Psychologists' experiences of decision-making in clinical work: A thematic analysis

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Abstract

Within the clinical decision-making literature, one under-researched area is related to psychologists' decision-making from the perspective of their experience. Given the varied backgrounds of clinical and counselling psychologists, insight is needed into their decision-making experiences to provide a comprehensive overview of clinical practices. This type of approach could offer a bridge between the didactic decision-making literature and real world clinical psychotherapeutic work. This qualitative study aimed to explore psychologists' experiences of clinical decision-making from a critical realist perspective. Eight clinical and counselling psychologists were interviewed, using a gradual reveal case vignette exercise and a semi-structured interview schedule. Data were analysed using Thematic Analysis and the pertinent aspects of participants' experiences of decision-making were captured in five themes. Each of these themes contains participants' reflections on the various foci of the therapeutic work that become the point of reference for decision-making at different stages. Additionally, participants discussed the impact of professional experience, reflexivity, and the context of decision-making. Some of the key findings in relation to the decision-making experiences of psychologists show that decision-making is overall a complex and potentially anxiety-provoking aspect of clinical practice. This complexity is a result of uncertainty in the work, which was noted as being tiring. Available literature has thus far neglected these key experiential dynamics within decision-making, creating the potential for a vast gap between theory and practice. Participants have stated that the challenges in ongoing decision-making are balanced by their collaboration with colleagues and attention to self-care. A number of theoretical and clinical implications for research and clinical practice arise as part of the findings of this study. These recommendations are offered with consideration of the cognitive implications of anxiety in clinical decision-making and contextual influences on the varied roles of psychologists.

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Definitions

As explained in the body of this thesis, the focus of this research is on clinical and counselling psychologists. For ease of reading, after the introduction of the subject, these practitioners are referred to as "psychologists".

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Psychologists' experiences of decision-making in clinical work: A thematic analysis

1. Chapter One: Introduction

1.1. Introduction to Subject

1.1.1. The psychologist identity and relevance of decision-making.

The philosophy of counselling psychology in the UK follows a holistic approach similar to that of most applied psychologies in the UK and US, which involves equal proficiency in research and clinical competencies. The doctorate path in counselling psychology in the UK allows for an opportunity to become a member of the Health Care Professions Council (HCPC), which offers the structure of protected titles under one of the seven "domains" of applied psychologies. Two of these are counselling and clinical psychology, which broadly have similar frameworks of training, practical guidance, and areas of clinical work, in contrast to the other five domains.

HCPC offers a guide to Standards of Proficiency for Practitioner Psychologists (2015) that details the 15 areas of proficiency required for all practitioners in applied psychologies to follow. Within this document, there is significant overlap between those items specified for clinical and counselling psychologists, particularly on the items that advocate the importance of the scientist-practitioner model. The scientist-practitioner model in this respect comprises the ability to be involved in, evaluate, and apply evidence-informed therapeutic approaches to the many roles a psychologist takes on, coalescing each of these aspects of practice into their holistic professional identity. The current literary trends in the application of psychology acknowledge that there is a need to expand the identity of the scientist-practitioner from a simple 50-50 approach (Blair, 2010; Nezu & Nezu, 1995; Shapiro, 2002), to that which takes into account the integrated humanistic components of the person-to-person contact that therapy offers (Blair, 2010). Shapiro (2002) addressed this in the lecture he delivered in his father M. B. Shapiro's honour at the Centenary Conference in Glasgow, outlining the emergence of the scientist-practitioner identity for psychologists in the 1950s and the evolution of this over time. He established his father's 1985 revised position on this, describing that he had identified a need for the scientist-practitioner to evolve and move towards bringing research into clinical work and vice versa. The possibility of clinical work informing research is part of a live debate that also touches on the importance of practice-based evidence that needs to be considered alongside evidence-based practice (Henton, 2012). For the effective application of theory, the added component to this comprehensive approach is reflective practice, which involves the understanding and

use of the self therapeutically in clinical work (HCPC, 2015). There is a necessity for the practitioner to be thoughtful and critical of their own work, to understand the gaps in practice that may give rise to further research, which in turn helps inform the more ethical and effective practice of psychology and the advancement of the field. In other words, the use of self in the room to review and explore the progress and the mistakes becomes another one of the central skills of a psychologist. This is also a philosophical position that allows the real-world therapeutic involvement of the practitioner, while making space for the client as an individual and applying the use of self as a meaningful theoretical component of therapy. Therefore, striking the balance of being a *reflective* scientist-practitioner (Lane & Corrie, 2006) becomes central to satisfying the HCPC Standards of Proficiency for Practitioner Psychologists (2015) and British Psychological Society's (BPS) Standards for Accreditation in Counselling Psychology (2017a).

Blair (2010) outlines the above, as an aspect of integrating the scientist-practitioner identity within the counselling psychology framework. This integration happens through the testing of hypotheses and application of relevant theories in the work, which is part of the empirical stance of the scientist-practitioner position. In addition, he suggests that this position is incomplete, unless done with consideration of each client's individuality, without forcing a fit between their needs and theory. In particular, from early on in training, psychologists are encouraged to understand their clients' needs in relation to the reported dynamics in their lives, to find a good fit between the presented problem and theory (Fonagy, 2010). Given the uniqueness of each client, a reasonable assumption is that there is no particular protocol or stock treatment that will serve every client in the same way. In line with this, over the course of the past century, continuous research and development in therapeutic approaches have given rise to specific protocols that address varying mental health needs (Runyan, 1977). With the advancement of the psychology field, this has meant that there are hundreds of different therapies that capture as many approaches to countless different presentations. This development is reflected in the example of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the continuous expansion of categories within each new version (Boysen, 2011). It is understood that no practitioner could possibly have working knowledge of all the therapies and this has led to a pursuit of transdiagnostic approaches that help streamline therapeutic support (Bugatti & Boswell, 2016). The pull towards unified approaches that aim to address any clinical

presentation and unite different applications of therapeutic practice represents the diversity and wealth within practical psychologies. Similarly, clinical and counselling psychologists, based on their training background as well as their positions within the current mental health scene in the UK, take on roles that involve varied components of the application of psychological practice. That is, the psychologist role within the UK mental health provision often involves research, clinical, and leadership positions that require a variation in approaches. Thus, the role of a contemporary psychologist inherently involves working within several aspects of the psychologist identity simultaneously.

Theoretically, the relevance of the different roles and identities of psychologists have been acknowledged in the HCPC Standards of Proficiency (2015) through items that address making effective clinical decisions. These standards, which encompass components beyond only research or training, are also supported by the BPS Practice Guidelines (2017) that outline four ethical values and five core skills that frame clinical practice and decisions in the work. The Practice Guidelines (BPS, 2017b, p.10) establish that through extensive training on "the relationship of theory to practice" psychologists regularly draw on multiple sources of knowledge and experience that culminates in clinical decision-making. Further to this, the guidelines state that "the ability to access, review, critically evaluate, analyse and synthesise data from a psychological perspective" is the decision-making process that separates psychologists from other therapeutic practitioners (BPS, 2017b, p.10). In this respect, the role of a psychologist involves continuous series of decisions aiming to resolve repeated dilemmas (Scaturo & McPeak, 1998). This sophisticated and ever-changing decision-making is no doubt a complex process that comprises the intricacies of evidence-based knowledge, experience, and the individuations of the client and the practitioner. The Practice Guidelines document (BPS, 2017b) addresses this specifically as part of their advocacy for reflective practice, stating that practitioners must engage in continuous evaluation of their work. This evaluation involves being aware of the several competing considerations and biases that transcend knowledge, training, or experience. Understanding and working with these components of psychological practice requires constant and ongoing decision-making skills that incorporate several competing aspects of the therapeutic work, including self-awareness. Thus, decision-making in clinical work is a complex phenomenon which requires breaking down the understanding of the components, outcomes, and perhaps most importantly the process.

1.1.2. The psychologist's experience of decision-making. As established by Shapiro (2002), the requisite of the scientist-practitioner identity informing all aspects of clinical practice necessitates a better understanding of the decision-making process of practitioners. While clinical decision-making has been researched extensively, the specific research questions have mainly entertained areas of ethics, risk management, assessments, and efficacy. These areas of the scientist-practitioner approach to psychology helps inform evidence-based practice, in a way that seeks to measure and evaluate decision-making. The measurement of success in clinical decision-making is necessary but limited in scope, as it focuses on average efficacy. This, as highlighted by Shapiro (2002), misses the iterative scientist-practitioner process that allows the application of a messier reality that is therapy. Arguably, the component more relevant to the real application of clinical work is in understanding the use and experience of decision-making through links to actual clinical work. As Blair (2010) outlines in his recommendations for future research, the psychologist is an individual who brings their self to the therapeutic relationship, impacting and influencing the process of therapy. He suggests that therefore, establishing a balance between the humanistic value base of counselling psychology and the scientist-practitioner identity happens through the psychologist's exploration of their own process as a part of the decision-making task.

For a thorough understanding of the individual process of decision-making, one must first understand current psychological research that is grounded in decision-making theories. Following an understanding of the field of decision-making in clinical practice, it is then possible to explore the process and the experience of ongoing clinical decision-making.

1.2. Introduction to the Literature Review

Given the vast literature on decision-making and varying works that look at different aspects of the task, the literature used as the backdrop to the central research question in this study has been chosen for consistency and focus. Thus, the theoretical framework that grounds this research in relation to decision-making is centred around existing literature that has previously evaluated the process of decision-making in clinical work.

Having a comprehensive overview of clinical decision-making literature relevant to psychologists offers an understanding of the gaps in the collective knowledge of the field. Simply searching for literature that encompasses "decision-making" and "therapy" yields overwhelming amounts of written works from varying disciplines, with specific journals and books dedicated to decision-making alone. These works include those looking at physiological therapies and treatments, which demonstrate that the concern around decision-making in relation to the overall physical and mental health of the individual has been empirically evaluated at great length. When the search is narrowed to "decision-making" and "psychology", there are more than 51,000 articles available from all domains of psychology, including those that are focused on health, education, marketing and consumption, fertility, artificial intelligence, forensic geropsychology, and so on. While there is much to be learnt from each of these micro approaches to the human psyche, most relate to fields within psychology that may miss some of the nuances of the specific applied therapeutic roles of clinical and counselling psychologists.

When the term "psychotherapy" is included into the search to narrow the focus on applied psychologies, there remains a relatively smaller number of results around 1,000 publications. These publications predominantly attend to the specific issue of ethical decision-making, but none look into the experiences of psychologists. The lack of literature on the experiences of psychologists further highlights the need for exploration of decision-making from the perspective of the decision-maker in clinical work. Thus, based on the gap in literature there is an apparent need for the evaluation of ongoing decision-making in clinical practice that holds the particular philosophical positions of clinical and counselling psychologies, which incorporates the *reflective* scientist-practitioner identity focused on the experience of the individual practitioner.

While I attended to each of the 1,000+ search results that came from the above key words in order to build a comprehensive narrative of clinical decision-making in psychology, I also wanted to capture the more specific key words that may present in applied therapies relevant to clinical and counselling psychologists. To ensure the literature search was able to capture the variability and flexibility of the work of counselling and clinical psychologists, I used several additional search terms that were key words extracted from the previous search, such as "clinicians' decision-making in their work", "therapy", "counselling", "CBT", "psychodynamic therapy", "integration",

and "trainees" compared to "qualified practitioners" and so on. For the purposes of maintaining a focused approach relevant to my specific research interest in clinical decision-making, I excluded all literature that did not discuss the applied use of psychology or therapy, and those that focused only on management of risk or ethics. Overall the remaining body of literature relevant to this subject area is mostly quantitative and evaluative of efficacy, with a small number of qualitative literature. The literature below has been explored in varying depth, with guidance from the Appraisal Checklists (CASP, 2013) in attempt to illustrate the relevance of particular research queries and methods for the issue of decision-making in psychology. The pertinent literature highlighted in the review below has been grouped into two broad categories, starting with a brief outline of relevant decision-making theories, followed by specific literature that looks at decision-making in therapy.

1.3.Literature Review

1.3.1. Decision-making.

It is essential to engage with the basic components of decision-making literature to situate psychologists' experiences within this vast area. In this respect, broadly speaking among the relevant literature, there are theories concerned with the accuracy of decision-making (Masias, Krause, Valdes, Perez, & Laengle, 2015; Pfeiffer, Whelan & Martin, 2000) and those that engage with the process (Chen, Froehle, & Morran, 1997; de Bono, 1995; Round, 1999). Specifically, those that examine the accuracy of decision-making look into possible biases and traps, while the literature that seeks to understand process may look into the components of the task.

Accuracy in decision-making. Research that aims to identify potential traps in decision-making takes into account biases, cognitions, and heuristics. This type of research examines statistical formulae, tools, or techniques to avoid errors (Masias, et al., 2015). One such study from a realist perspective looked at the initial formulations of psychologists and possible decision-making biases in relation to their hypotheses (Pfeiffer, et al., 2000). The authors identified that psychologists are more likely to rely on confirmatory biases in decision-making when they assess a client's presenting issue to confirm their initial hypotheses on plausible causes. This means that relevant information may be abandoned or missed if it does not correspond with the initial hypothesis. Consequently, this finding has potential implications on clinical case formulations and suggests that the practitioner may be less likely to continue seeking

relevant information when met with an explanation to the presenting issue that seems to fit with the initial hypothesis. Similarly, Sterman (1994) reviewed earlier studies and identified patterns of barriers that impede learning and decision-making. In this research, he discussed human cognitive processes and biases that impact decision-making; such as stopping the search for alternatives once an answer is found. This corresponds to Witteman and Koele's (1999) suggestion that such biases may be grounded in the 'schemas' that practitioners gain within their clinical training. These schemas relate to the patterns of knowledge that develop for practitioners over time, in becoming familiar with presentations and corresponding therapeutic approaches. In this respect, the practitioner who is faced with a familiar presentation may unwittingly exercise a confirmation bias in hypothesising on the presenting issue, based on their prior experience and knowledge rather than the client's narrative. Such research that looks at biases mostly approach the question of clinical decisions from the perspective of whether they are accurate or erroneous. Though binary in nature, this approach may help strengthen the understanding of any inaccurate early interventions made by psychologists. In turn, this understanding moves the empirical exploration of clinical decision-making away from exclusively involving the nomothetic approach and establishes a reason for formulations being necessarily collaborative and flexible (Cooper, 2009; HCPC, 2015).

Process in decision-making. It has been proven valuable to create increased awareness of biases within decision-making, to potentially help reduce their impact. In this respect, research has demonstrated that such biases were reduced in a clinical setting, when practitioners were made aware of the potential traps in decision-making (Chen, et al., 1997; Round, 1999). This provides a bridge to the literature that looks at the processes of decision-making for a better understanding of the components involved. Accordingly, two distinct types of cognitive functioning are named as being core to understanding and making decisions (Bruner, 1987; 1990). The paradigmatic cognitive functioning relies on rationality to resolve linear problems, whereas the narrative functioning supports meaning making from a descriptive perspective (Bruner, 1990). From a clinical standpoint, paradigmatic functioning supports clinical decision-making with respect to the linear evaluation of available information. On the other hand, the narrative functioning is closely linked to the exploration of subjective experience.

Similarly, de Bono (1995) looked at the different thinking skills involved in making decisions. He used an analogy to delineate between two approaches in decision-making; specifically hunting and fishing. Here, hunting skills are akin to the type of thinking that involves aiming for a distinct target in decision-making, where the goal and desired outcome are evident. On the other hand, fishing is likened to an open and exploratory thinking style, where questions are used to search for links to arrive at decisions. In a clinical sense, the hunting thinking style in decision-making equates to asking purposeful questions that may have informational responses, while the fishing is the exploration of meaning with the client.

Having considered the thinking skills involved in decision-making, the question of meaning-making arises with respect to understanding the components of decision-making as a task. The question of motivation often is featured in literature through the query of how and why individuals make decisions. Strevel (2018) divided intuition in decision-making into two categories and explored latent and inferential intuition through decision-making in business settings. These two categories were separated through the source and use of intuitive information. In this respect, latent intuition refers to a priori and non-logical judgement that contributes to the development of new knowledge. On the other hand, inferential intuition is the a posteriori and non-rational resolutions to irregular problems, and offers information where knowledge is absent. With respect to the clinical application of intuition in decision-making defined in this way, arguably latent intuition could refer to formulations and collaborative insights with clients, while inferential intuition could be the psychologist's interjections and interpretations in the work.

Bringing accuracy and process together. The above sections on *accuracy* and *process* provide a brief outline of approaches to understanding some of the core theories in decision-making literature. In terms of the relevance of this literature on clinical practice, some key texts combine the theoretical understandings of decision-making with their clinical applications in therapy. These texts are often presented as guides for clinical decision-making, with suggestions on best practice. One such guide was compiled by Magnavita (2016) on making accurate and concrete clinical decisions. He outlined the history of decision theories and discussed potential pitfalls or shortcuts in making clinical decisions. This is a comprehensive resource for clinicians, to avoid making flawed decisions in therapy, with a strength in relying on empirical ways of

understanding the therapeutic relationship. This type of guidance exemplifies decision-making literature in relation to the specific approach it takes when addressing the complexities of clinical practice. Correspondingly, the type of literature specific to therapy is most useful when it takes into account ethics and expertise, with a critical evaluation of the dichotomous approach to accuracy in decision-making.

1.3.2. Decision-making in therapy. Any aspect of decision-making in clinical practice is necessarily underpinned by ethical considerations that govern psychologists' approach to therapy. Psychologists are bound by the BPS Code of Ethics and Conduct (BPS, 2018) and the HCPC Standards of Conduct, Performance and Ethics (HCPC, 2016) for responsible clinical practice. Based on the suggestions of these guidance documents, psychologists are encouraged to continue developing their knowledge on ethical practice, through engagement with up to date literature. In this respect, decision-making literature must also be understood through the evaluation of ethical implications. To this end, ethical decision-making in therapy is a broad area that covers several aspects of clinical practice. An example of this is the literature that looks at the ethical relational dynamics in therapy with particular attention to managing conflicts between the practitioner and client (Ford, 2001). Similarly, the issues around ethical approaches to culturally relevant practices (Houser, Wilczenski, & Ham, 2006) and ethical considerations of the practitioner's impact on therapy (Haas, Malouf, & Mayerson, 1988) are examples of the diversity in this type of literature. One specific text by O'Donohue and Henderson (1999, p.10) emphasised the psychologist's "epistemic and ethical" duty towards the client. Here, they asserted that psychologists must aspire to gain the highest possible level of empirical and theoretical knowledge and aim to use it in the most appropriate ethical way possible. Congruent with this, if a clinician successfully subscribes to the humanistic value base, which is advocated by the HCPC and the BPS, they will attempt to collaboratively use their knowledge for the benefit of the client (Cooper, 2009; HCPC, 2015; BPS, 2018). More specifically, with regards to ethical considerations in decision-making, the BPS Code of Ethics and Conduct (BPS, 2018), ensures that awareness of own limitations as a professional is an essential competence of a psychologist. This awareness necessitates thoughtfulness around the clinical decisions made and interventions carried out. Consequently, this guidance is a common feature of decision-making literature, most frequently with regards to claims to expertise and accuracy in decision-making, where attention to ethical conduct is inherent.

The link between expertise and decision-making is emphasised by the designated APA task force on evidence-based practice, which seeks to define clinical expertise (Tracey, Wampold, Lichtenberg, & Goodyear, 2014). As part of this classification, they termed seven aspects of clinical practice that defines expertise in clinical work, which included decision-making relating to assessment, formulation, and treatment (Tracey, et al., 2014). This brings the issue of decision-making as a component of clinical competencies to the fore and underlines the role of decision-making in clinical expertise.

Broadly speaking, literature suggests that expertise in therapy is defined by length of practice and outcome success (Helm, McCormick, & Reyna, 2018). Additionally, these authors suggest that experts make superior decisions compared to novices, despite being more susceptible to decision-making traps such as the confirmatory bias. One possible reason for the improved decision-making for experts in therapy is explained through the benefits of familiarity with the task and information processing linked to this. In this sense, the suggestion is that experts in any profession hold a knowledge base that is relatively larger and better organised compared to novices (Tracey, et al., 2014). Furthermore, these authors suggest that experts in any field develop the ability to process their respective information faster, which offers them the upper hand in decision-making (Tracey, et al., 2014). Additionally, Banning (2007), looked at three available models of decision-making in clinical nursing and highlighted that the more experienced nurses become, the more efficient and confident they are in their practice of making clinical decisions. Conversely, other authors suggest that the length of time in a field does not equate better clinical outcomes, by demonstrating that trainees produce similar therapeutic outcomes as qualified professionals (Beutler, 1997; Laska, Smith, Wislocki, & Wampold, 2013). In fact, Spangler et al. (2009) investigated this point by conducting a meta-analysis of 75 studies on clinical decision-making linking experience to accuracy. The authors concluded that experienced clinicians acquire at most a 13% increase in accuracy in their decision-making over the course of their career (Spangler et al., 2009). Therefore, based on this disagreement in literature, it is necessary to consider the evaluation of the therapy expert position in relation to effective clinical decision-making, particularly whether outcome success can be considered as part of the mark of such expertise.

In literature, outcome success and the ability of the practitioner to predict results in therapy is a common measure of decision-making skills. This approach to decision-making holds the assumption that the clinician who is able to make accurate decisions in their clinical practice, would deliver efficacious outcomes in therapy. Furthermore, the same clinician would be able to foresee the progression of the work to assess its possible success. Therefore, studies have explored whether clinicians are in fact good at predicting therapy outcomes as a measure of efficacy in decision-making. One example of this type of research examined whether outcome measures that are used in therapy are better at predicting outcomes than therapists themselves (Gambrill, 2005). The study also sought to identify the kind of decision-making expertise that may contribute to successful therapeutic outcomes. This quantitative research compared practitioners' clinical decision-making with statistical predictions to assess whether the clinicians' claims to accurate expertise and decision-making held up against statistical methods of therapeutic outcome prediction. Gambrill (2005) found statistical predictions to be more accurate than clinicians' expertise and discussed the relevance of this in terms of decision-making within therapy. Similarly, another study sought to enhance decision-making practices through the use of protocol driven treatments and evaluated clinicians' outcome prediction abilities in comparison to statistical tools (Lutz et al., 2006a). They also found through quantitative exploration that statistical tools are more reliable in predicting outcomes in therapy compared to clinicians themselves.

On the other hand, a counter argument in this vein evaluates the appropriateness of outcome prediction in the assessment of practitioners' clinical decision-making skills. A systematic review of 67 studies conducted by Ægisdóttir, et al. (2006), evaluated 56 years of decision-making literature and concluded that statistical predictions discussed by previous research such as that of Gambrill (2005), are in fact not appropriate for the complete understanding of decision-making in therapy. The authors suggest that this type of focus on accuracy and efficiency in decision-making misses the humanistic component of the work. Ægisdottir et al. (2006) suggest that the results of this type of evaluation are misleading, as they most commonly fail to take into account the context in which such predictions are gathered. The context that is not taken into account might otherwise involve additional considerations that may impact the work, such as setting, client groups, and type of information available to practitioners. This perspective on decision-making suggests that the outcome prediction literature cannot capture intricacies of clinical work and will inevitably misrepresent the decision-making

abilities of several professionals (Tracey, et al., 2014). Here, the understanding is that many psychologists may be working with client groups whose therapeutic progress cannot be measured through an objective assessment of outcome success. This may include those practitioners working with clients who are inherently unmotivated or unconvinced of the need for therapy (Tracey, et al., 2014). These statements are particularly relevant to the Standards of Proficiency items specific to counselling psychologists (HCPC, 2015). The HCPC items assert that while predicting and measuring outcomes is a core component of impactful practice, they must be used in ways that are meaningful to the outcome the client expects (HCPC, 2015). This position contrasts to an approach that is a binary tally of relatively arbitrary quantitative evaluations of therapeutic success. Therefore, to address this balance, another trend in decision-making literature is one that seeks to standardise therapeutic approaches and the evaluation of accuracy in decision-making. These advocate for adherence to evidence-based approaches and protocols in decision-making for better efficacy and reliability.

Evidence-based therapies and empirically supported treatments appear to be favoured by decision-making literature, which emphasise accuracy and measurable outcomes in therapy (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013; Lutz, et al., 2006a; Lutz, et al.,2006b; Scaturo & McPeak, 1998). Within the evidence-based therapies, protocol driven approaches provide step-by-step guidance on the application of therapeutic practice in the clinical setting. The argument for the use of evidence-based therapies and specifically protocol driven approaches, suggests that the proven effectiveness of particular steps in therapy enhance the accuracy of decision-making (Runyan, 1977). For this reason, the predictability of protocol driven approaches are particularly preferred in situations where decision-making is considered to hold a degree of complexity. In this respect, guides to decision-making for particular psychological issues that may contain some complexity are a common aspect of decision-making literature. One of these such guides discusses decision-making in the treatment of PTSD and substance misuse (Litt, 2013). This guide provides a step-by-step look into choice points in the treatment of PTSD and substance misuse, to support the practitioner in their decision-making practices by creating some predictability in a potentially complex clinical presentation (Litt, 2013). In contrast, other authors criticise the strict adherence to evidence-based practice, claiming it is akin to a 'cook-book' type of approach to therapy, inhibiting the creativity and the humanistic attitude of the practitioner

(Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Grayson, 1997; Shahar, 1997; Westen, Novotny, & Thompson-Brenner, 2004). On balance, Reynolds (2000) discussed the importance and relevance of evidence-based practice in clinical work and explored steps to achieve this. She took a critical stance in this exploration by suggesting that the current empirical exploration of evidence-based practice does not suffice as a singular perspective. The particular importance of this literature lies in its proposal that evidence-based practice must not exclusively include quantitative explorations of the efficacy of decision-making. Instead, Reynolds (2000) advocates for the empirical exploration of topics that she considers relatively more neglected, through less prominent methods. In this respect, she suggests the key strategy to elevate the integration of clinical work with the relevant evidence-base would be through the translation of research into real-world clinical practice. Similarly, Spring (2007) discussed the role of decision-making in evidence-based practice and suggested that the task of decision-making in psychology involves the integration of several considerations. These include accounting for research evidence, clinical expertise, as well as the particular preferences of the client, which she acknowledged as being a complex process. In response to this complexity, Spring (2007) identified a need for a better understanding of decision-making processes with respect to the way in which the practitioner synthesises these varying components of their clinical approach.

