteme and phronesis “technical rationality” (p. 3), and “reflection-in-action” (p. 3). He effectively pits them against each other, providing the metaphor of the high-ground versus the low-and-swampy ground to differentiate between the two. High-ground knowledge equates to theory and best practice within an epistemological frame of “technical rationality” (p. 3), which “treats professional competence as the application of privileged knowledge to instrumental problems of practice” (Schön, 1987, p. xi). Conversely, the low and swampy ground equates to the reality of being in the room with the individual, faced with their “problems of...human concern” (p. 3). Schön argues that faced as they are with problems which are not “resolvable...by reference to the facts” (p. 36), practitioners operate in the low and swampy ground. Schön then asks the question, within a technical-rational ontology, what do practitioners do when the problems they face are not “resolvable...by reference to the facts” (p. 36). As an alternate, the theorist provides the model of the reflective practitioner, within which the practitioner is given tools, and permission, to generate informal theory, and respond to varied client presentations.
In support of Schön’s (1997) claims, and in contrast with how formalised psychology understands best practice, the results of my research suggest practitioners may use the client/clinician synergy (as opposed to published techniques), and their own subjectivity as the ultimate arbiter of what does or does not constitute effective therapy. They may use their feelings as a litmus or canary-in-the-mind test for what is going on for them within the therapeutic space, as the client’s experience unfolds before and with them. They may also present their feelings as being a signpost indicating their professional need to seek support in managing the client they are facing. These findings build on one of the themes of my thesis, which is that clinicians may draw on subjectivity as a matter of course to inform many components of their therapy.

For example, clinicians may draw on their own and their clients’ experiences and autobiography, their personal and/or philosophical belief sets, and their professional reflections. They may present their own wellness as being necessary to their ability to facilitate a comparable outcome for their clients. However, wellness, or the endpoint of therapy, may not be presented as an achievable entity in and of itself. Rather, it may be articulated as a process, which may involve the individual’s capacity to minimise or learn from their pain. This type of knowing about the world stands outside that which can be generated by an epistemic ontology. Clinicians may apply the nomenclature of “change” to the process of facilitating an evolution which forms the antithesis of “being stuck.” Permission, compassion, transparency, hope, and forgiveness are viewed by some clinicians as influencing therapeutic outcome, with clinical vigilance for minutiae, described by some as intuition, presented as being necessary to healing, particularly in cases involving extreme trauma. Underlying the facilitation of change is the client/clinician synergy and a belief in the client’s capacity to achieve this within a supported environment.

However, whilst some therapists may draw on these alternate knowledge-bases and resources, and seek to justify their approach using triangulation (a three-tiered justification process, through which clinicians determine the efficacy or not of their practice approach), they may concurrently express a sense that this is other to how they should be practicing. I defined othered psychology as being clinicians’ experience of the requirement by formalised psychology to practice in a particular, and for them undesirable way—understood primarily as CBT. This expectation may be presented by some
clinicians as a shift towards the creation of an Australian psychology which is focussed on quick treatment. Within this space, the litmus test of good practice becomes how well an approach fits into the time allotment stipulated by the Better Access Scheme.

Clinicians may respond to these inherent difficulties by presenting how they understand they are meant to practice as obfuscating their capacity to do what they understand to be their job, namely to respond to unique and varied client presentations. In such cases, clinicians may draw on intuition and vigilance for clinical minutiae, as they articulate noticing that something is not quite right with their clients. They may position their capacity to do this, as differentiating between best practice and potentially “dreadful” consequences, as their intuition is actively used to inform and guide their work with clients. This capacity for informed intuition, is presented as being particularly valuable for those therapists working with clients whose experience, being so extreme, has not yet been (and may never be) captured in a randomised controlled trial.

Faced with such circumstances, I have provided evidence that some clinicians do not turn to the edicts of formalised psychology for guidance. Instead, they may be interpreted as turning to the unique skills and experience which they bring to the therapy session. In such cases, they may concurrently use symptomology to highlight a need for change and what treatment avenues to explore.

