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Flying by the seat of your pants and magic behind doors: An Interpretative Phenomenological Analysis of difficult decision making in clinical practice

John Hickey

This thesis is submitted in part fulfilment of the requirements of the Doctorate in Clinical Psychology

The University of Edinburgh

2010

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Dedication

To my parents Michael and Breeda Hickey; Go raibh maith aguibh.

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1.0 ABSTRACT

Introduction

The process of decision making has been widely studied within different academic paradigms. Many theories and models have been developed from this research activity. However, there is a lack of in-depth research on individuals' experience of decision making. The present research explores this topic with Clinical Psychologists. This group of professionals are trained to be expert in a specific discipline, which emphasises the need for making informed judgements and for justifying decisions.

Objectives

To provide an in-depth account of how Clinical Psychologists experience decision making in the context of clinical practice.

To relate the analysis to theories and models of decision making and to research on factors thought to influence judgement and decision making.

Method

Semi-structured interviews were conducted with seven Clinical Psychologists. These were transcribed and analysed using Interpretative Phenomenological Analysis (IPA) methodology.

Outcomes

Elements of the decision making environment such as managing one's conflicting beliefs and difficult emotions, responding to uncertainty and changeable scenarios and normative versus unique elements of one's practice were elucidated in the analyses. The contribution of this work to research in decision making and the development of clinical practice are discussed.

2.0 INTRODUCTION

2.1 Decision making in clinical practice

The focus of the research is on decision making in clinical practice. This is clearly a broad concept and can relate to a huge range of activities carried out by the clinician in the course of their work with patients. What will be investigated here is the experience of decision making from the perspective of Clinical Psychologists working in an Adult Mental Health service.

The Division of Clinical Psychology practice guidelines (BPS, 2001) contain several references to both judgement and decision making. There is an acknowledgement that a decision is based on a judgement which fits with Baron's (2008) distinction between the two processes. Baron (2008) has written extensively about human cognition and has focused on aspects of thinking, including judgement and decision making. He defines a judgement as being the evaluation one undertakes of a possible course of action while taking a set of evidence into account. The choice of action to be carried out is the decision part.

With regard to judgements, the guidelines (BPS, 2001, p.18) state that "best clinical judgements" should be utilised when predicting the possible outcomes of a psychological intervention. There is also reference made to considering the best interests of clients and to considering a range of options before making a judgement. With regard to decision making, the guidelines make reference to the need to ensure that decisions are made on "firm ground" (p.23) by consulting with colleagues and others out with the profession and also to the importance of an individual being able to justify any decision made. There is also a call for clear decision making and a reminder of the responsibility the individual bears for their decisions. The Health Professions Council (HPC) Standards of Proficiency for Practitioner Psychologists (2009) highlights the requirement for the ability to make judgments in instances where information is incomplete and to make use of appropriate knowledge and skills in doing so. With regard to decision making these standards highlight that the

individual psychologist is responsible for the decisions they make and that these decisions and the reasoning behind them should be recorded. Not surprisingly, the fact that decisions will often relate to the therapeutic interventions carried out is noted. However the standards also note the requirement to ensure clients are provided with information to enable them to make informed decisions also.

The process of decision making can be described and conceptualised in different ways. Knowledge about how an individual approaches decision making may be instructive in that one may be alerted to biases they are prone to or shortcomings in their thinking processes (Baron, 2008). Indeed we shall see that many of the theories and models of decision making can lead to prescriptive rules for individuals to follow in specific decision making environments.

There is a wide body of research on judgement and decision making in general which extends across many disciplines such as economics as well as psychology (Hardman 2009; Baron, 2008). Baron (2008) writes about the study of thinking and decision making and distinguishes between three types of questions he has considered in his writing. These relate to; how thinking, judgement and decision making are evaluated, describing how we think and what prevents us from carrying these processes out more effectively and finally how we can improve these processes individually and collectively. Using this distinction as a frame of reference the research undertaken here would match the second question relating to describing decision making.

Schottenbauer, Glass and Arnkoff (2007, p.225) have described the research on clinical decision making as being in its infancy and others (Kahneman & Klein, 2009) admit to the limitations of their own research paradigms and express hope that the research can progress to increase our knowledge of these processes. It is proposed that this makes the experience of judgement and decision making a relevant phenomenon to investigate.

2.2 Introduction outline

To begin with an outline of the research will be provided starting from different theories of judgement and decision making from Psychology and other health-related research literature. Then, the literature on general influences on clinical practice in Psychology will be reviewed. The researcher concedes that this will not be an exhaustive account of the research studies and cognitive theories of decision making as this would be impractical for the current piece of work. However the aim here is to provide a background against which the research question and subsequent data and analysis can be compared and contrasted. The aim here will be to bridge that gap (Stricker & Trierweiler, 1995) between the scientific research base and everyday clinical practice.

2.3 The psychology of decision making

Theories of judgement and decision abound in research literature. As mentioned previously this literature relates to many different academic fields such as Cognitive Psychology, Behavioural Psychology and Economics (Galenter & Patel, 2005; Baron, 2008). This research has produced many theories and models of this phenomenon. Descriptive theories are provided to describe how an individual thinks when making a decision. Baron's (2008) Search Inference Framework and Kahneman and Tversky's (1979, 1984) work on biases in judgement are descriptive. Normative theories and models are concerned with rational decision-makers (e.g. Expected Utility Theory) and aim to outline how an individual can make the best possible decision (Galenter & Patel, 2005). Prescriptive theories are concerned with how one should make a decision (Galenter & Patel, 2005). The aim is to help individuals and groups to improve their decision making by combining elements of Descriptive and Normative theory (Chase, Crow & Lamond, 1996). In writing about the training of medical students Elstein (2001, p.364) states that "a normative rule is taught in the hope or expectation that it will become descriptive"

Thus we have an array of theoretical frameworks which help us think about decision making in different ways. Before going on to a discussion about what factors can influence these processes, some of these frameworks will be discussed in more depth.

2.4 The Search Inference Framework

Baron's (2008) idea of the Search Inference Framework (SIF) which he applies to both goal-directed thinking, formation of beliefs and decision making was found to be helpful in conceptualising the decision making process. He describes these forms of thinking as being based on "inferences made from possibilities, evidence, and goals that are discovered through searching" (Baron, 2008, p.XIII). The SIF framework is offered as a descriptive model and the concepts of active searching for goals, possibilities and evidence and the inferences one makes based on what is found are basic tenets of the model.

Goals are described as being a pre-requisite for decision making. One must think about what they are seeking and what is important for them to consider. This leads to the generation of possibilities, which are potential ways of achieving or satisfying the goal. There will be evidence for and against each possibility and Baron (2008) states that more evidence is likely to be found when one has an intuition or feeling about a possibility. The chance that a possibility will be acted on is dependant on the primary goals one may have and the evidence that supports one's belief that a particular possibility is valid and useful. The evidence for or against a possibility carries weight so is influential in a decision making process but Baron (2008) proposes that one has control over how this will influence the strength of a possibility. The inferences made in relation to goals, possibilities and evidence relate to the judgement we make about a possibilities and evidence in the context of a goal. This fits with Hardman (2009) who noted that a judgement is an evaluation of a situation and the options for action available to us.

Aberegg *et al*. (2008) have suggested the SIF is a useful model for medical students learning to match up patients' presenting complaints and medical history with information on disease states/presentations and for experienced medics faced with difficult diagnostic or treatment decisions. This suggestion appears to be based on the principle that the model can alerts one's attention to three main components of the situation; the goal of the exercise (diagnosis, options for treatment, relief from symptoms), the possible answers and options relevant to the exercise and the evidence for and against each possibility. This strategy seems similar to the standard problem solving approach often recommended in cognitive behavioural therapy books (Williams, 2006) and is potentially useful to minimise the deleterious impact of cognitive biases on decision making.

While the SIF is a useful descriptive model which can be applied to decision making it can be argued that there are limitations to the model. Baron (2008) concedes that the language (in relation to the term "goal") does not quite capture the extent of what the thing described as a "goal" could be and that the term is imprecise. Perhaps it is necessary to allow some flexibility for the language used when applying the model in the description and analysis of a decision making process.

Also, Hardman (2009) reminds us that the decisions we make are informed by our judgement and that there is a tendency to conflate the terms judgement and decision making. Within the SIF model it not entirely clear whether an inference is the same thing as a judgment. They certainly refer to the same process of evaluating goals but are they mutually exclusive terms? Again, this may be a case of different words capturing the essence of a process in slightly different ways but it is well to consider the process of decision making to be complex in nature, multi-faceted in terms of processes undertaken and that it is not necessarily explained completely by one model.

2.5 Utility theory

Decision making has been described in Bernoulli's (as cited in Hardman, 2009) Utility theory also. This theory is often associated with decisions made in economics (Baron, 2008). The idea of Utility theory is that we seek and then choose options (possibilities) that will provide the maximum utility (usefulness, goodness) possible. It does not describe how we search for or decide upon the possibilities but does outline a method of assigning value to and predicting the expected utility of various possible outcomes. In doing so the question to be decided upon and the possible outcomes must be outlined in terms of options (possibilities for action, choice between two or more things) and possible states of the world (e.g. therapy is beneficial for this type of presentation versus therapy is not beneficial for this type of presentation). This is a normative model of decision making, based on the premise that the individual should reason and infer rationally at all times (Galenter & Patel, 2005).

However these predictions are not always accurate and the decisions we make do not always follow the maxim of choosing the most useful option. For example, Kahneman and Tversky (1992) pointed out that we do not appear to make decisions based on mathematical probabilities as they are. In addition we are prone to framing effects and other biases which exert unexpected influences on decision making in the context of utility theory (Kahneman & Tversky, 1984)

Thus, while utility theory provides a model of how one can ascertain the utility of each available option in a decision making task. It would seem that it is useful for some types of decision, in which the probable outcomes are apparent and that mathematical probabilities can be ascertained. However we do not always make decisions while having all of the information (e.g. potential outcomes) at hand and some of the positions we take on the states of the world could be argued against. For example; is it possible to predict all possible states of the world when thinking about a complex clinical presentation?

2.6 Bounded Rationality and Fast and Frugal Heuristics

Girgenzer & Goldstein (1996) state that Bounded Rationality (BR) takes into account both the environmental conditions in which the reasoning and subsequent decisions are made as well as the individual's resources for reasoning. This differs from descriptions of decision making that focus on logical thought and the use of mathematical probabilities and brings the process of decision making closer to the world of clinical decision making. The premise of this framework is that people can make judgements and therefore decisions in a time-limited fashion by reducing the amount of cues attended to. Hardman (2009, p.13) refers to this as "limited-capacity" information processing.

The concept of an adaptive toolbox has been incorporated into the model of BR and is used to describe the decision making machinery. The adaptive toolbox is proposed to have heuristics to work on information. These can be cognitive and emotional (Muramatsu & Hanoch, 2005). The heuristics are said to have domain specificity as they work on specific types on information processing tasks. The work done on the information is carried out within a context which is characterised by cognitive, emotional, behavioural and social factors. The process of decision making is said to have psychological plausibility if it can be described within the context created by these factors. The decision making process can be more or less ecologically valid depending on the degree to which the decision made fits with the wider environment in which it is made. An ecologically valid decision is one which is based on possibilities that are appropriate to the situation and can be perceived as making sense in that particular context.

This theory seems to be similar to the SIF theory in that it describes how decision making requires cognitive operations to be performed (searches conducted and inferences made or cognitive or emotional heuristics applied) but it also provides a framework for how the process plays out. Three rules; searching, stopping and decision, are described. These indicate an obvious search process followed by a stop searching mechanism and a final decision making component. This theory serves as

a framework which researchers have used to provide descriptions of the reasoning and decision making process and also to determine causal relationships between these processes and behaviour. Thus we have theories of how heuristics operate in general and more specifically how emotional and cognitive components operate in decision making.

Various types of heuristics which provide a short cut in judgement and decision making have been described. Hardman (2009) describes this use of a short cut in terms of making a judgement based on one informational cue. Girgenzer and Todd (1999) describe Fast and Frugal heuristics as models of behaviour and have proposed a computational model of how they operate. It is suggested that there are different types of heuristic, available to us (from the adaptive toolbox) in different situations. For example a Fast and Frugal heuristic for stopping a search would be to use the first instance of a solution which appears preferable to other potential solutions as a cue to stop. The authors have tested heuristics like this and have shown that they match or perform better than model, which adopt more extensive (rational) information searching and processing.

However the heuristics are tested in experiments where the decision is a two-way choice (Hardman, 2009), in the clinical setting there will be more than one choice, conflicting demands and perhaps a requirement for some estimation (e.g. risk). So, although the models provided in the Bounded Rationality and Fast and Frugal heuristics research bring us closer to the world of clinical judgement and decision making they do not necessarily match up exactly. Perhaps it is a case of a normative model requiring more of a descriptive element to widen generalisability. This point has been disputed by those who state that descriptive accounts of judgement and decision making do not solve the limitations of more prescriptive and normative models (Elstein, 2001) but it seems as though the Naturalistic Decision Making (NDM) research has been able to extend the work on judgement and decision making to real world scenarios to some degree (Hardman, 2009).

2.7 Naturalistic Decision Making

The concept of Bounded Rationality (BR) inherent in the Fast and Frugal Heuristics framework is present also in the Naturalistic Decision Making (NDM) framework. NDM is concerned with the performance of experts in their particular judgement and decision making environment. Its starting point is not from mathematical probabilities inherent in a problem (as per utility theory and decision analysis) and so does not rely on a normative theory (Lipshitz *et al.* 2001). Instead it focuses more on what is happening in real environments which have meaning for the individual and the performance of the individual in judging and deciding. The environments typically relate to work-place scenarios and the implementation of a Cognitive Task Analysis (CTA) to investigate the nature of the judgement and decision making process is common. This approach is concerned with the cognitive processes undertaken by the individual in the context of the time pressures, stress, competing demands that may be present at the time (Lipshitz et al, 2001).

NDM has been described as being process oriented, governed by situation-action matching rules, concerned with context-bound information and the production of prescriptive models of decision making (Lipshitz *et al.* 2001). The first of these; process orientation, refers to the attention paid to the cognitive processes of the individual. This is where a CTA system such a semi-structured interview with an individual would be employed (Lipshitz *et al.* 2001). The idea of situation-matching rules stems from the concept of matching a solution to an encountered problem as opposed to choosing a solution from an array of choices. The approach here seems to be indicative of more attention being paid to the situational context and factors influencing any judgement or decision made. This point is emphasised by the rejection of more abstract models for situation specific information related to the expert's knowledge. The final characteristic of the NDM research is the production of prescriptive models of decision making designed to aid individuals to become expert in a particular area of work.

There have been many different NDM models proposed (Hardman, 2009). One such model, proposed by Klein (1998), is the Recognition-Primed Decision (RPD) model. This outlines a cognitive process which begins with the recognition of a situation as a typical or atypical scenario. This recognition component leads to the identification of relative cues and potential actions as well as expectancies and goals. This part seems to map on to the search part of Search Inference Framework model in which ideas and options are generated in relation to the problem while having scope to add or change one's goals (Baron, 2008). If a situation is identified as being atypical a process of data gathering commences. It is proposed that this help to build up a picture of what one is confronted with. Once the recognition component has been exercised a potential course of action is evaluated and carried out if it is believed it will work. There appears to be scope for revision of one's cognitions via feedback (e.g. in the event of an anomaly between the recognition derived information and the situation) and for modification of a planned action if it is believed that this is required for a successful outcome.