When considering the varying components of clinical decision-making, the idiosyncrasies of each practitioner draws attention in the literature. The unique approaches of each individual practitioner and its impact on therapeutic outcomes is a difficult one to research. Kahneman, Slovic and Tversky (1982) put together a collection of 35 papers on decision-making from different sources and disciplines, which may shed some light on this process. They based their approach on three components of decision-making literature; comparison between statistical outcome measures and clinicians' outcome predictions, heuristics, and the Bayesian paradigm (probability hypotheses) in decision-making. One of the key suggestions in this collection of papers assumes that the decisions and outcome predictions made by individuals are largely based on previous experiences available in memory. Whether a therapist orients their decision around prior familiar cases and how much their clinical knowledge base is dependent on their previous experiences are also explored in current decision-making literature. One qualitative study looking to understand the processes of systemic therapists responding to challenges within their clinical work, highlights the

common use of this particular type of knowledge that is dependent on components of the work that are less empirical and more "intuition-observation" (Heiden-Rootes, et al., 2015 p. 265). This study does not explicitly examine the varying practices within psychology but is grounded in the epistemological assumptions of the systemic approach that recognises the client within the context they exist (Becvar & Becvar, 1999). This approach, as a general holistic slant in psychology that aims to explore the human distress within a context, aligns itself well with the counselling psychology values of the humanistic value base. The implications of these studies overall support the possibility of clinical decisions involving more than just theoretical knowledge, making room for the individual in the work.

Acknowledging the influence of the individual practitioner in clinical decision-making was further explored by Witteman, Spaanjaars, and Aarts (2012, p.19) who used case study scenarios to investigate the role of what they term "intuition" in clinical decision-making. They understand intuition as automatic responses from trainee clinicians that are based on knowledge gathered though clinical, experiential, and academic information. Their case-study data collection methods circumvented having to ask participants to reflect on their intuitive processes by using a focus group and clinical vignettes. Their methods may have allowed them to engage the participants in a form of decision-making that does not only draw on the recollection of theoretical knowledge but is also engaged with the reactionary responses of the individual. The implication they drew from this qualitative exploration is a suggestion for clinicians to rely on empirical knowledge in equal amounts with professional insight. Nevertheless, perhaps this conclusion needs to be understood in relation to their choice in participants, who were psychology trainees and therefore may exercise a different balance in their engagement with empirical literature compared to a qualified practitioner.

Gyani, Shafran, Myles, and Rose (2014), explored the role of empirical knowledge in the decision-making processes of qualified UK therapists. The authors found that most participants self-reported empirical knowledge playing a limited role, while supervision was found to surpass the use of clinical experience, as the most important influence on clinicians' ongoing decision-making. Thus, while Gyani et al. (2014) draw our attention to issues relating to scientist-practitioners and their attitudes towards empirical information, it also raises the question of the contributing factors to clinical decision-making. Supervision is accepted as an essential component of clinical

work for psychologists and is recommended for good practice (BPS, 2018). The particular value of supervision is in consulting with a colleague, particularly for cases in which certain challenges and difficulties arise. Therefore, Gyani and colleagues' (2014) findings suggesting supervision as a central component to the process of making therapeutic decisions, also emphasises the question of managing challenges and problem solving in ongoing clinical decision-making.

With respect to approaches to problem solving and clinical decision-making, one assumption is that any two clinicians are unlikely to take the same path to address the same issue. In light of this, Garb (2005) suggested that from the outset clinicians do not understand disorders in the same way. He used literature on heuristics and biases impacting decision-making to illustrate the components that may influence a clinician's understanding of a disorder differently than another. Garb's (2005) research appears to hold a critical realist position in therapy, suggesting that within the framework of possible clinical decisions there are countless approaches that can be taken. Bieling and Kuyken (2006) explored the same question by evaluating practitioners' approaches to cognitive case formulation models. In contrast to Garb (2005), these authors found a higher rate of agreement between practitioners on the diagnosis of presenting problems than on the treatment of these issues. Based on these findings that suggest a modest reliability among practitioners' formulations, one possible take home message is that most clinicians view issues in a similar way but respond differently. Both these studies (Bieling & Kuyken, 2006; Garb, 2005) imply that in the assessment and treatment of psychological difficulties, there are copious ways the clinical work can take shape based on the psychologist's decisions. In response to this, literature advocates for the use of context-responsive psychotherapy integration to support such variation in practice (Bugatti & Boswell, 2016). Context-responsive psychotherapy integration was borne out of the variation in clinical decision-making, the need for transdiagnostic treatments, and flexibility within protocoled approaches. The particular literature proposing its use is a case study, looking closely at the decisions made by the practitioner. The authors advocate for incorporating the perspective of the practitioner in the understanding of decision-making (Bugatti & Boswell, 2016). Based on their suggestions, these three studies relating to clinicians' approaches (Bieling & Kuyken, 2006; Bugatti & Boswell, 2016; Garb, 2005) are particularly significant in decision-making literature. Each of these studies shift the focus from an exclusively accuracy and efficiency-based understanding of clinical decision-making, to one which includes the practitioner into

the equation as the decision-maker. This acknowledgement calls to attention the role of the reflective practitioner and the lack of suitability between a strictly nomothetic evaluation of decision-making and the reality of clinical work.

In addition to these gaps between the theoretical understanding and practical application of clinical decision-making, there is an issue in literature relating to continuity. That is, most empirical evaluations of clinical decision-making in literature look at the efficacy of therapy as a singular point in time, inherently excluding the process of ongoing decision-making in clinical work. The process of ongoing decision-making is significantly different to that of singular decision-making points such as initial treatment decisions and decisions grounded in therapy outcome. Nezu and Nezu (1989) identified that the most common decision-making approach at the commencement of therapy is through the problem-solving paradigm. This states that often the client's initial presenting problem is compared to the treatment goals identified by the practitioner. This assessment is followed by the decisions that are based on the needs of the client as defined through the options available within the modality the practitioner subscribes to (Nezu & Nezu, 1989). Their conclusions relating to the need for flexibility in ongoing work emphasises the difference in approach between the start or end of therapy, and the evolving process of clinical decision-making in ongoing work. In this sense, it is important to consider the challenges of ongoing decision-making for psychologists, as opposed to only focusing on initial assessments or therapy outcomes. The ongoing decision process necessarily includes flexibility in the practitioner's approach and an ability to shift focus in decisions together with the client, which may not be the case when evaluating the start or end of therapy.

An additional issue with the literary pursuit of accuracy in clinical decision-making is that of the publication bias, which is also self-cited as a limitation by Ægisdottir et al. (2006). That is, with significant results predominantly featuring in widespread publications, there is likely to be a misrepresentation of clinical work in literature. Specifically, in literature we mostly lack access to cases that may not have been deemed as "successful", indicating a comparable absence of understanding in parts of clinical work. This means that with the over representation of successful clinical decisions in research, there is a lack of balance on the realistic representation of therapy and limited room to understand the psychologist's experience of clinical decision-making in response to the real-world context.

1.4.Rationale for Research and Research Question

Literature demonstrates that practitioners are likely to approach presenting issues differently (Garb, 2005) and may also demonstrate variation in treatment decisions (Bieling & Kuyken, 2006). The variability in approaches raises questions on accountability in relation to decision-making, which is grounded in literature that offers insight into the biases and heuristics involving the cognitive processes of decisions (Garb, 2005; Magnavita, 2016). As outlined above, there is a developing understanding across literature acknowledging tensions between decision-making research and clinical work (Ægisdottir et al., 2006). Working as a *reflective* scientist-practitioner requires that different aspects of practice that include theory, research, clinical and personal experiences are brought together (Lane & Corrie, 2006). This often means that therapy is a non-linear decision-making setting, in which every choice the practitioner makes becomes relevant to the evolution and progression of the work (Scaturo & McPeak, 1998). Conversely, most literature concerned with the accuracy of decision-making emanates from a realist paradigm, which is mostly binary and seeks an objective description of 'success' in decision-making. In this respect, much of the psychological literature offers descriptive guides on improving decision-making (Arkes, 1981; Dumont, 1991; Garb & Boyle, 2003; Magnavita, 2016; Salovey & Turk, 1991), and less attention is given to the experience of decision-making. Lane and Corrie (2012) summarise this gap between literature and clinical practice, by highlighting that decision-making literature that has focused only on accuracy has sacrificed depth of information that would be valuable in understanding the mental operations of psychologists. They suggest that most literature is underpinned by an "information-processing framework" (Ivey et al. 1999, as cited in Lane & Corrie, 2012 p.33), whereby decisions are understood through linear, rational and sequential stages of information processing for a systematic application into context. This suggests that the descriptive and binary literature concerned with accuracy and efficiency so far, limits our understanding of decision-making by excluding the non-linear and non-sequential processes of therapy. The core humanistic value base of counselling psychology, understands the therapeutic work as a whole (Cooper, 2009) and in relation to decision-making, would emphasise the *process* of making clinical decisions as much as the outcome of therapy. Therefore, understanding success in decision-making would also involve an appreciation for the process, which may include the less comfortable components that may, at times, be unknown or unclear for the practitioner.

Additionally, decision-making literature itself offers support for the rationale for conducting qualitative research exploring psychologists' experiences of clinical decision-making. When considering the accuracy of decision-making, authors have queried psychologists' engagement with relevant literature (Lilienfeld, Lynn, & Lohr, 2003) and noted their biases. As mentioned in the evaluation of literature, psychologists' possible biases may be grounded in the 'schemas' they have developed over their training and practice (Witteman & Koele, 1999). Research suggests that when practitioners are given the opportunity to reflect on their own biases in practice, this is likely to reduce the possibility of these biases repeating in the future (Chen, et al., 1997; Round, 1999). In addition, for the evaluation of these, decision-making literature offers that clinical decision-making comprises varying thinking skills that include direct and exploratory approaches to information (de Bono, 1995) as well as latent and inferential intuition (Strevel, 2018). In these terms, so far, the majority of clinical decision-making literature has taken a paradigmatic perspective (as defined by Bruner, 1987) to explore linear clinical processes, which consequently leads to incongruity between research and actual clinical practice. When these elements are considered together, the lack of literature that may seek to understand clinical decision-making through the narrative exploration of inferential decision-making is surprising. Yet, decision-making literature also suggests that experience informs decision-making (Pang, 2018; Rebeka, 2018), further supporting the possibility of research focused on experience, informing future decision-making. In this respect, this research project seeks to address this gap, to understand the non-linear clinical processes through psychologists' *experiences* of clinical decision-making by enquiring about their processes.

Overall, the lacking consideration in the literature exploring the ongoing clinical decision-making practices of psychologists is the more reflective approach; a critical realist understanding of the experience of making decisions in the work. This kind of approach can offer the therapy field better insight into the process of clinical decision-making through the experiences of psychologists, which can contribute to bridging the gap between literature and practice. This insight can also promote the role of reflective practice within the scientist-practitioner identity, which in turn can support the accountability of psychologists' decision-making. Furthermore, this qualitative query can offer an opportunity for parity with the HCPC (2015) and BPS (2017a) standards that advocate reflective practice in psychology, which has been identified as one of the

defining features separating psychologists from other therapeutic practitioners (BPS, 2017b).

Therefore, the aim of this research is to understand decision-making experiences through qualitative exploration, to give support and offer insight into the shared practices and themes among practitioners. In line with this, the research question for this project is:

"What are psychologists' experiences of decision-making in their clinical work?"

This question has been explored through a critical realist lens, with the use of semi-structured interviews and a gradual reveal case study vignette, and the data has been analysed through Thematic Analysis (TA).

2. Chapter Two: Methodology and Methods

2.1 Overview of Chapter

This chapter offers a detailed description of each step of this research project. A declaration of the researcher's position to contextualise the approach to existing literature as well as situating the analysis and findings of this project, is outlined in this section. The chapter opens with a description of the epistemological and ontological considerations of this project, which is followed by the methods used to conduct the research including the ethical considerations, participants, and tools. The use of TA as a methodology is also discussed in detail, to outline the approach to the data and adherence to standards of quality within qualitative research.

2.2 Epistemological and Ontological Considerations

There are a number of assumptions about knowledge that provide the answer to the question "What and how can we know?", which relates to the epistemological and ontological positions of a researcher, and shapes their approach to information gathering (Willig, 2012a, p.9). While there are different ways of understanding approaches to epistemology (Guba & Lincoln, 1994; Morrow, 2007; Ponterotto, 2005), for the purposes of this research, I found Willig's (2012a) description of the epistemological terrain to be most suitable for my own understanding of knowledge. Willig (2012b) identified three main epistemological perspectives; namely realism, phenomenology, and social constructionism. She also discussed methodological pluralism, which allows the researcher to position themselves between different applications of paradigms. In my quest to critically understand the subjective experience of my participants I assume a critical realist epistemological position for the purposes of this project (Willig, 2012a).

Broadly, Willig (2012a) states the realist paradigm holds the assumption that the subject of research can be understood, as the researcher holds the potential to uncover and relay patterns that exist within the subject matter. She speaks of the phenomenological knowledge within research to help reflect the subjective experience of the participant, which neither claims the accuracy of nor a relationship to the so-called 'objective' constructs of the world. Finally, she discusses social constructionism, which she describes as being different to observations about phenomena and the relaying of subjective experience, and that it concerns itself with how each person constructs their subjective reality. In more specific terms, Willig (2012a) elaborates on the different variations between each paradigm in a way that discusses the

intersectionality of positions, and the possibility of holding more than one. She talks about direct and critical realism, descriptive and interpretative phenomenology, and radical and moderate social constructionism. Within Willig's (2012b) description of the epistemological terrain, critical realism is positioned as being able to accept data as informative of the real world, while acknowledging that it is understood through the subjective lens of the knower. The essential approach to understanding the subjective experience of the participant is through locating it within the context in which it exists. Furthermore, from a critical realist standpoint, it is not necessary for the participants to be aware of the underlying processes of the descriptive experiences they narrate.

For counselling psychology research and practice the question of epistemology is both variant in its manifestation and could be considered to be evolving. Each practitioner will take on a different position within the discipline in relation to the acquisition of knowledge, and the discipline itself is dynamic and not stagnant. Cooper (2009) and Kasket (2012) describe the humanistic value base from which counselling psychologists operate. Coming from this value base, Kasket and Gil-Rodriguez (2011) outline the trainee counselling psychologists' task of holding tensions between plurality in research and in practice. They suggest that understanding and working with the multiple underlying theories and modalities, is central to becoming a counselling psychologist. Furthermore, each counselling psychologist is also a researcher-practitioner (Kasket, 2012; Kasket & Gil-Rodriguez, 2011), who holds empirical information to equal value with practice-based knowledge. To my critical realist epistemological interpretation of these suggestions in counselling psychology, we can understand the observable phenomena of mental health through an interpretative lens, by focusing on the client's own subjective experience within the wider context.

In addition to this, it is important to acknowledge that one field cannot hold one single epistemological stance but can hold multiple positions causing tensions in the way knowledge is acquired and understood (Willig, 2012b). This is reflected in the research as well as the practice of counselling psychology. As a relatively younger field, counselling psychology has been informed by historical psychological research, which has largely been positivist or post-positivist (Ponterotto, 2005), or realist (Willig, 2012a) in its empirical quest. Most early research in psychology had been quantitative and focused on observing data, which sought objective realities that could be observed by the researcher (Morrow & Smith, 2000; Ponterotto, 2005; Willig, 2012a). Recent

developments in the field have combined research on empirical knowledge on the effectiveness of methods (realist), with subjective anecdotal clinical information (phenomenological), and practice-based research (Henton, 2012; Willig, 2012b). This has led to an approach that requires the clinician to be thoughtful of the applications of such epistemological tensions. For the counselling psychologist, this translates into balancing the scientist-practitioner role (Bury & Strauss, 2006) with the reflective practitioner one (Schön, 1987), which requires an ongoing reflective stance that incorporates the context in which both the therapist and client exist. These tensions within the field are particularly relevant to my research question, which explores psychologists' experiences of decision-making and situates this experience within the context of current training, research, and practices. Beyond a declaration of tensions, my acknowledgement of conflicting perspectives aims to illustrate the unbounded and continuous nature of a reflective practitioner attempting to adjust their practice to fit their clients (Cooper, 2009; Schön, 1987). Thus, to make sense of the participants' experience of clinical decision-making, I found the most appropriate descriptions of the acquisition of knowledge to be Willig's (2012a) critical realism.

Overall, TA (Braun & Clarke, 2006) fits well with my critical realist position inherent in my research question, as it holds an open view of any main themes identified in the data, while allowing the researcher to understand these themes under the umbrella of widely acknowledged theories or realities. Joffe (2012) states that good quality TA locates the data within an existing social context. Further to this, TA is thought to capture meaning in the data, make links between themes and map out concepts, ultimately adding value to descriptive information (Braun & Clarke, 2006; Harper, 2012; Willig, 2012a). Braun and Clarke (2006), state that researcher judgement is essential in identifying themes within the data, thus requiring the researcher to practice ongoing reflexivity while making their process explicit throughout (Sciarra, 1999).

2.3 Methods and Research Design

2.3.1 Ethics. Ethics clearance for the commencement of this study was given by the University of East London, School of Psychology Ethics Board, following an application outlining my proposed research (Appendix A). For the purposes of expanding the participant sample and research focus, an amendment was obtained through the ethics board (Appendix B & C). Recruitment for participants commenced after ethics clearance was attained. Further to this, to account for possible geographical

limitations in recruitment, a further approval of amendment was obtained to allow for Skype interviewing in addition to face-to-face (Appendix D), to ensure a possible wider pool of participants that would not be limited by the geographical access of the researcher. Ultimately, despite gaining approval, Skype interviews were not necessary and only face-to-face interviews were conducted.

Informed consent. All participants were sent information on the research project as part of the recruitment emails (Appendix E). Those who demonstrated interest were also sent a more detailed information leaflet that outlined the rationale for the study, as well as the different stages of the interview. Participants were also given the same informed consent leaflet at the start of the interview and were asked to sign to give their consent to participate (Appendix F). It was explained that they would be able to decline to answer any questions and/or withdraw from the study at any point in the interview if they wanted to. Following the completion of the interview, participants were debriefed, and were given a debrief document that explained a three-week cool-off period following the date of the interview to withdraw their data. No participants chose to withdraw.

Confidentiality and anonymity. Confidentiality and anonymity of the participants in this research project was ensured through various means to protect their data. Interviews were conducted in private spaces that were agreed by the researcher and each participant. Each interview was audio recorded on an encrypted device. The recording was processed with an anonymous code onto a laptop protected by a passcode at the end of the interview, the computer file was then encrypted with a code, and the recording was deleted off the recorder. All the relevant paperwork pertaining to each participant was coded with the same code used for the recording and held separately to the demographic information questionnaire that contained personal information. Transcription was done by the researcher, and all personally identifiable information has been changed. All paperwork is kept in a locked filing cabinet and will be destroyed following the completion of the project. Participants have been made aware of the handling of their data as per the Informed Consent (Appendix F) and Debrief (Appendix G) forms.

2.3.2 Participants and recruitment. Purposive sampling was used, inclusion and exclusion criteria was applied to recruit qualified clinical and counselling

psychologists, who have completed their doctorate in the UK. Public contact information was retrieved through the BPS "Find a Psychologist" website and several emails were sent inviting psychologists to participate. Additionally, snowballing was used, to contact psychologists known to the researcher's professional circles. Potential participants recruited through snowballing were also sent the same information by email. A total of twelve participants registered initial interest and eight agreed to participate. Eight interviews consisting of written and transcribed interview data were deemed sufficient by the researcher, based on the evidence of common themes from the data indicating saturation as suggested by Braun and Clarke (2006).

The issue of sample size in TA is complex, with some contrasting suggestions for researchers. Braun and Clarke (2013) suggest that a small research project using interviews and TA should use six to ten participants. They go on to explain that this does depend on the quality of the data and the saturation of themes. Braun and Clarke (2013) warn us against the possibility of collecting too little or too much data, causing the themes to lack substance in the former, while leading to an inability to engage effectively with the collected data in the latter. Fugard and Potts (2015) propose a challenge to this, stating that these participant numbers have not been defined by any explicit process or procedure and are largely dependent on the interpretation of the researcher. They proposed a quantitative approach and a tool to assess the required number of participants appropriate for research projects. The suitability of such a quantitative tool in qualitative research has also been debated in responses from authors such as Braun and Clarke (2016), Byrne (2015), and Hammersley (2015). Overall, the common denominator of the suggestions of sample size emphasises ensuring the depth and quality of the data, as well as the researcher's approach to the collection, analysis, and interpretation of it. Based on these principles, I ensured adequate richness of the data through saturation across themes and followed Braun and Clarke's "15-point checklist of criteria for good thematic analysis" (2006, p.287) to ensure quality (see section 2.5 Ensuring Quality in Qualitative Research for details).

Description of sample. Demographic information was obtained at the start of each interview (*Table 1*). The Demographic Information Form contained questions pertaining to the professional history of each participant (Appendix H). The participant sample of this study were eight psychologists, three of whom were counselling psychologists and five were clinical psychologists. All participants had completed their

doctoral psychology qualifications in the UK, having graduated from DPsych or DClin courses respectively. There was variation in the current settings in which each participant practices, which spans across privatised primary care, National Health Service (NHS), and private practice, with some working in more than one setting. The number of years since qualification also varied among participants, from two-and-a-half years to 15 years in the role. It is also noteworthy that most had already been practicing therapists before taking on their doctoral training, and therefore have been in the field between five to 18 years. Finally, three participants self-disclosed a dominant modality in which they work, while all spoke about drawing from varying modalities for a pluralistic approach in their practice.

Pseudonym	Age	Gender	Training	Work Setting	Number of years practicing
P1	36	M	Prof Doc CoP	Privatised Primary Care	11
P2	42	M	DClin	Private Practice	12
P3	35	F	DClin	Privatised Primary Care	7.5
P4	32	F	DClin	NHS & Private Practice	7
P5	36	F	DClin	NHS	8.5
P6	50+	F	Prof Doc CoP	Privatised Primary Care & Private Practice	5
P7	40	F	Prof Doc CoP	Education & Private Practice	8
P8	44	F	DClin	NHS	18

Table 1. Summary of demographic information

2.3.3 Data collection and analysis.

Pilot. A pilot interview was conducted, where the participant was asked for feedback on the interview process. This process comprised gaining informed consent from the practitioner and introducing the different interview stages, followed by a debrief after the interview. The interview was conducted in two stages, whereby the participant was first asked to complete a ten-minute gradual reveal case vignette exercise (Appendix I), and then was invited to answer questions from the semi-structured interview schedule (Appendix J).

The pilot participant was asked to comment on the case vignette exercise and the interview schedule after the debrief process at the end of the interview. Based on the feedback, some additional instructions were added to precede the case vignette exercise for clarity, but the interview schedule remained unchanged. The pilot interview was therefore used as data, with the permission of the participant.

Use of the gradual-reveal case vignette. The gradual-reveal case vignette was designed to both allow the participants to engage in a live experience of their decision-making processes and to make their access to self-descriptions of decision-making easier. Witteman and colleagues (2012) conducted their study on clinical intuition, by circumventing the issue of having to ask participants directly about their process. They predicted that participants may not know how they relate to this concept. Instead, they used methods with which they would be able to ask participants their views on the use of their intuition, after having done so in tasks relating to the central question. Thinking from a critical realist perspective using TA, this rationale is especially relevant, as it concurs with Willig's (2012b) suggestion that the subjective experience of a participant needs to be located within the context in which exists. This position suggests it is possible that the participant may not be aware of the process on which they may be reporting, which also corresponds to the possibility that individuals may possibly be unaware of the stimuli and its impact on their subjective responses (Nisbett & Wilson, 1977).

Based on this, I chose to invite my participants to take part in a 10 to 15-minute task that would engage them in a decision-making process at the start of the interview (Appendix I). The aim of this task was to circumvent the possibility of the participants feeling unable to access their usual decision-making experiences, and to open the conversation up quickly for our joint reflection on their experience of their practices. Additionally, this also provided me with written data, which I have coded using TA alongside the interview transcripts, affording me further depth and richness in data.

Further to this, the purpose of the use of gradual reveal as opposed to one body of text in the case vignette exercise, was also to allow the participants to experience the possibility of shifts in direction within the work. The gradual exposure to changes in the work was designed to engage participants with the presence of a (hypothetical) client,

and work through some step-by-step decisions. This allowed us to break down the decisions through each section, to discuss the possible changes and the psychologists' experiences of these changes, in a way that was reflective of a live clinical example. Each part of the five-step gradual reveal case vignette was presented on a different page and captured a different aspect of the client's narrative that may be relevant to the clinical decision-making of the participant. The structure initially introduced the presenting problem, followed by the client's relationship history, their own account of relationship challenges, the therapeutic alliance, and an emotionally challenging ending to the vignette. The case vignette was purposefully diagnostically not complex, did not contain any risk elements, and was ambiguous enough in terms of presentations to allow the participants to engage with their most comfortable practices. Each participant was given a single page summary of the case vignette for their convenience, to refer to during the subsequent section of the interview.

Interviews. The interview schedule (Appendix J) included open-ended questions to be used as prompts and a guide for the interviews, which followed the case vignette exercise. The aim of the questions was to engage the participant cognitively with the task of the case vignette and to link this to their current clinical practice and decision-making. Each interview lasted between 45 minutes and one hour, including the case vignette exercise. Upon the completion of the interviews, each participant was debriefed as part of the ending of the interview process.

2.4 Thematic Analysis

While navigating the tensions of my own epistemological approach to my research, I explored the borders of phenomenology, as part of the task of establishing an appropriate methodology. I initially considered using Interpretative Phenomenological Analysis (IPA) as a method, as it fit in with my aim to understand the data within the context that it is situated (Larkin, Watts, & Clifton, 2006). On the other hand, while this first step in analysis fits in with my own research question, the intricacies of the interpretative approach do not fit with my aim in this project. The emphasis in IPA's data analysis stage on double hermeneutics and a second-order interpretation of the participants' sense-making through the sense-making of the researcher, felt to be a position relatively closer to the social constructionist end of the epistemological spectrum than my own (Larkin, et al., 2006; Willig, 2012a). Therefore, for me, a more

flexible methodology in the way it approaches knowledge and analysis is TA (Braun & Clarke, 2006).