Even those clinicians whose practice approaches present as being most aligned with the dictates of formalised psychology, may be interpreted as struggling to draw solely on the discipline’s endorsed modes of practice. I have provided evidence that they may look elsewhere for inspiration as they seek to explore the “gut” of what is going on for their client. They may also attend to the clinical minutiae of their client’s presentation, which other clinicians would miss, with catastrophic consequences.

10.4 Working in a Catch-22: Best Practice as Application in an Insufficient Scientific Knowledge Base

By positioning application as best practice, clinicians who may be faced with clients whose presentations that may not be (and may never be), captured in a peer-reviewed journal, are left without any endorsed or legitimated plan of attack, save to make it up, drawing on the knowledge they have gleaned from
their experience of client diversity. However, as I have demonstrated in chapter four, clinicians who revert to this line-of-attack experience themselves as practicing in a manner contrary to how they are meant to, and which exposes them to the ire and professional sanction of their peers. Yet clinicians are effectively placed in a catch-22. Whilst they are required to apply the findings of knowledge to their practice, that same knowledge base provides insufficient absolute knowledge on which they may legitimately draw. Even clinicians who present as adhering most religiously to this frame, may experience this conundrum (albeit subconsciously).

However, if a discipline defines best practice as equating to the application of published research predominantly drawn from randomised controlled trials, then one would assume that the discipline ethically needs to provide an appropriately diverse range of applications from which clinicians may legitimately draw. My research illustrates that clinicians may not experience this to be the case. Moreover, the questions raised by my thesis, are those which all clinicians face as they grapple with the how to of practice. In providing evidence to demonstrate how these problems may manifest and be resolved (or not) by some therapists, I am providing the broader discipline with informed insight into how best or how better, to both train and manage practitioners throughout their career.

One ethical Songline flow-on for formalised psychology is that if it wishes to retain its current definition of best practice, it may need to considerably narrow down the scope of what the discipline can legitimately and ethically treat. However, as psychology is still on the rise as a profession, to do this, may result in the discipline being subsumed by a more agile profession. For example, the current rise of the peer worker in the mental health industry may see organisations favor these cheaper, more agile workers in preference to psychological clinicians (Professional Practice Academy, PPA, 2016; Slade & Longden, 2015). The individual in this role, is employed expressly because of their personal experience and demonstrated capacity to shift that experience into a tool, which can facilitate wellness and recovery outcomes for another person. Moreover, the position has evolved, in part, as a direct response to the perceived inflexibility of the evidence-based paradigm perpetuated, in part, by psychology, and the negative consequences of that positioning on the client (Slade & Longden).
10.5 Problems with Continuing Unchecked Along the Current Path

Whilst formalised psychology advocates for the use of knowledge generated by its definition of what constitutes an evidence base, findings from my data show that clinicians claiming to adhere to this requirement, in actuality, may, if they adhere to it at all, only adhere to the main tenets. Instead of using pure approaches, as published in peer-reviewed journals, clinicians may use this knowledge as inspiration to inform their practice. I termed this phenomenon morphing, which I described as being the subtle evolution of the pure forms of evidence-based practice approaches such that they are no longer quite the evidence-based practice tested using randomised controlled trials, promulgated in peer-reviewed journals, and presented as best practice by formalised psychology.

With reference to Kleinian notions of splitting, the process of morphing may facilitate clinicians’ capacity to coexist alongside ideas or techniques, which may be in contrast with their preference such that they no longer cause internal tension or “unpleasurable affect” (Laplanche & Pontalis, 1988, location 3507 of 13238). For example, as I demonstrated in chapter four, clinicians may reject the other, in the guise of formalised psychology, and denigrate it. However, the space of anxiety can also be shifted into a catalyst for growth, both professionally and theoretically, in the form of, in this instance, morphing.