Unlike Utility theory, what would be a successful outcome is not outlined. The model is concerned with the specifics of the situation and the expert's performance therein. It is for the expert to decide what would constitute an appropriate goal, which according to the RPD model must be plausible relative to the information encountered by the recognition component. The RPD model and NDM is attractive by virtue of the focus on experts dealing with real-world problems which are meaningful to them. NDM seems to fit well with the characteristics required for individuals to improve judgement and decision making referred to by Shanteau (1992).

As mentioned previously, Shanteau (1992) has considered domain knowledge, cognitive skills, psychological traits and task characteristics as well as the use of appropriate decision strategies in relation to achieving competence. With regard to decision making strategies the following are put forward as being widely used by experts on the basis of researcher observation; use of dynamic feedback, decision aids, breaking down complex problems and thinking ahead to solutions for difficult

problems. The dynamic feedback is catered for in the RPD model by the recognition system experiencing the real world situation which will often prove to be dynamic by virtue of new and changing information. The use of a decision aid would appear to fit with the clarifying anomalies and gathering more data and perhaps as a support to the recognition system. Breaking down problems is somewhat similar to the products of the RPD recognition system especially with respect to deciding on appropriate goals and attending to relevant cues. Thinking ahead to difficult situations is likely to add to the individual's knowledge base which is required to diagnose a situation or to ascertain the features of a situation which identify it as being typical or atypical. Thus the NDM framework offers descriptive theory of judgement and decision making which is applicable to many scenarios due to the focus on task specific information and factors and the dynamic nature of many decision making environments. One criticism levelled at NDM is that it might not necessarily generalise to situations which are characterised by a lack of time pressure (Hardman, 2009). Considering this to the case it may that additions or different versions of the model may be required for certain situation but Galanter and Patel (2005) state that, as NDM is concerned with dynamic situations where changes and gaps in information are common, the models proposed are applicable to a Psychiatric triage setting. Here it is proposed that the same would be true of a Clinical Psychology setting.

2.8 Common ground for the Heuristics and Biases and Naturalistic Decision Making frameworks

In discussing the relative positions of the NDM and Heuristics and Biases framework, Kahneman & Klein (2009) describe how NDM is focused more on expert judgement and decision making which is successful and how Heuristics and Biases focuses on error prone decision making in experts. They agree that their relative positions are not entirely opposed and point out that the success of an expert's judgement and decision making is dependant on the characteristics of the task environment (e.g. Shanteau, 1992). They maintain that experts are not always aware of the cues that influence them and that less-skilled individuals will be unaware of these more often.

2.9 Studies on judgement and decision making in clinical practice

Schottenbauer *et al.* (2007) have studied the decision making processes of therapists by providing them with a hypothetical case summary and asking what they would do if they saw the client for a certain length of time and improvement or generalisation of gains did not occur. The responses were recorded and coded according to a category of intervention (e.g. a specific therapy such as CBT or considering medication or consulting a colleague.) The researchers were primarily interested in how therapists make decisions with respect to psychotherapy integration. As such their conclusions mainly discuss the choice of therapeutic intervention, decisions to change type of intervention used and decisions to refer to another therapist. In discussing the results of the data the authors relate the types of decisions to the BR theory of decision making.

This approach to researching decision making seems useful in that certain characteristics of the decision-making process were highlighted. For example, the decision of most therapists to reassess a patient if they were not showing any improvement is evaluated with respect to the concept of an ecologically rational decision. Also, the tendency for therapists to refer patients on to a colleague raised

questions about the adaptive toolbox available to them. These are interesting features of the decision making process as they focus on a real clinical issue (e.g. what do you decide to do when the intervention doesn't appear to be helping?) and considers features of the decision making process. This research does lack contextual information however. It would be interesting to know how the therapists experienced the decision making process and the specific factors which influenced the process; be it lack of training in alternative therapies or an organisational or professional culture of referring patients to colleagues.

Karlsson (1988) used an Empirical Phenomenological Psychological method to conduct a qualitative analysis on decision making and on the experience of making a choice. The study required participants to recall examples of decisions and choices made at any point in their life. The participants were asked to describe one of three scenarios; experience of making a decision, experience of not being able to make a decision or an experience of making a choice It is unfortunate that there was little information provided about the participant group or the methodology as it would be interesting to know if the group could be described as normative in some way (e.g. by virtue of age, profession, cultural context) and the extent to which the descriptions were prompted and guided by the research protocol.

That aside, it was interesting that the resultant analysis highlighted the idea that decision making is a process concerned with a future that is likely to be realised as opposed to a process characterised by wishing for a future event. The author goes on to describe how a realisable future is one which comes from the subjective stance of the individual who has a personal history and a sense of who they are at the point of decision making (the "I") and a sense of the projected future. Thus, the individual's experience of decision making is firmly rooted in a historical and existential context. This experience is understood by the individual within this context and Karlsson (1988) has sought to understand decision making and choosing within this context also. This analysis of decision making points to the possibility of idiosyncratic factors influencing the decision making process. Karlsson (1988) argues that the analysis fits with the NDM model, Image Theory (Beach & Mitchell, 1987) with

respect to the individual making a decision according to personal objectives. This would fit also with the idea of searching for goals in the SIF model (Baron, 2008).

2.10 Influences on judgement and decision making in clinical practice

We have seen how different research paradigms study the processes involved in judgement and decision making from different perspectives and how there are differences in what variables are attended to in describing or testing a process. Another way to think about these processes is to take a wider view of the factors that can influence them in the context of clinical practice. As was mentioned earlier both the Health Professions Council and British Psychology Society guidelines for Clinical Psychologists make several references to the importance of clarity and sound reasoning in judgements and decisions made. It seems reasonable to suggest that the ability to work competently in a Clinical Psychology setting is based in part on judgement and decision making skills. The next section of this introduction will focus on the Theory of Expert Competence and a range of influences on judgement and decision making within the domain of clinical practice.

2.11 Competence in clinical practice

Shanteau (1992) developed the Theory of Expert Competence and emphasises that expertise (having the ability to carry out specific roles/task to a high level as judged by others in the same field of work) is specific to a particular domain (such as the profession one has trained for and is working in). The theory outlines five conditions necessary for competency. These are outlined here (Shanteau, 1992, p.252);

1. A sufficient knowledge of the domain
2. The psychological traits associated with experts
3. The cognitive skills necessary to make tough decisions
4. The ability to use appropriate decision strategies
5. A task with suitable characteristics

Domain knowledge includes that which is learned from books and from experience. Psychological traits such as good communication, self-confidence, ability to adapt to different situations and an unambiguous sense of responsibility are cited. The cognitive skills referred to seem quite general in their scope. They include well-developed attention skills, an awareness of what is relevant, being able to identify exceptions to the general rule and the ability to work well in stressful situations. Expert decision making strategies are considered to be those which manage information in a systematic manner and help overcome limitations in cognitive ability; such as breaking problems down and the use decision aids and feedback. Shanteau (1992) also posits that the nature of the task being undertaken by the individual will have a role to play in how successfully it is completed. The suggestion here is that tasks which involve dynamic stimuli with an environment which offers little feedback or decision aids are more likely to lead to poor performance.

The main thesis of this paper is that the performance of experts is not wholly competent or incompetent but can be somewhere between these two poles. While one may question the broad definition of what constitutes an expert, this paper does draw attention to some of the variables which could be influencing the performance of individuals in real-world work-related tasks. In the context of the present research two points are note worthy. The first is that good decision making abilities are part of the repertoire of the more competent expert. The second point is that the five characteristics referred to above are likely to interact to create more or less competent experts. One could reasonably assume that individuals will have varying degrees of each characteristic and will have different experiences of them dependant on their own biographical (Karlsson, 1988) and contextual factors.

Clinicians must decide on how to approach assessing a new patient, whether to treat the patient or not, how to treat the patient and what therapeutic goals should be worked on (O'Donohue *et al.* 1990). Of course many other judgements and decisions can crop up in the course of clinical work such as when to terminate treatment, whether to refer on to another clinical or service or not at all. Some of the decisions

made will be based on the clinician's own judgement, and others based on consultation with fellow professionals or with the client themselves. Other decisions will in a sense be reflect institutional (or departmental) policy and the research evidence base (Lucock, Hall & Noble, 2006). It hardly needs to be stated that in the context of a Clinical and Counselling Psychology setting that the decisions made by staff will most likely represent a mix of these influences.

Lucock *et al.* (2006) conducted a questionnaire survey of influencing factors on the practice of therapy carried out by NHS therapists and NHS Trainee Clinical Psychologists. It was found that information from evidence-based guidelines and treatment manuals were ranked relatively lowly and for both groups (qualified staff and clinicians in training) the psychological formulation, current supervision, and client characteristics and feedback are rated most highly. The qualified group also rated post-qualification training relatively highly (Table 1).

Table 1. Top Fourteen Influential Factors on Clinical Practice; Ranked by Qualified Psychotherapists*. Adapted from Lucock *et al.* (2006)

1. Psychological Formulation
2. Current Supervision
3. Post-Qualification Training
4. Client Characteristics
5. Client Feedback
6. Professional Training
7. Intuition and Judgment
8. Things picked up along the way
9. Peer discussion
10. Personal Philosophy
11. Seminars/Workshops
12. Personal Therapy
13. Professional Guidelines
14. Theory based Journal Articles

*Other factors included for rating in the questionnaire were; textbooks, research based journal articles, other journal articles, electronic journals and databases, other information on the internet, treatment manuals, government documents, evidence based practice guidelines, non-professional literature such as novels, spirituality, friends and family with psychological problems friends and family in general, major life events, activities and interests, television and films, alternative therapies, providing supervision, organisational constraints, environmental limitations, NHS philosophy, conferences, and providing teaching/training.

The authors posit that the emphasis on evidence-based practice in supervision and in the Clinical Psychology training programme may influence the clinicians' practice despite the relatively low rating of influence of evidence based information provided in the survey. They also discuss the relatively high rating of the influence of intuition and judgement on clinical practice by both groups. They accept that neither concept is clearly defined in their paper. They also express their hope that clinical judgements and intuition would relate to clinically effective decisions and suggest that measurement and verification of this could be helpful in enhancing clinicians' practice.

The authors are evidently concerned with the relatively low ranking of evidence based information and state that further research is required to elucidate the reasons for clinicians perceiving certain factors as more influential on their work than others. This is something which has been debated in the literature along with the question of what is the best way to make a decision in clinical practice (O' Donohue et al 1990).

2.12 Evidence base as an influence on clinical practice

Stricker and Trierweiler (1995, p.999) address the perceived gap between science and clinical practice in Clinical Psychology. They describe the need for the clinician to use both scientific knowledge and "critical judgement" in the clinic setting. They state that at time science will provide a partial answer to help the clinician decide on a suitable course of action.

Stricker and Trierweiler (1995) remind us that although scientific research does not always map on to clinical practice this does not necessarily mean that the clinician does or should work in an unscientific manner. Instead they point out that the clinician ought to adopt the same style of critical thinking, in generating and testing hypothesis and monitoring progress and outcomes, which is associated with the scientist. They describe the clinician as a "local" clinical scientist to emphasise the point that the clinician is making observations, collecting data and testing out hypothesis at a contextual level very different from the general or universal context. They make reference Shakow (1976) to who wrote about the practice of Clinical Psychology and training in the profession who defined the "Scientist Professional" as being "the combination of the skilled acquisition of reality-based psychological understanding and the attitude of constant enquiry toward this knowledge" (Shakow, 1976, p.554)

The conclusion reached by Stricker and Trierweiler (1995) was that science influences clinical practice by providing a theoretical basis to help structure and shed light on clinical observations and by providing an enquiring attitude to information that is gathered in a general nomothetic context or in the local idiographic context.

However, the limitations in applying scientific method and knowledge to clinical practice must also be considered. O' Donohue *et al.* (1990) cite sub-optimal conditions in the clinic for gathering information and ever-changing circumstances within which one is working as factors which complicate the decision making process. They question how clinicians justify decisions made in the course of clinical work. They portray a relatively pessimistic view on the ability of clinicians to engage in systematic decision making processes following a review of case records which focused on choice of assessment method, therapy goals and type of therapy. Their main concern was the low level (between 2 per cent and 8 per cent) of systematic decision making being outlined by the clinicians. One wonders if this is an overly pessimistic picture. There isn't a clear description of what a systematic decision making procedure would be but in the context of the article it seems as though this may relate it to use of scientific research or influential papers on clinical methods. Also, it may be that the influence of the scientific evidence base and scientific theory has a subtle effect on the work carried out via other factors which were described by the therapists as being influential such as the institutional policy, past success with a procedure and informal discussion with colleagues.

O' Donohue *et al.* (1990) conclude that a more in depth investigation may have uncovered more evidence of systematic decision making processes that would appropriately justify the choices made. What would be of interest here is a more idiographic approach to the participants' made sense of how they decided on a particular course of action, especially in relation to feedback such as "It just seemed to make sense" and "That is what I always do" (O' Donohue *et al.* 1990, p .425).

2.13 Aided and unaided judgment: Actuarial versus clinical judgement

Both actuarial and clinical judgements are subject to the processing of informational cues (Hardman, 2009). The former is based on the use of a statistical model to predict a particular outcome. The latter is referred to as "unaided human judgement" (Hardman, 2009, p.11) and relates to the clinician making a judgement by considering the information they attend to. In general Adult Clinical Psychology settings judgement can be aided by using a structured interview or a psychometric measure of a psychological variable such as depression or memory.

Social Judgement Theory, which is concerned with common decisions in a particular setting such as diagnosis in a Psychiatric department or Community Mental Health Team, led to the development of Lens models (Hardman, 2009). These models describe how actuarial methods can be applied to make a judgement and many experiments have shown them to out-perform clinician's judgments (Grove *et al.* 2000). Robyn *et al.* (1989) contend that even with the help of decision aids, a clinician's judgement performs more poorly than an actuarial tool. They describe an actuarial tool as an automatic statistical method which is based on scientific relationships between data and a particular condition. The main contention is that even for real-world scenarios such as a Psychiatrist judging the likelihood of a patient having a Psychosis or a Depressive disorder, an actuarial tool yields more correct diagnostic judgements. They warn that individuals are prone to bias in these scenarios (e.g. attending too much to evidence which confirms an initial thought about a diagnosis) and receive little feedback as to the accuracy of their judgement or to the extent which specific data were useful predictors of eventual outcome. This paints a pessimistic picture of the ability of clinicians to make judgments and surely casts doubt on decision making ability given that making a judgement is part of the decision making process (Baron, 2008).

However even Robyn *et al.* (1989) point to the fact that individuals' judgements, such as inferring information from a facial expression during a clinical interview, are important in aiding a decision making process. They also point out that for rare events and for outcomes for which there are either very complex relationships between variables or no relationship between variables, an individual's judgement is a valuable tool. Shanteau, (1992) and Kahneman and Klein (2009) posit that such pessimism about experts' judgement should be tempered by considering the nature of the task environment. They state that individuals can become competent and skilled at making judgments in environments where the cues necessary to collect data are apparent, where feedback on judgements made is quick and unequivocal and that the variables in the environment are stable and predictable. In addition they remind us that experts are needed to collect data and to monitor how the actuarial method is applied over time. Thus it would seem that experts have their place in providing judgements in decision making tasks but there is a call for experts to play to their strengths and make use of the actuarial method where there is valid data available.