Boyatzis (1998) introduces TA as a form of pattern recognition, and a way of making sense of information. In line with this, Braun and Clarke (2006) describe TA as a foundational method within qualitative research, based on the aims of gathering data and capturing meaning within. They describe TA as being open to use with several research paradigms, and compare the choice of methods to the inherent epistemological positions within qualitative research. Linked to this, Braun and Clarke (2006) also offer the reflection that TA is likely the most flexible and adaptable method for analysis. They discuss methodologies such as IPA and Conversational Analysis, elaborating that these approaches have epistemological assumptions that guide the structure of analysis. They also suggest that other qualitative methodologies such as Grounded Theory, Discourse Analysis, and Narrative Analysis sit within a broad theoretical framework, yet have defining boundaries of the assumptions they make on how knowledge is acquired. Similarly, Willig (2013) also proposes that TA can be used effectively with most of the paradigms, conceding that the researcher establishes their epistemological stance early on in the research process. Boyatzis (1998) suggests that TA is a form of seeing, which requires the researcher to be extensively thoughtful with the information that roots this flexible analytic method with their understanding of how knowledge is formed.

TA is known to be a method suitable for identifying and analysing patterns of meaning across a dataset (Braun & Clarke, 2006). The possibility of the bigger picture over the data in this sense, is also valuable where the focus of a study is to map out a range of concepts or where there is a need to summarise into categories (Harper, 2012). This contrasts to other approaches mentioned above, whereby the focus may be themes within individual experiences or the phenomenological meaning of the different approaches. TA's flexibility of use with different epistemological approaches (Joffe, 2012) and varying data collection methods make it a good fit for this project that approaches the research question from a critical realist position and employs written information and interview transcripts as data collection methods. This is relevant to my use of a two-stage interview involving written data from the gradual-reveal case vignette exercise and the interview transcripts.

To further the observation that TA is a good fit with my research question and epistemological position, Boyatzis (1998)'s proposition that TA bridges the gap between qualitative and quantitative research is also significant. As noted in 'Chapter One: Introduction', much of the research that looks at decision-making has been either quantitative or offers a realist perspective on decision-making that is centred around efficacy and accuracy. In this respect, my critical realist approach in TA bridges the gap between the preceding literature and my research query relating to the experience of decision-making. This is in line with Boyatzis' (1998) suggestion that TA can be used to understand qualitative data in a quantitative manner and that due to its historical use in quantitative research; it is able to provide a multi-dimensional understanding of developing information. While epistemologically and methodologically I position myself within the qualitative approach, I believe that a critical realist use of TA is an appropriate way of offering the field new information that can be understood and situated alongside existing empirical knowledge. I have endeavoured to achieve this within this research project, through ensuring richness of the data and through my application of the seven-stages of TA proposed by Braun and Clarke (2013).

2.4.1 Stage 1: Transcription. As the researcher, I began by following Braun and Clarke's (2013) guidelines for orthographic transcription. By doing the transcription myself, I was able to ensure familiarity with the data and annotating relevant nuances that were available to me as the researcher in the interview recording.

2.4.2 Stage 2: Reading and familiarisation. After having completed the transcription, I familiarised myself with the data by reading and listening to the recordings repeatedly. At this stage, I recorded initial thoughts and ideas relating to the data as preliminary notes. This process led to the beginnings and production of initial codes.

2.4.3 Stage 3: Coding. I annotated the features of the transcribed interviews that appeared relevant to the research question as codes, after giving full and equal attention to each item in the data set, in line with Braun and Clarke's (2006) recommendations. I then coded the data by writing notes in the margins of the transcript with multiple codes being assigned to the same excerpt where appropriate (for a representative example see Appendix K). Data extracts with the same codes were collated and compared. I followed this with a traditional and low-tech manual cutting

and pasting method (Green & Thorogood, 2010) to begin developing a map of codes that were linked to one another. From these codes, I developed a coding manual to guide analysis. This manual included a coding number, the name of the code, an inductive descriptive definition of what constituted the code, and examples of quotes from participants that represented the code (for a representative example see Appendix L). To reduce researcher bias and to confirm the coherence of the coding manual, I presented the work at this stage to my research supervisor and any discrepancies were adjusted for consistency. This final version of the coding manual then guided the remainder of my analysis, involving the identification of themes.

2.4.4 Stage 4: Searching for themes. At this point, I used the cutting and pasting method once again to focus the analysis from the exploration of coding, to the identification of broader themes. I grouped the different codes under sections that appeared to carry a common thematic narrative. In this process, I took examples from quotes within the context of the wider interviews to make sense of the themes overall and to ensure coherence within the individual themes. The codes under each theme included contradictory positions of the participants, under the same topic.

2.4.5 Stage 5 and 6: Reviewing, defining, and naming themes. After identifying the themes and subthemes, I used the coding manual to bring together the definition of codes as well as the quotes from participants, to ensure an adequate overview of the layers within and across each interview. With the purpose of TA offering an overall view of the meaning of the dataset (Braun & Clarke, 2013), it appeared essential to define and name the themes according to the overall narrative of the data, as interpreted through the research question. A relevant title was assigned to each theme and subtheme, based on the summary of the overall descriptions (Appendix M). Naming the themes was an ongoing process that continued throughout the writing stage of the analysis, to ensure a good fit and loyalty to the quotes from participants.

2.4.6 Stage 7: Writing – Finalising analysis. According to Braun and Clarke (2013), the writing up of the themes is an essential final component of the analysis process, to help shape the overall argument of the research project. That is, part of achieving a coherent story in relation to the research question, is through the iterative and immersive process of making sense of the data that the researcher engages in.

Accordingly, my findings from this research project are reported in the results chapter, with the subsequent interpretation of the results in the discussion chapter.

2.5 Ensuring Quality in Qualitative Research

The flexibility and adaptability of TA, also brings with it weighty responsibility on the part of the researcher, to ensure quality of the data presented (Joffe, 2012). This involves a clear stance from the outset, on the theoretical position as well as epistemological assumptions that guides the researcher (Madill, Jordan, & Shirley, 2000). That is, unless the research has been conducted from and is presented to a realist perspective, by definition the subjectivity of the research position will allow for flexibility in interpretation. This interpretative position therefore possibly poses a question of validity in research. Yet, the evaluation of critical realist qualitative research through realist quantitative research criteria, could essentially be compared to evaluating the experience of a good meal through the quantity on the plate. More specifically, taking the question of the approach beyond an epistemological position, the axiological and ontological presumptions of qualitative research would not allow for the same standards to be applied in evaluating quantitative and qualitative research. Therefore, robust criteria for evaluating the qualitative research process need to be applied and demonstrated, to ensure the value of the findings are projected accurately and without uncertainties of the standards. To this end, many psychologists have established ways in which certain criteria can be applied to ensure high standards in qualitative research (Braun & Clarke, 2006, 2013; Elliot, Fischer, & Rennie, 1999; Tracy, 2010; Yardley, 2000, 2008). Arguably, those criteria that were derived from quantitative approaches to ensure standards in research (Elliot, Fischer & Rennie, 1999), and those that are centred around more phenomenological or constructionist approaches to research (Yardley, 2000, 2008) are less suitable for the critical realist perspective I am taking to my use of TA. For this reason, I have chosen Braun and Clarke's (2013, p.287) 15-point checklist to be the most theoretically neutral and appropriate criteria to ensure the sustaining of high standards in my research. To demonstrate how each step was achieved I summarised the criteria and my use of it in *Table 2*. The application of these 15 points can also be observed throughout my thesis.

Number	**Process**	**Criteria**	***Application***
1	Transcription	The data have been transcribed to an appropriate level of detail, and the transcripts have been	*Orthographic transcription, as demonstrated in Appendix I*

		checked against the tapes for 'accuracy'.	
2	Coding	Each data item has been given equal attention in the coding process.	*Sample of coded data available (Appendix I)*
3		Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.	*Sample of coded data available (Appendix I)*
4		All relevant extracts for all each theme have been collated.	*Coding manual designed to encapsulate all codes and themes (Appendix J)*
5		Themes have been checked against each other and back to the original data set.	*Coding manual designed to encapsulate all codes and themes (Appendix J)*
6		Themes are internally coherent, consistent, and distinctive.	*Themes were reviewed and discussed with supervisor to further ensure coherence and distinctiveness. They are also described in detail so that the reader can evaluate their coherence, consistency and distinctiveness.*
7	Analysis	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described.	*Use of detailed descriptions of data to ensure depth.*
8		Analysis and data match each other – the extracts illustrate the analytic claims.	*Extracts were chosen carefully to provide the best illustration of analytic claims.*
9		Analysis tells a convincing and well-organised story about the data and topic.	*The results have been approached as an overall narrative gleaned from participants.*
10		A good balance between analytic narrative and illustrative extracts is provided.	*As evidenced in results section.*
11	Overall	Enough time has been allocated to complete all phases of the analysis adequately, without rushing	*Overall, three years have been spent developing, conducting, and writing up research; with nine*

		a phase or giving it a once-over lightly.	*months specifically devoted to analysis, excluding the writing-up of findings.*
12	Written Report	The assumptions about, and specific approach to, thematic analysis are clearly explicated.	*As evidenced in Methodology chapter.*
13		There is a good fit between what you claim you do, and what you show you have done – i.e. described method and reported analysis are consistent.	*As evidenced in Methodology and Results chapters.*
14		The language and concepts used in the report are consistent with the epistemological position of the analysis.	*Themes do not 'emerge' from data, thematic analysis involves ownership of interpretation, with clarity of critical realist epistemological and ontological assumptions.*
15		The researcher is positioned as active in the research process; themes do not just 'emerge'.	*Ownership of a relationship with the research is evidenced through the first-person language where appropriate in the write-up stage.*

Table 2. Application of the Qualitative Research Credibility Criteria proposed by Braun & Clarke (2013, p.287).

3. Chapter Three: Analysis

3.1 Introduction to Findings

The pertinent aspects of participants' experiences of decision-making are captured in five themes generated during the analysis (*Table 3*), which provide an overall story of their clinical decision-making processes. Each of these themes contains participants' reflections on the different foci of the therapeutic work that become the point of reference for decision-making at different stages. Furthermore, the corresponding subthemes provide a more in depth and nuanced narrative of participants reflections on their experience of clinical decisions in their therapeutic work. The foci that are central to the themes relate to the influences on psychologists' decision-making with respect to the client as an individual, the psychologist themselves, and the intersubjectivity of their exchange. In addition to this, participants discussed the impact of professional experience, reflexivity, and the context in decision-making. I provide a brief overview of the themes, before discussing each theme individually and in depth.

List of Themes with Subthemes
Theme 1: Adaptable practice as the focus of decision-making
Subtheme 1.1: Managing the challenges of adaptability
Subtheme 1.2: Evolution of the professional self through adaptability
Theme 2: The client as the focus of decision-making
Subtheme 2.1: Working with the client's "otherness"
Subtheme 2.2: Psychologist's use of self
Subtheme 2.3: Bridging the gaps and connecting the dots
Theme 3: Decision-making guided by professional experience
Subtheme 3.1: Theory as a frame
Subtheme 3.2: Practitioner experience and idiosyncrasies in adapting theory
Subtheme 3.3: Use of supervision
Subtheme 3.4: Use of empirical literature
Theme 4: Reflective practice and therapeutic decisions
Subtheme 4.1: Evaluation of the process of decision-making
Subtheme 4.2: Being a reflexive practitioner and participant
Subtheme 4.3: Personal inclinations in decision-making
Theme 5: Decision-making dynamics when practicing within a context
Subtheme 5.1: Negative contextual influences on decision-making
Subtheme 5.2: Positive contextual influences on decision-making

Table 3. Themes and subthemes generated during analysis

3.2 Overview of Themes

All participants of this study have at least a working understanding of varying therapeutic theories and modalities due to their pluralistic training. Irrespective of the dominant therapeutic modality they practice in, all participants spoke about their awareness and training in differing therapeutic approaches. Therefore, across the data, participants declared a tendency to evaluate clinical presentations from this pluralistic awareness. According to the participants, this type of pluralistic awareness results in exercising flexibility and adaptability in clinical decision-making practices. Such adaptability in decision-making involves evaluating the available theoretical options that correspond with the client's needs and seeking the most suitable fit. All participants valued this pluralistic possibility in the work, while also identifying it as a challenge. They spoke about managing the challenges of adaptability in their decision-making and identified ways in which these challenges shape their professional practice in the long-run.

Participants were also careful to delineate the client as the "other" who influences the progression of the work, when considering clinical decision-making. In this sense, the participants explored their decision-making practices with respect to the information the client offers verbally, in conjunction with their own understanding of the client through their use of self. This information is then put together to make sense of the client's narrative, by using the psychologist's professional knowledge and clinical experience. In this respect, participants spoke about their use of theory as a frame that grounds their clinical understanding of the client, while also discussing their idiosyncrasies in adapting theory. Their adaptation of theory and decision-making were also considered through their use of supervision and empirical literature.

As a result of delineating the client as the "other", all participants established the value of the separation of the individuals in clinical work. In this respect, participants spoke about their own influence on their clinical decision-making through the use of reflexivity. Reflexivity was used to discuss clinical practice, the psychologists' participation in this research, and their individual characteristics that influence decision-making. As part of their reflections on their relationship to their decision-making, participants also spoke about the negative and positive contextual influences on their clinical work. These influences mainly related to the settings in which clinical practice

takes place, with particular attention to the role of the organisation in the participants' professional confidence.

The above summary of the data is broken down in detail through five themes generated from the analysis of the case vignette exercise and the semi-structured interviews. The themes are: Adaptable practice as the focus of decision-making; The client as the focus of decision-making; Decision-making guided by professional experience; Reflective practice and therapeutic decisions; Decision-making dynamics when practicing within a context. A detailed narrative of each of these themes is outlined below, with supporting extracts from interviews included to demonstrate the interpretative approach of the analysis (see Appendix N for Presentation Key for participants' quotes).

3.3 Theme 1: Adaptable Practice as the Focus of Decision-making

Regardless of the participants' self-declared dominant modalities, they spoke about their knowledge of varying therapeutic options and theories. Given their pluralistic trainings, even though some participants work with one single therapeutic modality, they have an understanding of other ways of addressing the same presenting issue. Based on this understanding, participants have disclosed that flexibility has become the defining feature through which they conduct therapeutic work by aligning with the client's narrative and exercising adaptability to the client's needs. This also involves managing several competing theoretical approaches available to them through training and experience, and adapting these to the client's presenting issue. The participants' experiences of this adaptability in decision-making centred around two particular aspects of their work, which are separated under two subthemes. These subthemes highlight the challenges of this adaptive approach in decision-making and the impact on the participants' evolution as practitioners.

3.3.1 Subtheme 1.1: Managing the challenges of adaptability.

According to participants, their pluralistic background affords them the opportunity to work in ways that are adaptable and fluid. That is, their awareness of several therapeutic avenues available in response to different clinical issues raises the possibility of various ways of addressing the problem. While this wide perspective on psychological theory can be useful, participants also spoke of its challenges. These challenges mostly relate to the tensions of moving between approaches and managing the ensuing confusion. In

response to this fluidity in the work, participants spoke about seeking stability and the potential impact of this. Over the course of the interviews and within the case vignette exercises, participants described and demonstrated actual changes in the foci of their work and evaluated their experiences of these.

Initially, some participants described their response to the case vignette client material to shift in focus as the narrative progressed. This change, allowed them to explore the possibility of navigating competing foci in the work, based on their pluralistic knowledge of varying theories and modalities. For example, Aisha expressed her oscillation between different theoretical perspectives when describing her reactions to the case vignette exercise, expressing the pull between her self-declared dominant clinical modalities:

> So I was thinking from a psychodynamic perspective, and just kind of wanting to find out history. Cause I do think history is really important. Although, because I had from section one kind of thought, anxiety and panic attacks were the thing, I was thinking CBT. Once we thought out psychodynamically what's going on, then we kind of maybe go down a more CBT type route. Then by section two I was back to thinking about psychodynamic, because we're talking about wrong crowds and well, but then that's kind of CBT and psychodynamic anyway. (…) By section three, we are- I'm fully in psychodynamic mode by that point. ***(Aisha, p.19, l.314)***

This was echoed by another participant who explored their own approach to holding several competing foci in the work. For Martina, the experience of navigating this theoretical fluidity was expressed through holding the varying clinical issues in either the centre or the background of the work with the client:

> So I've always placed a lot of importance on early attachment. And my ears would always be very receptive to hearing about attachment difficulties presenting in adulthood. And, so you know, in the first session, or even if I was reading before I saw the chap (…) I would already be formulating something perhaps about availability and previous experience, plus, so the attachment stuff. I know CBT is probably the best intervention for anxiety, and well, I know it is for sleep issues. Anxiety and sleep issues. So I'd be holding that too. And panic attacks particularly. And then I would be holding the depression in the background, and also be getting ready to work on that if that actually presented as being more pertinent than the anxiety in the moment. ***(Martina, p.11, l.165)***

Based on the clinically non-complex case vignette, participants explored different foci of the client's narrative. This navigation of the foci involves adaptability in their approach as illustrated in Aisha and Martina's descriptions, which inevitably brings challenges associated with assessing and deciding on the central aspect of the work.

Kyle describes these challenges as being "painful" and "confusing". He ascribes the competing modalities he holds as the different "parts of" his professional self, indicating a depth in the level of engagement with the work:

> Painfully. A bit. Because (…) I think I'm, I often, get confused as though, I mean I'm sort of pluralistic, but that's quite confusing. So the dynamic part of me was like well, explore the family and then you know, the brother. But the sort of ACT part of me was saying go to make sense of his values, you know, look at the past but also focus on the here and now so I was a bit kind of confused, where do I go with this? (…). ***(Kyle, p.11, l.137)***

The confusion identified by Kyle was also noted by other participants as being anxiety provoking. In this respect, due to the available theoretical possibilities in their adaptable approach, participants spoke about changing their decisions in the work at times. These changes in decisions are experienced as being "messy" and create uncertainty for some. Yvonne, spoke about managing this messiness and uncertainty by adopting some regular practices such as having review sessions, which provide a routine in the work. It appears that for Yvonne, reflecting on her decisions on the case vignette example was an opportunity to evaluate some of her usual clinical practices. The main aspect of her regular practice she evaluated was of reviewing the work with the client at a particular point in therapy. She initially identified that in a situation where she changed her decisions involving the progression of the therapy, the work would feel "messy". She added that this in turn would create a reluctance in her application of the flexibility and fluidity that was discussed above:

> So I think that's really interesting and also, you know, I think the point you made earlier on, you know, is there actually scope for reviewing my decisions a little bit more frequently, and not just wait for session six to come, or for the review session to come. Because, I think in my mind at the moment, if I change the decision, it might feel a little bit messy (…) ***(Yvonne, p.26, l.482, continued below)***

As she continued this reflection, Yvonne demonstrated flexibility in evaluating her usual clinical decision-making practices. She went on to explain that by placing the client's needs at the centre of the work, her priority would be to accommodate and respond to the client. Her reflections may suggest that in feeling lost in the work may inevitably create some unavoidable inflexibility in practice that actually sits in opposition to the adaptability that drives her decision-making:

> ***(Continued from previous quote)*** (…) but actually that doesn't necessarily obviously need to be the case. Because if new information has transpired, then it's okay- or actually really important to respond to that. And I'm not sure if I sometimes, you know, just get lost and think well, this is what we set out, and we have still two sessions left because we said, we wanted to do eight in total or whatever else it is. So maybe being a little bit more reactive to what's actually going on. ***(Yvonne, p.27, l.488)***

As identified by most participants, part of the influence of a theoretically pluralistic background is the adaptive decision-making in the work, which can be experienced as challenging for the psychologist. The adaptability involves psychologists being open to shifting their foci and theoretical approach in the work based on their observations of the client presentation. According to the participants, the challenges of this fluid approach and the adaptability to the client's needs create some uncertainty in the work, which can be resolved through adopting regular practices such as reviewing the work collaboratively with the client at a certain point to evaluate the direction of therapy. On their own, these types of practices demonstrate inherent flexibility and good practice. Nevertheless, when positioned in the work as a response to the anxiety that flexibility may bring, they have the potential to become inflexible practices in their own right. In turn, managing these challenges in decision-making may shape the professional evolution of the psychologist over time.

3.3.2 Subtheme 1.2: Evolution of the professional self through adaptability.

The ongoing decision-making practices of participants that centre around managing the challenges of adaptability appear to have an impact on their clinical approach in the long-run. Participants spoke about ways in which they have evolved through ongoing adaptive practices over the course of their careers. With respect to their professional evolution, participants discussed their management of anxiety in the work, as well as the changes in their decision-making over time as they gained more

experience. Despite the ways in which adaptability has shaped their decision-making, participants connected with the core of their identity as psychologists in their ability to ground their clinical decisions in theory.

Max, spoke about his early career and feeling a need to gain more theoretical knowledge, to appease the anxiety he felt in making clinical decisions. He described attending several further training courses after his clinical training to build on his knowledge of varying theories and approaches to clinical practice. He explained that, in fact it was the fluidity and application of flexibility in the work, as well as his experience with clients that allowed him to "relax" in his work:

> It's not that I've got more, kind of fluidly eclectic or integrative. (…) I mean there was a stage, I guess when I was, after I tried all these different, like I said, ACT and CAT and bla bla bla for certain things, I went on all these courses, I managed to calm down ((Laughs)) after all, and from all of that, and I think just the experience was the thing actually. Just seeing lots of patients gradually helped me relax about that. ***(Max, p.23, l.382)***

This statement highlights the challenge of seeking and navigating ways of working with a theoretically pluralistic background. The quote also establishes the subjective experience of clinical decision-making as being separate to the depth of theoretical knowledge held. That is, Max's description of seeking further theoretical knowledge is representative of many participants, who identified that ultimately their experience of clinical decision-making was independent of their confidence in their theoretical knowledge. This is echoed by Amy, who also reflected on the influences of her training, with which she states her practice has evolved over time to become more adaptable placing the client at the centre of her work:

> I think having come from training that's CBT and now using kind of, other sort of therapeutic approaches, and not actually having to have such a protocoled approach, and actually kind of seeing where things take you and then kind of adapting what you kind of do based on that. (…) ***(Amy, p.2, l.15)***

Amy elaborated on this point, by establishing this as part of the evolution of a practitioner's journey of development in clinical work:

> (…) I think that's just part of like how you evolve as a practitioner anyway. ***(Amy, p.5, l.59)***

Her suggestion ascertains the point made by several other participants; the impact of practicing in a flexible manner in the long-run, shapes the type of clinician that a psychologist develops into over the years of their practice. Camille also highlighted this point in her own experience, identifying her practice as being more flexible now compared to her earlier career:

> I think what struck me is how it's evolved over time. So, I think in the earlier days of my career, it was much more driven by probably generally agreed things about what one should do around the set of symptoms of a diagnosis. Whereas now I think I'm a bit more flexible ((Laughs)). ***(Camille, p.28, l.488)***

All participants highlighted the importance of flexibility within clinical decision-making, though central to this reflection was the emphasis on developing theoretically informed case formulations as a psychologist. Hence, each participant declared their decisions as being rooted in formulations, regardless of their varying journeys to their current clinical practices. Melanie, identified a key moment in her own development as a psychologist, when this had been highlighted to her as a trainee:

> But for us to be really aware of why we do the things that we do, cause I remember when I was on clinical training, (…) I remember the clinical psychologist there on my placement said "What makes you different from, say the nurses that are offering CBT? Or other professionals in the team?" and I dunno and she said "Because at any point, you should know why it is that you're doing something, what is informing your approach", she said "Other people will do things, cause they'll just do it, but as a psychologist you need to be thinking about what informs your- what approach you're using, what theories or-" and she said "You must always be aware of those things, because that's what makes you different". It's our training, and you know in many different approaches and models, which helps inform. And why we can adapt our interventions to lots of different client groups. Because we have that understanding. And when you feel like you have that, I think it strengthens your identity and your confidence in your clinical work. But it means probably constantly stepping back and questioning why it is that we are doing something, (…) ***(Melanie, p.34, l.573)***

Melanie's memory of an exchange with a colleague outlines the ethically responsible and fundamental strength of a psychologist's process of clinical decision-making. One of the key aspects of this reflection resides in the last sentence where Melanie reflects the ongoing challenges of psychologists' experiences of decision-making. According to the participants, adaptability in theoretical formulations is central to the work they are able to offer. On the other hand, the challenge that ensues is often experienced as anxiety, uncertainty, and at times even a type of professional "pain", as noted by Kyle. In turn, this ongoing challenge appears to be translated into an evolution of the practitioner over time, through the management of the challenges to adaptability as part of decision-making.

3.4 Theme 2: The Client as the Focus of Decision-making

This theme focuses on the client as the "other" in the therapeutic decision-making process. Participants acknowledged the client as being influential on their decision-making and linked this with their view of the client as a separate person. According to the participants, this implies that the information the psychologist is given by the client is filtered through the experiences, expectations, and agenda of the client. This story is then received by the psychologist who tunes into their own experience of being with this individual to make sense of this narrative. The psychologist then uses the information available to them through the client's description, their own experience, and the therapeutic relationship to make clinical decisions.

3.4.1 Subtheme 2.1: Working with the client's "otherness".

In their descriptions of clinical decision-making practices, all participants acknowledged the client as a separate other in the room. That is, the emphasis for participants was on the separation and individualisation of the client as a person who may have their own thoughts, feelings and expectations of the therapeutic process. With this in mind, each practitioner described ways in which they would work with this "otherness" to ensure that equal attention is payed to different aspects of the client, such as their presentation, any diagnoses, or history. In this sense, as a separate "other", the client has the control over their own narrative, choosing when and what to disclose in therapy. The participants noted in their accounts their awareness that they are bound by the information that the client is willing or able to offer, and the impact of this on the progression of the work. Further to this was the participants' evaluation of their

experience in relation to this reliance on the client for information and they spoke about navigating working with the "other".