Even if formalised psychology chooses to remain on the current path of favoring practitioners’ application of treatments published in peer-reviewed journals, as opposed to providing a more comprehensive theory of practice, we come up against a serious problem. Due to the increase in knowledge creation, it is expected that the unadulterated practitioner will be unknowledgeable within 5.6 years, unless they continue to train extensively (Neimeyer, Taylor, Rozensky, & Cox, 2014). These authors apply the construct of a “half-life of knowledge.” This is defined “as a metric for measuring the rate of change that accompanies the profusion of new knowledge” (p. 92), to the rate of knowledge generation within psychology. For Neimeyer et al., the “half-life of knowledge” is the “time it takes a practicing professional, in the absence of any new learning, to become roughly half as knowledgeable or competent to practice in his or her field” (p. 92). Using this construct, within the current frame of practice defined as application, “newly minted doctoral graduates might be expected to experience significant, perhaps disconcerting, levels of knowledge..."
obsolescence within a matter of only 6 or 7 years after their graduation” (p. 93). Thus, it will become nigh on impossible for any one practitioner to hold in their head, all the knowledge necessary to be a successful practitioner within the frame provided by formalised psychology.

What is interesting in this critique, is that Neimeyer et al., (2014) present different streams of psychology as having different half-lives. For example, they may vary “from as much as 17.75 years (in the area of Psychoanalysis), to as little as 7.33 years (in the specialty of Clinical Health Psychology)” (p. 95). This variance is “presumably because of the differential levels of research and new knowledge generated in the respective fields” (p. 95). The authors do not consider the possibility that the difference is due to psychoanalysis being more likely to privilege practice generated knowledge through reflection-in-action (Schön, 1987), such that its knowledge is more likely to be produceable by the clinician with each unique presentation. In contrast, clinical health psychology privileges technical-rational knowledge, which requires being abreast of the most current evidence-based practice.

The irony in all of this, is that psychology is moving to a stage where the knowledge taught to practitioners at the beginning of their initial training, will be defunct before they even have the chance to complete their degree. At the very least, there is a need to question the sustainability of the current scientist-practitioner model, which privileges scientifically-generated knowledge within psychology. Furthermore, it may be pertinent for psychology to reflect on whether knowledge generation is the way to go or whether the formulation of a theory of practice beyond application may serve to provide therapists with a frame within which to apply, test, create, synthesize, and evaluate their interactions with clients, “live” during therapy sessions.

10.6 Training Provided by Formalised Psychology may be Experienced as Providing Insufficient Language for Clinicians to Conceptualise and Work with the “Gut” of Therapy. One Set of Responses is to Use Metaphoric Diversity, as Opposed to Scientific Knowledge, as a Means of Opening up Therapeutic Avenues in which to Work with the Client.

Some therapists who seek to work within the edicts of formalised psychology’s notion of best practice may be confronted with an additional problem, namely, that there is a relative lack of language flowing out of this
discourse, which clinicians can use to deal with, for example, the existential concerns their clients may be facing. This experienced lack may leave therapists grasping for verbal tools with which to circle, explore, and clearly work with the “gut” of what is going on for them and their clients within the therapeutic space.

Within the evidence-based practice paradigm, formalised psychology does not clearly delineate precisely what the practice of psychology is seeking to move its clients towards. Yet in chapter seven, I provided evidence that some practitioners seek to articulate answers to exactly those existential questions as a matter of course. For example, they may use the language of “change,” “hope,” “permission,” “compassion,” and “transparency” to describe both the process of becoming well and the tools necessary to facilitate this outcome. They may explicate change as being that process which helps their clients become unstuck. The key to this process is articulated by some clinicians as the therapeutic relationship, which is explicated as being a microcosm of real-world interactions, and a tool for diagnosis, teaching and exploration. Practitioner history may be presented as informing that process.

10.7 Ideas for Training

Considering these findings, the infrastructure of formalised psychology, including academic institutions may benefit from shifting their selection process for prospective psychological practitioners, from an academic focus to one which seeks out diversity of experience, capacity to articulate and reflect on that experience, and ability to develop rapport.

To illustrate this finding further, I have used the microcosm provided by how clinicians may speak about the aetiology of mental illness or psychopathology. I have used the term metaphor to describe the diversity of theories which therapists say they may apply to their varied client presentations. Clinicians may be understood as throwing each metaphor into the therapy, and testing for its usefulness using the client/clinician synergy. If one metaphor does not work, they may then seek to create another metaphor in collaboration with their client, or draw it out of their bag. In this way, practitioners may be viewed as responding to the inherent difficulties of practice, by testing for the veracity of each Songline or metaphor they are injecting into the therapy, or which arises out of it. If the flow-on of the Songline seems to facilitate wellness
and recovery, or at the very least, a desirable outcome for their client as tested over time by triangulation, the Songline is reinforced and expanded on. If not, another song or metaphor by needs is searched for. I have termed the process behind this pivoting, phronesis thinking.