2.14 Supported decision making in clinical practice

Lutz et al (2006) refers to the gap between scientist and practitioner in relation to selection and application of different therapeutic approaches or techniques. They suggest a move away from research focused on treatments in a highly controlled experiment to research in the clinical setting (less controlled) which is focused on the patients presenting to the clinic. This patient-focused research is described as having the potential to inform clinical decision making by comparing specific variables (such as well-being, duration of symptoms, patient's expectation of improvement in psychotherapy) between a new patient and previous patients from whom pre and post therapy data has been collected. This is a statistical method which, given a large data set of reasonable quality that could well support the decision making process within a particular clinic. Such a statistical approach is not used in the Clinical and Counselling Psychology Department involved in this study but the researcher is aware from clinical experience that some NHS Primary Care Mental Health Teams are building data sets on clinical work, which may be used in a similar way to

support decision making. Indeed, within the NHS adult psychological therapies context, Lucock *et al.* (2003) have outlined a method of gathering data (using psychometric questionnaires) and feeding this data back to assist with service evaluation, risk assessment and evidence-based reflective practice.

2.15 Emotions and judgement and decision making

Muramatsu and Hanoch (2005) posit that emotions have an important role to play on cognitive processes involved in decision making and that they can function as a Fast and Frugal heuristic. This is a theory put forward by many other researchers in the field of Cognitive Psychology. For instance Bechara (2004) describes the Somatic Marker Hypothesis which proposes a link between a bodily feeling and decision making. In their research they found a correlation between the ability to experience emotion (as measured by skin conductance responses) with more effective decision making in a gambling task. Successful performance on the task was defined by the amount of money won by deciding on whether or not to select cards (over a course of 100 selections) from high risk or low risk decks of cards. They found that a group of participants with damage to the ventromedial (VM) area of the prefrontal cortex performed more poorly on the task relative to control groups. They also found that the damaged VM group did not experience increased skin conductance just before selecting a card in contrast with control. The researchers posit that this correlation between poor task performance and a lack of what they called an anticipatory emotional response supports the theory of emotion being an influential factor in decision making.

Of course in the gambling task it can be seen that having an emotional response is correlated with better performance on the task but this does not imply that there is a causal link between the two. While it certainly seems plausible that emotions have an influence on our encoding of memories (LeDoux, 1996) and influencing judgement and decision making (Damasio, 1994) the broad issue here is the nature of the effect or role emotions have on our judgement and decision making. Lambie (2006) contends that emotions may have a detrimental effect on the rationality of our

judgement and decision making unless we are aware of the emotion experienced and we consider whether or not to act on the basis of the emotion. As an example Lambie (2006) refers to a case where an individual's emotional response to a stimulus can lead to decision making which has a deleterious effect on future goals. This is something encountered often in the Cognitive Behavioural Therapy literature (Beck, 1976), in which emotional responses are seen to alter one's goals (e.g. fear increases avoidance) and behaviour in a way that fosters an overestimation of the severity of the situation and an underestimation of one's ability to tackle the problem or cope with it.

From a research point of view it is interesting that Lambie (2006) highlights that the phenomenological experience of the emotion is an important consideration. He states that being aware of one's emotional response is quite a different thing to experiencing an emotion and that it may be difficult to develop this awareness. One would suggest here that while the debate over whether emotions are a positive or negative influence on judgement and decision making, it may be worthwhile considering the individual's experience of the phenomenon of emotion in relation to these processes. What is also interesting here is the idea that being aware of emotions can lead to more rational judgement and decision making.

One wonders whether this is likely to be possible for many individuals to achieve given that it could prove resource intensive (we make decisions under time pressure) and as Lambie (2006) himself states it is dependant on the ability of the individual to recognise, attend to and understand emotions as well as the ability to revise a plan of action according to one's goals and the evidence available to the person.

2.16 Reasons for this research project

It has been suggested that research into decision making in a psychotherapy setting could be usefully applied to the question of how the decisions taken by a therapist are aligned with patient and therapy setting factors (Schottenbauer *et al.* 2007). The same author has also pointed out the potential usefulness of qualitative research in interviewing therapists about their clinical practice and their decision making.

What is of interest in this research project is the individual Clinical Psychologist's experience of the judgement and decision making processes they go through in the course of their work. It is proposed here that the models of decision making, discussed above, do not necessarily account for the meaning a particular decision has for the individual or how they experience the process of judging and deciding. This brings us back to the gap between science and practice discussed by Stricker and Trierwieler (1995). The current research is focused on how decision making is experienced and understood by clinicians and as such the work starts from the clinical practice side of the "gap". This approach is proposed to be a valid research endeavour in to increasing our understanding of the phenomenon of decision making in the complex and dynamic context of Clinical Psychology practice. Klein (1997) states that decision making can be viewed as a type of expertise which is not just confined to well-structured tasks. He also proposes that developing an understanding of how experts think and learn may be helpful in educating students/trainees in strategies for developing decision making skills. While the present research does not set out to elucidate appropriate decision making strategies it shares Klein's (1997) focus on studying the dynamic, real world conditions in which experts work; the aim being to provide an informative and considered description and analysis of the phenomenon of decision making. It is hoped that the results of this work will be useful for trainees and clinicians in reflecting on and developing their own practice by proving an in depth account of decision making experiences.

As stated at the beginning of this introduction, the present research can be couched in terms of describing judgement and decision making processes as opposed to

evaluating the processes or prescribing an improved method for making judgement and decisions (Baron, 2008). A specific qualitative method, Interpretative Phenomenological Analysis, (IPA) will be utilised in designing the study and collecting and analysing the data. In taking an IPA approach the aim is to investigate how people understand their experience of decision making rather than provide an explanation or theory of decision making. This approach is considered by Starks and Brown Trinidad (2007) to be suited to providing clinicians with a rich description of a phenomenon that goes beyond the general assumptions which may be held about it. What is proposed here is to describe what is happening from a holistic perspective that includes cognition, emotion, behaviour, and the social and professional environment and to provide an interpretation of what the Clinical Psychologists have experienced and how they have made sense or meaning of this.

Theories of judgement and decision making and some general factors which can influence these processes have been discussed here. It seems fair to say that each model has limitations, some of which have been referred to here. Individual clinicians are likely to be subject to a wide range of factors not fully accounted for in one model of decision making. Factors such as personal and professional aspirations and beliefs about what a "good" decision or outcome would be are likely to reflect individual concerns and experiences relating to clinical work. However, each of these theories and models offers a framework within which to consider specific elements of the processes involved. A further aim of this research project will be to relate the results of the data analysis to these theories. This research project is not concerned with testing a particular model or examining levels of competence in judgement and decision making in Clinical Psychologists. The primary and secondary research questions are outlined below.

2.17 The research question

2.17.1 Primary research question

- How do Clinical Psychologists experience clinical situations in which difficult judgments and decisions are made?

Smith *et al.* (2009) note that it can be useful to keep a number of objective steps in mind to help keep the research focused on the open-ended question. Thus it was decided that the goals of the work would be to:

- Describe the main features of each participant's experience of making a difficult judgement or decision.

- Describe these main features from a psychological perspective.

2.17.2 Secondary research question

As a secondary aim to the research it was decided to compare the qualitative description and interpretation with a section of the Cognitive Psychology research. Smith (2004) notes that referring back to a specific theoretical account can assist the researcher to retain a thorough and well-founded approach to the inductive process of the data analysis.

Thus the secondary research question is stated as:

- How does the way participants make sense of the experiences discussed in the qualitative interviews relate to the theories of decision making and the literature on influences on clinical practice?

3.0 METHODOLOGY

3.1 Choice of Interpretative Phenomenological Analysis as a research methodology

An Interpretative Phenomenological Analysis approach was employed in designing the research, collecting data and analysing this data. This approach has been described as being influenced by phenomenology, hermeneutics and symbolic interactionism (Smith & Osborn, 2008). This approach is considered suitable for forming a rich description of a psychological phenomenon, which is constructed from the view-point of the participant (participant as expert approach). In addition this approach involves an interpretive account of the information gathered being constructed by the researcher. With the IPA model, it is accepted that this account is subjective, but that it is relevant and accessible to the participant's and the intended reader. IPA is considered to be particularly useful for exploring psychological aspects of a phenomenon; cognition, emotions and behaviour and for investigating how a participant makes sense of a particular experience or phenomenon (Larkin, Watts & Clifton, 2006).

Dallos and Vetere (2005) outline specific reasons why one would choose to adopt an IPA as a research method. The reasons which the researcher believes are most applicable to this work are; the primacy afforded to each participant's "point of view" and the linking of the themes of this information to the research literature. Also, the researcher had access to a homogenous group, and theoretical sampling (as per a Grounded Theory approach) would not have been practical given constraints on time and number of available participants.

It was decided that the process of decision making was a suitably engaging and valid psychological phenomenon for investigation and that therapists would be able to discuss their experiences of this process with the researcher. As outlined in the introduction section, decision making has been the subject of much research within the field of Cognitive Psychology but the experiential aspects of the process are of

interest also, especially with regard to clinical work. Also, it was proposed that a producing a psychologically informed analysis of the phenomenon of decision making in clinical practice would be best completed with the IPA method.

3.2 Other methodologies considered

Grounded Theory

It was decided that another theory of the decision making process, as would be the process in a Grounded Theory approach, was not the aim of research. Rather a focus on a rich description of each participant's experience of the phenomenon in addition to an interpretation of how participants actually experience making difficult decisions was chosen as a chief aim of the work.

Single Case Study

The researcher favoured conducting the study with a number of clinicians as opposed to conducting a single case study. This was deemed to increase the likelihood of gathering rich data as well as providing the opportunity for some careful comparison across participants.

Direct Observation

It was decided that qualitative observation of clinical sessions would not be pragmatic in terms of recruiting clinicians and their patients and in terms of accessing episodes where a difficult decision would be made. For example it is likely that clinicians make difficult decisions over the course of more than one session as well as in one session.

Narrative Approach

A Narrative approach was rejected as the researcher was unsure whether linking the participants' sense of self as a clinician to stories or narratives about the decision making process would fit with the research question or the aims of the research work. It was posited that the decision making process could relate to more than one's sense of self as a clinician and a technique allowing for a broader focus was preferred.

Discourse Analysis

The use of Discourse Analysis was not favoured as the researcher was not so much concerned with the meaning constructed via language in a social relationship as in the specific process of decision making, which the researcher posits, could be an individual as well as an interpersonal or group process. Also, Smith, Flowers and Larkin (2009) note that a discourse analysis focuses more on how language is used and how it functions in particular contexts. The present study is more concerned with the participant's lived experience of decision making rather than an exclusive focus on language.

3.3 Application of Interpretative Phenomenological Analysis in psychological and health-related research

Smith (2004) notes that IPA can be applied to a wide range of subjects of interest to Psychologists across many disciplines such as Clinical Psychology, Health Psychology and Counselling Psychology. The importance of a fit between the research question and the focus of IPA on lived experience and meaning-making is emphasised over any differences between academic branches of Psychology.

Indeed there have been many IPA research papers published in a range of Psychology and Nursing journals. Jarman, Smith and Walsh (1997) published a study of the psychological construct of control in the context of professional carers treating patients with anorexia nervosa. The authors found that there were gaps in the research literature with respect to advice clinicians could follow in their work. They decided that to address the meanings attached to and experiences of working with patients with anorexia nervosa would be important in developing the research topic. The idea of control was one theme resulting from the IPA analysis. The transcript excerpts relate to carers opinions on patients in general rather than specific cases so one would expect there to be differences in how carers related to their work. However, what is of interest in this study is that the exploration of how the difference in carers' experience of control leads to differences in the way care is provided. The fact that the individual carers' experience does not fit with the standard care that is recommended as they are experienced differently is indicative of a hermeneutic circle in itself, populated by the individual carer and the group/team of carers. The authors suggest that individual therapists' experiences of providing care should be studied to assist in the training of staff (from the individual carer to a group of carers and back again). In this way the authors challenge the framework of this particular professional care system and suggest that more interpretation of the context of the system of care provided could be beneficial in developing care and professional training. The hermeneutic activity of interpretation in this paper is strengthened by the phenomenological activity of revealing something of the experience of the carers' professional life; e.g. Jack's statement that he "gets more out of" the families he

works with by manipulating both them and the control in the family, which, the authors inform us, contrasts with how the other carers manage control in the care provided.

IPA has also been used by NHS Clinical Psychologists to investigate how nurses make sense of and approach their assessments with dementia patients' carers. Carradice, Shankland and Beail (2002) contrasted the themes arising from their work with a process model of stress; highlighting areas which they believed could be improved upon in nursing training. The main thrust of the paper was that a greater understanding of how stress-related factors are mediated would aid the provision of staff support and improve the clinical assessment procedure. Another paper from this department (Thompson, Powis & Carradice, 2008) used IPA to study the nature of CPNs' experience of deliberate self harm in the course of their clinical work. The emergent themes were related in the discussion to NICE guidelines, to current psychological understanding of deliberate self harm and to models of therapy. In doing so Thompson *et al.* (2008) highlighted aspects of service delivery which could be developed. While both these studies did not change the frame within which a psychological construct (carer stress and deliberate self harm) is understood the work carried out did relate both the experience and meaning-making NHS staff had engaged in when confronted with these constructs. The use of IPA in this way is surely relevant to the development of staff training and shared understandings of psychological constructs and processes encountered in the course of clinical work.

3.4 Conducting an Interpretative Phenomenological Analysis

3.4.1 Phenomenological aspects

The aim of an IPA analysis is two-fold. Initially the researcher is focused on the content of the participant's experience. The focus is directed toward a phenomenological stance and to a description of the participants' perception of an object or experience is produced (Smith, Jarman & Osborn, 1999). The approach has been described as a process disengaging from the object or process under investigation and attending "to the taken for granted experience of it" (Smith *et al.* 2009, p.13)

The task of the researcher is to focus on the key objects of concern and on the experiential claims made by the participant (Larkin *et al.* 2006). According to Heideggerian phenomenology this is achieved by describing the phenomenon in question "as it is in itself" (Larkin *et al.* 2006, p116). It is necessary to have an awareness of the theories one has formed about the phenomenon so that they can be placed aside (bracketed) while conducting the analysis. Smith *et al.* (2009) advise that the use of bracketing is a circular process in which ones goes from the information gathered to one's a priori conceptions and then back to the information. In doing so the preconceptions are organised in the mind of the researcher and are less likely to block or confound the interpretive process.

It is accepted that the researcher is unable to provide a true first person account of another person's experience. As such one is striving to get to the core of the phenomenon as it really is while accepting that this is unlikely to be fully realised. The participant has made meaning (sense) of their experience then related this to the researcher who has then to make meaning of this account. This is referred to as a double-hermeneutic. Smith *et al.* (2009) note that hermeneutic insights are required in order to interpret the phenomenon being described. Thus there is a constant interplay between the phenomenological and hermeneutic parts of the research activity.

3.4.2 Interpretative aspects

In IPA the focus on how an experience (an event, a process, or a relationship) appears must lead to an interpretation of that experience or phenomenon. Thus the researcher aims to provide an interpretation of what the experience of the phenomenon being investigated means for the participant.

In doing so, the context of the research situation must be taken into account. The participant has given an account of some aspects of their experience but the thoughts and emotions they describe may not be fixed in time and are likely to change (Larkin *et al.* 2006). The account given is provided in a particular interpersonal and inter-professional context also. In addition the researcher has his own set of biases, understandings and limitations, which must be overcome as much as possible. These factors are kept in mind in order to contextualise the interpretations being made by the researcher. The analysis therefore should offer a holistic interpretation of both the participant and the experience they are discussing (in the case of research interviews) with you (Smith *et al.* 2009).