The separateness of the client as the "other" in the room was expressed by all participants in similar ways. One example common to most participants was the reflection that Melanie offered while describing the client's process of revealing their narrative. She gave an example from her own practice when speaking of the client's separateness, pace, and control over information that would impact the formulation within the work:

> I suppose this is kind of what happens, you know as we get to know people, you know they might offer us more information and that can happen I suppose, moment by moment in a session or you know *over* sessions and you know I think sometimes clients don't tell us important information because they may not trust us early on, and- but that might be a really key part of the presenting problem or the formulation that's missing and until we have that information, you know we're going to be lost as clinicians just like. And just thinking of the client I was working with who was quite depressed (…) and it wasn't until maybe three sessions in, she said that she had been sexually abused by her grandfather and this brought up all, you know, I had the safeguarding issues that had to be acted on that very session. And but it really changed the direction of the intervention and the formulation as well completely. So I think, you know, I think as a clinician you have to be just ready for that, prepared at any time that we may be missing information or- and what it would mean for our formulation, for our treatment or the intervention and even our relationship with the client and yeah that sort of thing. ***(Melanie, p.10, l.139)***

This kind of flexible and fluid position that a psychologist takes in relation to their decision-making is beyond the adaptability or the collaborative aspects of the work. It emphasises the input from the client as a core ingredient of the psychologist's clinical decision-making, with particular attention paid to allowing the client their own pace. Inherent in this is the client as an individual who is separate to the psychologist and the clinical task. Observing and attending to the client as an individual requires engaging with several aspects of the client's presence in the room as highlighted by Max:

> Ongoing, psychodiagnostic fairly implicit kind of assessment of how he's relating to me, how he's experiencing himself, how cut off he is from his own feelings, especially his anxiety, where it's shoring itself in his

> *breathing*, and his arms and his legs, and his sweating, and his panic attacks, (…) The state of the transference, the state of the positive kind of aspects of the relationship, how much hope there is, how much work I have to do in trying to mobilise the kind of like, be kind of, make a stand for, healthy, warm, empathic, hopeful, caring constructive work. ***(Max, p.13, l.193)***

Therefore, there is an acknowledgement of the client's process in therapy as being separate to that of the psychologist. This is a process that may require a particularly attuned type of attention from the psychologist, who will need to assess the client's position in therapy and attempt to respond to it appropriately as described by Max. This type of attunement to the client's position is then taken into account in the decisions made by the psychologist to allow for the client's individuality. In this sense, Aisha reflected the complex process of making room for the client and their process, by describing the potential cost to the practitioner as being "tiring" but potentially "rewarding":

> Yeah ((Laughs)). I guess, generally it's tiring and occasionally I guess when it feels as though the- the decisions have been very well timed, and very well. But even though I have *absolutely*- in some ways I'm not responsible for how the information comes to me. But if it feels as though it went how I'd like it to go, then it's rewarding. And I don't mean that the client skips out of the room, I just mean that I was able to make decisions which were helpful. Which created a little bit of a shift perhaps for a client. ***(Aisha, p.27, l.452)***

The "tiredness" arising from the complexity that Aisha spoke about is another expression of the challenges of clinical decision-making, echoed by other practitioners in similar ways. A further complexity according to participants, is that the experience of making room for the client as an individual also requires the psychologist finding a balance between being passive and active in the work. That is, making room for the "otherness" of the client relies on being able to give the client the space to disclose their narrative at their own pace, while also actively engaging in an exploration of this narrative that will inform the formulation. In this respect, a psychologist will have competing and evolving hypotheses relating to the possible therapeutic avenues to follow, while the client's narrative unfolds and changes. These choices are then narrowed step-by-step, based on the interaction between the client and the psychologist. Much like other participants, Camille's description captures the balancing task of

allowing the client their own space to reflect on the support they need, with the process of making clinical decisions based on the narrative. In this respect, the first step for Camille is to annotate the client as a separate "other":

> (…) it's more than hypotheses. Because I think it's also multiple hypotheses could be true. Multiple things might be useful, but it's almost being guided by him around what might be most useful at this point in time given where he's at. Some of the things you may never ever know, might be shaping his decisions. I don't know if that makes sense. ***(Camille, p.11, l.173)***

Each participant spoke about the different ways in which they would work with the "otherness" of the client. An agreement across all participants appears to be that the client could not possibly provide the full picture of their story to the psychologist verbally. Inevitably, as Camille suggests, there will be aspects of the client's experience that is not communicated verbally, to which the psychologist will need to tune into by other means. Linked to this, all participants also spoke about making sense of the available information by relating to the "other", referring to their use of self in the work.

3.4.2 Subtheme 2.2: Psychologist's use of self.

The use of self appears to be one of the core tools that guide decision-making for the participants. Here, the use of self refers to a process of exploring and reflecting on the participants' own sense of the relationship with the client, used as information to guide the work. Most participants spoke about checking in with themselves to identify aspects of the therapeutic relationship that supersedes verbal exchanges. At this level, participants seemed to consider decision-making as an introspective process that happens alongside the clinical work, as described by Kyle:

> How do I use that internal communication that my body gives me with this person? How do I use that to make decisions? And then what? Cause usually decision-making is based, *for me* I mean I'm sure everyone will disagree in terms of whether therapy is an art or a science, but there is some kind of trust and a creativity in it, that you sort of, and when there is doubt then I usually take that. Like, what do I do next, sort of thing. ***(Kyle, p.23, l.364)***

Fundamentally in Kyle's evaluation of therapy as an art or science, there is the possibility of a creative role within psychology that explores the intersubjectivity

between the psychologist and the client as individuals. Based on this description, one assumption in this dynamic could be that decision-making in therapy involves more than the co-creation of a relationship, which is mainly based on the client's narrative. That is, decision-making inherently involves the psychologist as a self-aware decision-maker, who also has their own psychological timeline, as noted by Max:

> I'm- we're part of a process, I've got my kind of things I'm looking out for, not particularly consciously, but things I'm sensitive to, like how anxious is he and so on. How has he- what kind of psychologist does he seem to have right now? I suppose that's a way of putting it. Am I like the scary dad, or the- I'm the withholding parent or whatever, or you know all those kinds of things. (…) And then what- my kind of, my assessment of it I don't think, it's not a separate moment in my own psychological history. You know, my own current psychological, you know timeline as it were, from my making adjustments, which kind of leads the therapeutic relationship in certain directions. ***(Max, p.10, l.139)***

In this respect, the necessity of the use of self is not just a creative aspect of the "art" or "science" of therapy, but also is a part of responsible practice in relation to the self-awareness of the practitioner. Kyle captures this self-awareness by noting the anxiety in the room:

> There's two scared and anxious people in this room. (…) I don't just want a story, I want a lived experience with a client. ***(Kyle, p.27, l.428)***

For some participants like Kyle, the use of self is a part of decision-making that is informed by their own experiences of the client in the room, which is an involved experience. Being able to use self-awareness as a source of information, without becoming overinvolved to lose sight of the professional boundaries of therapy is also a balance that will need to be maintained with respect to decision-making.

3.4.3 Subtheme 2.3: Bridging the gaps and connecting the dots.

The participants described their decision-making process in relation to the information gathered from the client. In this sense, the parts of the narrative that the client chooses to offer as the "other" in the room is understood in conjunction with the psychologist's use of self. At this point, the participants spoke about interpreting the client's story, making sense of their relational history and the therapeutic relationship, which then is used to make clinical decisions. Here, the focus is not on what is brought by the client

and how that is made possible by the psychologist, but specifically *what* the psychologist does with this to inform the work.

At the start of the process of making sense of the client's narrative, all participants spoke about the way they understand the client's difficulties in relation to their history. All participants used the example of the case vignette client used in the first part of the interview to illustrate this process:

> So, in my mind already, I was picturing these non-available parents who probably weren't that available, able to give him the sort of support and comfort that he needed, or to give him the right guidance, or to settle in and to make the right adjustments. And that this what I would have seen in terms of the anxiety and the panic attacks and insomnia, and understanding his history of depression, would say inevitably comes from a sort of attachment issue. ***(Martina, p.2, l.27)***

As exemplified in Martina's process of making sense of the client's narrative, the psychologist is not concerned with the symptoms of distress at face value. This is where the complexities of the client as a person come alive, which is far from a linear explanation that may fit into a protocol. Participants state that this is one of the complexities of decision-making, in that a simplistic linear chain of causation may be more appealing but less useful in therapy, as described by Kyle:

> And I think the trap that we have sometimes and our clients have is that they want a narrative chain of causation, want a- "Ah, I'm feeling this because this and this happened." And I'm, you know, so that's what I'm trying to be curious not to just follow the train because I think we wanna create a linear you know chain of causation. ***(Kyle, p.13, l.167)***

In this respect, the complexities of decision-making, may require tuning into more than the client's narrative, the available theory or treatment protocols. For this, the participants spoke about having to tune into the relational aspects of the client's presentation that help contextualise the information that is available to them. Building on the psychologist's use of self, these relational aspects include the relationship between client and psychologist as noted by Max:

> But at the level of actual decision-making, the point is that I wouldn't be making decisions based on the information that's present in the vignette.

> I'd be making decisions mainly, probably largely automatically, somewhat semi-consciously based on my kind of ongoing assessment of his defensive functioning and his anxiety levels, and the transference. ***(Max, p.8, l.116)***

The possibility of the psychologist creating space for the client to bring themselves and their narrative was also discussed through the balance between the client's therapeutic focus and the psychologist's own. The participants evaluated the way they might achieve this working balance, by reflecting on their interventions and particularly on their decisions to honour the client's own therapeutic concerns or choose to prioritise their own clinical judgement. Subsequent to this, each participant described in their own words, the way they would also make room for their own therapeutic interpretations and subsequent decisions:

> There's something about, kind of, on the one hand, making sure I ask the patient what he actually wants rather than assuming that I know from his presentation or from his presenting problems, or from his *presented* problems, what does he *actually,* what does he actually want? But on the other hand, I would be happy to allow myself to think about what he needs independently from what he says about what he wants. (…) And so, I'd allow myself my own angle on it. ***(Max, p.31, l.532)***

When evaluating their exploration of both verbal and non-verbal aspects of the client's narrative, participants were also interested in the information they chose to tune into. This was framed by most participants as another aspect of their decision-making experience that is less apparent and was inherently a curious experience:

> Or being aware that, actually at every point I'm making a decision, what question am I going to ask? What am I curious about? Why am I curious around that? You know, or how I might kind of recommend even sending certain *resources* (…) why those resources? ***(Melanie, p.30, l.505)***

Decision-making in the clinical work appears to come alive for these participants with respect to information gathering regarding the components they may choose to tune into. This subjectivity in information seeking is another aspect of the complexity of decision-making as it highlights the numerous other components of information that may be missed. As noted by Max and several other participants, it is not solely the linear narrative that informs a formulation in the work, but the aspects of information otherwise unavailable to a practitioner who may not be tuned into the therapeutic

relationship. In this respect, it is the "otherness" of the client and the psychologist's use of self that offer part of the information lacking in a linear narrative.

3.5 Theme 3: Decision-making Guided by Professional Experience

Participants discussed the influence of their learned knowledge on their clinical decision-making. In this sense, learned knowledge refers to the theoretical information psychologists gain and maintain through training, CPDs, supervision, and simply keeping up-to-date with new literature. In this respect, this theme focuses on the professional knowledge that informs clinical decisions and is independent of the two individuals in the room. Specifically, the theme relates to decision-making processes involving the use of modalities, theories, protocols, or practices participants use. The emphasis is on their experiences of using practical strategies gained from varying theoretical backgrounds, which influence their approach to clinical work, supervision, and use of empirical literature.

3.5.1 Subtheme 3.1: Theory as a frame. All participants spoke in detail about their relationship with theory. As highlighted in theme one, participants identified that their professional strength as psychologists resides in their ability to use theoretically driven formulations as a base for their clinical decision-making. In this sense, participants discussed their approach to the use of theory with respect to prioritising presenting problems and their levels of professional confidence. At the core of their relationship with decision-making, participants returned to the acknowledgement that they resort to theory as a frame, even when they feel they have departed from the strictly protocol driven approaches in therapy.

Using the case vignette example, Martina explained the split between using theory as a frame within the work and reflecting on the relational component of the therapeutic exchange to inform practice. According to her description, the therapeutic needs of the client inform her approach of prioritising symptoms through evidence-based therapeutic protocols:

> Because from the first session I would have already formulated in my mind that I would work on the immediate presentation of anxiety and insomnia, because it's so intrusive, and it's very difficult to sort of work existentially when those issues are present. And so, I knew that I would be working at two levels, which would be that initially just using CBT

> approach to manage the presenting symptoms, but then beginning to encourage relationship where we could explore what's really behind all this. ***(Martina, p.3, l.43)***

According to the participants, the theory is an essential base in building formulations of the client's difficulties. Nevertheless, this finding needs to be considered together with the flexibility and adaptability, which was also established as being central to the work in Theme 1. With these two aspects of decision-making held together, it is safe to assume that there will be some divergence in the way the theories are then applied in the work. For some, the extent they choose to stay committed to the practices suggested by theory was noted to be linked to their confidence in their work:

> But like I said you know, because I'm also one of those that isn't really really confident in what I do. So I haven't sort of thrown myself wholeheartedly into I don't know an ACT sort of practitioner. Like I said, I always use CBT as my fall back. ***(Amy, p.5, l.73)***

Based on this, the decisions that depart from the familiar theoretical guidance may be mediated by the level of confidence a practitioner feels they hold in their clinical work. For some participants like Amy, this professional confidence in decision-making was in part-based on their amount of clinical experience in the field. Others, who felt more confident in their decisions, spoke about clinically drifting further from theory at times. Even though the relatively more experienced practitioners may have spoken about their divergence from practical theories and protocols, they were clear that their decisions are informed by theoretical frameworks:

> I'm aware that when I seem to have only just recaptured that aspect of my work as it were. So the aspect of my work which is even less intervention focused than what I've described here. So what I described here was I wasn't gonna go gung ho with scientist-practitioner kind of driven kind of, empirical research based kind of interventions. But even when I describe what I'd do instead, I still went, "I'm gonna be assessing the transference, assessing the anxiety" and so on. And then I'm gonna be, you know, reacting on that basis. ***(Max, p.34, l.591)***

At this point, having acknowledged the use of theories as a framework to inform practice, it appears all participants are at times likely to use their own idiosyncratic approaches to inform the work. These idiosyncrasies are central components of the

decision-making practices of these psychologists, helping us further understand the participants' experiences of adapting theory in their work.

3.5.2 Subtheme 3.2: Practitioner experience and idiosyncrasies in adapting theory.

At the base of clinical decision-making, participants spoke about the way they feel they have departed from the use of strict therapeutic protocols over time. In this sense, their relationship to the element of responsibility and confidence in decision-making has guided their use of the theory. Perhaps complementary to the acknowledgement of varied and adaptable approaches outlined in Theme 1, participants agreed that while there may be several ways of addressing the same issues, the clinical understanding that guides the decision-making is comparable across psychologists.

Amy summarises these idiosyncrasies in her use of theory, which have been discussed by each participant, by explaining psychologists' evolving practice over time:

> (…) obviously your training is your grounding in kind of clinical psychology, but then you start to want to develop your own style or, you know, what it is to be a psychologist is going to be different for different people. ***(Amy, p.4, l.61)***

The development of the psychologist identity that Amy spoke about refers to an evolution of practices over time. For most participants, this correlates with the development of their confidence in clinical decision-making, which also touches on accountability and responsibility. This is echoed in different ways by each participant but is held as a central part of the decision-making experience for most:

> Something about confidence in decision-making being able to- that's been really helpful thing that has developed for me. So being decisive in decision-making I suppose, rather than having decisions in the sense of reasoned arguments and evidence rather than decisiveness. And putting myself on the line, not putting David Clarke, you know not kind of deferring authority for what I do to something else or someone else but be willing to just own a decision. ***(Max, p.37, l.653)***

Owning a decision, as described by Max, is a complex aspect of decision-making that may incorporate confidence (described by Amy in Theme 3.1), which may influence the use or adaptation of theory. On the other hand, accountability in decision-making is also closely linked with having a concrete theoretical foundation in decision-making

(described by Melanie in Theme 1.2), which may delineate the practices of a psychologist from other clinicians. The pluralistic position of the psychology training is key to the understanding of accountability and idiosyncrasies in decision-making. It is not solely varying interpersonal preferences that define the direction of the work, but the training and perhaps past clinical experiences that allow for participants to identify the way they may use some theoretical knowledge in favour of others:

> I think as a systemic therapist, you sacrifice information. So if I think I'm doing a CBT assessment, I do it quite differently. But generally, I prefer to sacrifice information. I don't really care what his brother's name is, or what company he works for, you know. What I'm looking for is the repeated patterns. So I'm more likely to tune into repeated patterns. Whether that's patterns from his life or patterns from my clinical experience. They guide me, more than detail. ***(Camille, p.16, l.265)***

Camille's point in case is not only about the variation within the theoretical knowledge each practitioner may use. Melanie describes the professional differences in the adaptation of theory among practitioners through the different foci practitioners may hold:

> (…) we're all looking at the same terrain, but we might have mapped it differently, you know different maps have different things they might be interested in. ***(Melanie, p.20, l.316)***

The differences in practices across practitioners of similar training backgrounds may be subject to evaluation with respect to ethical practice and use of theory. For this, each participant spoke candidly about their use of supervision to make sense of these shifts in clinical practices that may impact their processes of decision-making.

3.5.3 Subtheme 3.3: Use of supervision.

Each practitioner reflected on their own use of supervision as a component essential to their decision-making process. The evaluation of their clinical experiences commonly depended on the discussions in supervision, which they reported to shape the ensuing decisions. Participants also reflected on the possibility of a difference in opinion between supervisor and supervisee and evaluated this with respect to professional confidence.

Many participants spoke about their supervision as being a resource or setting in which the experiences of decision-making were thought about and weighed with the clinical needs of the client in mind. For most, the main component of therapy they bring to supervision was identified as the therapeutic relationship:

> What might be going on for me, if he presses buttons for me? You know, I might feel rather frustrated towards the end of sessions or whatever else, you know. Or feeling like we're not getting anywhere, feeling stuck. That's definitely something I would reflect on in supervision as well. ***(Yvonne, p.14, l.251)***

> Cause I think supervision helps me to make decisions around sort of what I do next with this person, what my focus is. I think certainly I think, (…) it's the relationship that I will bring. Like if I'm feeling scared or frustrated or confused. And then what do with that? (…) what do I do next, sort of thing. ***(Kyle, p.23, l.359)***

According to all participants, the relational components of the clinical work are often evaluated in the supervision context. Each psychologist identified that the most helpful aspect of supervision is the opportunity to consult with a colleague when reflecting on the process involving clinical decisions. On the other hand, this does raise the point that the supervisor as another practitioner, will have their own preferences and decisions in relation to the supervisee's narrative:

> I guess I've been thinking that and I think that's been quite a big influence on me recently, particularly on my confidence where actually again, you know, my supervisor uses much more CBT and maybe not other things. So then some of our discussions about patients or like decision-making, we've maybe- so we've come at it from different angles. (…) And maybe how we formulate things have been quite different. And I think that's been like quite a major influence in terms of, you know, what do I go with then, do I go with their suggestion, or some of my gut? But then, because ((Laughs)) I'm not really confident in my own response (…) ***(Amy, p.7, l.122)***

It may be this type of difference for those participants who are more recently qualified, in comparison to the more experienced practitioners, that impacts and shapes decision-making in response to supervision. This influence was reported to impact confidence in practitioners who have more recently began developing their practice. For many, this is balanced by their involvement in further development and search for additional

information through the use of empirical literature. This relationship with the literature is used either as a complement to their standard practice and use of supervision, or at times to resolve such differences of perspectives between supervisor and supervisee.

3.5.4 Subtheme 3.4: Use of empirical literature. The use of empirical literature for many of the participants was identified as being supplementary and not always central to developing their clinical decision-making. The use of such resources was identified as being less likely to be a first point of information, in comparison to supervision or consultations with colleagues. Nevertheless, it appears that for most participants, the use of empirical literature to inform practice is treated as a "last word" in points that may cause difficulty or confusion in the work.

When considering their reports on their use of empirical literature, it is important to hold in mind the participants' relationship to psychological theory in relation to their decision-making practices. In this respect, their idiosyncratic practices suggest a critical approach to theoretical knowledge. When asked to reflect on their most comfortable use of empirical literature, the participants described often seeking further information on the practical application of modalities and theories. This is in contrast to seeking literature on the theoretical understanding of phenomena in the work:

> Well I think if I were to read something empirically, it I would be if I'm really confused or I wouldn't know what to do next. (…) So it's less about the theory of anger but more what do I do with it in the room. But with him, or with this individual, the 32-year-old male living in the central area of a large city, it kind of feels quite logical to me like, like he's grown up in a family that there is changes there's challenges and now he's 32. You know, and I suppose I'm seeing his low motivation, low mood, anxiety as quite healthy thing. So for me it I think is making sense of it does doesn't feel challenging, well I suppose I would be- I would be more curious to look up as if- if he is more and more challenging with me, what to do then I guess. ***(Kyle, p.22, l.340)***

Depending on their context, the participants have also noted using literature to gain further knowledge on their area of practice. An example of this use of literature is that of Yvonne, who works in a specialist health setting. She spoke about seeking content-based information to complement her therapeutic practice:

> At the moment though, because of the work that I'm doing, it's not so much that I'm reading up on different treatment modalities, for example, or how would I do this in CBT, or this in ACT, or this in schema based therapy. I think for me it's more at the moment thinking about, depending on what the difficulty is, how to have really difficult and sensitive conversations and then around that. So for me, I think just because of the area I work in, that has changed a little bit. So it's more content based, rather than intervention focused if that makes sense. ***(Yvonne, p.21, l.373)***

Empirical literature appears to be a significant source of support in decision-making for the participants in this research. An important aspect of their relationship to empirical research is embedded in the ability to exercise critical thinking, to appraise the literature they engage with. In this respect, these critical thinking skills that complement psychologists' approach to decision-making are also relevant in evaluating their own relationship to the work, in the form of reflexivity.

3.6 Theme 4: Reflective Practice and Therapeutic Decisions

As part of the research interviews, the participants explored the importance of reflexivity in their decision-making processes. Subsequently, this theme relates to the personal reflections of the participants, which include expressions of feelings associated with the process of decision-making, meta-cognitive descriptions of their practices, and participation insights relating to this project. In essence, this theme specifically looks at the participant as the person doing the work with reflexive access to their own individuality. This is different to the participants making use of the self as part of their decision-making, as it is independent of the theoretical knowledge they hold. The subthemes under this theme separate participants' critical evaluation of their decision-making practices, their thoughts on being a reflexive practitioner, and their position as a professional individual. Among these subthemes, I have delineated their reflexivity on their professional identity from their reflections on the process of decision-making. In this respect, the former refers to ongoing and in depth critical evaluation of the experience of being a psychologist, while the latter is their off-the-cuff thoughts on experience.

3.6.1 Subtheme 4.1: Evaluation of the process of decision-making.

Inevitably as part of the ongoing engagement with decision-making as part of this study, the participants often chose to evaluate their own decision-making processes. That is, they described their processes when considering their experiences and drew their own

conclusions on their relationship to decision-making. As part of this, participants evaluated their experiences of confidence and the sense of responsibility in the "tiring" but "rewarding" task of decision-making. Additionally, they considered the role of intuition as part of clinical decision-making.

For some, owning the responsibility of decision-making does not come as easily and is experienced as a source of anxiety in the work. According to some participants, this is the type of issue that requires the support of a more experienced practitioner, to avoid the feeling of loss in the work, which Amy characterises as "drowning":

> I think I panic when I should you know, (…) I'm a band 7 and I *should* know a bit more what I'm doing, and I shouldn't have to, kind of always go to my supervisor and check things out. You know, like I should be able to trust my own judgement as well. So again, you have that sense of, I wanna do a good job, but if I don't feel like I know what I'm doing, it can make you feel like you're drowning a bit. ***(Amy, p.20, l.369)***

In contrast to this experience, Max's earlier input on the necessity to own the decisions being made in the work comes to mind:

> And putting myself on the line, not putting David Clarke, you know not kind of deferring authority for what I do to something else or someone else but be willing to just own a decision. ***(Max, p.38, l.658)***

A common narrative among participants was the acknowledgement of the effort and energy that goes into making, evaluating, and owning clinical decisions. Particularly having identified the different components of clinical practice relevant to decision-making as identified in earlier themes, the complexity of ongoing decision-making in clinical practice can be "tiring" though simultaneously "rewarding":

> Until I did this, I wasn't really aware of how many decisions are being made while you're seeing- while *I'm* seeing somebody. It's just kind of, is something that I do, but breaking it down has made me aware that my decisions are continuously changing, and *actually* it helped me understand why I am sometimes so tired ((Laughs)) when I see quite a lot of clients, because there's a lot of brain work. And a lot- cause it's not just, cause it's decision-making, and it all feeds back to what they say, to what you think. And the process of doing that, within an organisation, within time constraints, within you know, wanting to do the right thing, and say it in

> the right way, and use the right words and the right language, it all makes it quite a complex task. But very rewarding. ***(Aisha, p.26, l.436)***

Beyond the conscious task of holding the different aspects of clinical work relevant to decision-making, there are also the aspects that cannot be described tangibly or objectively. For most, this is a way of *being* within the decision-making practice, rather than working with it. Participants used different terms to identify this aspect of *being within the decision-making,* such as a collection of clinical "experiences" or "intuition". Nevertheless, every participant agreed on part of the process of evaluating the decisions-made in the work as being an internal experience of the psychologist:

> So it's that kind of learning through experience. And maybe the experience has taught me to trust my intuition. (…) But I think in the early days, I would have kind of ploughed ahead when things didn't kind of, stack up. ***(Camille, p.29, l.502)***

> I suppose that it's even if I don't think to myself, on my own, "How did I reach this decision?", it's always *implicitly* there. Because I have to not justify it, but have to articulate it. How did I reach that decision? Where did I get that from? So (…) I don't think, I would actively say to myself, how did I arrive at that decision, because as I say, it feels intuitive. But I'm aware that there's a lot of background work, that goes into that feeling of being intuitive. ***(Martina, p.24, l.408)***

As highlighted by the participants, the internal process of evaluating the clinical decisions-made for practitioners is one that is based on "a lot of background work", which will culminate in the experience of "intuition". While arguably there may not be a scientific method available to evaluate the accuracy of this part of the decision-making process, this is widely accepted by participants to be the human component of the work. Therefore, this human component is also the person who is interested in the client as the "other" and is the individual who brings their own clinical and relational epistemological framework into the work.