This way of working, can be likened to a lean start up (Ries, 2011). Within this discourse, Ries argues that when we do not know what an end product will look like, or needs to be, or even how to get there, we need to avoid “making complex plans that are based on a lot of assumptions” (location 297 of 4069). Instead, working in such a space requires idea agility and a capacity to “make constant adjustments” based on a “feedback loop” (location 297 of 4069). Integral to the idea of a lean start up, is a vision, which can be likened to the therapist’s and client’s shared belief sets around what it is that will facilitate wellness and an associated recovery journey for them. “Every setback” then becomes “an opportunity for learning how to get” to that point, or closer to that point (location 307 of 4069). Within this way of thinking, the end result, or vision is what pulls the therapist along. Getting there requires a constant dance.

The nomenclature and associated metaphor employed by a discipline articulates how its professionals conceptualise within that space and consequently act, facilitating some paradigmatic avenues, whilst discouraging others. Across a number of disciplines, diversity within this space is highlighted as being the conceptual crux to human creativity (Feldman, 2008; Gruber & Bodeker, 2005; Leary, 1990; McFague, 1982; Pepper, 1942; Warren, 1971). Lakoff and Johnson (1980), and Leary (1990), argue that all scientific understanding is esoteric in nature, a positioning they label “metaphoric”. Lacking definitive explanations of the aetiology of mental illness, as evidenced by contradictory aetiological research (e.g. Kagan, 2012; Kendler, 2005; Wilkinson & Pickett, 2010), clinicians by needs draw on diversity of language and metaphor in an attempt to bring insight to that “which can never be dealt with directly” (McFague, 1982, location 451 of 3354) and articulate “the great unknowns” (location 292 of 3354).

The irony here is that historically, psychology has had access to an extraordinarily diverse nomenclature and metaphor base from which to explore and unpack the “gut” of therapy (e.g. Corcoran, 2009; Leader, 2011; McNally, 2011; Yalom, 1980, 2002). However, in a manner reflective of the stoush between psychology and psychiatry, formalised psychology has effectively
required its clinicians to split off the exploration of the ontology of Being, questions of the soul, and the aim of seeking to define what it is to be human, from best practice. Yet, philosophical psychology may facilitate language around ontological and existential questions regarding the nature of Being, purpose, and the study of the soul (Corcoran, 2009; Yalom, 2002). Scientific psychology, or epistemic knowledge, may facilitate language around discrete tool-sets, applicable within the therapeutic setting. Alternatively, scientific psychology may provide early career practitioners with concrete approaches to employ within therapy until, over time, they enjoy the experience of a “flowing in” or “mish-mash” of varying therapies, which they have triangulated and morphed to inform “who they are as a psychologist,” and what their therapeutic approach is now. Moreover, considering the previous discussion regarding the value of metaphor, and the way in which different positionings facilitate different epistemological and ontological pathways, the resulting confound may be viewed as a gift in that the inherent clash may facilitate metaphor creation and allow exploration of alternate Songlines along which paradigmatic change, or innovative technologies may arise (Gergen, 1990; Lakoff & Johnson, 1980; Pepper, 1942).

Some recommendations can be extrapolated from these findings. If nomenclature diversity is integral to the practice and extension of psychology, then practitioner training may be enhanced by reflecting this. For example, university curriculum could include cross disciplinary lectures highlighting key disciplinary metaphors. These varied metaphors could then be applied to hypothetical clinical situations, or teased out to explicate potential application to psychological theory and practice. Additionally, future research could build on existing research (e.g. Sinai, 1997) and more explicitly explore practitioners use of language diversity in the clinical setting. Through the embrace of nomenclature diversity, used as a creative mechanism for expanding available theory and practice, we may potentially provide clinicians with a plethora of avenues by which to explicate the experience of psychopathology with clients. From that paradigm, within the therapeutic space psychology may be empowered to more effectively co-create wellness.
10.8 Clinicians may Access Supervision from Sources Homogenous with their Professional Leanings