The overall interpretation is described as a theoretical framework, which stems from the participant's own language and conceptualisations (Smith, 2004). The description (insider's view) and the interpretive analysis can explain what a phenomenon means for the participant and how they make (or have made) sense of it within the context of their life (Larkin *et al.* 2006).

3.5 Variations in the extent with which hermeneutics and phenomenology are applied in research

McLeod (2001) provides a review of some of the criticisms of the use of hermeneutics and phenomenology in psychological research. He emphasises the concern that hermeneutics can be used simply to provide an interpretation and descriptions of experience being classed as phenomenological. It would seem that a thorough application of hermeneutics and phenomenology in an IPA framework necessitates a deep questioning of the framework within with the research topic is understood, an interpretation which extends the researchers' and readers' understanding of the phenomenon and the careful practice of suspending a priori knowledge so that the researcher is able to reveal more of the phenomenon.

3.6 Considerations for interview methodology

3.6.1 Aims and approach

The aim of the interview was to gain a rich description of the decision-making process. This phenomenon has been described in the introduction.

When deciding on how to approach the interview process the most difficult question that arose was how to prompt the participant to discuss decision-making in clinical practice. Should the researcher ask them to think of this in advance of the interview, and perhaps select case examples of this process? It was decided that a semi-structured interview served the research best and that in the initial meeting with the participant the phenomenon under investigation would be explained. Kvale (1996, cited in Cisneros-Puebla, Faux & Mey, 2004) states that the interview should be used to generate meaning and interpretation around the topic of discussion rather than gathering facts. This approach is consistent with a phenomenological approach, which is less concerned with identifying and controlling variables associated with a phenomenon but is more concerned with exploring the phenomenon in the context in which it was experienced by attending to the individual's first hand account of their experience of it (Giorgi & Giorgi, 2008). This was based on the idea that what was of most interest was the participants' explanation of the ideas they held (thoughts) and their explanation of their actions rather than the meanings they attributed to specific therapeutic relationships or events.

The researcher is also aware that the use of an interview assumes the ability of the individual participant's to examine and explain their thoughts and actions within their clinical practice (Harre & Secord, 1972, as cited in Dallos & Vetere, 2005). This was thought to be a reasonable assumption to make. All participants had received professional training and regular supervision during their clinical work so one might reasonably expect that they had developed a capacity for reflecting on and describing how they approach various aspects of their clinical work, including decision making.

3.6.2 Structuring the interview

Robson (2003) has described a method of structuring the interview process, which allows for beginning (introduction and warm up) middle (main body of interview) and end (cool off and closure). This sequence was used in setting up the research interviews, as the researcher believed it provided a suitable structure to the interview process. It also allowed for a consistent approach to be adopted for all participants.

An interview schedule was created to help the researcher focus the interview on the phenomenon under investigation while allowing the participant an opportunity to expand on points that s/he has raised. In addition the use of process-intervention type questions were used (e.g. can you tell me more about that?) was considered an important part of the research interview. Rennie (1996), states that this form of questioning is helpful in probing the topic being discussed, while allowing the participant freedom regarding the content of the discussion.

3.6.3 Observations during the interview

From an interactionist perspective it is important that the social context of the interview is considered (Silverman, 1993) and this seems to fit with the researcher as participant-observer role. The researcher was mindful of this throughout the interview process as the need to provide participants with an opportunity to provide their own account of their experience is consonant with the idiographic focus of the IPA approach. Contrary to a positivistic approach the researcher does not assume that the information gathered in the research interview is representative of facts, which are independent of the context of the interview and of the relationship between the interviewer and interviewee. In addition, Dallos and Vetere (2005) emphasise the importance of attending to both verbal and non-verbal information in the interview.

3.7 Participant group

The Clinical and Counselling Psychology service is part of an NHS Adult Mental Health service. All seven participants were recruited from this service.

3.7.1 Service Aims

The aims of the service are outlined in the staff handbook as follows;

1. To provide an efficient and effective Clinical and Counselling Psychology service across the area, within available resources.

2. To assist and support the delivery of mental health services in Community Mental Health Teams through the provision of consultancy, teaching, training and supervision for staff of other professions.

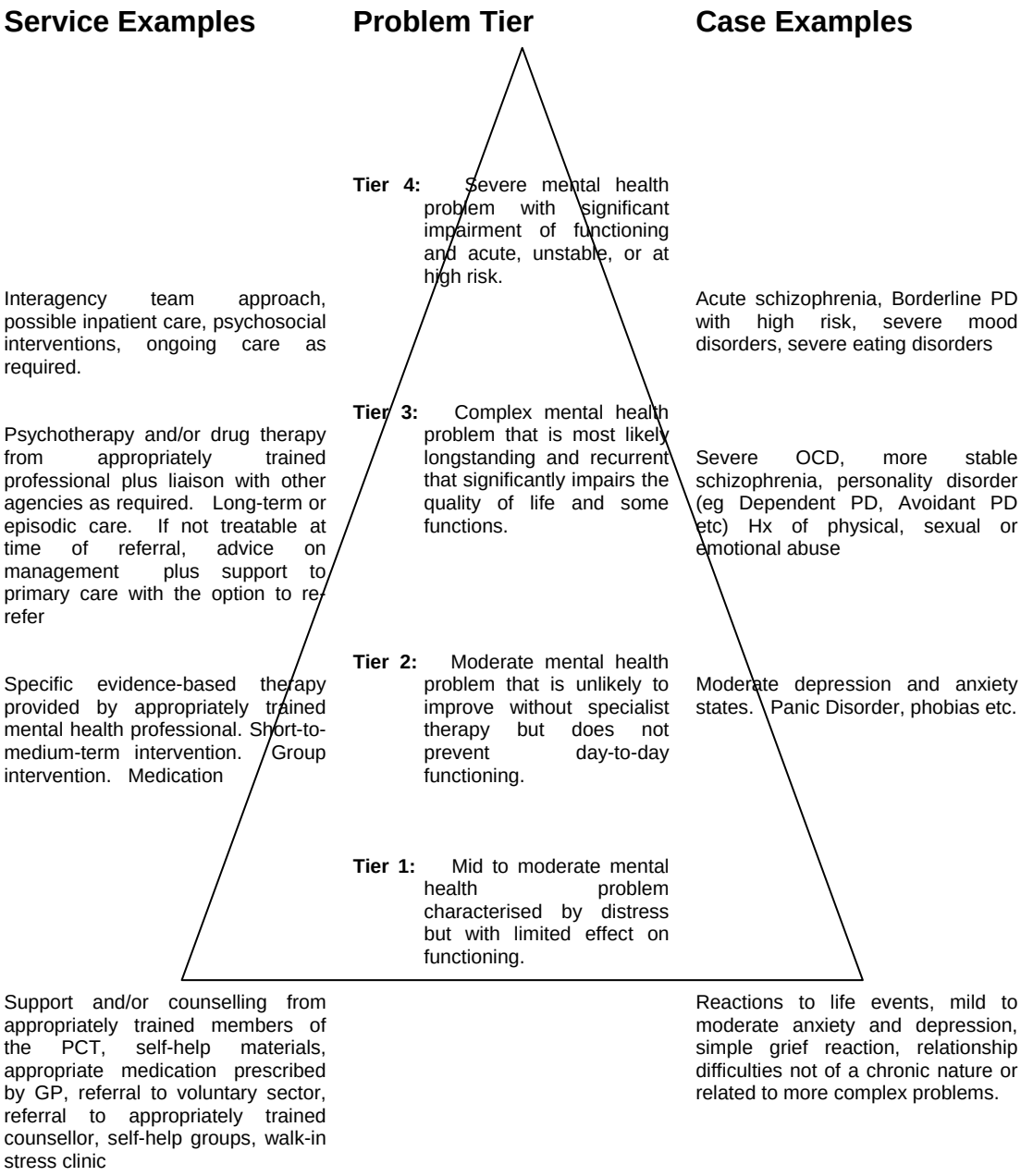
3. To contribute to the professional training of Applied Psychologists for the NHS and of other professions as appropriate.

3.7.2 Service Provision

Clinical and Counselling Psychology services are provided for adults aged between 18 and 64 years. Psychologists are attached to a Community Mental Health Team (CMHT). Referrals are accepted by each Psychologist from GP's and CMHT colleagues. The main problem areas accepted for referral are depression, anxiety, psychosis, trauma, personality disorders and characterological problems and anger problems which are in the context of another presenting problem. Referrals are not accepted where anger is the main presenting issue, for issues related to physical health, relationship problems, Attention Deficit and Hyperactivity Disorder, or addictions.

The service operates a four-tier model of service provision with the majority of direct clinical work geared towards tier 3 and 4 (Figure 1). The number of sessions allocated for therapy is set at a maximum of 20. Having conducted 15 sessions with a patient the clinician is expected to discuss the progress of the work and the suitability of further sessions.

Figure 1: Tiered Model as outlined in Staff Handbook, based on Northumberland Tiered Model (Paxton *et al.* 2000).



3.7.3 Clinical and Counselling Psychology Department

The majority of the clinical work is undertaken on an outpatient basis in clinic rooms at a central service base or in community NHS resource centres. The Psychology staff attend bi-weekly meetings with their colleagues covering the same geographical area and departmental meetings with regular Continuing Professional Development (CPD) slots are held also.

3.8 Data collection

The research project was reviewed by the local Research Ethics Service committee. It was decided that the work did not require further ethical approval (Appendix 1). However the researcher ensured that ethical considerations were discussed with the clinical supervisor and NHS line manager. Two of the key considerations here were to ensure the work was carried out in a way that ensured the confidentiality of the participants and that the researcher conducted the work in a manner that was acceptable to the participants. To ensure the participants were able to raise queries and complaints about any aspect of the work they are instructed on the participant information leaflet (Appendix 2) that they could contact the researcher's line manager. The other main ethical issue that arose in discussions with the clinical supervisor was what action should be taken in the event that the researcher perceived there to be evidence of mal-practice in a clinician's work. It was decided that the researcher should broach any such concerns with both the head of service for the department and the researcher's line manager.

The Head of the Clinical and Counselling Psychology Service introduced the research project to staff at a departmental meeting and the researcher sent a group email to staff. The email included the Participant Information Sheet the Consent Form and the Interview Outline (Appendixes 2, 3 & 4). Staff were informed that participation in the project would be voluntary and that the researcher was available to discuss the project should anyone have queries about this.

Seven participants took part in the research project. All were qualified Clinical Psychologists working in the Clinical and Counselling Psychology Department. All participants had received their formal Clinical Psychology training in the United Kingdom. Four participants had less than five years post qualification experience and three had more than five years post qualification experience. Details such as name, age and gender are not provided to help ensure the anonymity of each participant. In the results and discussion each participant is referred to as CP (Clinical Psychologist) followed by a number (CP1 – CP7), which corresponds to the number of that participant's transcript.

3.9 Recording and transcribing

Dallos and Vetere (2005) recommend that researchers transcribe at least three interviews so that one is spending more time with the data and becoming familiar with the content. It also allows for the addition of non-verbal events in the transcript. In this instance the researcher transcribed all of the interviews.

Each interview was recorded by using an Olympus WS-311M Digital Voice Recorder. The interviews were transferred to the Express Scribe which is a digital software programme designed to transcribe audio recordings on a computer. All seven interviews were transcribed verbatim by the researcher.

Six participants availed of the opportunity to receive a Microsoft Office Word file of the interview transcript. One of these six participants replied to suggest one minor correction and to identify a missing word from the text.

3.10 Analysing the data

The use of the QSR*NVivo software package was considering for this stage of the research. The advantages of using software have been debated in the literature. Ayres *et al.* (2008) state that, while it is important that the use of software should not preclude genuine hard work on the part of the researcher in conducting a data analysis, the use of software can help the process. They argue that using software may reduce the likelihood of biases going unchecked and of the analysis being stopped before a though examination of the data and emerging themes has been completed. It would seem that the benefit of a software package is to help organise data and allow for ready access to emerging themes and notes taken during the analysis. However, this in itself is unlikely to be sufficient to ensure a valid data analysis. The researcher has to engage fully with the data and ensure that steps are taken to render the analysis valid and transparent. It was decided that there was little advantage to be gained from using a software package as the researcher did not find it to be helpful in increasing efficiency of data management. It was noted that extra care required to be taken in keeping track of the steps taken in the analysis so that each theme could be traced back to the original transcript and also that no part of the data was disregarded in the analysis stage.

3.10.1 Step 1: initial impressions, reading and initial notes made

The procedure for analysing the data was based closely on that outlined by Smith, Flowers and Larkin (2009). Initial impressions of the interview were noted in a research journal while listening to the audio recording. The transcript of the first interview was read through twice before progressing on to make initial written comments on the right-hand side of the margin. In making these initial comments the focus was on describing the content of the dialogue, commenting on the use of specific words or style of language, and on making conceptual comments about what was being described by the participant. The concepts that were of interest here were those relating to the decision making process and how the participant experienced this. Of course many other concepts such as describing work cultures and how the

participant identified with psychology as a profession were also evident in the initial transcript. These were noted in the right hand margin also so that no data was lost in the early stages of analysis. The balance between being empathic and critical toward the transcript was considered carefully at this stage and acted as a guiding principle in the analysis (Smith, 2004). It was found that initial notes were highly descriptive and therefore close to (empathic) the transcript. As the analysis progressed and the themes developed the analysis included more interpretative analysis.

This initial stage is illustrated for lines 557 to 561 of the first transcript.
So I don't know if there was anything concrete but there was just a sense, just a felt sense of there is something here that he is not able to access, you know obviously he's traumatised, his own defences are going to leap in and say "just don't go there"

The initial notes in the right hand margin can be seen on the original transcript, which is reproduced on the following page.

2 B

And well, I suppose that set my mind thinking, well if can give a normalised response and it didn't seem to be sorta he was detached from it, it just seemed to be well this happened and so on and so forth but there was something in my mind saying "well how come many years on you're being significantly affected by this" you know so

Mhmm

So I don't know if there was anything concrete but there was just a sense, just a felt sense of there is something here that he is not able to access, you know obviously he's traumatised, his own defences are going to leap in and say "just don't go there"

Right, yeah yeah, I guess that's interesting; that kinda sense that "there's something we haven't spoken about yet here, something that doesn't fit quite right". Did you share that with the patient;" I have a sense there is something we haven't spoken about or there's something else? Did you share that awareness or that sense that you had?

Yeah..I mean I guess I did, I..obviously by this point we were a number of sessions in…ahm because he was, he was kinda somebody who at that time had been hospitalised, had come out of hospital and so the first part was kinda building up therapy relationship and obviously kinda doing the assessment but over an extended period of time and you know he, when we spoke about things and I had fed back my formulation and said "look this is how I make sense of things but you know I'm wondering if there is kinda anything more that perhaps is going on" and I suppose then it was kindof for him it felt like he was dipping his toe in the water, it was such a horrendously scarey place to go, he just didn't want to do it..

Mhmm

..understandably so

Yeah

But actually when he did there was obviously a bit of fall out from that but actually things improved for this person.

48
- Wondering about/questioning self re patient. (3)

49
- Evidence not always tangible (C2).

50
- Articulating what ψ defences may be present.