3.6.2 Subtheme 4.2: Being a reflexive practitioner and participant.

Participants reflected on their experience of the ongoing use of reflexivity in their work. Alongside this, they also considered their participation in this project from the perspective of their roles as psychologists engaging in continuous clinical decision-

making. Within these reflections, they touched on their own motivations and anxieties as psychologists, and their reactions to evaluating their decision-making practices.

At the centre of participants' reflexivity was an exploration of the meaning of clinical decision-making and the impact of this on their sense of identity as psychologists. Most participants considered their role in decision-making and their possible influence on the therapeutic alliance as individuals. In part, this was about being able to balance the needs of the client in therapy, with their own interests and curiosities. Inherent within this, perhaps, is the assumption that the individual who became the psychologist, was motivated in pursuing the profession with a natural curiosity about people. Nevertheless, the balancing act comes from being aware of this motivation and not allowing it to overtake the priorities of the client, thus requiring ongoing reflexivity in the work:

> And I think for *us*, you know we kind of have our own agenda- not agendas but things we're quite curious about and might wanna work on (…) and I can imagine if I'd pushed that too far you know, it might lead to a rupture or the client not coming back, or so I think needing to be aware of those things and how our decision-making might, you know impact on the relationship the therapy whether good or negative kind of way. ***(Melanie, p.14, l.206)***

This reflexive stance also extended to their participation in this research. Most participants stated that this exploration of their experiences of clinical decision-making coincided with a process of shifts in their work and identity as psychologists. These participants expressed that actively engaging in the research task created some momentum in their already mobile evaluation of their current work. While some stated this was a neutral and natural evolution in their careers, others spoke about using this opportunity to establish a relatively more comfortable relationship with their profession than before. For Amy, reflecting on her experiences of decision-making allowed her to feel more comfortable in the possible challenges in her practice:

> It's been interesting actually, to reflect on it. And I think maybe, you know, obviously coincidentally I've come to do your research, but I think it's very- a poignant point for me at the moment of having felt quite ambivalent about being a psychologist in the past few months. And like I said, (…) it's definitely been something I've been reflecting on a lot. And am I doing the right thing? And actually, it's maybe reaffirming that, no it

> is. You can't- you just don't get it right all the time, but that' okay. ((Laughs)). ***(Amy, p.22, l.401)***

Part of the psychologists' reflections on their participation, centred around the use of the gradual reveal case vignette, which was received as a novel experience in the use of case examples. This exercise appeared to be an opportunity for participants to evaluate their clinical decision-making experiences in their ongoing practice, in a way that allowed for a recognition of anxiety surrounding possible errors in the work:

> Doing this particular experience, there was a little bit of anxiety actually, about getting it right. I really wanted to get it right. And actually, I guess I do have that in reality as well. And that is why I will kind of, check back. But I sometimes I will make a mistake, and that's kind of okay too. But in wanting to take the right route, and get as best a change as possible, in the shortest space of time that's where the anxiety comes I guess. ***(Aisha, p.12, l.173)***

An interesting reflection that each participant offered in their own way was that they had not reflected on their decision-making processes at all, up to their involvement in this research project:

> (…) you know, until I read the outline of your research, I hadn't particularly thought about how I would- I make decisions in an active way. But I'm not surprised by anything I said ((Laughs)) if that makes sense. ***(Martina, p.25, l.420)***

This finding offers an important consideration with respect to the variation and pluralistic approach in trainings, the multitude of roles of practitioner psychologists in the workplace, and consequently the significance of reflexivity to ground the psychologist identity. Nevertheless, most participants agreed that regular engagement with such reflection on decision-making would be helpful. Like most participants, Yvonne spoke about the benefit of slowing and breaking down her clinical practice, to evaluate her decisions:

> I think it would be helpful to be a little bit more conscious about how I actually come to conclusions and how I make decisions in my clinical practice. And almost maybe, consciously breaking it down a little bit. ***(Yvonne, p.26, l.472)***

Part of the task of breaking down the decision-making process is engaging with reflexivity. Specifically, the ongoing awareness of the practitioner's own individual characteristics and relational frameworks that may influence their decision-making processes, is part of the task of breaking down decisions. The participants engaged with such reflexivity while considering their personal inclinations in their practices.

3.6.3 Subtheme 4.3: Personal inclinations in decision-making.

At the core of the discussions on clinical decision-making, it is important to delineate the psychologist as the individual making the decisions. Having noted the client as the separate "other" in the therapeutic exchange in Theme 2.1, this subtheme relates to the second part of the equation involving the two individuals in the therapeutic relationship. With respect to their individual characteristics influencing decision-making, participants spoke about their own psychological processes in their work as well as their personal characteristics. This subtheme holds the individual practitioner as a person at the centre of the reflections, with their approach to decision-making as a frame. Therefore, this subtheme is about the psychologist as a person, rather than just a professional.

Some participants spoke about their individual history with respect to their professional evolution and the way their internal and personal processes contributed to this:

> I think at that time, I mean I don't know, it was part of my defensive kind of strategies and operations. So I needed to feel that I knew what I was doing. I needed to feel I was being *useful*, (…) there was another part of me which was somewhat able to make, you know, quite sweet kind of, innocent, naïve, relationships with the patients as well. And then so, the patient and this kind of, anxious young man kind of had to make some space kind of, for this knowledge obsessed kind of psychologist person who, sometimes was helpful, sometimes wasn't. ***(Max, p.21, l.344)***

Most participants spoke about similar experiences and linked these with their own needs within the therapeutic relationship early on in their careers, recognising the impact of this on the work. On the other hand, there were the more static and concrete features of the individual participants' identities, such as heritage, which were also highlighted as influences on their clinical decision-making practices:

> (…) it's probably partly training, systemic training in particular. But also partly my cultural heritage, I think in Scotland we tend to be very direct. ((Laughs)) ***(Camille, p.14, l.234)***

Participants also identified certain aspects of their own identity and that of the client as being relevant to their experiences of decision-making. These were considered as the features of the interaction between themselves and their clients, as well as their understanding of the client as a person:

> I suppose that I think I'm also curious about my being male. Cause I think gender in decision-making has a big role to play, so not just modality but also gender bias in the room. Cause I see, I think as a 32-male engineering, and my dad was an engineer ((laughs)), so I'm kind of curious about gender bias. How I would respond to him. And I'm curious would I respond differently if he was a *female* engineering student? ***(Kyle, p.30, l.470)***

Overall, reflexivity, in consideration of what each practitioner brings into the therapeutic equation and the impact of the psychologist as a person, has been central to the narrative of every participant. Though generally identified by participants as good practice clinically, reflexivity can be lost at times as part of the limitations of resources and the impact of the workplace as a context.

3.7 Theme 5: Decision-making Dynamics When Practicing Within a Context

This is a theme that provides an illustration of the context in which the participant's decision-making takes place. The quotes under this theme relate to participants discussing the limitations and the freedoms associated with the setting, capacity to practice, and particular contextual influences that shape decision-making in their current work. The theme is divided into two subthemes that collect the participants' comments on negative and positive contextual influences on their decision-making. In this respect, context refers to both the frame of the workplace and the wider external influences on the practices of decision-making.

3.7.1 Subtheme 5.1: Negative contextual influences on decision-making.

For all participants, the common aspect of the negative influences on their experiences of decision-making was centred around the limitations of their work setting.

Regardless of the type of setting, each participant echoed distress associated with feeling their flexibility was limited as part of the resources available to clients through their work place. These resource constraints were largely considered to be impacting participants' ability to make decisions, consequently influencing their sense of identity as a psychologist:

> So, and what that might bring up for us as clinicians as well, and our identity in the *role* or how- or feeling competent in our work if *clinically* we think our decision-making would be completely different if I was working privately with this client, or in a service where I could work a bit more long-term, medium long-term, how might I feel about the client and about the work and about myself as a psychologist? Feeling I can offer good therapeutic intervention, compared to the feeling that you're always limited by what you can offer here. ***(Melanie, p.24, l.391)***

The constraints that impact the experiences of decision-making were not only associated with the resources available to participants in their work places. As noted by Melanie, the possibility to make decisions comfortably in a work setting, has implications on the practitioner's sense of identity. Here, the psychologist identity is intertwined with the core professional values. Linked with this, some participants outlined the challenge of having to make decisions in a setting that approaches human distress from a contrasting epistemological perspective to their own. For these participants, the tension lies in their own preference for a professional approach that accounts for the subjective construction of experience by the client, rather than the medicalised preference for diagnosable and measurable distress. Some identified that this tension results in an impact on their professional confidence in communicating their decisions to other practitioners who may not share their approach. Here, they express a wish to be heard, alongside feelings of being overpowered by the contrasting approach:

> (…) the job I'm currently in, I've been in for a year now, and it's been real up and down in terms of settling in. And I've sort of taken some confidence knocks as well about not necessarily in terms of like using an intervention or a therapy, but more around actually decision-making in terms of communicating with other professionals. You know, working within very medical teams. You are having to, you know, give your opinion in a world that isn't always very psychologically minded. So, and I think that's what I mean in terms of my confidence as well. I have- not always been able to feel that I have been able to communicate that, and that to be heard. ***(Amy, p.6, l.91)***

The tensions between the organisational approach that concerns itself with efficiency and practitioners who are guided by their ethical duties to clients, are difficult to reconcile for every participant. Some, express this as a concern beyond the practicalities of clinical decision-making, linking it with an issue of morality:

> Well the obvious thing is the constraints of the organisation. So we were just at a meeting where we talked about kind of, almost it feeling morally compromised because, for example you're told you shouldn't have a waiting list. Or you're told you can't accept somebody, but clinically you know if that was purely a clinical choice, you'd do something quite different. And I think increasingly we're hitting that arena in a way that we've never before. And I think we're being duplicitous and not very honest about it actually. ***(Camille, p.25, l.437)***

This type of tension was expressed by all participants working in non-private settings, and each described the impact of this dilemma on themselves as individuals and professionals. It is safe to deduce based on the overall narrative of the participants that the efficiency-focused organisational approach inflicting resource constraints on staff is a negative experience for the practitioners. Most expressed that in such limited settings, they feel unable to make the decisions they would like to or deliver the therapeutic support they hoped to offer when they chose this career:

> I hate it. I find it deeply, I find it quite distressing, but also feel sort of defiled actually. Because I think we've got to have our values, and one of our values I think is to do the best job we clinically can for somebody (…). Well I have a value about transparency and honesty and being straight. and when I feel I can't do that, or I'm selling something to somebody that I don't quite believe. that doesn't sit well. And I think that happens more and more. So, where for example, you see somebody and you're thinking, "What I think would be ideal for you is, say some individual therapy, and then we'll maybe see you and your partner, and we'll do some work with you and your partner" or whatever. But actually, the only thing you've got to offer somebody is a group. ***(Camille, p.26, l.450)***

Given the candidly expressed distress due to the negative influences of context in clinical decision-making, it is important to consider the wider implications of resource limitations in terms of ethics and safe practice. Nevertheless, it is the flexibility, openness, and the many other resources that each participant identified as being

influential in their decision-making, which also allows them to continue practicing in the therapeutic career they chose. In this respect, as a counterbalance to the contextual hindrances on clinical decision-making, it is uplifting to consider the positive contextual influences that participants spoke about.

3.7.2 Subtheme 5.2: Positive contextual influences on decision-making.

Largely across participants, most reflections with respect to the positive external and contextual influences on decision-making were less to do with the setting and more with their own choices in practice. That is, participants appeared to be more readily able to identify tips and strategies that supported their decision-making, which ultimately also increased their confidence in their work.

For some, positive influences on their decision-making were directly linked to the support they received from colleagues who closely understand the challenges of the role of a psychologist. Similarly, some identified the direct support of other more experienced practitioners such as supervisors who were positive influences on decision-making:

> So I think some of the influences have been I guess around the support you have. So some of that comes from kind of supervision. ***(Amy, p.7, l.120)***

For others, it was the value of the solidarity with other practitioners and the collegiate exchanges of professional knowledge that helped them with their own decision-making practices in their clinical work:

> So I think in the service, we're pretty good at feeding back to each other, or kind of communicating with people around cases if we have the time, and so you get an idea of how people might work differently or why they might of been a block in your work compared to with someone else. Yeah, and the case discussion groups are really good kind of, spaces, evidence of just the plurality of approaches in our service, and how we might all be looking at one case. ***(Melanie, p.19, l.303)***

The participants also shared a common approach to the influence of information gathering in their decision-making practices, whether it may be directly with the participant or externally from other resources to situate the knowledge that they have been given by the client. This was both in the form of basic theoretical formulations of

the client's needs and by simply conducting internet searches on contextual information that is not immediately available through the participants' experience:

> Try to, you know, get a formulation either shared, or at least for me in my head, and then based on that, trying to come up with a treatment plan. And obviously depending on what the client says, you know, their therapy goals or treatment goals, trying to fit that all together. ***(Yvonne, p.8, l.133)***

> I think it helps me empathise. Because I often do it where somebody's life experience, or life circumstances are very different to my own. So I don't get it. So it's almost like I'm trying to understand. (…). And then you look and you think "Gosh, it's such a different world" and I guess drawing on a general knowledge about say, (…), normative stuff, it kind of all made a bit more sense what was in front of me. ***(Camille, p.24, l.421)***

The information gathering was also echoed by other participants in the form of more concrete CPD type approaches to gain further knowledge:

> I'm a very big believer in CPD. And I attend lots of training. (…) I would always be, (…) interested and share and learn from my peers, with regards to any literature or information that's new, on any particular you know, presentation. ***(Martina, p.21, l.359)***

Ultimately, all participants agreed that there was a need for self-care at the centre of clinical decision-making. Participants' own descriptions of their clinical decision-making experiences were often evaluated through the lens of maintaining ethical and helpful practices for clients. In addition, these practices were also considered through the projected sustainability of their work:

> Having breaks helps. Holidays. Seems to help me function better. Seeing less patients seems to help do the work better. Looking after myself in such ways. Trying to make sure my emotional needs aren't being met in the session. ***(Max, p.25, l.429)***

Through the glimpse into the negative and positive influences on decision-making, it is possible to begin conceptualising ways of managing the aspects of psychologists' roles and responsibilities in the most ethically sound and professionally fulfilling way. In this sense, it is also possible to begin identifying the potential contextual constraints in practice and address them with the wealth of experience and insight shared by these

participants. In turn, this insight offers a better-informed picture for psychological practice that makes room for psychologists' real-life experiences in decision-making.

3.8 Summary of Findings

The themes from the interviews relate to the participants' own reflections, as well as the corresponding written data from their case vignette exercises. As part of the exercise, the participants had written notes for themselves in relation to the case, which were mostly one-word statements that helped draw links to the interview data. The participants' own understanding of their decision-making processes is at the centre of the five themes, which they evaluated through their experiences.

All participants agreed that adaptability is a key feature of their clinical decision-making practices, which they noted as being a way of working from their pluralistic training background. They stated that the ability to hold multiple theoretical frameworks in mind not only creates adaptability in the work, but can also cause uncertainty and consequently anxiety. This type of uncertainty in the work is met with the inevitable evolution in the participants' practices, through their departure from evidence-based theories and protocol driven approaches as they gain confidence in their work. The confidence in clinical work was not linked exclusively to the amount of theoretical knowledge the psychologist has, but was linked to the experience of this adaptable practice with clients. For the participants, adaptable practice does not equate to the eclectic use of part-theoretical knowledge but is grounded in theoretically driven formulations, which they have stated is a strength of their psychologist identity. According to the participants, adaptable decision-making is based on their assessment of the client's needs through the verbal and non-verbal communication in the room. This assessment carries the inherent assumption that the client is a separate individual to the psychologist and has their own expectations of therapy. In relation to this separation, participants spoke about creating a space for the client to exist independently from their presented problem and the psychologist. As part of the experience of making this space, the psychologist is also bound by the responsibility to at times override the client's own assessment of their clinical needs. This, on the surface may appear to contradict a flexible and collaborative approach, though is in fact another strength of the psychologist's clinical decision-making. The assessment of the client's needs involves the practitioner developing a clinical formulation based on their interpretation of the client's story, as well as reflecting on their own individual responses to the client.

Decision-making then takes place in this space that both the client and the practitioner occupy, both separate and together, which is reliant on the scaffolding of the psychologist's theoretical knowledge. The theoretical knowledge is gained through practice, supervision, and engagement with literature. These steps towards decision-making are tiring and at times anxiety provoking for the psychologist, as it involves their use of self as well as their interpretation of the varying information available. In relation to this part of decision-making, the acknowledgement of the role of reflexivity is essential as it also links to the critical evaluation of the therapeutic relationship. These experiences discussed by the participants must be understood through the contextual influences on their work, with the setting impacting their sense of identity and confidence as psychologists.

Some of the key findings in this project can be considered through the acknowledgement of the participants' lack of prior reflection on their experiences on clinical decision-making. Despite taking a reflective approach to their clinical work and their participation in this study, each participant spoke about not having considered their own experiences of decision-making before. This is a significant contribution of this study to the existing literature, in the acknowledgement that clinical decision-making is not always a linear or conscious process. This finding is separate to the role of intuition, as it refers to participants' a posteriori self-evaluation of their decision-making experiences. In this sense, the adaptability noted by the participants to be central to their decision-making practices has significant experiential consequences that shape their professional identity. These experiential consequences have been summed up by participants as "anxiety", "lack of confidence", "pain", and a "tiring" aspect of their "rewarding" work. This evident distress can be considered the key finding of this study, as the real-world clinical rendition of adherence to the mostly binary and linear decision-making literature that guides practice. It is important to note the participants' statements on balancing these challenges in ongoing decision-making through practices such as collaboration with colleagues and perhaps most importantly self-care. These experiences in decision-making are relevant for more than the practitioners' accountability in clinical work and relate to the reflective scientist-practitioner identity at its core.

4. Chapter Four: Discussion and Conclusion

4.1 Overview of Chapter

The aim of this research project was to gain an understanding of psychologists' decision-making from the perspective of their experience. The findings that are divided into themes highlight each aspect of decision-making as identified by the participants with evaluation of their experience of engaging in these features. Subsequently, this chapter seeks to consider the key findings in relation to the project's aims and the central research question with links to existing literature. Coming from a critical realist epistemological position, the links made to the literature are tentative and assume one of many ways of making sense of the participant's experiences in relation to the shared knowledge of the field. Following this discussion of the key findings, a consequent critical evaluation then follows on to consider the implications, recommendations and limitations of this study and its findings.

4.2 Discussion of Findings

One of the important components of the findings in this study relates to the emphasis on the discrepancy between the linear approach to decision-making and the real-life acknowledgement of the complexity in clinical practice. Specifically, in relation to the five themes discussed in the previous chapter, much of the procedural disclosures by the participants are reflected in decision-making literature, which can be understood as a confirmation of the sound practices of these clinicians. On the other hand, the particularly valuable findings of this study relate to the experiences of decision-making for psychologists, which had not been previously explored, and therefore, stand as the unique contributions of this project. To understand the significance of the participants' experiences as part of the findings of this study, we must also understand the application of the decision-making processes of these practitioners. In this sense, the underlying assumption that guides the evaluation of the findings is that the process and experience of decision-making are distinct but must be considered together, in order to support the reflective scientist-practitioner approach. When evaluating and exploring the key findings of this study, I refer back to the research question as well as existing literature to locate participants' experiences within the shared knowledge in the field.

The research question is:

What are psychologists' experiences of decision-making in their clinical work?

4.2.1 The process and experience of decision-making. The findings of this study suggest that adaptability is a key factor in the decision-making practices of participants. The core of this finding does not only relate to the process of adapting decisions to the various and competing foci in clinical work, but also speaks to the complexity of decision-making which cannot be captured as a linear task. Existing literature suggests that while this adaptability is a desired aspect of psychologists' practice, it is fraught with questions that seek standardised, valid, and reliable treatments (Lilienfeld, et al, 2013). It appears that broadly speaking, literature expects the practitioners to adhere closely to theoretical constructs within therapy, while allowing room for the clients' individuality (Stewart & Chambless, 2018). My participants have spoken about their experience of this position in therapy and the consequent challenges that ensue. According to these practitioners, decision-making involves holding and managing several competing foci in the clinical work simultaneously, which can be messy, tiring, and anxiety provoking. Linked with this, when making decisions that would impact the direction of therapy, participants spoke about the multiple ways of doing the same thing and finding an appropriate fit for the client therapeutically. According to literature, this is the variable component in clinical decision-making, which may raise questions on the consistency and validity of practice. While some research suggests that the most effective decisions may arise from adherence to evidence-based practice (Stewart & Chambless, 2018), others highlight the possibility and the value of flexibility in holding boundaries and making decisions that are ethically and therapeutically sound (Pope & Keith-Spiegel, 2008).

Part of the consequence of this adaptable decision-making for the participants, is a critical position in relation to the strict adherence to evidence-based practice. While adopting an evidence-based approach, the participants appear to often pursue a "fit" with the client as an individual, which may consequently lead to departure from evidence-based theory while making decisions. Literature that contrasts this position suggests that evidence-based practice is the most effective therapeutic approach (Reynolds, 2000; Spring, 2007; Stewart & Chambless, 2018). Though research also shows that practitioners often do not choose to follow the evidence-base closely, despite strong substantiation from literature to suggest that it is effective (Beutler, 2000). Even though some of the participants' discussed their departure from evidence-based practice, they all spoke about formulating their clients' difficulties through psychological theories. Some research that suggests relevant steps for evidence-based decision-making

(Reynolds, 2000) offers support for the participants' distinctive position in using theory. In summary, these recommendations highlight the need to formulate while continuing to research theory (Reynolds, 2000). The particular significance of this guidance to the findings in my study is its suggestion that evidence-based theory provides transparency and accountability within therapy. This emphasis on transparency corresponds to the participants' approaches, in their practices that aim for theoretical accountability through the use of psychological case formulations. Therefore, the participants appear to emphasise the importance of theoretical knowledge without overshadowing the needs of the client, which corresponds to ethical psychological practice (BPS, 2017a, 2017b; HCPC, 2015). In this sense, the participants' selective position in their use of evidence-based theory, may in fact allow for adaptability in decision-making, to create more room for the individuality of the client than suggested by the existing literature.

Looking further into the departure from evidence-based literature in favour of adaptable decision-making, literature advocates the use of supervision or consultation with colleagues as a regular practice to address dilemmas in clinical work (Clayton, 1998). The participants spoke about this type of professional collaboration as a positive influence on their decision-making, though they also discussed the challenges as a result of any potential differences in approach between the practitioners. These dynamics in relation to the professional collaboration with colleagues raise questions for the recommendations of the profession (BPS, 2017b; HCPC, 2015) in terms of their guidance on the minimum frequency for supervision and its impact on psychologists' experiences of decision-making. Specifically, the consideration of how clinical decisions are shaped in light of these collaborations and their possible contribution to the evolution of the psychologist identity is significant. In situations where the discussions with colleagues do not prove to be fruitful, research suggests practitioners will resort to literature as the 'last word', though they will most likely follow the suggestions of literature if it is written in a clear and descriptive way (Cohen, Sargent, & Sechrest, 1986). Based on my participants' experiences of decision-making, this need for clarity in literature may be due to several factors that may include limited time and a clash with preferred practices. The selective attitude to literature may also involve a critical approach to theoretical knowledge (Lane & Corrie, 2012; HCPC, 2015). This critical approach relates to the adaptable decision-making the participants spoke about, in which literature may be complemented with consultations with colleagues, supervision, and their individual practice preferences. In this sense, the participants of

this study hold a third position in contrast to the research findings that suggest a binary approach to engagement with evidence-based literature as identified previously. Specifically, the findings indicate the participants' preference for different sources of consultation to support their decision-making, which includes supervision, literature, or other practices.

Participants' expressed that their intentions relating to their adaptable decision-making was to create a space for the client to feel able to bring themselves to therapy. Research demonstrates that while the therapist's approach is central to creating the space for the client to feel safe enough to explore their vulnerability, ultimately the client makes the choice to trust the therapist enough to open up (Knox & Cooper, 2011). Literature supports the participants' intentions and shows that the space the practitioner creates to allow the clients' preferences in therapy results in better treatment outcomes overall (Swift & Greenberg, 2015). Correspondingly, the ability to offer such an experience is deemed to be the mark of a good therapist (Baldwin, Wampold, & Imel, 2007), and appears to be a feature of a client-focused collaborative approach. Nevertheless, the participants also reflected on giving themselves permission to clinically navigate the client's needs as part of collaborative practice. In literature, this potential negotiation of priorities is thought to culminate in two possible options available to the practitioner at points of impasse in response to conflict in focus between the practitioner and the client (Park, Goode, Tompkins, & Swift, 2016). These two options comprise either overriding the client's intentions or fully yielding to the client's agenda without any critical evaluation of clinical relevance (Park, et al., 2016). While Park and colleagues (2016) identify the many errors that can arise from either extreme position, the critical point raised by my participants takes a third position, which was delineated as the ideal yet underused approach by the authors. This third position allows for both possibilities, of ensuring decisions arising from theoretically ground formulations, while acknowledging and making room for the client's own agenda. According to the participants, this once again, is a space where decision-making becomes challenging and in fact, tiring. It is this complex experience involving a negotiation of positions between the practitioner and the client, which has been shown to involve the stringent use of the theory of mind (Butterfill, & Apperly, 2013). The use of the theory of mind to base decisions on the estimations of another's experience has been shown to be neuropsychologically demanding (Steinmann, et al., 2014), thus may

offer some understanding of the participants' descriptions of "complexity" and "tiredness" that may result from clinical decision-making.