An additional finding of my thesis is that some clinicians appear to access supervision from sources homogenous with their professional leanings, thereby reinforcing their current belief sets/theoretical-practical frames. The result may be a hidden curriculum of regulated supervision, which maintains a status quo-of conformity or resistance. However, giving consideration to the developing findings of this thesis, professional growth and clinician creativity may be facilitated by requiring clinicians to have regular supervision with practitioners who work within an ontological/theoretical frame at odds with their own. This may force clinicians to reflect in different ways about issues they face within the therapeutic space.

Additional source of therapist support articulated as valuable by interviewed clinicians, or inferred by me, included the use of humor in thinking about challenging clients or client presentations, and conversations with lay-people. The supervisory regulations placed on practitioners, may be improved by including training around use of humor to diffuse negative client/clinician interactions, and to minimise practitioner stress. However, care would need to be taken in any pilot program, because some types of conflict were presented by practitioners as facilitating their client’s movement towards wellness, when handled in a particular manner. It may also be useful for research/pilot groups to be conducted to explore the benefit (or lack thereof) of facilitating supervision from sources that are not directly related to psychological practice. Such a pilot group could include other health professionals, and in keeping with the findings within this thesis, it could also explore the role access to diverse metaphor may play in facilitating wellness for clients.

10.9 Conclusion

In my thesis, I asked the question, how do psychological practitioners navigate conflict between the legislated expectation to (a) be a good professional as they have been taught (i.e. being a scientist applying research-based knowledge to their clients) and (b) being a good professional as they have learnt through their experience, in relationship with their clients and peers, and through their reflection on the same. I have provided evidence illustrating the need to broaden what constitutes a legitimate knowledge-base within
psychology. By narrowing practice approaches to the application of knowledge generated by science, formalised psychology may in fact be failing to capture what it is that allows one individual to facilitate wellness and recovery outcomes for another individual. Viewed from this angle, current recruitment practices drawing and retaining students into psychological programs of study, are effectively turned on their head. Instead of entrance into the profession being determined by academic acumen, and the capacity to maintain a distinction average in statistical subjects, of greatest value is the individual’s propensity for phronesis thinking, belief sets around what it is they are seeking to move their clients towards, and the ability to self reflect and build relationships.

Even more than this, I have illustrated the existence of a comprehensive, sophisticated, evolving understanding of practice developed by psychological clinicians through their practice. The evidence demonstrates how therapists can draw on this enmeshed, metaphoric, phronesis thinking, and subjective approach to practice can be drawn on more comprehensively than they can draw on the currently endorsed avenues. The dilemma faced by proponents of the edicts of formalised psychology, and the current framing of the scientist-practitioner model, is whether to position the wisdom and insights obtained by clinicians immersed in practice as inherently valuable, or to continue to view this as “quasi-scientific” (Long & Hollins, 1997, p. 77), and a “disappointment and an embarrassment to the discipline” (Nathan, 2000, p. 250).

Moreover, in contrast to formalised psychology’s privileging of knowledge generated by science, in this thesis I have provided evidence that it may in fact be in the space of practice that new knowledge is created, or at the very least, evolved. This way of thinking effectively flips the status quo of psychology on its head, with practice and not science becoming the gold standard against which best practice is measured.

10.10 Additional Implications for the Industry: Recruitment, Education, Supervision and Professional Development

Within Australia, evidence-based responses to the diagnosis and treatment of mental illness have risen in popularity such that the current push within academic institutions responsible for the training of prospective psychological clinicians favors related approaches, primarily CBT (e.g. RMIT, 2016; Sydney University, 2016). Acceptance into these courses is highly
competitive and predominantly based on demonstrated academic capacity. For example, preference is awarded to students with First Class Honours and/or scholarly publications (e.g. Macquarie University, 2016). In contrast, the findings of my research illustrate that clinical practitioners may look to sources other than scientific knowledge, for insight into how to treat their clients. As first point of call, some clinicians present their interpreted personal histories as being the crux to their practice, taking the view that if it works for them, it may work for their clients. At the very least, the navigation of childhood experiences may be viewed as channeling clinicians into the lines of work they now inhabit and enhancing their capacity to understand and respond to clients with related presentations. In context, this suggestion raises questions pertaining to the process of becoming a therapist/practitioner and whether the discipline of psychology may benefit from seeking to attract prospective practitioners from diverse backgrounds to commence psychological studies. By encouraging diversity here, a flow-on of efficacious treatments and therapeutic relationships targeting specific client populations may be ensured.