51
- Addressing issue with p

52
- Some evidence more clearer for th

53
- Acknowledging p's difficult struggle / experience

3.10.2 Step 2: Focus on initial notes and write down initial themes

The next step was to read through all of the comments written on the right hand margin and to describe an emerging theme which was entered in to the left-hand side of the margin. The purpose of this was to condense the initial notes in to a more focused statement which captured sufficient information from the original transcript. The process of describing the emerging themes involved paying closer attention to the initial comments and was a first move away from the original transcript.

For the extract above the initial theme noted was “evidence not always tangible”. This was the 49th of 104 initial themes for the first transcript.

3.10.3 Step 3: Grouping themes together and looking for over-arching themes

The emerging themes were typed out on a separate Word file and the process of looking for connections between them and overarching or super-ordinate themes began. This was done by considering the different clinical episodes described by the participant, searching for experiential statements and concerns and by paying attention to the overall context of the interview as well as specific episodes contained within it. Smith et al (2009) describe this as being akin to a hermeneutic circle and regard it as being an important feature of the IPA research.

Developing the themes and super-ordinate themes involved going forward and back between the list of emerging themes and the initial comments and the original transcript. Several changes were made to the themes included; how themes were grouped under super-ordinate themes and the wording used to label each theme. After much analysis and movement along the hermeneutic circle a list of 4 over-arching themes and 19 sub- themes were produced for the first transcript (Appendix 5). Theme 49 was grouped under the over-arching theme: Certainty and Uncertainty in Carrying out the Work.

3.10.4 Step 4: Searching for patterns in themes across all transcripts

The over-arching themes and sub-themes for each transcript were imported in to a Microsoft Office Excel spreadsheet. This helped to keep track of the work carried out up to this stage and to facilitate a comparison across transcripts. A list of the 29 over-arching themes from all seven transcripts was compiled (Appendix 6) and the process of looking for super-ordinate themes across the transcripts began. The method employed was similar to that described above with the researcher being immersed in the data and moving themes around under different heading to see if they were related. The process yielded four super-ordinate themes. The analysis of these super-ordinate themes is provided in the results section.

The over-arching theme; Certainty and Uncertainty in Carrying out the Work was changed to; Certainty-Uncertainty for brevity and is number 3 on the list of over-arching themes from all seven transcripts. This theme from transcript one was one of the themes which lead to the formation of the super-ordinate theme; Experiencing the Decision Making Environment (Appendix 7).

3.11 Reflection during initial stages of the analysis

In the initial stages of the analysis I found myself thinking in terms how the therapist might be positioning themselves in relation to the patient in order to decide how to progress with the clinical work. This is reflective of my own experience while in clinical training and of my reading of Casemore (1985) and my attendance at an experiential group where approaches to clinical work were discussed with peers and an experienced therapist. This is one instance of an a priori thought at play in the research. This has the potential to become a bias and therefore a conscious effort to bracket this while continuing with the analysis was made.

Potential biases which can narrow down or change the course of the descriptive and interpretative aspects of an IPA analysis proved to come from different sources. In a discussion with my supervisor about data quality it was found that I had judged one transcript not to be as valid as the others as it didn't quite fit the same pattern as the others. This judgement had to be confronted and set aside so to allow for as complete a set of themes as possible to emerge.

Of course the research is beset by bias from the outset. I have chosen to research this topic and am approaching it from somewhat of an insiders perspective having worked in various NHS Psychology department for four years. I had an interest in carrying out a qualitative research project and when it didn't prove feasible to conduct a study with a patient group my attention turned toward staff groups. This began with me reading up on therapy process literature related to process outcomes and the influence of the therapist on the therapy process. Having initially considered exploring therapists decisions with regard to choice of therapeutic modality, feedback from the University Ethics committee and my supervisor led to a change in topic towards exploring the experience of decision making. It was felt that the initial idea would not add much to the research base. Two staff groups were identified to carry out the research with and practical considerations resulted in the work being carried out with Clinical Psychologists.

This process has influenced the research and this influence can be seen in the inclusion of influential factors in decision making which stems from an interest in process issues in therapy. I have also asked participants about how they approach their work as a precursor to discussing decision making. This is a remnant of the initial idea to explore choice of therapeutic modality. The interest in process research has meant that I favour theoretical models and research papers which focus on real world or naturalistic settings. I feel comfortable and confident in critiquing and using such research and feel less so with regard to theory which applies the use of mathematics (probability estimates in particular). This is a source of bias and in the use of research literature to introduce the research and to interpret the data.

The reflective process will be illustrated further with extracts from the research diary in the discussion section.

3.12 Validity

Ensuring that the research work carried out is valid is an important consideration in carrying out qualitative research (McLeod, 2001). Elliot, Fischer, and Rennie (2001) have produced guidelines to be considered when conducting research for publication, which have been helpful in planning the research. The following steps have been undertaken to ensure validity in this research project.

- I kept a diary of the research process to aid reflections on the research process and to engage in reflexive exercise with regard to my influence on the research. Extracts of this diary are included in the discussion section.

- I have used supervision to discuss progress of research and thoughts about the analysis. Supervision has been helpful in realising my own biases towards the data.

- I have acknowledged biases in research interests, and motivation for conducting the research. This is detailed in the methods section and is provided to allow the reader an insight into the context of the analysis of the results and my role in influencing this.

- I have grounded the descriptive and interpretive elements in examples from the transcripts. Quotes have been provided in the results section to illustrate the super-ordinate themes. This is to make it clear to the reader where the description and analysis has arisen from and help me to stay on track when going between the transcript data and the super-ordinate themes. In addition to this the descriptive and interpretive elements of the results section are outlined in the discussion section. This is to help clarify the approach I have taken in carrying out the data analysis and to show the rigour with which attention has been paid to the descriptive and phenomenological aspects of the IPA methodology.

- I have provided a sample of transcript and analysis in the method section and in appendix 5. Again this is to show how the analysis was carried out.

- I have ensured credibility of the data by providing reflective feedback in each interview to ensure clarity with regard to what issues have been discussed. I have kept in touch with all seven participants during the analysis of the data and all participants have noted their consent for the quotes to be used to illustrate the super-ordinate themes.

4.0 RESULTS

The results of the data analysis are presented here. The themes emerging from each transcript are outlined in the sections describing the background of each of the seven participants. This has been included to illustrate the contribution of each participant to the overall super-ordinate themes arising from the analysis. While the super-ordinate represent the result of a collection of seven transcripts it is considered useful to pay attention to the individual accounts also. The experience of each participant is bound to have unique features given differences in stage of career, varying influences on their work and differences in how they respond to the research interview. IPA does begin from the perspective of the individual and this idiographic approach is considered a useful way of exploring a phenomenon (Smith 2004). As such, it was felt that including some background information on each participant would allow the reader to place the themes arising in some context. These emerging themes lead to the four super-ordinate themes. The analysis of the four super-ordinate themes is provided here also.

4.1 Individual Transcripts

Transcript 1- Clinical Psychologist 1 (CP1)

Over-arching themes from transcript 1:

1. Therapy models
2. Searching for and working toward common ground
3. Certainty - Uncertainty
4. Judging and Deciding

Background

CP1 has less than five years post-qualification experience. They describe their clinical practice as being eclectic and their formal training as being CBT-based. They note their use of Schema-focused Therapy, Eye Movement Desensitization and Reprocessing (EMDR) and Mindfulness. Their case load is noted as fitting within tier 3 within a tiered service model. They also refer to the upper limit of 20 sessions which is outlined in the departmental staff handbook.

Transcript 2 – Clinical Psychologist 2 (CP2)

Over-arching themes from transcript 2:

1. Framework for decision making
2. Sources of information
3. Responsibility
4. Pressure
5. Uncertainty
6. Nature of Psychology work

Background

CP2 has less than five years post qualification experience. They described their core training as being CBT – based and described their general practice as eclectic. Their clinical case load is noted as being complex with a wide range of clinical presentations being seen. They note having an interest in Schema-Focused Therapy, Psychodynamic therapy, Acceptance and Commitment Therapy (ACT) and Interpersonal Psychotherapy. CP2 made reference to the service model, stating that their case load would fit with a secondary and tertiary service, and made reference also to the 20-session limit for clinical interventions.

Transcript 3 – Clinical Psychologist 3 (CP3)

Over-arching themes from transcript 3:

1. Progressing the work
2. Decision making environment
3. Decision making tools
4. Emotions
5. Judging

Background

CP3 has less than five years post-qualification experience. They state that their approach to clinical work is eclectic with a developing emphasis on an integrative approach. Their case load ranges from self-esteem work to bipolar disorder and psychosis and reference is made to the 20 session model employed in the Clinical and Counselling Psychology department.

Transcript 4 – Clinical Psychologist 4 (CP4)

Over-arching themes from transcript 4:

1. Managing information
2. Emotions
3. Decision making context
4. Judging the therapeutic intervention

Background

CP4 has more than 5 years post-qualification experience. They describe their training as being CBT-based and their approach to therapy as being varied, using different therapeutic models (Schema-Focused Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Acceptance and Commitment Therapy (ACT) and Mindfulness) for different presentations. They describe their case-load as consisting of complex anxiety and depression presentations as well as abuse and characterological difficulties. They also refer to the departmental 20 session model.

Transcript 5 – Clinical Psychologist 5 (CP5)

Over-arching themes from transcript 5:

1. Emotion
2. Changeable decision making environment
3. Working towards clarity
4. Working through judgement and decision making tasks

Background

CP5 has less than 5 years post qualification experience. They describe their core training as being in CBT and their approach to therapy as including elements of Schema Focused therapy and Mindfulness. They made reference to the tiered model approach and noted that their case load can comprise cases from tiers two and three. They explain that most of the case load would fit with tier two. They also refer to the departmental 20 session model.

Transcript 6 – Clinical Psychologist 6 (CP6)

Over-arching themes from transcript 6:

1. Working towards clarity
2. Managing information
3. Deciding on approach to therapy

Background:

CP6 has more than 5 years post-qualification experience. They describe their core training as being CBT based and their approach to therapy as having become more eclectic over time. They describe their work as consisting of CBT, Schema-focused Therapy, Eye Movement Desensitization and Reprocessing (EMDR) and mindfulness and as having an interest in Psychodynamic theory.

Transcript 7 – Clinical Psychologist 7 (CP7)

Over-arching themes from transcript 7:

1. Decision making environment
2. Managing information
3. Managing in the decision making environment

Background:

CP7 has more than 5 years post-qualification experience. They describe their training as being CBT-based and their approach to therapy as eclectic, with elements of Schema Focused therapy, Solution Focused Therapy and mindfulness and Eye Movement Desensitization and Reprocessing (EMDR). They describe their case load as ranging from simple phobia presentations to severe and enduring presentations.

4.2 Results of the data analysis

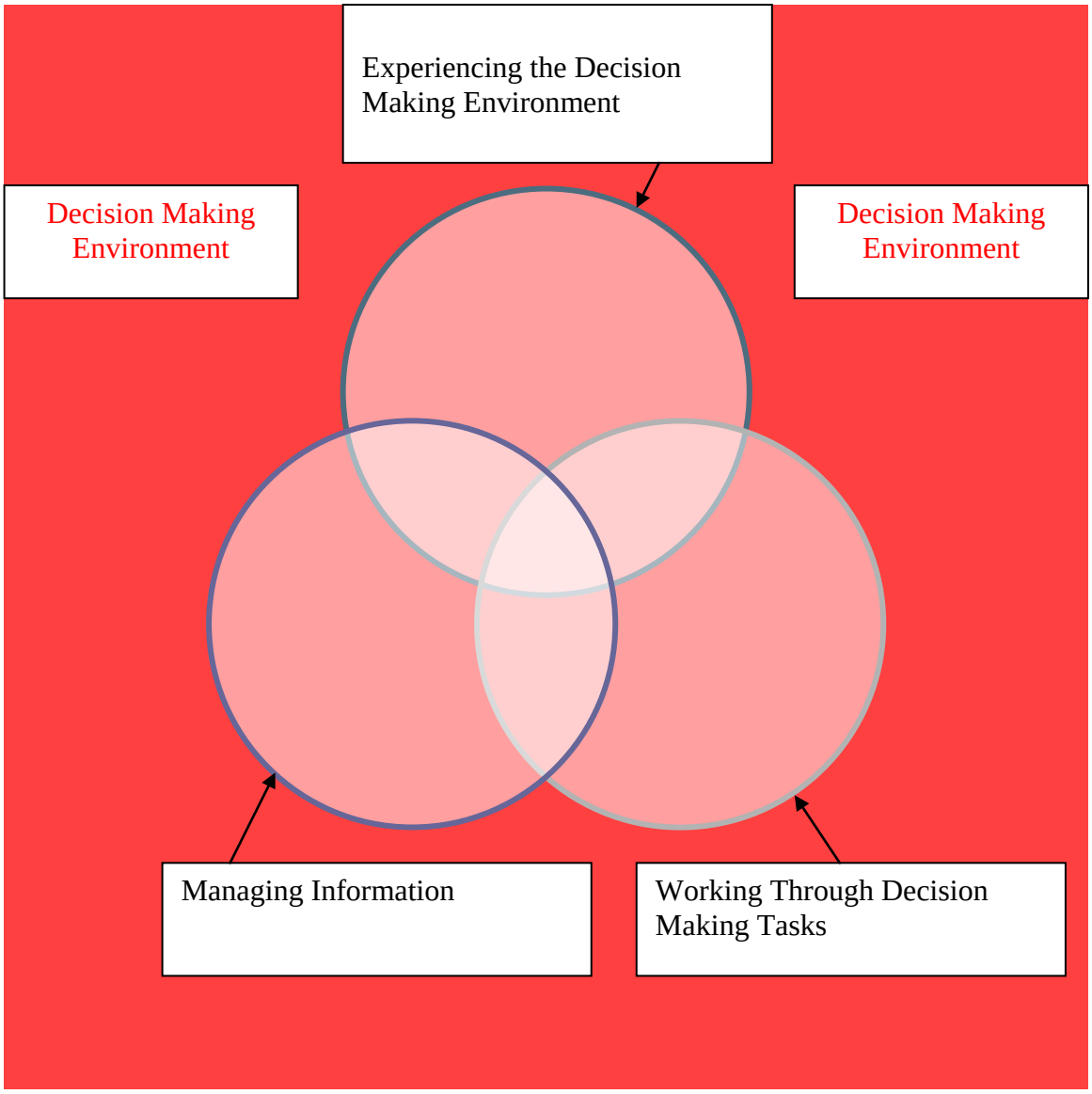
The analysis of the super-ordinate themes was guided by the research aims outlined above and the principles of IPA. This involved moving away from the data in each transcript towards a more interpretative account before going back to the data again. (Smith, 2009). In doing so each super-ordinate theme is linked to quotes from a selection of transcripts.

With a limitation on scope to write an analysis for each participant it was decided to write an analysis for the group of participants. It is hoped that provides some breadth to the analysis by writing up data from all seven participants while providing a deep analysis of the super-ordinate themes.

The results of the analysis focused on four super-ordinate themes which are regarded as being representative of the group of participant's as a whole. The four super-ordinate themes are not mutually exclusive with overlaps between them. The theme, The Decision Making Environment, is perceived to be the main context for the other three super-ordinate themes (Figure 2). It was important not to forget that the initial steps of data analysis focused on the each transcript separately and that the nature of IPA reflects an idiographic perspective. The experience of each participant in the study will comprise a unique set of influences and contexts. The analyses provided are not intended as an interpretation of how Clinical Psychologists in general will perceive and act in a similar situation. Each of the quotes selected for each super-ordinate theme is representative of that particular Clinical Psychologist's experience. In some cases there will be a similar theme coming through in the transcripts. Therefore there will be references to similarities and differences between participants in the analysis.