Participants discussed the experiential impact of the complexity of decision-making, by noting the influence on their professional confidence over the course of their careers. For some, this was more pronounced in their expression of anxiety, and others spoke about it as being tiresome and challenging. To link these experiential points with the participants' observations of their distance to theory in decision-making, it is helpful to refer to Lane and Corrie's (2012) suggestion that therapy protocols can be containing in managing the practitioner's anxiety at the early stages of their career. My participants spoke about this explicitly, when considering their own evaluation in their work over time. The participants who noted their relatively novice position in their careers, spoke about retreating back to the use of psychological protocols to contain their anxiety at times. This is echoed by research that suggests practitioners who may feel less confident in their early career may choose to stick to protocols and theory more readily, in search of guidance and a reduction in uncertainty and anxiety (Scaturo & McPeak, 1998). Linked with the containment of anxiety, independent of the stage of a practitioner's evolution of confidence in their work, the use of protocols can also be assistive in managing and reducing risk (Truscott, Evans, & Mansell, 1995). One particular consequence in terms of the practitioner's experience influencing the course of therapy is the possibility of the professional's anxious use of theory resulting in a rigid approach that loses flexibility. Mozdzierz and Greenblatt (1992) discuss the impact of following protocols as a novice and anxious practitioner, explaining that this can potentially lead to errors in decision-making. In this respect, as the anxiety of the challenge rises and the practitioner resorts to the comfort of familiar practices that reduce uncertainty, the habitual application of protocols can cause the practitioner to become inflexible in their practice. With respect to recovery from such anxiety and subsequent inflexibility in the work, Kavanagh (2015) suggests appreciating the value of errors and imperfections, and staying focused on continuous development on the part of the practitioner, which she states will increase the practitioner's confidence. The more experienced participants in my study echoed this, by expressing that through their ongoing work with clients they were able to relax in their clinical decision-making over time. Accordingly, the participants who discussed feeling limited by strict adherence to protocols, stated that they were able to use their reflexivity and individuality to counterbalance this. This is supported by literature suggesting that the prescriptive stance of the protocol-based

treatments, can be experienced by the seasoned practitioner as being limiting of their creativity and individuality within the work (Castonguay, et al., 1996; Grayson, 1997; Lane & Corrie, 2006; Shahar, 1997; Westen, et al., 2004), which in turn may also have an abrogating effect on therapeutic outcomes. Therefore, the individual differences in the use of protocols among the participants of this study, may suggest that the psychologists' confidence linked to their level of experience may influence the way decisions are made in therapy. The correlation between the length of time in the field and confidence is supported by literature discussing the practices of psychologists' decision-making (Tracey, et al., 2014). On balance, some contrasting research also states that longer time spent in clinical practice does not necessarily equate to better clinical outcomes (Beutler, 1997; Beutler, et al., 2004; Okiishi, Lambert, Nielsen, & Ogles, 2003), which is also interesting when considering the role of ongoing anxiety and distress in my participants' decision-making regardless of their level of experience in the field. Specifically, all my participants discussed some level of distress or discomfort in their decision-making experiences, due to the various pressures in their clinical work. This particular finding is independent of the level of confidence and level of experience for the practitioner. Therefore, perhaps when considered together with literature that suggests the influence of confidence and length of time in practice on clinical outcomes (Beutler, 1997; Beutler, et al., 2004; Okiishi, et al., 2003; Tracey, et al., 2014), the issue of ongoing distress in decision-making is one to explore further.

Though the noted difference in confidence over time must be attended to critically, research also suggests that an increase in confidence may not always be an accurate self-estimate in efficacy (Dawes, 1994; Friedlander & Phillips, 1984), which consequently may also lead to misjudged interventions delivered by the practitioner in therapy (Lane & Corrie, 2012). This dilemma in the balance of anxiety, flexibility, ethical practice, and confidence for the practitioner can be considered through the honing of the skills that the participants identified as being central to the identity of a psychologist. That is, being able to collaboratively formulate the work with the client (McLeod, 2001) and to continue to adhere to the BPS (2017b) and HCPC (2015) practitioner guidelines is at the core of offering responsible adaptability, as identified by the participants. This corresponds to Ericsson's (2006) description of deliberate practice for the development of expertise, which may offer an opportunity for growth in confidence when managing the complexities of decision-making (Miller, Hubble, Chow, & Siedel, 2013). In addition to this, it is useful to also consider the possible

impact of continued exposure to anxiety over time for practitioners who have expressed the task of decision-making as a challenge. With regards to this possible influence on decision-making, some considerations may include; ongoing stress impacting decision-making negatively (Friedel, et al., 2017), worry changing the way decisions are made (Metzger, Miller, Cohen, Sofka, & Borkovec, 1990), and decision-making biases being stronger when the individual is challenged emotionally (Lane & Corrie, 2012). These particular issues raise questions regarding the implications of my findings, as discussed later within this chapter.

Another link to the introspective experience for the participants in decision-making, can be considered in the use of the therapeutic relationship (Clarkson, 2003; Hobson & Kapur, 2005) between the practitioner and the client. The consideration of this relationship requires a delicate balance in the participants' approach, whereby being too engrossed in the relationship may result in misinformed decisions, while the absence of any acknowledgement of this type of information in the room will also be problematic. With ample research establishing the therapeutic relationship as a key factor in therapy (Costello, 2012; Lindgren, Almqvist, & Mehler, 2010), it is also important to consider on balance, the research that demonstrates an overreliance on the relationship as a problematic factor in therapy (Shafran, et al., 2009) and its subsequent relevance for therapeutic decision-making. In this respect, the balance for the participants in this project would involve the equal consideration of the interpersonal and contextual factors in the relationship.

When discussing external influences on practice, the participants identified the setting in which they work as part of the basis for ongoing anxiety and challenges relating to confidence in decision-making. Particularly, the limitations inexorably imposed by the work setting appeared to be noted as the primary source of distress for the participants. While the main issue was the impact of resource restrictions on participants' decision-making, a secondary cause was the difficulty related to working within multi-disciplinary teams with contrasting approaches to working relationships with clients. Specifically, the idea of collaboration in any form of treatment that involves the individual as the recipient of health services, has been linked to the appreciation of consent from adults with mental capacity exercising choice over their body (Lown, Hanson, & Clark, 2009) and their mind (Hamann, et al., 2009). Shared decision-making in psychiatry still has some room for growth, to move away from the

idea of 'doctor knows best' and to exercise more joined-up thinking together with the client where appropriate (Hamann et al., 2009). This is an important point of difference for psychologists who may come from a humanistic approach to human distress (Cooper, 2009), while working within teams that follow the medical model (Elkins, 2007). Accordingly, the participants' concerns highlighted the difficulty in working within such settings without subscribing to the same epistemological understanding of the human psyche. Reportedly for the participants, this can be experienced as a "defiling" (Camille, p.26, l.450), professional distress and a knock in confidence, which brings the literature on the impact of stress on decision-making back into relevance (Friedel, et al., 2017; Metzger, et al., 1990; Lane & Corrie, 2012).

Arguably linked with these challenges in decision-making, one surprising aspect of the findings was the unanimous disclosure from the participants stating they are at a point of self-evaluation in the evolution of their clinical practice. That is, regardless of their current career stage, the participants described re-considering their role and professional evolution as psychologists in their work and their decision-making. This appeared to be expressed with some confusion and uncertainty, but unfailing enthusiasm for their commitment to the work. It is important to note that, despite the challenges of decision-making in clinical practice, according to my participants, their motivation to continue the work remains. This appears to be linked with their dedication to and curiosity about the "other" and is evidenced in their statements that the work is rewarding. While their curiosity seems to keep them interested in the work, it is also essential to ensure engagement with ethical decision-making, to equalise the practitioner's curiosity about the "other" with the clients' actual clinical needs (Swift & Greenberg, 2015). From my findings that focus on adaptability in decision-making evidenced in participants' statements of wanting to 'get it right', it appears that they concern themselves with delivering good therapy while wondering about the clients' own perspective. In this respect, one positive take home message comes from literature that addressed this question directly with clients (O'Donohue, Fisher, Plaud, & Link, 1989). Within this research, therapy clients participating in the study stated that they prefer practitioners to be informed by prior experiences as well as research, also commenting that they expected this would also be the practitioners' preference (O'Donohue et al., 1989). O'Donohue and colleagues' (1989) findings can be considered an encouraging message to my participants, given the balance my participants appear to seek between their use of literature, professional collaboration, and personal experience.

4.2.2 Summary of discussion. Overall, there appears to be confirmatory links between the findings of this study and the existing literature, which affirm the process of decision-making described by the participants. The findings of this study suggest that the participants' ability to ensure their decision-making is adaptable while being contained within a theoretical frame seems to be a priority. The aspects of the findings that appear to challenge the existing literature specifically highlight psychologists' experiences as exceeding the binary and information-processing type of understanding of clinical decision-making. In the literature thus far, the practitioner as a decision-making individual has been considered through susceptibility to biases (Helm, et al., 2018; Meehl, 1997; O'Donohue & Henderson, 1999; Pfeiffer, Whelan, & Martin, 2000), individual practice preferences (Leipold, Vetter, Dittrich, Lehmann-Waffenschmidt, & Kliegel, 2013) and motivations for taking on this type of work (Farber, Metzger, & Saypol, 2005; Hill, et al., 2013), but not in relation to decision-making with consideration of the experience of the psychologist. Contrary to most of the existing literature, these findings position the psychologist as an individual, not only in relation to the possible cognitive traps in decision-making, but as a person who is also impacted by the decisions. Situated in relation to the literature that often holds a binary and realist perspective, the findings of this study emphasise the complexity of decision-making expressed through the challenges and consequent distress. Thus, from the findings of this research, the key theoretical and clinical implications relate to adaptability in decision-making and the psychologists' experiences of anxiety and distress. These implications of the findings are discussed below as part of the critical review of this study.

4.3 Critical Review of Research

The findings of this study have both theoretical and clinical implications that are important to consider in relation to future research and practice. As part of the critical review of this research, I have outlined recommendations and limitations that are important as part of the discussion of the findings.

4.3.1 Theoretical implications. Based on the literature reviewed for this research project, it is apparent that there is a notable lack of decision-making research from the perspective of experience. Lane and Corrie (2012) discuss this using the two modes of cognitive functioning proposed by Bruner (1987) to suggest that most of the literature relating to decision-making comes from a paradigmatic cognitive

approach rather than a narrative one. The theoretical implications of this study relate to this aspect of the gap in literature specifically. It is important for the field of psychology to maintain the theoretical and empirical link for the continued development of the scientific approach; however, this cannot be successfully applied in practice if it is done at the expense of an appreciation for the real world clinical dilemmas. It is apparent from the findings of this study that there are distinct barriers between the available literature on decision-making and the real-life applications of it in the clinical setting among these participants. Therefore, it is important to consider some theoretical implications of my findings to offer new directions for possible future research in this area.

One of the important areas of the participants' reflections was within their responses to the gradual reveal case vignette exercise. Each spoke about this type of case vignette being an unfamiliar approach to looking at the summary of a case, which according to them captured the non-linear aspect of therapy. This issue of therapy being non-linear has been considered by Lane and Corrie (2012) who state that therapy and decision-making in therapy are not linear pursuits, and thus cannot be surmised by the overly linear approaches in decision-making literature. This may also correspond with their description of decision-making in clinical practice abounding with uncertainty and chaos. These authors use Pascale, Millemann, and Gioja's (2000) description of the "edge of chaos" from a therapeutic perspective, to consider this state of uncertainty as a state in which creativity can be bred (Lane and Corrie, 2012, p.51). Lane and Corrie (2012, p.52) suggest that this creativity can be used in the "emergent space", where the clinical work happens through the *process* between the therapist and the client. Linked with this, based on the findings of this research, one inference could be that the emergent space may be the paradigm in which the work in the narrative sense is possible, allowing the challenging but rewarding work to take place. It is possible to argue that the paradigmatic cognitive functioning (Bruner, 1987) that allows a practitioner to follow protocols and procedures happens in a more linear fashion, while the edge of chaos (Pascale, et al., 2000) is where the narrative cognitive functioning takes place for the participants of this study.

One possible evaluation of these inferences, may be that the anxiety and distress outlined in some aspects of clinical decision-making for the participants of this study can be located within the experience of the 'edge of chaos'. In this respect, as identified

in the previous section, questions relating to the impact of practitioners' experiences of continued anxiety in decision-making could be a theoretical line of future inquiry. Considering stress (Friedel, et al., 2017) and worry (Metzger, et al., 1990) have been shown to impact decision-making, perhaps decision-making literature would benefit from a less didactic and nomothetic understanding of adaptability in clinical practice.

It appears that for my participants, this 'edge of chaos' is an internal space that is not easily described but is often understood intuitively. My participants spoke about their use of intuition in decision-making, which they described as a collection of knowledge that is informed by prior experiences as much as it is by theory and interpersonal awareness. This is described by Miller, Hubble, and Duncan (2008, p.19), who state that the therapists who are regarded as experts tend to have a type of "situational awareness" that relies on being alert and aware, with the flexibility of critically comparing new information with what is already known. This is supported by Kahneman and Klein's (2009) work on the two conditions needed for intuitive expertise, which includes a predictable environment and the opportunity to learn, as conditions that support the development of intuition in clinical work. Consequently, when considering intuitive expertise together with the findings of this study, it may be helpful to develop a better understanding of the role of the theory of mind in decision-making. It is particularly relevant to examine the neuropsychological demands of the theory of mind, in conjunction with situations described by the participants whereby the conditions for intuitive expertise may be compromised due to the external contextual pressures.

4.3.2 Implications for clinical practice and further research.

The clinical and research implications of this study, capture a broader perspective in comparison to the theoretical ones. To appreciate the possible clinical implications and areas that may benefit from further research inquiry of psychologists' decision-making experiences, it is important to understand the political and social context in which many of my participants currently practice.

Social and political context of current practice. At present, NHS in England (2017) is operating through the vision of a Five Year Forward View proposed in 2014, which strategises better access to mental health care based on the needs of the population. This document suggests that there is an increase of emphasis and visibility

of mental health care, which is a positive shift towards the normalisation and acceptance of mental health needs. In addition, the increased visibility of mental health must also be understood against the social background of the need for immediacy in access (Department of Health, 2014). While the NHS has responded to this greater need through the delivery of Increased Access to Psychological Therapies (IAPT) Services, these organisations have also created a new context of mental health work, which is based less on the qualitative evaluation of treatments and is more focused on the quantifiable and measurable outcomes (Thornicroft, 2017). At the same time, this positioning within the NHS that may emphasise a measurable approach to 'resolving' mental health concerns, brings with it some considerations that may prove difficult to align with the humanistic value base of psychologists (Cooper, 2009). Adding to this shift in the past few years, NHS England (2017) has moved towards implementing waiting time standards that seek parity with medical health services, implying a reduction in waiting times for therapy. While overall this is an improvement in practices, it also increases pressures on the already limited service provision at the client-facing level. This comes alongside a proposal to increase the mental health workforce significantly over the next few years, in roles that include practitioners of varying levels and types of training (NHS England, 2017).

Clinical implications. The clinical implications of my findings in relation to the political and social context comes with a number of considerations, specifically linked to the challenges experienced as part of ongoing clinical decision-making.

A starting point to consider in the clinical implications of my research relates to the development of decision-making practices from the beginning of the psychologist's career. That is, in the professional growth of the psychologist, there may be room early on in doctorate trainings to accommodate the gap between the expectations of organisations from the qualified psychologist in terms of decision-making practices, and what the trainee expects to deliver in their future career. This may translate to additional academic, theoretical, and practical explorations of clinical practices that make the reflection on the experience of decision-making explicit. The experience of decision-making may currently be an implicit component of much of the theoretical and practical training content. By linking the tensions of divided loyalties between organisational, clinical, and personal responsibilities of the practitioner, the training may offer an opportunity to also make explicit the role of experience within decision-making, possibly also resulting in additional skills in reflexivity.

Possibly due to the extent of their training, once qualified, psychologists are likely to occupy leadership positions within organisations. These leadership roles often involve a clinical component in addition to the managerial one, and at times may require the cross-sectionality of making clinical decisions in a managerial position. My findings suggest the tensions of decision-making may give rise to anxiety, which may in turn have implications relating to the question of the role of such anxiety in decision making in the context of leadership and expertise. Perhaps organisations that employ psychologists in leadership roles in the position of the expert clinician may benefit from considering the cross-sectionality of these roles and may account for the tensions that could possibly arise. Practically speaking, more room could be offered for the psychologists' reflection of these tensions in the form of managerial reflective spaces, such as the shared peer meetings of psychologists that occupy similar leadership roles across different organisations.

A potential way in which the noted anxiety in decision-making within my findings may play out in the clinical setting relates to the possibility of errors. For psychologists who balance a range of responsibilities in their work, the role of anxiety may inevitably raise the possibility of some errors in decision making (Friedel et al., 2017). This possibility of errors may subsequently also have organisational consequences, particularly for those practitioners who occupy leadership positions in their roles. This acknowledgement may in turn offer another invitation for the role of anxiety and distress to be considered further by organisations, perhaps linked with ways in which practitioners may be able to find opportunities for self-care within their work setting.

One of the ways in which my participants noted the positive and reparative influences on their distressing experiences of decision-making was through their own suggestions relating to the benefits of consultations with colleagues. Perhaps framed as a form of professional self-care, the opportunity to share a professional reflexive space seemed to be a valuable commodity, which participants noted they would like more of. In light of this, another clinical implication may relate to the recommendations for the frequency of supervision (BPS, 2017b; HCPC, 2015), and its role in the development of decision-making. Taking this further, there may be a benefit in considering the wider use of peer supervision as a clinical provision within organisations. Within this, there

may be a possibility for organisations to perhaps offer and enforce ring-fenced opportunities for psychologists to access a shared professional reflexive space with their colleagues, for the benefit of their improved decision-making experiences.

Implications for further research. The further research implications stemming from the findings of this study and their possible relevance for clinical practice must also be understood in light of the social and political context of clinical practice as outlined in this section. There may be several research enquiries that draw on the findings of this study, that in turn may contribute to the further development of clinical practice in psychology.

- The delineation of the position of HCPC accredited psychologists against the current number of mental health practitioners that may be practicing in similar domains, may be a contemporary question for future literature. This type of research could aim to capture the decision-making processes within the developing and changing roles of psychologists in the current political and social climate outlined above.
- Linked to the query of the developing role of psychologists, there could be further research interests aimed at understanding the gap between confidence and actual efficacy in clinical work (Dawes, 1994) in relation to their experiences of decision-making.
- Participants found slowing and breaking down their decisions as part of their interviews helpful and novel. There may be several reasons that could explain the participants' prior lack of reflection on their decision-making experiences including the lack of time as a resource. Perhaps additionally, their expression of the "anxiety of getting it right for the client" may also have a role in this. Having established through the findings that this concern does not necessarily correlate with the length of practice or expertise in the field, it may be useful to pose this as a question for future research to enquire whether this anxiety has a relationship with practitioners' lack of engagement with decision-making reflection and literature.
- Lane and Corrie (2012) raise the question of for whom decisions are made in the context of therapy, which appears to be a concern echoed by most participants in this study. That is, the concern remains on whether the decisions made in clinical work can favour the client, the practitioner, and the organisation equally. Though there is no available literature that considers these questions from a

critical realist perspective on decision-making, literature on the misalignment between the practitioner's own values and those of the client states that the practitioner is ethically bound to attune to the client's own preferences (Boswell, Constantino, & Kraus, 2017; Eldridge, 1981; Feltz & Cokely, 2018). The potential conflict that can arise emphasises the divided loyalties in practitioners' decision-making as one of the findings of this study that highlights the gap between literature and clinical practice. Therefore, exploring the questions around psychologists' loyalties in relation to decision-making, when considering the needs of the client, practitioner, and organisation equally, may be useful to explore further.

- According to the participants' accounts, restrictions in their usual practices can bring up internal doubts about their own competence, mainly due to a lack of fulfilment associated with some poor outcomes relating to limited resources. This is an important issue in need of specific attention to address the impact of resource limitations on the decision-making abilities of practitioners. Nevertheless, to offer the participants some solace from the distress in decision-making it can also be helpful to take a critical approach to their doubtful perspectives. Most participants had stated they would offer a longer-term treatment to the client in the case vignette exercise, despite suggesting that his presentation appeared to lack complexity. This is interesting to consider with respect to the literature that suggests practitioners are more likely to recommend longer-term therapy to clients they perceive to have enduring and complex issues, regardless of risk (Murdock & Fremont, 1989). One interpretation of this could be the over-assessment of needs, relating to the impact of the anxiety in wanting to deliver the best therapy possible added to the known resource limitations, resulting in a feeling of 'not providing enough'. An interesting follow up to this would be a research enquiry with psychologists on their evaluation of such tensions, specifically looking into wavering professional fulfilment as a consequence of restricted decision-making within limited resources.

Overall, my findings relating to the implications of distress in decision-making as a contrast to the apparent delivery of ethical and effective work by my participants, have raised several considerations for clinical practice and further research in psychology and therapy. These clinical and research considerations are interlinked in

many ways, therefore may offer additional ways of contributing to greater coherence on this topic in the field for scientist-practitioners.

4.3.3 Implications for counselling psychology. The general implications of this study can be relevant to several areas within psychology. Nevertheless, as a counselling psychologist in training, I specifically relate to the implications for counselling psychology, due to my experiential familiarity with the philosophical underpinnings of this particular domain. Therefore, I have observed that counselling psychology in the UK is based on the principles that involve ongoing reflection in the work (Schön, 1987), which in turn support accountability in decision-making (BPS, 2017b). This implies that from early on in their therapeutic career, counselling psychologists are encouraged to be aware of every decision they make, in order to provide a theoretically sound rationale to ground their work. In this respect, this study offers further support for the training structure of counselling psychology, in that the findings align well with the values of the domain. In addition, the particular value of this study for counselling psychology is in highlighting the necessity of upholding continual reflexivity on decision-making over the course of the practitioner's career, as suggested in reflective practice items by BPS (2017b) and HCPC (2015). Specifically, the findings that indicate the relevance of a balance between the scientist-practitioner and the reflective-practitioner support the foundational values that the domain is based on (Blair, 2010). The findings that draw attention to the participants' experiential challenges of decision-making offer further considerations for counselling psychology, with respect to the management of such potential distress in clinical work. Some of these challenges can be further considered through the recommendations outlined below.

4.3.4 Recommendations. Based on the findings and implications of my research, I would like to make some recommendations for future research, clinical practice, and training.

I have found the critical realist exploration of the experiences of psychologists' in their decision-making practices to be a good fit with TA, due to its ability to offer a broad overview of the common narrative in relation to the research question. TA enabled me to explore the issue of experiences of decision-making *across* the participants and gain a wider overview of the psychology terrain in terms of decision-

making, with specific attention to experience. This gives me an opportunity to situate my perspective against the backdrop of the social and political context of decision-making, while also considering the individual experience. Thus, my epistemological and methodological approach in this research provides me with a balance between the macro and the micro perspectives. On the other hand, in consequence of my findings and their implications, the psychology field may benefit from gaining further phenomenological insight in to the decision-making experiences of psychologists from a hermeneutic angle. In this sense, future IPA research on the tensions in decision-making may provide further insight into the individual nuances of the potential distress as a consequence of the task of making decisions as identified by my research.

Additionally, based on the theoretical and clinical implications of my study, I would also recommend further investigation into the role of anxiety in clinical decision-making. This, from a theoretical position, may be to specifically attend to the role of anxiety in clinical decision-making practices with particular attention to cognitive biases in the work. On the other hand, clinically, it may also involve a closer look into the tensions in decision-making when balancing practitioner loyalties between client and organisational responsibilities.

Finally, I believe there can also be some added attention within training courses, on the development of expertise in relation to decision-making, from the angle of managing the varying roles and positions of practitioner psychologists. As research notes (Chen, et al., 1997), further exposure to decision-making biases are likely to reduce the activation of such issues. Thus, this could possibly be an argument for a component of training whereby the decision-making issues that practitioners are likely to face (such as the pressures and consequent anxieties) are considered systematically, with some indication of how these tensions can be resolved practically and experientially. From my own experience within a Professional Doctorate in Counselling Psychology, I understand that the Process Report assignments aim to do just that. These assignments offer students the opportunity to critically evaluate their own clinical work step-by-step. However, due to the pressures of an intense training programme, the assignments that aim to give such a space for learning are often overshadowed by the pressure of the task and the anticipation of results. In this sense, much is sacrificed in the richness of content and context in this task, in favour of success. Therefore, it may prove to be further beneficial for trainees, to support them to think about their clinical

decision-making in a different way, by making explicit the value of exploring the experience of clinical decision-making.

4.3.5 Limitations. This study addressed the issue of psychologists' experiences of decision-making, with key findings relevant to the management of the complexity of clinical decisions and the consequent role of distress. As all research has limitations, it is essential to help other researchers address such issues in future.

All participants offered depth of information and candid expression of their decision-making experiences throughout their interviews, yet at times some participants expressed reservation in sharing the full extent of their apprehensions. This was especially relevant in their responses to the gradual reveal case vignette exercise, in which most expressed feeling anxious or exposed. Based on the participants' reflections, most of these responses related to the clinical decision-making anxieties outlined in the findings of this study. Therefore, given the new insight this study offers in relation to the experiences of decision-making, one option may be to account for this potential distress in the design of future studies.

Another limitation of this study is its positioning in a vast area of existing literature. Though the relevant literature situates this research within the psychology field, decision-making appears to be a discourse in its own right, which spans across several schools of thought and fields of expertise. The wide attention in literature attests to the view of decision-making as a phenomenon applicable to almost any area of human thought, which has vast axiological reach. My study looks at specific experiences relating to one use of decision-making, which is a unique perspective of the phenomena that offers insight into one aspect of decision-making. Thus, there could be important implications and considerations that were beyond the scope of this study. These considerations might relate to fields linked to decision-making that have implications relevant to psychologists' clinical experiences, with some of these subjects including examples such as business, law, or pedagogy.

4.3.6 Reflexivity. Reflexivity is known to be a central component of qualitative research that maintains accountability and reliability (Sciarra, 1999). However, if only done for the purposes of observing the quality standards of qualitative research, Braun and Clarke (2013) note it can become rigid and even flippant. As a

trainee counselling psychologist, I aspired to be curious about my own relationship to the research as much as possible, without letting it overtake the focus of my project. Some of these reflections were inherent in my approach to the topic throughout this thesis, and others, I will note here.

Initially, I was aware of my arrival at my research question being a challenge in itself. I had always been interested in the variation of process and subsequent experience in other practitioners' clinical work, independent of modality. Additionally, I was also conscious of the reasons for my interest in this question, which appear to be linked with my own developing confidence in the work. My understanding of therapy involves not only the subjective experiences and realities of the individuals, but also the contextual influences and the external realities their experiences are situated in. I find balance in a critical realist understanding of the world, recognising the interaction between the internal and the external (Willig, 2012b). Consequently, this approach led me to seek an understanding of other practitioners' experiences of making clinical decisions as psychologists, to perhaps better situate myself in the profession I embark on with the confidence and improved understanding of the overall variation in practice. Thus, I found the connection between my professional growth and my curiosity of others' practices to be part of my motivation to pursue this research question. As the interviews progressed, my reflections on my motivation gave way to a more intimate understanding of my participants' anxieties in the work, normalising some of my own doubts in my clinical decision-making. Similarly, I also aim for this project to provide an opportunity for other trainees like myself to reflect on their own professional anxieties, by offering insight into one of the more mysterious aspects of others' clinical work.