Yet formalised psychology does not seem to value diversity of attributes in any overt manner, as evidenced in the recruitment process for clinical masters programs restated briefly previously. Would be psychologists are not: asked about the depth and breadth of their life experience as informant of their suitability for the profession; tested for their capacity to work creatively; grilled regarding their ability to invoke metaphor, use diverse language, and listen to and interpret stories; or questioned about personal attributes such as applied compassion or transparency. Rather, first point of call is academic prowess, evidence of publication, and preferably a First, rather than a Second Class Honours (e.g. Macquarie University, 2016). A capacity to pay the necessary course fees of approximately $40,000 is also required. Yet the practitioners presented here may be construed as suggesting that it is exactly because of their life experience, or capacity to think in particular ways, that they are able to work with the people who come into their rooms “in pain,” and facilitate for these people some level of ease, and a movement towards wholeness. It is interesting to consider here the critiques of Alexander (2011), who raises concerns regarding the current recruitment process and the resultant resume/socio-economic status of contemporary entry-level practitioners. Alexander posits that such a process invites entry level practitioners from privileged
backgrounds, who are likely to return to that place of privilege to practice. This is in contradiction to, for example, the findings of the Australian Mental Health and Wellness Survey (Australian Bureau of Statistics, 2007) and the work of Wilkinson and Pickett (2010) which lends support to the argument that the experience of mental illness includes a socioeconomic component.

Considering of the findings of this research, the curriculum for trainee practitioners may be enhanced by including subjects devoted to the development of open-ended therapeutic tools, such as those outlined above. Furthermore, the PsyBA, through mandated professional development, could also insist on practitioner extension in these areas. Alternatively, recruitment protocols could move away from what is currently favored, and instead explore targeting individuals whose personal/biographical history lends itself to working with prioritised client groups/presentations as predicted, by for example the WHO and the Australian Bureau of Statistics (2007). It would be interesting to trial a psychological training program commensurate with that provided by the University of Newcastle, for medical doctors. However, additional research is required to explore these possibilities.

10.11 Limitations

There are always limitations to every piece of research. However, its limitations may also form its strengths. As argued previously, my experience of being a student of psychology may have influenced some of the data produced. However, as evidenced by the length of the interviews and the openness of the clinicians responses, my identity as a student of psychology appeared to facilitate participants speaking openly about their experiences. Riessman (1991) and Silverman (2000) suggest this is often the case. It is unlikely, for example, that a plumber (however competent) would have elicited similar results. However, without additional and varied research, and the application of differing methodologies and world views to the question of how psychologists experience working within the Songlines created by the Boulder model frame, we cannot know.

Regardless I would argue for the validity of this research as it stands. The interviews had a flow to them which was suggestive of an honest reflection on the behalf of the clinicians (Mauthner, 2002). Moreover, Seidman (2006) suggests that good interview technique, and listening skills are discernible in
part by the length of the interviewee’s, as opposed to the interviewer’s, responses. Evidence of this exists within my transcripts, as the therapist’s voices amount to pages and pages of uninterrupted sharing of their stories. This also provides evidence for the integrity of the stories as opposed to something orchestrated and manipulated by the researcher. Additionally, evidence of a careful analysis of the transcripts, with consideration of the co-created intersubjective space is visible throughout this thesis. However, irrespective of this defense against potential criticisms, it seems the resulting story of psychologists’ experience of working within the scientist-practitioner model is of sufficient concern to be taken seriously by an ethical psychology.