The results are arranged under the heading of each super-ordinate theme and the selected quotes are numbered (Q1-Q24) and labelled (CP1-CP7) for ease of reference when reading the discussion section. The section prior to a quote is more descriptive with the following section moving towards interpretation.

Figure 2: Inter-relatedness of Super-ordinate Themes



4.2.1 Super-ordinate themes

A) Decision making environment

In discussing decision making many different elements of the decision making environment were mentioned. The elements highlighted here are; lack of information feedback, lack of control in the decision making environment, and an environment that is shaped by idiosyncrasies in the patient-therapist relationship and by the quality of professional relationships. Four participants in particular discussed various elements with notable detail.

CP3 described their thought process in reflecting back on how a therapeutic intervention had progressed and on their choice of actions during the intervention:

Q1.CP3. Sometimes yeah you do kinda think "maybe I shouldn't have said that at that moment in time" or "I should maybe have thought about that intervention" or "I shouldn't have looked at that at that point" And I guess sometimes you can look back and think "maybe that's what ultimately led to therapy being unsuccessful or someone dropping out of therapy perhaps". Lots of times you don't really know, you're just guessing, an educated guess.

Here CP3 engages in repetitive questioning of action taken. They indicate a possible causal link between those actions and the nature of the ending of therapy. The focus here is on an unsuccessful or a pre-mature ending. What is noteworthy here is that CP3 finds it hard to substantiate the possible causal link. It is hard for them to answer or respond to the "maybe, I should" suggestions and it seems as though this could be due to a lack of feedback. The therapeutic intervention has ended and CP3 is left to wonder which if any of their actions were linked to this. The lack of feedback is not overstated here though as CP3 indicated that although a guess is made about what action to take, there is scope for the guess to be educated or informed.

The nature of the decision making environment is also described in terms of control over decision making. CP3 describes how difficult it can be to judge the degree to which they should guide the patient through the therapy. The judgement here relates to the how and when of providing guidance to the patient. CP3 notes that at times the client will be receive less guidance and this decision is couched in uncertainty. This quote seems to refer to relatively more complex cases where the progress of the intervention is less obvious:

Q2.CP3. But yeah for other cases when it's not so clear cut, that's when I tend to struggle a bit more and ahm kindof often thinking how and when do you kinda guide them, the client, a bit more and let them go and see what happens …flying by the seat of your pants therapy.

What will happen isn't certain and the Psychologist has given up a degree of control over how the client progresses. The decision isn't so much defined as exercising control or influence by allowing the client some freedom within the therapy framework but more in terms of uncertainty and of taking a chance and seeing what happens. The essence of the decision making environment is at that moment seems to be captured by the phrase; "flying by the seat of your pants". There is a sense of things progressing quickly and the outcomes not being certain. The Psychologist has to work with this and there is less control over the decision as to what action will be taken and how this will be done

CP5 discussed having less control that they would wish over decision making. The following quote refers to a decision regarding the ending of therapy with a patient. The decision has been discussed with peers and has been influenced not by a 20 session limit model but by the lack of time available to the therapist to continue with sessions:

Q3.CP5. I'm aware now that that decision to say 30 sessions and then end, I'm not happy with that decision now and I'm not comfortable with that decision….. and some of that decision is out of my hands, I feel.

The Psychologist has revised their initial judgement on the suitability of completing the therapy in the near future but situational factors mean they are not fully in control of decision making and cannot therefore decide to act on the revised judgment. There is a stark image here of the Psychologist being limited in the actions they can take now that their hands are, metaphorically, taken away from the decision. Progress may have been made in the therapy to justify continuing but this is confounded by situational factors; a sharp reminder that the care provided is done so within an ever-changing and finite NHS resource.

The decision making environment is also referred to in terms of being susceptible to unanticipated influence. CP5 notes that they have found themselves questioning their actions, having taken a different course than would be customary for them:

Q4.CP5. …why haven't I made the same decisions with her I've made with other people? Why have I got to this point and not done this when I've done that with most of my other people, and what's going on here?

Here the Psychologist seems to be outlining the inner dialogue which would take place once they have recognized inconsistencies in their approach to the therapy. The decision making process has followed an idiosyncratic path, which up to now has not been fully controlled by the Psychologist. One wonders if this is matched by an

idiosyncratic patient presentation, which has surprised the Psychologist, causing them to question the entire process broadly by wondering "what's going on here?"

The decision making environment is also referred to in terms of how functional and healthy it is. CP7 notes that difficult decisions are often made and influenced by the quality of interpersonal relationships within the professional team:

Q5.CP7. I suppose, what I'd like to able to say is based on factual judgement, lots of things about the client's case and so on but I suppose a lot of it when you're working with other professionals does come down to personality and how approachable or how amenable another individual might be to my ideas or my formulations.

How well individuals get on together is seen as an influential factor in how decisions about care are made and the Psychologist's apparent but open reluctance to state this seems to be indicative of a sense of disappointment with the situation. There is an acknowledgement that this isn't the ideal way to make decisions but relationships with colleagues are an influential factor. This is expanded on further when CP7 states:

Q6.CP7. …you feel that any concerns you might have wouldn't be taken seriously or that people would be quite dismissive or even critical, they wouldn't perceive things in the same way so we wouldn't have the same formulation. So then it could be very detrimental to effective decision making and could contaminate what you might instinctively regard as your clinical judgement, you could be more hesitant to ahm consider options in other circumstances that really should be available to all clients regardless of teams.

Here the Psychologist is aware of the potential for professional relationships characterised by dismissive or critical attitudes to create an unhealthy decision making environment with negative consequences for the Psychologists' capacity to consider all appropriate options and for patient care.

B) Experiencing the decision making environment

The experience of the decision making environment was of particular interest in this research. The experiential concerns recounted by the participants were numerous and varied. Experiential claims ranged from being uncertain as to how a decision was made to feeling uncertain or pressured in making a judgement or decision to emotions of concern and regret.

Quite often participants found it hard to describe exactly how or why they made a particular judgement or decided on a particular option. CP1 for example recalls being able to judge successfully that a patient would have more information to discuss as the therapy progressed:

Q7.CP1. So I don't know if there was anything concrete but there was just a sense, just a felt sense of there is something here that he is not able to access, you know obviously he's traumatised, his own defences are going to leap in and say "just don't go there".

It is interesting that the Psychologist describes their own intuitive sense of the patient's presentation as not being concrete. Their perception of what would count as concrete does not include "a sense of something" going on. . However, this does not prevent them from maintaining their awareness of this possibility, which is probably helped by them being able to reason why the proposed process could be occurring. Thus, the experience and perception of a vague sense of what might be happening for the patient is followed by an investigation of the likelihood of this being a valid piece of information.

The experience of decision making is also described in terms of the critical nature of the work involved. For example, CP4 recounts what it is like to be concerned about suicide risk and deciding whether or not to keep a patient in the clinic room. The judgement of risk and the decision about ending the session or not are completed under time pressure:

Q8.CP4. .. and it's a decision you have to make on the spot, but you know you're talking about one thing and all the time you're thinking; "can I let them go out the door, can I let them go out the door?"

The psychologist describes talking to the patient while at the same time working on the judgement of risk. While trying to decide what to do there appears to a lot of mental activity on going, the intensity of which is reflected in the repeated "Can I let them go out the door?" One can imagine the psychologist asking themselves this question covertly throughout the time they are with the patient and becoming sensitive to any indicators proving or discounting the evidence for concern, while maintaining a dialogue with the patient. The experience of this situation is characterized by intensity of thought, pressure to decide quickly and concern as to what might happen when the patient leaves the clinic room.

Concern for the patient is a common feature of participants' discussion on difficult decision making and this does not necessarily involve risk of suicide or self-harm. CP2 describes their perception of the decision making process in relation to a patient who had provided information which raised concerns about their ability to carry out their work competently. CP2 was clearly aware that they had a responsibility for ensuring the information revealed was shared with the patient's employers. This made the judgement about what to do somewhat easier but the experience is not described as being a straightforward decision making task. Instead, the fact that the judgement and decision to act on this was clear is reported as making the decision a difficult one to act on.

Q9. CP2. I knew it was my duty to do that, ahm so making that decision was very very difficult but it was also very very easy, I know that's a strange thing but it was easy cos I knew I had to do it, it was difficult because I knew I had to do it.

There is a stark contrast between describing the situation as difficult and as easy here. The psychologist seems to be stuck between two positions and is effectively going around in circles until finally acting on the judgement made. This, going around in a circle, does not seem to reflect behavior (at least none is reported) but rather mental activity characterized by worry about the consequences of one's actions for the patient. This is captured in the following quote from CP2:

Q10.CP2. You know you can see the implications of your decision making just spreading out and that's very hard to then sometimes take the decision, I'm responsible, but also I quite like defaulting to that position of "it's not my decision, this decision is already made, I have to do that" and that's helpful.

The Psychologist finds the decision making process easier to manage by distancing themselves from the act of deciding. Again this does not seem to reflect actual behavior as the Psychologist did discuss with the fact that they would be passing the information on. The distance created by adopting the "default decision" seems to help ease the Psychologist's worry and concern which arises at the prospect of the negative consequences for the patient. The metaphor of grasping the nettle might be appropriate here given the decision taken is associated with worry and concern.

One wonders also if the adoption of the "default position" helps to create some distance between the Psychologist as a person and as a professional or perhaps it is a more straightforward case of distancing oneself from the decision. In either case, it seems clear that the judgement is supported by duty of care guidelines but the decision making process is experienced as difficult and worrisome. The decision making process is taking place in the context of a therapeutic relationship and it must go somewhat against the grain of the Psychologist to take an action which will have deleterious consequences for the patient's career. However the duty of care is a more

pressing factor so the worry and discomfort evoked by the decision making needs to be tolerated.

In addition to worrying about decisions and being concerned or uncomfortable with the likely consequences, the decision making environment is experienced as pressured. CP2 describes an instance where there is uncertainty in the CMHT team with regard to a patient's care and are asking CP2 to continue treatment. CP2 is unsure whether or not the psychological intervention is indicated at this stage and so is faced with a decision to continue with therapy or not:

Q11.CP2. .. where nobody is sure what's going on so ……and whether actually that the, that psychological treatment is appropriate at this time particularly when my other colleagues are floundering and saying please keep this person on…

The air of uncertainty within the team is obvious here and the Psychologist is certainly feeling uncertain as well as pressured. They have to judge whether or not a psychological intervention would be beneficial and then to decide what action to take with respect to the patient's care. The process appears to have become pressured; perhaps there is not much time or scope to make a decision and it seems as though the Psychologist feels pressure from pleading colleagues to carry on with the intervention regardless of whether or not such treatment is indicated.

In reflecting on difficult decision making experiences CP5 the critical time period for decision making is highlighted in the following quote:

Q12.CP5. …sometimes I think that's a shame, you kind of miss opportunities potentially, maybe to really home in on and explore on things and it's something I know I could raise again with this person if I wanted to but you might not get to the same place or it might not be the same kind of experience as it would have been had you grasped the opportunity when it came…

What is notable here is the sense of regret that a chance for a within session intervention has been missed. There appears to be regret expressed here as the Psychologist thinks that while the subject matter can be addressed it may not have the therapeutic impact that would have been possible at an earlier stage. They are being self-critical for missing an opportunity and seem unsure as to whether or not that specific moment in therapy will re-occur.

C) Managing Information

The super-ordinate theme of managing information relates to the participants' descriptions of how they gather information about the patient and how these use this information to inform the therapeutic intervention. Information management begins from the first assessment session and continues to the development of a formulation and to the piecing together of unusual twists and turns in the therapy.

With regard to the assessment process participants noted that the assessment was influential in deciding how to approach any therapeutic intervention. Factors such as motivation to change, the patient having goals to work towards, appropriate timing for therapy, psychometrics and previous experience with patients were mentioned as important aspects of the assessment process. The following quote from CP1 captures something of the approach to assessment, which appears involve a mind set of wondering and careful observation:

Q13.CP1. … firstly you know does the person want to be here?, does the person or again have they been recommended or you know kindof pushed in to it sometimes by relatives or family members, so ehm, I guess I would be assessing for that, you know, what brings them along?

Here the Psychologist is focusing on one aspect of the presentation; what has brought the patient to the session? They have asked this question to themselves and continue the inner dialogue with some hypotheses as to what the answer to the query might be. It seems as though the approach to this query tends to be one of wondering where the patient is in relation to the context of the Psychology session. A different approach would be to assume the patient attended a session as they had received an appointment letter and were keen to speak with a Psychologist and that the assessment and intervention could start from that point. However, no assumptions are acted upon immediately, rather they held as hypothesis and it seems as though the Psychologist will actively seek information until the query has been answered.

This approach of wondering about the patient's experience of the Psychology session is also captured in the following quote from CP1:

Q14. CP1. … And well, I suppose that set my mind thinking, well if he can give a normalised response and it didn't seem to be sorta he was detached from it, it just seemed to be well this happened and so on and so forth but there was something in my mind saying "well how come many years on you're being significantly affected by this?" you know.

Here the Psychologist seems to recounting the line of thought they engaged in. Something has elicited doubt that all elements of the presentation make sense together. There is reference made to the nature of the patient's description of a traumatic event and the Psychologist goes back over this. At the same time their internal questioning is framed as a direct question to the patient. It is as though the patient is present while the Psychologist is going through the information gathered and wondering how it relates to the nature of the patient's difficulties.

It was notable that CP4 described being able to work productively with a patient without a detailed history of traumatic events. They describe a situation where they seem to have had enough information to work with and to decide on an external resource (a workbook in this case) to continue the therapeutic intervention:

Q15. CP4. You know for instance some of the sexual abuse stuff, they don't have to tell you anything you can work through the work book together talking about other people's examples, how it made them feel, what made them feel better, they don't have to tell you at all what happened to them….. So sometimes they're not telling you very much but sometimes they don't have to.

The lack of detailed information does not disrupt the progress of an intervention as there is enough provided for the Psychologist to be able to make a sensitive judgement as to the appropriateness of the use of the workbook. The Psychologist is comfortable with the situation and is likely to be looking out for indicators from the patient that the intervention is progressing in an acceptable and helpful way.

The ever changing nature of the decision making environment as referred to above must not be forgotten. There may not always be a conclusive answer and the information gained may change with time. In general the participants described having a keen awareness of this, including CP 4. Here they are referring to the importance of a psychological formulation in guiding the approach to a therapeutic intervention and the dynamic nature of the factors making up that formulation:

Q16. CP4. They give you the information and it's in separate pieces and it's your role to see the links and to show them how it's dynamic, if you do this, then this happens, you get more tense, and you know, so I think that has to inform what you're doing.

In this case the information provided by the patient is synthesised by the Psychologist and related back to the patient. The various factors presented are linked causally and the reasons for feeling tense are outlined to the patient. The Psychologist has taken on

the role of making sense of the information from a Psychological perspective and they experience this as being helpful for themselves and for the patient.