During the process of writing up my findings and discussion, I encountered what appears to be a symptomatic expression of the most prominent decision-making discourse I have been writing about. Specifically, I noted that my natural process was to attempt to separate the procedural findings from the experiential components of the participants' narrative, possibly forcing a linear fit. Eventually, I acknowledged the inherent paradox in this, having been influenced by the literature I have been reviewing over three years. I noted that by attempting to write about them separately, I was inherently assuming the decision-making processes of the participants would be independent of their experiences. This is based within the fundamental assumption that

we 'do' and then we 'reflect', where the action is followed by the exploration of the experience. After acknowledging this, I found it helpful to draw on the idea of reflecting-in-action versus reflecting-on-action (Schön, 1983) to consider my process of researching decision-making. This allowed me to return to my initial position when setting my research question, that the process and the experience are interconnected, thus must be considered together. Consequently, I used this realisation to attempt to reflect-in-action (Schön, 1983) as I completed the final drafts of this thesis. To me, this also proves once again that the writing stage in TA is inherently a part of the ongoing analysis (Braun & Clarke, 2013), shaping the presentation of the overall research.

4.4 Conclusion

This study aimed to explore psychologists' experiences of decision-making in their clinical practice from a critical realist position though TA to gain an overview of individual experiences against the contextual backdrop of psychological theory. The findings show that decision-making is overall a complex and at times anxiety provoking aspect of clinical practice, and that available literature often misses this dynamic, creating a vast gap between theory and practice. The findings specifically suggest that the practitioners often exercise flexibility in creating a safe space for the client, in which initial information can be shared. This is then followed by the practitioner aspiring to understand and formulate collaboratively with the client to gather a detailed picture of the narrative, which can then be evaluated through the theoretical knowledge of the practitioner, supported by empirical literature and supervision. The practitioners use reflexivity to also create room for themselves in the work, which contributes to the individualisation of the therapeutic approaches of each practitioner. These considerations for decision-making are at times experienced as being challenging, difficult, anxiety provoking, and tiring, but also rewarding. This is the human aspect of the psychologist as an individual who also exists within a context that may help or hinder decision-making. A number of considerations arise as part of the findings of this research, including the cognitive implications of anxiety in clinical decision-making and contextual influences on the varied roles of psychologists. Some recommendations are drawn from the implications, which overall support the reflective scientist-practitioner approach in counselling psychology. These recommendations call for attention to the ongoing application of a reflective approach on clinical decision-making, over the course of the psychologists' career.

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List of Appendices

Appendix A – Initial Ethics Approval Form

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates

REVIEWER: Max Eames

SUPERVISOR: Irina Anderson

COURSE: Professional Doctorate in Counselling Psychology

STUDENT: Melissa Barkan

TITLE OF PROPOSED STUDY: Counselling Psychologists' Experiences of Decision Making Processes

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved.

Minor amendments required *(for reviewer)*:

N/A

Major amendments required *(for reviewer):*

N/A

ASSESSMENT OF RISK TO RESEARCHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

	HIGH
	MEDIUM
X	LOW

Reviewer comments in relation to researcher risk (if any): N/A

Reviewer *(Typed name to act as signature)*: Max Alexandre Eames

Date: 6 February 2017

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments *(for students)*: **N/A**

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature):* Student number: Date: *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here:
http://www.uel.ac.uk/gradschool/ethics/fieldwork/

Appendix B – Ethics Amendment for Change in Research and Focus

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to: http://www.uel.ac.uk/gradschool/ethics/

If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also.
Please see details on www.uel.ac.uk/gradschool/ethics/external-committees.
Among other things this site will tell you about UEL sponsorship
Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised.

Before completing this application please familiarise yourself with:

The *Code of Human Research Ethics (2014)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

And please also see the UEL Code of Practice for Research Ethics (2015) http://www.uel.ac.uk/gradschool/ethics/

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.

2. Type your name in the 'student's signature' section (5.1).

3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc** (See page 2)

4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identity its content. Your supervisor will then look over your application.

5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants (see 23 below)

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external organisation if you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another

organisation if separate ethical clearance from another organisation is required (see Section 4).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

  If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at m.j.spiller@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another in order to conduct research with vulnerable populations.

Your details

1. **Your name**:
   Melissa Barkan

2. **Your supervisor's name**:
   Dr Irina Anderson

3. **Title of your programme**: (e.g. BSc Psychology)
   Professional Doctorate in Counselling Psychology

4. **Title of your proposed research**: (This can be a working title)
Psychologists' Experiences of Decision Making Processes

5. **Submission date for your BSc/MSc/MA research:**
   August 2018

6. **Please tick if your application includes a copy of a DBS certificate** ☐

7. **Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons (Chair of the School Research Ethics Committee) (m.j.spiller@uel.ac.uk)** ☐

8. **Please tick to confirm that you have read and understood the British Psychological Society's Code of Human Research Ethics (2014) and the UEL Code of Practice for Research Ethics** (See links on page 1) ☐

2. About the research

9. The aim(s) of your research:

This study proposes to explore from a critical realist position the decision-making processes of counselling and clinical psychologists, in response to a hypothetical case vignette, aiming to capture the meta-cognitive processes of clinical decisions involving interventions excluding risk. The research project will aim to collect data through semi-structured interviews, and analyse the data through Thematic Analysis (Braun & Clarke, 2006). Research Question: How do counselling and clinical psychologists experience decision-making in response to a hypothetical case vignette?

10. Likely duration of the data collection from intended starting to finishing date:

From January 2017 to August 2017 (8 months) pending ethics approval. This will include recruitment and data collection.

Methods

11. Design of the research:

(Type of design, variables etc. If the research is qualitative what approach will be used?)

The proposed project intends to explore the decision-making processes within counselling and clinical psychology from a qualitative perspective, with emphasis on the subjective experiences of clinicians' processes while making decisions based on a case vignette.

Within the UK the counselling psychologists who qualify at a doctoral level register with the HCPC as a demonstration of their standard of training and professional practice. The HCPC identifies a group of practitioner psychologists as having protected titles that are grouped under seven modalities (HCPC, 2015), which includes both counselling and clinical psychologists. Within the seven modalities, most areas of practical psychologies require their own unique path in training and qualification, while the current structure of training required to become a clinical or counselling psychologist is broadly similar. Both groups emphasise the researcher-practitioner identity, and have a requirement to submit research meaningful to their clinical practice as part of their training (HCPC, 2015). Furthermore, both groups begin their clinical experiences alongside one another, and tend to work in similar settings after qualifying. Therefore, while recognising that there are five other practical psychology modalities as defined by HCPC, for the purposes of homogeneity as part of this

research the focus on recruitment will only include counselling and clinical psychologists. For ease of reading, the following text will refer to them as one group "psychologists".

When working with presentation specific treatment protocols, counselling and clinical psychologists are encouraged to hold in mind differences unique to the client and their personal history. Understanding and working with these differences requires constant, ongoing, and on the spot decision-making skills. While the openness, and transparency of psychologists will allow for mistakes in these decisions to be mended collaboratively with the client, the aim is to get these therapeutic treatment decisions as close to ideal as possible first time around (Cooper, 2009). As integrative practitioners, psychologists are expected to understand fully, and make use of different therapy modalities and tools, however as a group they vary in the way they exercise these HCPC Standards of Proficiency items specific to psychologists (HCPC, 2015). The BPS Code of Ethics and Conduct (BPS, 2009), prescribes that awareness of own limitations, as a professional is an essential competence of a psychologist. Thus working integratively necessitates reflective practice, which involves becoming aware of the intricacies of relational dynamics and the impact of decisions on the therapeutic relationship. This is a vital component in the ethical and epistemological underpinnings of becoming a counselling psychologist (BPS, 2009; HCPC, 2015).

Counselling psychologists use of reflexivity in their practice means they often consider and account for the relational dynamics in the therapy room, while tailoring the work for the needs of the client collaboratively (Cooper, 2009). There is a need to understand such processes qualitatively, due to a lack of structural understanding of how these decisions are taken within the practice of counselling psychology. Doctoral training in psychology is different to many other sorts of therapeutic training, in that it relies on the trainee's own sense of direction in integration of the different modalities they learn as they become experienced practitioners in the field. Further to this, there is also significant variation in the types of psychology training in the UK, as well as the deviations of various institutions structuring the same courses in different ways. This leads to a very diverse population of practitioner-researchers, who have likely been influenced in the way they work by the training, supervision, placements and clinical experience they are exposed to, as well as the research knowledge they develop as part of their training. It is important to understand the practices of clinicians from a qualitative point of view, in order to support the quality assurance gained from the accreditations that can be earned through the BPS and HCPC.

Based on the rationale described above, this research project proposes to explore qualitatively the decision-making processes of counselling and clinical psychologists. The exploration will be looking at the process of decision-making that excludes the relational aspect between the client and the practitioner, which allows for the use of a case vignette to be fit for the purpose of this study. The participants will be presented with a case vignette of a hypothetical client who does not exhibit risk **(Appendix G)**, and will be asked to take decisions as they would in their own clinical practice. Each section of the hypothetical client's narrative will be revealed gradually, allowing the narrative to be more authentic to a clinical setting. Following this brief 10-minute exercise, participants will be invited to reflect on their experience of taking these

decisions in a semi-structured interview, which will focus on the participants' meta-cognitions of decision-making.

The data collected from these hour-long semi-structured interviews will be analysed through the use of Thematic Analysis (Braun & Clarke, 2006). This type of analysis fits well with the critical realist position that this research question holds, in that it holds an open view of any main themes that emerge from the data, while allowing the researcher to understand these themes under the umbrella of widely acknowledged theories or realities. Joffe (2012) discusses that good quality Thematic Analysis locates the data within an existing social context. Further to this, Thematic Analysis is thought to capture meaning in the data, make links between themes and map out concepts, ultimately adding value to descriptive data (Braun & Clarke, 2006; Harper, 2012; Willig, 2012). This allows for some of the data to lack phenomenological components, while allowing for depth to emerge through encouraging the reflexivity of the researcher. Braun and Clarke (2006), state that researcher judgement is essential in identifying themes within the data, thus requiring the researcher to practice ongoing reflexivity while making their process explicit throughout.

12. The sample/participants:

(Proposed number of participants, method of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research)

In line with recommendations for Thematic Analysis, to gain detailed data that has a subjective representative voice within the psychology population, I intend to recruit 6 to 14 counselling and clinical psychologists including one for a pilot interview (Guest, Bunce & Johnson, 2006). The prospective participants will all be qualified counselling or clinical psychologists recognised by BPS, who are currently working in the field with no minimum level of experience. There will be no exclusion criteria within the psychologist profession, as the varied demographics of this population is presumed to be part of the homogeneity and is expected to add depth to the data. I intend to recruit through placing adverts in a number of clinical settings (non-NHS), inviting counselling and clinical psychologists to join **(Appendix B)**. As a back up strategy for recruitment, I plan to email counselling and clinical psychologists who are listed under the "Directory of Chartered Psychologists" on the BPS website with an invitation to participate in the research **(Appendix A)**. Prospective participants will only receive one email, which will invite them to participate while making it clear that they will not be re-contacted for the same study and that they are not under any obligation to respond if they do not wish to do so.

13. Measures, materials or equipment:

(Give details about what will be used during the course of the research. For example, equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application)

Hour-long one-to-one, face-to-face interviews comprising of two parts will be conducted, and audio recorded. Initial part of the interview will be the participant working through a brief hypothetical case-vignette, and writing down their responses **(Appendix G)**. The remaining component of the interview will be based on a semi-structured interview schedule which asks about the process of working through the

case vignette, the links of these responses to their ongoing clinical practice, and their reflections on taking clinical decisions in general **(Appendix H)**. The interview schedule will focus on three main areas informed by the research question:

1- The participants' experience of responding to a gradual-reveal hypothetical case vignette.
2- The participants' insight into the responses they provided as part of the initial exercise, and the links they make with their usual ongoing clinical practice.
3- Their general meta-cognitive reflections on the process of decision-making, and the components that influence decisions in their clinical practice, as informed by the case vignette exercise.

14. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

~~YES~~ / ~~NO~~ / NA

15. Outline the data collection procedure involved in your research:
(Describe what will be involved in data collection. For example, what will participants be asked to do, where, and for how long?)

As part of the recruitment process, the details and aims of the study will be made public to all prospective participants. Upon the prospective participants' initial agreement to take part, they will be offered further information on the rationale as part of the consent process **(Appendix D)**. Consent will be sought after clear description of what the study will involve, including a clear statement on the participants' right to withdraw **(Appendix E)**. Interviews will take place preferably on UEL premises (pending approval and permission of the university prior to each interview), however due to the busy schedules of psychologists, the researcher will be willing to attend the interview at the clinical setting in which the prospective participants work, should this be preferable to them. In situations where this is preferable to the prospective participant, the researcher will follow the lone-working procedures outlined in the risk assessment provided as part of the registration process for this research project **(Appendix J)**.

Once the setting has been agreed on, the participant will be invited to a two-part interview. The participant will be informed in detail of the process of the interview, including the set up of the initial exercise. After the consent forms have been signed (pending agreement of each participant on the day), a short demographic questionnaire will be administered **(Appendix F)**. The initial section of the interview will comprise a 10-minute case vignette exercise, which will reveal the details of a hypothetical case gradually. Each section of the case vignette will be on a separate A4 sheet, with prompts for the participant to record their responses and the decisions they take based on the information given **(Appendix G)**. The participant will complete this task without the input of the researcher, while the researcher will be available in the room for any questions they might have. Once this exercise is concluded, the researcher will commence the 50-minute, semi-structured interview based on the

schedule **(Appendix H)**, which will encourage the participant to reflect on the exercise they completed, while drawing links to their usual ongoing clinical practice.

The interviews will be audio recorded in their entirety (including case vignette exercise) using a digital recording device; each recording and case vignette response sheet will be anonymised immediately, and interviews will be transcribed as soon as possible following the completion of the interview.

Participants will be debriefed once the interview has been completed, and will be offered a debrief sheet **(Appendix I)**.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

16. Fully informing participants about the research (and parents/guardians if necessary): Would the participant information letter be written in a style appropriate for children and young people, if necessary?

The recruitment process will not commence until ethical clearance has been received from UEL. Once ethical clearance has been gained, participants will be recruited from clinical settings and email addresses open to public. Participants will be fully informed about the general aims of the research in the initial invitation poster/email **(Appendix A)**. Information will be given in language that is easy to understand throughout all interactions with participants. Should the prospective participants express interest in participating, they will be given detailed information of the rationale and background of the research question **(Appendices C and D)**. Additionally, the researcher will ensure that the participants are fully informed of all aspects of the study throughout the research process, including after the dissertation has been submitted. There will be no obligation for any participant to take part or remain in the study. No coercion will be used to entice participation.

17. Obtaining fully informed consent from participants (and from parents/guardians if necessary): Would the consent form be written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians?

Once each participant expresses initial agreement to participate, they will be provided with a consent form, which outlines their right to take a break or withdraw completely from the study **(Appendix E)**. The details of the research will be provided in simple language that does not contain jargon throughout all interactions with prospective participants. The process of seeking consent will ensure clarity and conciseness of information provided, continuously throughout the research process.

18. Engaging in deception, if relevant:

(What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.)

Participants will be informed of all aspects of the research, no deception will be involved.

19. Right of withdrawal:

(In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve deciding not to participate in your research and the opportunity to have the data they have supplied destroyed on request. This can be up to a specified time, i.e. not after you have begun your analysis. Speak to your supervisor if necessary.)

Psychologists who are contacted via email will be informed that they are under no obligation to respond to the email, and that they will not be re-contacted if they choose not to respond. The email will also outline their rights to withdraw consent prior to their agreement to participate **(Appendix A)**. This will also be stated on the consent form **(Appendix D)** and will be reiterated verbally at the start of the interview process. Withdrawal of data will involve completely and securely (shredding/electronic deletion) destroying all personal data the researcher holds of the participant. In each instance, participants will be informed of their right to withdraw for three weeks after the interview takes place. The rationale for this will be clearly explained as this three week period in estimation will accommodate for the transcription of interviews, however will be before the analysis of data.

20. Anonymity & confidentiality: (Please answer the following questions)

20.1. Will the data be gathered anonymously?

(i.e. this is where you will not know the names and contact details of your participants? In qualitative research, data is usually not collected anonymously because you will know the names and contact details of your participants)

~~YES~~ / NO

21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

(How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually names and contact details will be destroyed after data collection but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? Make this clear in this section and in your participant invitation letter also.)

The British Psychological Society (BPS, 2010) and Health Care Professional Council (HCPC, 2009) guidelines on the use and retention of data for research will be adhered to throughout the process of this research. Each participant will be given a numerical code that will be used to locate their names and contact details with the corresponding interview data. The interview transcripts will be anonymised by the allocation of these numerical codes, as the personal data belonging to each participant will be kept in a separate encrypted electronic file. Written data emerging from the case vignette exercise will be given the same code, and will be stored electronically with the transcript after being scanned and attached to the same transcript document. Any real names or personal information emerging from the transcripts will be omitted or anonymised.

All anonymised electronic data will be kept in their separate files both on the UEL secure cloud provided by the IT services, and the personal home computer of the researcher which is password protected and encrypted.

All data will be kept securely and anonymously for 5 years after its collection according to the Data Protection Act (1998), allowing for its potential use in future publications arising from this research.

This data protection method will be outlined to the participants in the information and consent forms **(Appendices C and D)**.

22. Protection of participants:

(Are there any potential hazards to participants or any risk of accident of injury to them? What is the nature of these hazards or risks? How will the safety and well-being of participants be ensured? What contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?)

N.B: If you have serious concerns about the safety of a participant, or others, during the course of your research see your supervisor before breaching confidentiality.

There are no known hazards associated with the study that have the potential to cause physical injury to the participants. The potential risk or hazard of taking part of this study for the participant may be of emotional distress. While the risk is low, participants may find discussing their decision-making processes distressing. Each participant will be given the opportunity to take a break, re-schedule, or withdraw, should they find the interview distressing for any reason. Prospective participants of this study are counselling and clinical psychologists, who are expected to have supervision and/or personal therapy in place throughout their training. For this reason, it is assumed that they will have access to a professional support network for issues that may arise as a result of their participation in this study. Participants will be reminded of these resources available to them as part of the consent and debrief procedures **(Appendices D and I)**, and will be encouraged to access them should there be any expression of distress associated with the interview process. In addition to this, as part of the debrief procedure, participants will be offered contact information of UEL staff overseeing the research process, for any grievances they may have resulting in their participation.

The participants will be asked to complete a hypothetical case vignette exercise to anchor the discussion around decision-making, partially as a way to circumvent the possibility of historical difficult or unethical decisions they may have had to take as part of their clinical practice. This will aim to ensure that disclosures involving the researcher having to take action will not emerge, however should this type of situation present itself, the researcher will consult their Director of Studies (while maintaining the anonymity of the participant), before acting on the disclosure. The researcher will adhere to BPS (2010), HCPC (2009), and UEL (2004; 2013; 2015) research ethics guidelines throughout the research process, including items relating to researchers' ethical responsibilities around disclosures.

23. Protection of the researcher:

(Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant's house?

There are no known potential health and safety risks to the researcher associated with the research procedure. For a detailed review and assessment of all the risks a risk assessment form has been completed as part of the registration process for this study **(Appendix J)**.

This research project will be carried out on UEL premises where possible, however may take place at another professional/clinical setting convenient to the participant if necessary.

Participants will be invited to attend the interviews on UEL premises, however as the prospective participants will be practicing psychologists with busy schedules, having to attend a location in East London may limit the recruitment possibilities. For this reason, for participants unable to attend at the UEL location, the researcher will attend at their practice locations (offices) for the interviews to take place.

While the risk involved in either of these situations is very low, with low likelihood of any damage being incurred by researcher or participants, the safety plan is to ensure lone working strategies are in place. The researcher will contact two people by text messaging to give them the postcode of the location when attending interviews off site. The researcher will also contact both these individuals when leaving the premises, to let them know that the interview has been completed. The two nominated people to be contacted will be the Director of Studies, and the next of kin of the researcher.

24. Debriefing participants:

(Will participants be informed about the true nature of the research if they are not told beforehand? Will participants be given time at the end of the data collection task to ask you questions or raise concerns? Will they be re-assured about what will happen to their data? Please attach to this application your debrief sheet thanking participants for their participation, reminding them about what will happen to their data, and that includes the name and contact details of an appropriate support organisation for participants to contact should they experience any distress or concern as a result of participating in your research.)

The researcher will abide by the BPS (2010) and HCPC (2009) codes of professional conduct throughout the research process when interacting with participants. In addition to this, each participant will be debriefed in person at the end of the interview and will be given a debrief sheet **(Appendix I)**. The verbal debrief will involve asking participants how they felt at the end of the interview, reminding them of their rights to withdraw, and provide them with information to seek support if needed. Sources of support will be both specific to the participants (their supervisors or personal therapists if relevant) and general such as Samaritans or MIND. The participant will also be provided with information of relevant departmental staff overviewing the research (DoS) for any issues or complaints arising from the interview process in general. The researcher will remain in contact with the Director of Studies for any issues the come up in the interview process, including but not limited to distressing material or disclosures. Lone working procedures outlined in risk assessment **(Appendix J)** will be followed, and researcher will inform a third party of the completion of the interview if they are off site, for the protection of the researcher and participant.

25. Will participants be paid? ~~YES~~ / NO

If YES how much will participants be paid and in what form (e.g. cash or vouchers?) Why is payment being made and why this amount?

26. Other:

(Is there anything else the reviewer of this application needs to know to make a properly informed assessment?)

4. Other permissions and ethical clearances

27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

~~YES~~ / NO

If your project involves children at a school(s) or participants who are accessed through a charity or another organisation, you must obtain, and attach, the written permission of that institution or charity or organisation. Should you wish to observe people at their place of work, you will need to seek the permission of their employer. If you wish to have colleagues at your place of employment as participants you must also obtain, and attach, permission from the employer.

If YES please give the name and address of the institution/organisation:

Please attach a copy of the permission. A copy of an email from the institution/organisation is acceptable.

In some cases you may be required to have formal ethical clearance from another institution or organisation.

28. Is ethical clearance required from any other ethics committee?

~~YES~~ / NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? ~~YES~~ / NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation is acceptable.

PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary.

29. Will your research involve working with children or vulnerable adults?*

~~YES~~ / NO

If YES have you obtained and attached a DBS certificate? ~~YES~~ / NO

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

~~YES~~ / NO

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see www.uel.ac.uk/gradschool/ethics/involving-children/

30. Will you be collecting data overseas? ~~YES~~ / NO

This includes collecting data/conducting fieldwork while you are away from the UK on holiday or visiting your home country.

* If YES in what country or countries will you be collecting data?

Please note that ALL students wanting to collect data while overseas (even when going home or away on holiday) MUST have their travel approved by the Pro-Vice Chancellor International (not the School of Psychology) BEFORE travelling overseas.

http://www.uel.ac.uk/gradschool/ethics/fieldwork/

IN MANY CASES WHERE STUDENTS ARE WANTING TO COLLECT DATA OTHER THAN IN THE UK (EVEN IF LIVING ABROAD), USING ONLINE SURVEYS AND DOING INTERVIEWS VIA SKYPE, FOR EXAMPLE, WOULD COUNTER THE NEED TO HAVE PERMISSION TO TRAVEL

5. Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Melissa Barkan

Student's number: u1516284 Date: 06 January 2017

Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name: Date:

Appendix C – Ethics Approval for Change in Research and Focus

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates

REVIEWER: Max Eames

SUPERVISOR: Irina Anderson

COURSE: Professional Doctorate in Counselling Psychology

STUDENT: Melissa Barkan

TITLE OF PROPOSED STUDY: Counselling Psychologists' Experiences of Decision Making Processes

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved.

Minor amendments required *(for reviewer)*:

N/A

Major amendments required *(for reviewer):*

N/A

ASSESSMENT OF RISK TO RESEARCHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

	HIGH
	MEDIUM
X	LOW

Reviewer comments in relation to researcher risk (if any): N/A

Reviewer *(Typed name to act as signature)*: Max Alexandre Eames

Date: 6 February 2017

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments *(for students)*: **N/A**

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here:
http://www.uel.ac.uk/gradschool/ethics/fieldwork/

Appendix D – Ethics Amendment for Skype Interviews

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mary Spiller (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the 'student's signature' section (page 2).
9. When submitting this request form, ensure that all necessary documents are attached (see below).
10. Using your UEL email address, email the completed request form along with associated documents to: Dr Mary Spiller at m.j.spiller@uel.ac.uk
11. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
12. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

4. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
5. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.

6. A copy of the approval of your initial ethics application.

Name of applicant:	Melissa Barkan
Programme of study:	Professional Doctorate in Counselling Psychology
Title of research:	Psychologists' Experiences of Decision Making Processes
Name of supervisor:	Dr Irina Anderson

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
To incorporate Skype interviews into the data collection methods, in addition to face-to-face interviewing.	To enable the possibility of more varied data, and to be able to recruit a higher number of participants.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): Melissa Barkan

Date: 12/06/2017

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Mary Spiller

Date: 30th June 2017

Appendix E – Recruitment Email

Dear …,

My name is Melissa Barkan and I am a counselling psychologist in training, currently in my second year of the Professional Doctorate in Counselling Psychology at the University of East London (UEL). As part of my doctoral training, I am currently conducting research on the decision-making processes of psychologists.

This research involves qualitatively exploring the decision-making processes of psychologists. There is ample quantitative evidence looking into the effectiveness of decisions made within therapy. On the other hand, the empirical explorations of the experience of making decisions within therapy from a qualitative perspective are few and far between. Given the current context of clinical and counselling psychology and the humanistic value base underpinning the therapeutic approach that psychologists' use integratively, there is good reason to explore the process of clinical decisions within this area. Adding to the knowledge base stemming from this research question aims to help support the unique approach adopted by psychologists and understand the components of clinical decisions taken in therapy.