Whilst some may argue that the number of participants in this research poses a limitation, I would argue this is not the case. Instead this is one of the many strengths of qualitative research, and inimitable in quantitative studies. In working with a small sample, the researcher is able to delve deeply into what an experience is. Moreover, in asking open ended questions, the researcher is less likely to impose their interpretations, and understandings of that experience onto their participants in the first instance. Instead, assumed within qualitative research, is that individuals’ use of words, interpreted within context, provides us with insight into what they are experiencing, and how they are positioning themselves within that experience. Hollway and Jefferson (2013) state

> It is this blindness to the issue of what research subject is being assumed which comprises not only efforts to develop a more ‘sensitive qualitative understanding’ of the (topic of research), but all the other attempts by qualitative researchers rectify the problems of quantitative, survey-based approaches. (location 452 of 4956)

Additionally, in allowing uninterrupted reflection and sharing around experience, the researcher is better able to provide evidence to support their interpretations (and resulting conclusions) around what a participant is meaning with their choice of words. Hollway and Jefferson (2013) state this is one of the reasons they developed their methodology in the first instance. Furthermore, qualitative research provides a rigorous platform such that experiences which may not yet have been clearly articulated, or may not yet even have sufficient language to be spoken about, are able to be voiced, explored, and understood.
An example of this is provided on page 97, as Michelle seeks to articulate what for her is the “gut” of therapy. Thus, as stipulated throughout this thesis, what is important is that the problems I am interested in, that is, the questions raised by my thesis, are ones all clinicians may have to manage. In articulating how these questions can be managed, I have gone some way towards addressing what needs to be considered in the recruitment, education, supervision, and professional development of our clinicians.

The findings of my thesis illustrate the experience of some Australian psychologists. For some of them there is a level of angst, resistance, and othering in their response. For still others, there is evidence of the existence of an incredible practice-generated wisdom. Yet Australian clinicians remain caught in the space of waiting for formalised psychology to provide legitimate and meaningful avenues along which their developing wisdom can be used to grow, change, and influence the profession of psychology. The challenge to formalised psychology is whether it will seek to understand and respond to this experience, thereby increasing the capacity of psychologists to facilitate wellness; individually, relationally, and collectively for the Australian and broader population (Corcoran, 2009), or whether it will continue with the status quo.
References


Running head: MAPPING SONGLINES

publications.aspx


Australian Psychological Society. (2011a). CBT fundamentals: Processes and techniques in cognitive behaviour therapy: Module 1: Introduction to the


behaviour-therapy/


Slater, J. (2007). *The cargo is fine but the container is cracking up a bit: An examination of the experience of pregnancy*. Unpublished doctoral dissertation, Department of Psychology, Charles Sturt University, Bathurst, Australia.


Stopford, A. (2004). Researching postcolonial subjectivities: The application of


Appendices
Appendix A
Ethics Forms
Appendix B:
Collective Biography Information Sheet

Process (takes approximately 2 hours)
1. Sit in circle.
2. Explain process-exploring discourse through collective biographies (ours)...and the highlighting that we are not individuals...but socially created beings...and our biography is created c/o social experience....radical relationality (Bradley, 2005)...our biography is individual, but created through the social process ...and the idea of social constructionism....psycho-social beings.
3. Identify topic i.e. What is your experience of being a psychologist in Australia?
4. Share an experience/event that gives meaning to this theme based on your own life.
5. Time to think about your experience....write down if you prefer...needs to be an experience/event that gives meaning to this theme based on your life.
   a. Doesn’t need to be linear
   b. Smells
   c. Textures
   d. Tastes
   e. Feelings
   f. Impressions....
6. Go around the circle and share your experiences
   a. Clarification questions can be asked...but mostly just let people tell their stores uninterrupted
   b. People can choose to not share an experience
   c. Opportunity for people to share another experience if they would like whose memory has been sparked by hearing others’ stories
7. As a group, identify themes, commonalities, points of difference...what insight do the collection of stories provide into discourses around that topic...and the idea that we are not individuals but created social beings?
   a. Consider what kinds of social structures have produced those experiences in the first instance.
b. What is generating our subjective experience? e.g. Language? Practice?

Concluding comments.