CP5 described a situation in which they were surprised by the fact they had approached the Psychology sessions in a different manner with one particular patient. They describe getting to the intended point eventually and they wonder about how this process may have taken an unexpected route:

Q17.CP5. I suddenly got in and she asked me a question in session one day and I went, oh my god I haven't done that with you, I haven't, why haven't I done that, I don't know. So that was wondering what that process was about, was that about just her particular presentation and the nature of her difficulties and then it's, "gosh am I colluding with them or what's going on?"… Yeah, maybe I was just getting a wee bit caught up in her stuff and my stuff and actually just, kindof relax a bit, you know it's not a big thing, we kind of got there eventually, it doesn't matter if didn't happen by session x so we did that.

When the deviation from the normal procedure is brought to their attention the Psychologist is surprised and puts forward some hypotheses as to why this may have occurred. It is not clear whether the uncertainty about this is resolved but the fact that this was brought to the attention to the Psychologist was enough for them to make progress with the sessions and reach the desired point. Here some information about what could be happening in the sessions is enough. This can be contrasted with CP6 describing how deviating from the normal course is more easily understood when one has a range of theories to relate this to:

Q18.CP6. I think also you've had more treatment models you've worked in, you've a clearer idea about why you might do something different to the norm, you've got more of a theoretical framework about how to kind of understand what you're doing.

The clarity relating to novel or unexpected decisions made by the Psychologist seems to be provided by being able to reason out what has happened in relation to a model or framework. The reasoning is supported by this making it more likely that a conclusive answer will be reached.

Of course academic texts and research are an important source of information in addition to the patients' presentation. This was frequently referred to across the interview and the following quote from CP2 describes the use and non-use of such sources:

Q19.CP2. I tend to delve back into books which I bought when I was a student you know the kinda bibles we carry around almost, I would tend to fall back on them as well. I at times if I have time I will conduct some research, I would do a lit. review for example I might have a quick look at that to see if there is more up to date research as well……Well you know your Hawton and those kind of things you buy, which cost you sixty quid and ultimately they act as a pretty good door stop for your entire training and then you realise I actually really need to read these.

The use of the term bible seems to point to the importance of the textbook. It is perhaps seen as a foundation of the Psychologist's practice and something which even if is has been set aside for a while can be returned to when needed. There is something here too about the setting aside of the book; perhaps this was easier to do during training with more intensive supervision and less complex caseloads. It seems that returning to the textbook, which was carried around during training can satisfy the needs of the Psychologist. What the needs are is open to speculation. In a concrete sense one can state the need is for knowledge. In another sense this quote elicits the idea of a transition object so one speculates that the textbooks can provide a sense of certainty or confidence for the Psychologist.

D) Working through decision making tasks

We have already seen how the participant's have described the decision making environment, their experiences within this environment and their descriptions of how information is managed. The theme; working through decision making tasks, reflects the manner in which the participants go about making decisions and then acting on them. What has come to the fore in the analysis is the approach to communicating a decision to a patient by two participants, comparisons with colleagues and descriptions of how decisions can be broached in the first place and reconsidered at a later stage.

CP5 discussed a difficult decision making experience in which they had judged it best to address the patient's tendency to cancel psychology appointments. Having then decided to do so they note that being honest about this is their preferred way of carrying out the decision:

Q20.CP5. Yeah, it was difficult, there was things that had to be done I think and I tend to find that honesty is the best policy and it's better to be frank with people. Obviously you have to be careful about how you couch things but there's no point in beating around the bush if it needs to be said.

The Psychologist describes having a number of tasks to complete in the session. Having made a judgement that discussing the cancelled session has opted to be direct in their approach to this. They are aware of the need to be tactful and sensitive but are sure that a less direct approach to acting on the judgement would be unhelpful. In this way the Psychologist is clear in how their judgement is communicated and has acted on the judgement to broach the issue with the patient. This approach is mirrored by CP1 when they refer to a situation in which they addressed the issue of avoidance in therapy with a patient:

Q21.CP1. Just being honest with her, again just saying, "the reality is this"…Cos I think you know people, obviously if it wasn't the right time for her or she didn't want to carry on with therapy I'd rather people are in full view of the full facts.

Again the Psychologist has taken a frank approach to explaining their judgement of how the therapeutic intervention was progressing. In both cases any uncertainty there may have been about whether or not to broach an issue with the patient has been replaced by a firm decision to do so and a decision to do so in a direct manner. The objective seems to be to adopt a well-defined position so that the perspective taken by the Psychologist will be obvious for the patient.

While some judgements and decisions are difficult to broach in the first instance others may be made on the spot and require to be readdressed at a later stage. CP3 refers to one such example and notes that this is not necessarily detrimental to progress in therapy. The miss-timed comment can be readdressed (by the patient in this example) and the therapy continues from there.

Q22.CP3. …you've got a good enough rapport with someone, a good enough therapeutic relationship I think they will usually come back from if you miss-time a comment or they can usually ask you about it, I've had people come back the week after and say "you said this last time and I wanted to ask you about this. I wasn't really sure about that" So sometimes that can be really helpful actually and it can help them begin thinking about something that you weren't really sure if they had started to think about or not.

While the decision to comment on something to the patient may have been misjudged progress is still made. The Psychologist has an opportunity to address the topic again when the patient mentions it and they work towards clarification of a point or further exploration a feature of the patient's presentation. The context of this situation remains a key feature of how the initial decision to make the comment is brought back to the Psychologist's attention. It occurs in the context of a good therapeutic relationship which withstands the impact of the mistimed comment and the prospect of working successfully toward the therapeutic goal remains. We are reminded that while the Psychologist is making judgements and acting on decisions made there are contextual factors that influence this work.

While each therapeutic intervention may be idiosyncratic in the therapeutic relationship or the way in which the therapeutic intervention is approached the Psychologists will tend to compare notes with colleagues with regard to what they would do. CP6 refers to this in terms of working in a way that would be normative for a Psychologist:

Q23.CP6. … it's good to hear how another therapist would have managed that situation, whether they'd have managed it different to you, it's a certain amount of validation or normalisation of your reactions so it's good that your not deviating too much from the norm in how therapist's behave.

In carrying out the clinical work the Psychologist appreciates there will be a standard of practice, which is relevant to the judgements and decisions they make. They experience the normative standards as reassuring insofar as their approach to the work is validated when it is comparable to that of fellow colleagues. In the context of difficult judgement and decision making tasks a degree of consistency in approach across peers defines the role and behaviour of individual Psychologists.

This comparison among Psychologists is referred to by CP2 when discussing the development of their style in therapy. CP2 describes how they wonder about how their fellow Psychologists approach clinical work:

Q24. CP2. So it kind of becomes this thing, you are doing it in this room and you are a psychologist yourself but you are no longer comparing yourself to all these other people so it's hard to describe what my style is…because I can't compare myself to my colleagues because I don't know how they work …what magic they do behind their doors.

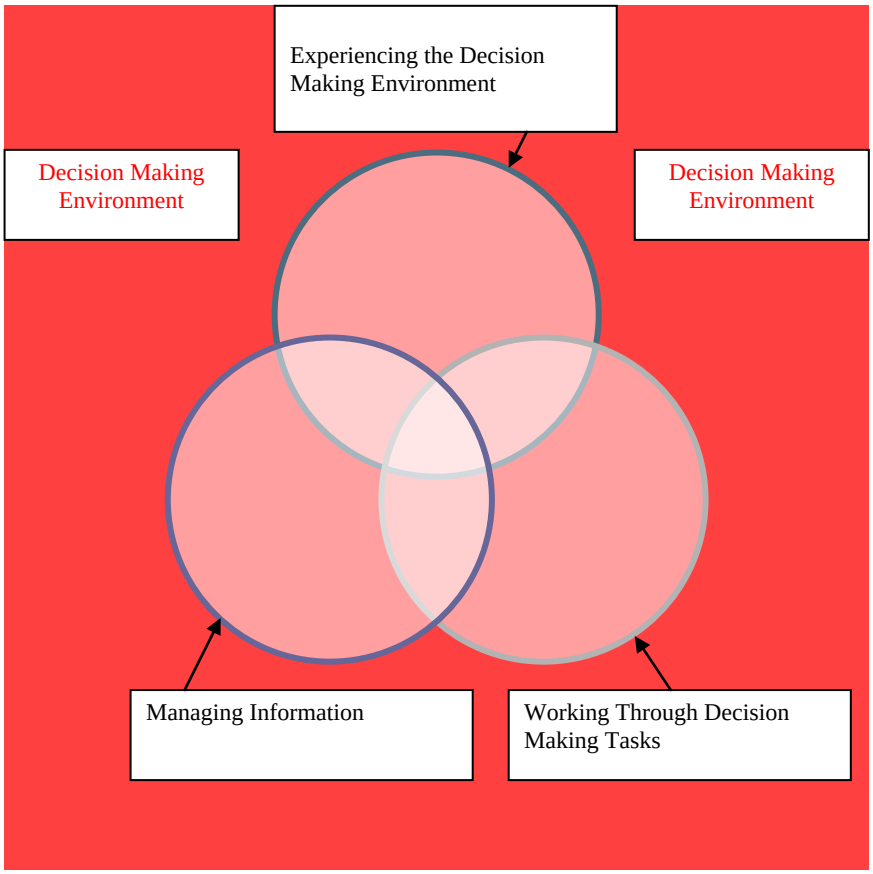
It may be that for specific instances such as that referred to by CP6 above (Q23.CP6, p.84) one can compare notes with a colleague but in general there is some ambiguity about how colleagues approach their work. One assumes the goals of the clinical work will be similar across Psychologists but there will be some variation in the means of working towards these. The "magic behind doors" seems to refer to the style of carrying out clinical work which will surely include the approach to making judgements and decisions. Working through decision making tasks can involve considered comparisons with colleagues and will be influenced to some degree by the particular approach adopted by each Psychologist.

5.0 DISCUSSION

Four super-ordinate themes have been outlined in the results section:

A. Decision making environment
B. Experiencing the decision making environment
C. Managing information
D. Working through decision making tasks

Figure 2: Inter-relatedness of themes



These four super-ordinate themes have been drawn from the over-arching themes (Appendix 6) emerging from the seven interview transcripts. The themes have been described and interpreted in the results section according to IPA methodology (Smith *et al.* 2009). In doing so it is hoped that the aims stated in the introduction section have been met. The initials aim was to focus on the primary research question:

- How do Clinical Psychologists experience clinical situations in which difficult judgments and decisions are made?

The secondary aims were to:

- Describe the main features of each participant's experience of making a difficult judgement or decision.

- Describe these main features from a psychological perspective.

The degree to which this has been achieved will be discussed here in addition to addressing the secondary research question. This question has been stated thus:

- How does the way participants make sense of the experiences discussed in the qualitative interviews relate to the theories of decision making and the literature on influences on clinical practice?

In this discussion section the analysis of the transcript data provided in the results section will be discussed and a further analysis of the data which draws on theories and models of decision making and influences on clinical practice will be provided. In general IPA studies do not present the discussion section in this manner (e.g. Jarman *et al.* 1997 and Thompson *et al.* 2008). However, it was decided to present the results in separate sections (outlining the interpretative and phenomenological elements and discussing the four super-ordinate themes separately) to allow the reader to track the development of the analysis. Also, it was hoped that this format would help to clearly indicate the distinction between the results section which

remains close to the transcript data and the discussion section which takes the analysis further away from the participants' perspective by bringing in information from the research literature. It is hoped that the process of analysis and interpretation is made sufficiently clear that the reader can judge the credibility (Starks & Brown Trinidad, 2007) of the work and also retain the scope to allow their own ideas about the phenomenon of decision making to come to the fore.

5.1 Discussion of the analysis presented in the results section

5.1.1 Phenomenological elements

The aim of the phenomenological part of the analysis is to provide a valid account of the experiences discussed by the participants at the interview stage. The aim is also to describe the experiences therein in such a way as to give prominence to the experience itself rather than to any a priori ideas about the topic (Smith, 2009).

The analysis features references to the participants' cognitions, emotions and behaviours in relation to their experiences of difficult decision making. These are relevant for each of the four super-ordinate themes. The analysis also includes the participants' experiential claims and concerns. These features provide the descriptive part of the analysis and they provide the basis for the interpretation of each super-ordinate theme.

5.1.2 Psychological features of the phenomena of decision making

Cognitive elements include references to the style of thinking (e.g. questioning, perspective taking and reasoning). CP3's account of reasoning about what they could have done during a therapy session (Q1, p.69) and CP2's perspective taking in discussing the "default position" (Q10, p.74) are examples of the cognitive elements.

The behavioural elements were particularly in evidence when analysing how participants managed information and how they worked through judgement and

decision making tasks. So, the description given by CP4 of organising information and showing the patient the dynamic factors within it (Q16, p.78) and the references CP5 and CP1 make to communicating with the patient in a frank manner (Q20, p.81 & Q21, p.82) are indicative of this.

The emotions experienced by the participants in relation to difficult decision making cropped up throughout the transcripts and in the final analysis of the super-ordinate themes. For example, CP5 expressing surprise having taken an unexpected approach to the clinical sessions with a particular patient (Q17, p.79) and CP4 experiencing concern with regard to a potentially suicidal patient (Q8, p.73).

The descriptive parts of the analysis are described above in cognitive, emotional and behavioural elements. This is just one way of structuring these elements. The descriptive elements could have been grouped together according to references to therapy models or to systemic issues within Community Mental Health Teams (CMHTs) or according to types of decisions referred to. This serves to indicate the breadth of the data and the numerous conceptual frameworks available to define them. These frameworks are a useful tool to help organise and understand the phenomena being described but it was an important and challenging part of the analysis to bracket these and allow the interpretative elements to emerge in the analysis.

Taking a wider perspective on this part of the data analysis, there are numerous references to experiential claims and concerns of the participants. Topics such as the relationship one has with the academic texts (Q19, p.80) and the influence of professional relationships (Q5, p.71 & Q11, p.75) are two such examples.

Again it is hoped that that a breadth of experiences that are relevant to the research question have been allowed to come through from the interview and data analysis stages and that these are presented clearly in the transcripts and in the results section. A concerted effort has been made to attend fully to the experiences described by each participant as discussed in the section on validity.

5.1.3 Interpretative elements

The interpretative parts of the analysis provided in the results section resulted from a process of engaging with the data and keeping in mind the analytical tasks to be carried out. Again this process was guided by the IPA approach outlined most recently in Smith *et al*. (2009). Particular attention was paid to the experiential claims and concerns of each participant and the language which they used to describe these. In addition the movement around the hermeneutic circle, from the single quote to the interview transcript as a whole, provided different perspectives on the data.

Smith (2004) has suggested that the interpretative analysis of data can be divided in to three levels, with level three being the most interpretative. Level one seems to be more descriptive (Smith (2004), gives the example of interpreting the participant's action as engaging in a social comparison). Level two is slightly more in depth with the introduction of images or ideas elicited in the researcher on studying the data and a more in depth interpretation of the language used by the participant. Level three seems to be even more interpretative and marks a further departure from the transcript data. Smith (2004) provides the example of attending to the way in which a participant refers to events in relation to time and how this may reflect her perspective on life events. It is proposed here that the present research has provided an analysis at level one and level two.

Given that the focus of the research is on the descriptive questions of how Clinical Psychologists experience difficult decision making it is perhaps not surprising that many of the interpretations made relate to how the participants thought through difficult decisions and how the experiences were described. The interpretations of quote 1 (Q1, p.68) and quote 7 (Q7, p.72) relate to the reasoning process engaged in by the Psychologist. In the former this relates to the search for causal links between decisions made and subsequent developments in therapy. It is interpreted as a reasoning process which is characterised by a style of thought that is questioning but speculative. In the latter the interpretation reflects the idea that the Psychologist had an intuition of what was happening for the patient and their awareness of how this

intuition could relate to the overall clinical presentation helps them to keep it in mind and use it to reach a decision.