My supervisor for this project is Dr Irina Anderson. This research has received ethical approval from the UEL School of Psychology Ethics Committee. Participation will involve taking part in audio-recorded semi-structured interviews that will take approximately one hour. The interview is in two parts. The initial component of the interview will involve a 10-minute exercise, where you are asked to read and respond to a hypothetical case vignette. Following the completion of this, the remainder of the hour will be a semi-structured interview where you are asked to reflect on the process. The interviews will be transcribed for data analysis purposes and all of the information collected will be anonymized through allocated numerical codes. All consent forms, demographic data, and any other details will be anonymised and stored separately to the transcripts. Audio recordings of the interviews will be destroyed upon completion of the study. Remaining written data will be kept on a secure password protected computer on encrypted digital files, which will be stored in accordance with the Data Protection Act (1998), allowing for its potential use in future publications arising from this research.

You remain free to ignore this email and you will not be contacted again. Should you initially decide to participate but then change your mind you would be entitled to withdraw within three weeks without giving a reason and without any disadvantage to you.

Thank you for taking time to read this email, if you would like to receive further information regarding this study, I would be very happy to email a detailed information sheet summarising the background literature that inspired this research, details of what will be involved, what will happen to the information gathered, the advantages and disadvantages to taking part of the study. How to contact my supervisor and how to request information after the study is completed.

I can be contacted on the following email address. u1516284@uel.ac.uk

Yours sincerely,
Melissa Barkan

Appendix F – Informed Consent Form

University of East London
School of Psychology
Water Lane
London E15 4LZ

Title of Study:
Psychologists' Experiences of Decision-making Processes

Before you decide whether you would like to give consent to take part, please take the time to read the following information, written in order to help you understand why the research is being carried out and what it will involve.

The researcher
My name is Melissa Barkan and I am a counselling psychologist in training, currently in my second year of the Professional Doctorate in Counselling Psychology at the University of East London (UEL). As part of my doctoral training, I am currently conducting research on the decision-making processes of clinical and counselling psychologists.

What is the purpose of the research?
The project intends to explore the decision-making processes within clinical and counselling psychology from a qualitative perspective, with emphasis on the subjective experiences of clinicians' processes while making decisions.

When working with presentation specific treatment protocols, clinical and counselling psychologists are encouraged to hold in mind differences unique to the client and their personal history. Understanding and working with these differences requires constant, ongoing, and on the spot decision-making skills. While the openness, and transparency of these psychologists will allow for mistakes in these decisions to be mended collaboratively with the client, the aim is to get these therapeutic treatment decisions as close to ideal as possible first time around (Cooper, 2009). Those who are integrative practitioners are expected to understand fully and make use of different therapy modalities and tools, however as a group they vary in the way they exercise these HCPC Standards of Proficiency items specific to psychologists (HCPC, 2015).

Further to this, there is also significant variation in the types of psychology training in the UK, as well as the deviations of various institutions structuring the same courses in different ways. This leads to a very diverse population of practitioner-researchers, who have likely been influenced in the way they work by the training, supervision, placements and clinical experience they are exposed to, as well as the research knowledge they develop as part of their training. It is important to understand the practices of clinicians from a qualitative point of view, in order to support the quality assurance gained from the accreditations that can be earned through the BPS and HCPC.

With the apparent significance of the question of how decisions are made in therapy, there has been a significant body of research done on the matter of the uses and the impact of such decisions in clinical work. Quantitative research has taken a broadly realist approach looking into the question of accuracy (Gambrill, 2005; Lutz, Lambert, Harmon, Tschitsaz, Schürch, & Stulz, 2006) and reliability (Bieling & Kuyken 2006) of

clinicians' decision-making in their practices. On the other hand, researchers approaching the issue from a qualitative perspective have varied in their relativist perspectives, looking into making successful decisions (Scaturo & McPeak, 1998), and the components that contribute to making decisions in therapy (Kahneman, Slovic & Tversky, 1982; Witteman, Spaanjaars & Aarts 2012; Gyani, Shafran, Myles & Rose, 2014). While numerous other literature situated in between the realist and relativist positions have been identified as part of the literature review for this project, it is evident that there is a lack of research looking into the question of what the experience of making clinical decisions is like for psychologists. Thus, a research question arises from such an approach, intending to understand the subjective experiences of clinical and counselling psychologists while making decisions in clinical practice.

The themes that arise from this detailed analysis of the data will contribute to the wider knowledge base of decision-making, from a counselling psychology point of view (Cooper, 2009). I aim to contextualise the information gleaned from the data by situating it in the aspects of clinical practice relevant to all psychological therapies.

By the end of this research project, I hope to have insight into some accounts from practitioners on what it is like to be taking decisions, and what their reflections on the process reveal. Insight from this kind of research will have potential practical uses in psychotherapy trainings, as well as other applied disciplines that are required to make ongoing decisions based on limited relational and interpersonal information.

Why have I been invited to take part in the study?
You have been invited because you are a clinical or counselling psychologist. Clinical and counselling psychologists listed on the BPS website have been contacted, as well as those who have responded to posters distributed in clinical settings where psychologists work. I am hoping that between six and fourteen individuals will agree to take part and share their experiences for this study.

Do I have to take part?
You are under no obligation to take part; participation is entirely voluntary and even after agreeing to do so you may change your mind for *three weeks after the interview*, without having to give a reason. There is a three-week time limit, to accommodate for the beginning of the analysis period. After three weeks, your data will have been anonymised and added to the remainder of the data pool to be analysed. If requested within the three-week period, your data will be removed from the study and all recordings and notes destroyed. Your decision will not give rise to any discrimination or disadvantage.

What is involved?
If you decide that you would like to take part, please contact me using the details below. I would be happy to provide further information about the research, or we can arrange a time and place to meet.

During our meeting I will attempt to answer any further questions you may have, and if you are still happy to go ahead I will ask you to sign a consent form confirming that you have read this information sheet and are happy to take part in this research. The consent form will be kept in an encrypted file separate from the interview data.

After you sign the consent form, I will ask you to fill out a very brief demographic survey for information purposes. I will then ask you to complete a 10-minute

hypothetical case vignette exercise, in which you will be prompted to take decisions based on the client's narrative. After you complete this exercise, we will move on to the remainder of the semi-structured interview. In this portion of the interview, you will be asked to reflect on the exercise, and the decisions you took, as well as being asked to make links to your ongoing clinical practice. The entire interview, including the exercise will be audio-recorded and later transcribed, and all identifying information will be changed. The notes you write during the exercise will be scanned and linked to the personal numerical code you have been assigned, to ensure the coherence of the data, while prioritising your confidentiality and anonymity. After the interview you will have an opportunity to ask any questions and raise any concerns you may have.

What will happen to this information?
The recording of our interview will be transcribed as soon as possible. After the three-week period, the transcripts of these interviews will be analysed in detail. The analysis will involve examining common themes within and among interviews, in order to establish patterns of commonalities or differences in each narrative. I will aim to represent each participant as authentically as possible and will aim to give voice to each narrative. Anonymous extracts from your interview may be included in the write up to illustrate themes that have been discussed. These extracts will not include any identifying information regarding yourself, your workplace, colleagues, or service users.

A short article may be written for publication in an academic journal, this may also include brief anonymous extracts of the interview. Again, this would not include any identifying information. I will also ask if you would like me to forward to you a summary of the research findings when the study is complete. Audio recordings will be destroyed upon the completion of the study, while remaining written data will be kept for 5 years on a secure password protected computer on encrypted digital files, which will be stored in accordance with the Data Protection Act (1998), allowing for its potential use in future publications arising from this research.

What are the possible disadvantages of taking part and what if there are any problems?
You will be asked to reflect on your clinical work and your processes of decision-making. This kind of reflection has the potential of raising issues that may cause you frustration or concern. If during any part of the interview you feel upset or simply do not wish to answer a question you will be able to skip it. If you wish to take a break during any part of the interview, you are welcome to do so without need for explanation. Following the interview I will be available by email if you have any concerns about this study, you will also be provided with the contact details of my supervisor. Please see contact details at the bottom of this form.

How will my taking part in this study be kept confidential?
All information which is collected will be anonymised by assigning each interviewee a number and the record of these numbers with matched participant information will be locked in a secure location, separate from the data and research study write up. Data from the study will be stored on a password protected, encrypted key and computer. The participant's real names and any identifying features of their work places will be changed.

What will happen if I don't want to carry on with the study?
If you decide you want to withdraw from the study please contact me on the email address provided below for up to three weeks after the interview. Your decision of whether to take part or withdraw from the study will not disadvantage you in anyway.

Research ethics permission
The proposal for this study has been examined and approved by the School of Psychology Research Ethics Committee at the University of East London, to protect your wellbeing, safety, rights and dignity.

Contact Details:

Melissa Barkan
(Professional Doctorate in Counselling Psychology candidate 2018)
Email [redacted]

Supervised by:
Dr Irina Anderson
University of East London, School Of Psychology, University of East London Water Lane, London E15 4LZ
Email: i.anderson@uel.ac.uk

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Consent to participate in a research study

Psychologists' Experiences of Decision-making Processes

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study, which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study for three weeks after the interview without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..…….

Appendix G – Debrief Form

UNIVERSITY OF EAST LONDON

Debrief Form

Thank you

Thank you for taking the time to participate in this research. This aim of the study was to explore the experience of decision-making among psychologists using Thematic Analysis (TA). The desired impact of this research is to provide a body of knowledge within the field to empirically support the decision-making processes in therapy. Your contributions to this study will complement the development of information in this area.

The possible implications of this study include bridging the gap in existing knowledge within the field of psychology and therapy in general, and informing clinical practice based on the thematic information gained by the exploration of the different components of decision-making. This research may also provide insight into further new areas for exploration within the field.

Withdrawing

If you wish to withdraw from this research project, you are able to do so within three weeks of this interview by emailing the researcher with your request. Withdrawing your interview from the project will mean that all data belonging to you will be electronically and physically destroyed by the researcher, and none of the information you have provided will be used. After the three-week period, the interview will be analysed as an anonymous part of the collective body of data.

Data protection

The demographic details that you have provided are for purposes of analysis. Data arising from this interview will be used anonymously, and selective quotes will be anonymised to support the data. All data will be retained securely and anonymously as outlined in the consent form for 5 years after the interview takes place, in accordance with the Data Protection Act (1998), allowing for its potential use for future publications arising from this research.

Distress following participation

There are no known forms of distress anticipated as a result of participating in this project. Nevertheless, you have kindly been involved in discussions relating to decision-making as part of your clinical practice, which may have touched on difficult emotions. If you do experience distress associated with taking part in this project, please remember to contact your supervisor or personal therapist. Additionally, please refer to the contact information below for further support:

MIND Mental Health Charity:
www.mind.org.uk
0300 123 3393
or Text: 86463

Samaritans:
www.samaritans.org
116 123
jo@samaritans.org

If you have any questions or concerns about how the study has been conducted, I can be contacted on the following email address:
u1516284@uel.ac.uk

For any concerns relating to the study, please contact Director of Studies for this project:
Dr Irina Anderson
i.anderson@uel.ac.uk

Appendix H – Demographic Information Form

Demographic Questionnaire

(For researcher to complete: Participant anonymous ID number:…….)

Please Complete Questions Below:

Name:

Age:

Gender:

Full title at current workplace:

Type of service currently working in (e.g. primary service, private practice etc):

Qualification:

Accrediting bodies:

Highest level completed training:

Number of years since qualification:

Number of years of active clinical practice:

Appendix I – Gradual Reveal Case Vignette

Hypothetical Case Vignette:

- **This case vignette is hypothetical, with no links to any real people known to the researcher.**
- **This task is set to take up to 10 minutes of the interview time.**
- **There are 5 sections containing part information on a hypothetical case.**
- **Each section contains more information about the client given through the client's own narrative and up to 4 questions which are meant to be prompts.**
- **The task is designed to engage your decision-making practices in response to such a case, please answer briefly but freely, with all relevant information you'd like to note.**
- **Please remember there is no right/wrong answer, and I am only looking at how you experience decision-making (not the decisions), which we will discuss in the second part of the interview.**
- **On each page, please note down any additional information you would like to know about the case, any intervention you would like to use, and please note whether these have changed in each section.**
- **For the purposes of this study, interventions refer to any comment made to client, any question asked, any interpretation offered, or any protocol followed.**
- **Please do not return to a section once you have completed it and moved on to the next one.**

Section 1
F is a 32-year-old male, living in the central area of a large city. He is currently completing a PhD in Engineering, and has come to counselling reporting difficulty with sleep, a constant sense of heightened anxiety, and panic attacks. F has a history of depression and is currently using anti-depressants prescribed by his GP. He states that the medication has helped somewhat since he started taking them, but that most days he feels low in mood and lacking motivation.

- What do you think F would like to work on?
- What do you think the primary task is based on the information you have?
- What else would you like to know?

Section 2
F states that he has had a "good childhood" coming from a family of four that includes an older brother and parents who are still married. He recalls a happy childhood in which his parents were high achieving researchers who moved from Australia to England when he was 9 and his brother was 14. He recalls finding it difficult to adjust to his new school in England, and his accent being made fun of by his peers. He recalls devoting himself to his schoolwork until around age 13, when he became good friends with people he states were "the wrong crowd".

- What is your response so far?
- What do you think the primary task is based on the information you have?
- What are the kinds of interventions you would find suitable so far?
- How has the work changed (if at all) compared to the first section?

Section 3
F states that in his teen years, he found it difficult to get on with his parents who expected him to do well academically, and were restricting in response to rising tensions due to him skipping school and failing some exams. He recalls frequently staying over at his friends' houses during this time without letting his parents know. He described an incident where his father became very angry after such an evening, and that he then took the decision to leave home for a couple of weeks to stay with his then girlfriend's family. He states this changed his relationship with his parents permanently.

- What else would you like to know?
- What are the kinds of interventions you would find suitable so far?
- How has the work changed (if at all) compared to the previous section?

Section 4
F is currently attending his second session with you, to which he arrived a couple of minutes late, and asked to use the facilities. The session commenced 7 minutes late, and F has started the session stating he is reluctant to talk about his past. He states that his anxiety is a current issue, would like this to be resolved. He has appeared to be short tempered on a couple of occasions, without demonstrating any risk or hostility.

- What else would you like to know?

- What are the kinds of interventions you would find suitable so far?
- How has the work changed (if at all) compared to the previous section?

Section 5

In this session, towards the final 5 minutes, F becomes tearful and talks about his bullying brother and always feeling like he was a lesser man compared to him. He also mentions that he recalls his mother never interfering with what he perceived to be his brother's bullying, and he describes her as being "withholding".

- What is your response so far?
- What are the kinds of interventions you would find suitable so far?
- How has the work changed (if at all) compared to the previous section?

- Please note how many sessions you would **like to** offer F, and what the work would focus on, based on the information given so far.

- Do you have any further comments you would like recorded as part of this portion of the interview?

Thank you for your responses so far. Your answers to the above questions will be recorded as data which corresponds with the second part of the interview. The interviewer will now ask you to reflect on this exercise, and your responses to the case, in relation to decision-making in psychology.

Hypothetical Case Vignette Summary

Section 1

F is a 32-year-old male, living in the central area of a large city. He is currently completing a PhD in Engineering, and has come to counselling reporting difficulty with sleep, a constant sense of heightened anxiety, and panic attacks. F has a history of depression and is currently using anti-depressants prescribed by his GP. He states that the medication has helped somewhat since he started taking them, but that most days he feels low in mood and lacking motivation.

Section 2

F states that he has had a "good childhood" coming from a family of four that includes an older brother and parents who are still married. He recalls a happy childhood in which his parents were high achieving researchers who moved from Australia to England when he was 9 and his brother was 14. He recalls finding it difficult to adjust to his new school in England, and his accent being made fun of by his peers. He recalls devoting himself to his schoolwork until around age 13, when he became good friends with people he states were "the wrong crowd".

Section 3

F states that in his teen years, he found it difficult to get on with his parents who expected him to do well academically, and were restricting in response to rising tensions due to him skipping school and failing some exams. He recalls frequently staying over at his friends' houses during this time without letting his parents know. He described an incident where his father became very angry after such an evening, and that he then took the decision to leave home for a couple of weeks to stay with his then girlfriend's family. He states this changed his relationship with his parents permanently.

Section 4

F is currently attending his second session with you, to which he arrived a couple of minutes late, and asked to use the facilities. The session commenced 7 minutes late, and F has started the session stating he is reluctant to talk about his past. He states that his anxiety is a current issue, would like this to be resolved. He has appeared to be short tempered on a couple of occasions, without demonstrating any risk or hostility.

Section 5

In this session, towards the final 5 minutes, F becomes tearful and talks about his bullying brother and always feeling like he was a lesser man compared to him. He also mentions that he recalls his mother never interfering with what he perceived to be his brother's bullying, and he describes her as being "withholding".

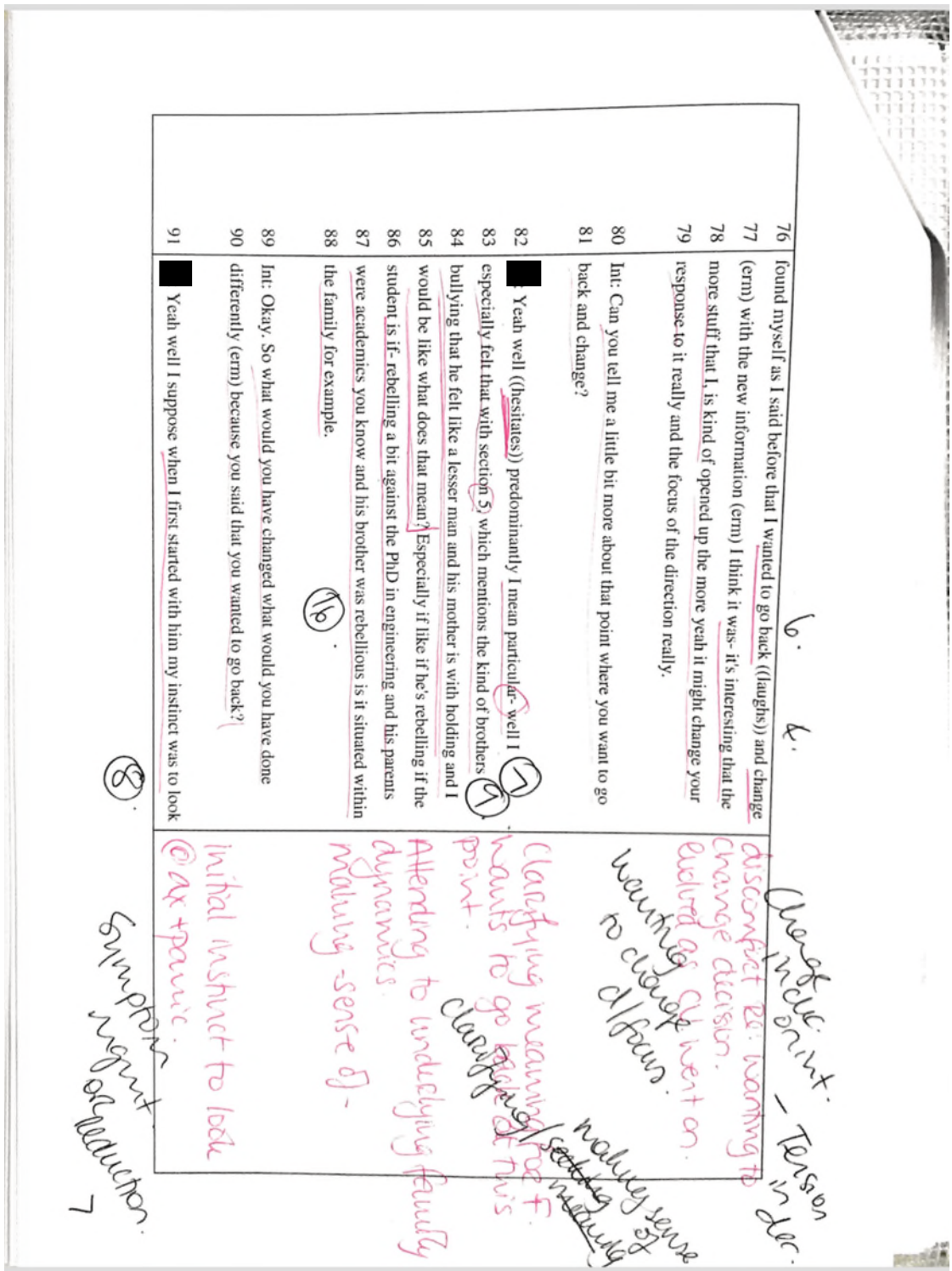
Appendix J – Interview Schedule

Thank you for completing the exercise. Now I would like to ask you some questions with the previous task in mind. This section of the interview is aimed to reflect on what it was like for you to complete the case vignette exercise, and what responses this has brought up for you with respect to decision-making in your clinical work. In this context, decisions refer to all interventions and related reflections you might have had when responding to the client.

- What was the case study exercise like? Any general responses?
- What was it like to have each section revealed to you gradually?
- How did the gradual reveal influence your decision-making?
- What was it like to make decisions based on the information you were given?
- How was this case similar or dissimilar to the kinds of presentations you encounter?
- How does the context of your work influence the responses you gave/would have given?
- What would you have done differently if this client presented at your place of work?
- What kinds of contributing factors influenced the decisions you made?
- What part of this case, if at all, would you be tempted to take to supervision?
- What part of this case, if at all, would you look up in empirical literature?
- What other resources would you use to help you make decisions for future sessions with this client?
- Can you tell me what reflections you have about the client?
- Can you tell me how you feel about this exercise in decision-making in general?
- How do you feel this links to your ongoing clinical work?
- Is there anything else you would like to share with me in response to the discussions we have had so far?

Thank you very much for your time and contributions.

Appendix K – Sample Coded Transcript



found myself as I said before that I wanted to go back ((laughs)) and change (erm) with the new information (erm) I think it was- it's interesting that the more stuff that I, is kind of opened up the more yeah it might change your response to it really and the focus of the direction really.

Int: Can you tell me a little bit more about that point where you want to go back and change?

[redacted]: Yeah well ((hesitates)) predominantly I mean particular- well I especially felt that with section 5, which mentions the kind of brothers bullying that he felt like a lesser man and his mother is with holding and I would be like what does that mean? Especially if like if he's rebelling if the student is if- rebelling a bit against the PhD in engineering and his parents were academics you know and his brother was rebellious is it situated within the family for example.

Int: Okay. So what would you have changed what would you have done differently (erm) because you said that you wanted to go back?

[redacted]: Yeah well I suppose when I first started with him my instinct was to look

Appendix L – Sample Coding Manual

DM Coding Manual

Code Number	Code Name	Definition	Example
1	Participant anxiety	Participant demonstrates or expresses anxiety about exercise and/or interview; also expressed in awareness of relationship with researcher	**P1**p2L25; **P1**p3L32; **P1**p3L35; **P1**p26L420 **P2**p3L41; **P2**p4L44 **P3p4L41; P3p4L44; P3p4L48; P3p4L52; P3p5L54; P3p28L480; P3p28L490** **P4**p1L8; **P4**p21L380 **P5**p4L59; **P5**p23L422 **P7p11L174;** **P8**p29L509
2	Checking in during exercise	Participant checks-in or clarifies points during case vignette exercise	**P1**p3L32; **P1**p3L35; **P1**p3L38; **P1**p3L40 **P3p1L8; P3p2L18** **P2**p2L22; **P2**p2L27; **P2**p2L29; **P2**p3L34; **P2**p3L38; **P2**p3L41; **P2**p4L50; **P2**p4L54
3	Reassurance from researcher during exercise	Researcher reassures participant during case vignette exercise	
4	Actual change in decision on intervention	Expresses a change in decision	**P1**p7L76; **P1**p8L95; **P1**p10L128 **P3p7L100; P3p14L230** **P5**p23L412 **P7**p9L124; **P7**p20L320; **P7**p20L341

Appendix M – Sample Descriptions of Themes with Codes

Theme 1: Adaptability

Description: Theme gathers codes that relate to the participants flexibility, and emphasis on change in decisions during work. Codes capture actual changes during the case vignette exercise, as well as self-description of how their approach would change with the client narrative, and changes over the course of career. Includes pluralism as a positive, while also identifying challenges of varied options available to the practitioner.

Code NUM	Code TITLE	Code DESCRIPTION
4	Actual change in decision on intervention	Expresses a change in decision
6	Wanting to change direction/focus	Highlights point of consideration of change in decision, however may not act on
10	Variation in execution of theory	Awareness of competing theories on same issue
14	Emphasis on flexibility in decision-making	Decisions are open to change, provides flexibility in way of working
16 & 69 (W5)	Interpretation/making sense of	Participant interprets case vignette narrative
20	Evolution of professional self	Description of past and/or current changes in way of working

Theme 2: Client focus

Description: Codes in this theme focus on collaboration as part of therapeutic decision-making. Participants' comments under this theme emphasise the importance of information gathering together with the participant, as well as the assessment of client's readiness, but also touch on management of possible difference in opinion, as well as professional collaboration with other colleagues.

Code NUM	Code TITLE	Code DESCRIPTION
7	Clarifying with client	Exploring further information with client
12	Relying on availability of information from client	Emphasising client's choice in disclosure
13 & 68(W4)	Decisions led by client	Participant's decision to base interventions on focus identified by client
15	Shift in decisions with evolving narrative	Participants decisions change based on client's developing narrative
23	Conflict in client vs psychologist focus	Identifies difference in what client appears to want to focus on in therapy, in contrast to Participant's decision to attend to a different task
24	Decision on overriding client focus	Statement on decision to override client's perceived therapy focus, based on professional assessment of current

Appendix N – Presentation Key for Quotes in Chapter Three: Analysis

Minor changes were made to extracts from interviews for confidentiality/anonymity, accurate representation, and ease of reading.

Pseudonyms have been used to protect participant anonymity and any identifiable information has been removed.

In some cases (…) has been used to annotate omitted words that have been eliminated to shorten quotes or eliminate identifiable information. This was done in a way that would not change the meaning of the extract.

Expressions of false starts (and- and,) and verbal pauses "(erm)" were removed for ease of reading.