The interpretative elements also reflect the researcher's thoughts about the perspective taken by Clinical Psychologists in relation to the experiences being described. For example in quote 2 (Q2, p.69) the interpretation is that the Psychologist feels they give up control at times during the clinical work and in quote 5 (Q5, p.71) the interpretation is that the Psychologist is disappointed with the influence of personalities in the decision making process.

The emotions experienced by the Psychologists in relation to difficult decision making also form part of the interpretation. The language used in quote 17 (Q17, p.79) is taken to indicate surprise and both the language and the context of quote 8 (Q8, p.73) were taken to indicate concern. The function of the approaches taken in relation to difficult decision making are also interpreted. For example, the potential use or value of a "default position" (Q10, p.74) is discussed and the comparison between colleagues referred to in quote 23 (Q23, p.83) is interpreted as being reassuring. The use of a metaphor as an aid to interpretation was employed for quote 10 and for quote 19 (Q19, p.80) the relationship with sources of information is explored in depth. The analysis of quote 10 and quote 19, in particular, are regarded as being close to a level 2 analyses (Smith, 2004).

5.2 Secondary research question: Discussion of the analysis with reference to the research literature

This section is heavily biased by the models, concepts and academic literature that have been chosen to compare and contrast the results of the analysis with. As stated in the introduction an exhaustive account of the research into decision making has not been undertaken but a number of different models of decision making which reflect different ways of conceptualising the processes involved have been selected. The primary concern here is to focus on how the data derived from the research interviews relates to a section of the academic literature on decision making and influences on clinical practice. This part of the discussion provides a more speculative analysis of the transcript data as it draws on a range of material outside the data which increases the distance between the data and the interpretative analysis (Smith, 2004).

A) Decision Making Environment

This theme reflects the features of the context within which the participants have to make difficult decisions. As noted previously (and outlined in Figure 2) it is perceived as being the background to all of the other themes. The theme includes various features of the decision making environment which are interpreted as being influential in decision making. Here, the features are discussed with reference to research literature.

It is not surprising that the quotes selected to represent this theme in the discussion section (quotes 1 to 6) include many references that can be readily linked to the concept of real-world decision making. The decision making environment is characterised by lack of feedback information, limited scope to assess all possibilities before acting and decisions being influenced by idiosyncratic patient-therapist relationships and by professional relationships. The concept of real-world decision making is an integral feature of the Bounded Rationality (BR) (Girgenzer & Goldstein, 1996) and Naturalistic Decision Making (NDM) (Lipshitz *et al.* 2001)

frameworks. In quotes 1 (Q1, p.68) and 2 (Q2, p.69) CP3 mentions having to make an “educated guess” and “flying by the seat of your pants therapy” respectively. Both relate to trying to judge what the best approach to take in therapy would be. This fits with the notion of individuals making decisions in resource limited contexts (e.g. time pressured and lack of information). It does not seem likely that the decision making environment being described allows for an exploration of all possible options so the rational employed needs to be restricted. One can imagine the speed at which the searching, stopping and deciding operations are carried out at as the Psychologist adopts a particular approach in the clinical session and is feeling as though they are taking a chance as opposed to an approach for which all possible consequences have been considered.

In terms of BR, it seems that CP3 is required to use some kind of fast and frugal heuristic (Girgenzer & Goldstein, 1996) to make a judgement and act on it within the therapy session. CP3 notes that although one has to make a guess as to what to do. At times this can be an educated guess. While there is a limit to the rational that can be employed, there is scope for a guess/judgement to be an informed one. The fact that CP3 is a trained Clinical Psychologist will surely mean that there are well-honed tools in the adaptive toolbox, a source of cognitive and emotional heuristics which can operate on specific decision making tasks in a way that is appropriate (ecologically valid) in the context of a therapy session.

In terms of NDM the educated guess can be related to the idea of matching a solution to a problem; i.e. situation matching (Klein, 1998). The Psychologist is having to decide whether or not to guide the patient (Q2. p.69) and so has encountered a problem to be solved. A decision is made to “let them go and see what happens” and it seems that the information utilised to make this decision and to monitor the effectiveness of the approach will be primarily context bound. The Psychologist is referring to difficult decision making in cases where the presentation is not “clear-cut” so it may be that information which is sourced directly from the context of the clinical session rather than more abstract theoretical information will be more useful (or more readily available) in the first (time-pressured) instance. The fact that the

decision making is occurring in a changeable environment (Q2, p.69; “see what happens”), which is time pressured and is influenced by various factors in the environment makes it relevant to the real-world decision making models such as BR and NDM.

Another factor in the decision making environment that emerges from the analysis is the influence of professional relationships on the decisions made. Quotes 5 (Q5, p.71) and 6 (Q6, p.71), from the results section, refer to the influence of professional relationships on decision making. As mentioned previously there seems to a sense of disappointment at the fact that personalities can be influential as well as “factual judgment” (Q5, p.71). We know from Lucock *et al.* (2006) that peer discussion is an influential decision making factor but here we are shown that it isn’t necessarily a positive influence. In fact it is referred to as being a potentially “detrimental” (Q6, p.71) influence and one which may preclude the consideration of some treatment possibilities. With regard to the Search Inference Framework (SIF) this would lead to a weakening of the strength (or weight) of some possible courses of action making them less likely to be selected. The fact that they are less likely to be accepted could be considered to be indicative of a lack of ecological validity, to use a fast and frugal heuristics term. However, it would seem from the quotes that the reasons for certain possibilities being invalid are not necessarily acceptable to the Psychologist.

Where there is contention and debate it may be useful to go back to reappraise the goals, possibilities and evidence of the situation. Baron (2008) suggests this way of open-minded thinking (within the SIF framework) reduces the likelihood of a high value (utility) outcome being missed. Of course we are left with the debate as to which possibility (option) holds the most value (utility). The application of scientific knowledge (research evidence base) and critical thinking to clinical practice (Stricker & Trierweiler, 1995) would be applicable here. In quote 5 (Q5, p.71) the Psychologist seems to acknowledge the fact that a focus on factual information would be the optimal way to go about the decision making but in an unhealthy decision making environment this seems to be de-railed by poor professional relationships.

Of course the client characteristics are also perceived as an influential decision making factor (Lucock *et al.* 2006). In quote 4 (Q4, p.70) we see that the Psychologist is surprised by an unanticipated influence on their approach to sessions with a particular client. They are aware that their approach is inconsistent with that taken with other patients. They are left to wonder what might be going on and although the nature of the influencing factor may be unclear at this point it could be the lack of specific goals being achieved which brought the inconsistency in approach to their attention. This latter point is drawn from the SIF framework (Baron, 2008), which posits that the goals one sets influences future decision making and that a wider range of goals will lead to more evidence (information pertinent to the goals) being sought. The possibilities for action can then be evaluated in light of the evidence. Of course, the Psychologist's response (Q5, p.71) to this unanticipated influence could also be viewed in terms of a belief about how a goal should be met being contravened by the adoption of an idiosyncratic approach to the sessions. Once this inconsistency between belief and course of action taken is brought to their attention the Psychologist is wondering how this has happened and what has caused it. This view stems from Baron's (2008, p.12) statement that a decision is based on a belief about what actions will achieve a goal. The Psychologist is likely to have built up many beliefs about how to achieve specific goals but their actions are subject to unanticipated influences also.

B) Experiencing the Decision Making Environment

This theme is perceived as being a feature of the overall decision making environment (Figure 2). It came to the fore in the analysis due to the rich descriptions of decision making provided and by the participants. The commitment of IPA to attend to the experiential concerns of the participant will have been an influential factor here as well. The primary features coming through in the analysis are the emotions experienced by the participants and the perspective they take in relation to difficult decision making and the environment in which it takes place.

In quote 7, (Q7, p.72), we see how the Psychologist views their experience of becoming aware that all the information available to them was not quite adding up or making sense. They seem to be referring to an intuition that the patient had more information to discuss in session. They needed to judge whether or not to follow up on this intuition (e.g. by seeking more information or directing the therapy as if the sense was an accurate reflection of the patient's situation). Their perspective is that the intuition is not concrete evidence but this does not disqualify it from further consideration. The Psychologist judges it best to continue with the line of questioning despite the initial perception that the evidence doesn't qualify as concrete evidence. This relates clearly to Baron's (2008) definition of intuition as a judgement made without evidence and to his assertion that an intuition is likely to lead to more evidence being found.

Quotes 9, (Q9, p.74), 10 (Q10, p.74) and 11 (Q11, p.75) reveal something of the nature of the decision making environment, but in particular how the Psychologist responds to or works within this environment. In quotes 9 and 10 the Psychologist is describing their sense of it being both easy and difficult to make a particular decision. This type of experience is something which isn't necessarily taken into account by a decision based on achieving maximum possible utility (Kahneman & Tversky, 1992). However, given that the concern experienced by the Psychologist with regard to the potentially negative consequences of their decision for the patient, this is surely an important part of the decision making process. It is as though there is

a cost to the Psychologist even though the decision taken would be perceived by peers to a good (correct) decision.

In quote 11 (Q11, p.75) the Psychologist appears to be feeling pressured and uncertain in the context of a "floundering" team and a lack of consensus with regard to patient. Such a situation is reflected in the NDM framework which accounts for a lack of information available about an ever-changing situation (Galenter & Patel, 2005). Shanteau (1992) makes the distinction between the characteristics which can be ascribed to the task to be completed (decision making in this case) and to the individual (the expert) carrying out the task. He proposes that task characteristics such as dynamic stimuli, lack of feedback information and decision aids are more likely to lead to poor performance. In the context of quote 11, it is proposed that the decision making task is characterised by a lack of decision aids. The Psychologist is unsure if Psychological therapy is appropriate at this time for the patient but it seems as though consideration of this factor is being influenced by systemic pressures within the "floundering" team. It is as though the expert is hampered in exercising the characteristics that make them a competent expert and again they experience the situation as pressured and uncertain.

Again, it is perhaps the focus on the phenomenological experience of decision making that has brought this aspect of the decision making to the fore. Perhaps a reasonable way of framing this is in terms of the emotions experienced by the Psychologist in relation to the process of decision making. In quotes 9 (Q9, p.74) and 10 (Q10, p.74) the concern of the Psychologist for the patient causes them to evaluate the decision taken a little further. They recall thinking ahead to the possible consequences of the decision and this seems to make the decision more difficult to make. On the other hand the decision making here is perceived as straightforward as there is a clear guideline with regard to duty of care which is to be applied to the situation. As discussed in the analysis there is a sense of the Psychologist going around in a circle before acting on the judgement made. In essence there seems to be a gap between the judgement being made and the decision being carried out.

The emotion experienced at this time indicates the decision making process has an impact on the Psychologist; but what is the role or function of the emotion here? It may be that the emotion of concern indicates that a belief along the line of "do no harm to a patient" is in danger of being contravened and thus serves as some kind of heuristic (Muramatsu & Hanoch, 2005) or a type of somatic marker (Damasio, 1994) to help bring the potential consequences of the judgement to the attention of the Psychologist. Of course this matching up of the Psychologist's experiential claim is speculative. One could also argue that a different belief or a combination of beliefs were being contravened and the actual process of emotion influencing the decision making process has not been a primary influence here. However, the advice posited by Lambie (2006) could well be relevant whatever the nature of the processes involved in this example of difficult decision making. As mentioned in the introduction section Lambie's (2006) thesis is that emotions will have an impact on decision making but the nature of this impact may depend on whether or not the individual is aware of the emotion and has considered how the emotion might influence behaviour.

Another feature of the theme Experiencing the Decision Making Environment is how the Psychologist manages aspects of their experience. In quote 10 (Q10, p.74) we have a description of the Psychologist finding the adoption of a "default" position helpful. This seems to a cognitive strategy to help manage the concern raised by the difficult decision. The idea of a sense of responsibility was raised in the analysis. The Psychologist seems to be describing a process of perceiving the responsibility for the decision in different ways. While they may feel responsible with regard to the consequences of the decision, they find it helpful to remind themselves that they are also responsible with regard to duty of care. This seems to lessen the perceived level of responsibility for the consequences for the decision and perhaps this is what the Psychologist finds helpful. In his description of the psychological traits of competent experts, Shanteau (1992) included an unambiguous sense of responsibility as one such trait. It seems reasonable to suggest that this trait would be helpful in making difficult decisions, possibly by helping to manage the emotions that arise in that period between making a judgement and acting on it.

With regard to managing aspects of their experience, it was notable that in quote 12 (Q12, p.75) the Psychologist seems to be reflecting on the experience of regret following missed opportunities in session. In the analysis it has been suggested that there is also an element of self-criticism also. One wonders if the experience and subsequent recall of regret helps to guide future decision making by the missed opportunity more salient and is put in mind of the description of "things picked up along the way" as an influential factor on clinical practice (Lucock *et al.* 2006). Could it be that quote 12 is representative of the experience of picking up of knowledge through clinical work for this particular Psychologist?

C) Managing Information

The super-ordinate theme of Managing Information seems to have arisen from questions about how one approaches the clinical work and about factors that help with difficult decision making. The use of the word managing reflects the sense of the Psychologist working with and gathering information in the process of their work. In the introduction we have seen that sufficient knowledge of one's area of work is regarded as being one of four conditions for competency (Shanteau, 1992) and that many of the influences on clinical practice cited in Lucock *et al.* (2006) involve information gathering of some sort. This in itself is hardly surprising because in the context of a Clinical Psychology assessment and intervention/therapy information is key in deciding how to proceed with the work. Here, one is working from the premise that something is informing decisions made, whether it be emotion or cognitions expressed by the patient or experienced (or elicited in) by the Psychologist or a Psychological formulation to name a few. Thus, this theme is regarded as being one particular aspect of the overall Decision Making Environment and as overlapping to some degree with the other two super-ordinate themes (Figure 2).

The analysis of quote 13 (Q13, p.76) focused on the approach taken by the Psychologist to the assessment of a patient. It seems that the Psychologist has delayed acting on any assumption about how the patient perceives or is experiencing

the psychology session. It seems instead that they were waiting to gather more information before deciding how to proceed. In relation to the SIF framework (Baron, 2008), this would refer to very start of the decision making process. This process seems to reflect a rather open-minded manner of approaching to situation rather than a situation-matching type approach such as that modelled in the RPDM model (Klein, 1986). As stated in the introduction the RPDM model and NDM theory in general it is assumed that decisions will be made under time pressure but in the context of quote 13 it seems that the Psychologist is making time to gather information in order to make a decision later on. It may be that the open-minded thinking envisaged here is allowing the Psychologist to manage information in a competent manner outlined by Shanteau (1992); e.g. managing information systematically and making use of feedback.

However it is not always the case that a Psychologist will continue to gather more information. In quote 15 (Q15, p.78) the Psychologist is aware that they are making decisions about how to approach the psychological intervention without having all of the information relating to the patient's presentation. In this instance the gathering of extra information is balanced with the desire not to cause too much stress to the patient. This is referred to in the analysis as a sensitive judgement. This episode seems to exemplify the BR view of decision making, with little information being available when making judgement (Girgenzer & Goldstein, 1996). The Psychologist is attending to a limited number of cues but finds that this is sufficient to make a decision about the psychological intervention. It could be argued that in overcoming the lack of information and progressing with the psychological intervention, the Psychologist has utilised effective communication skills which is considered by Shanteau (1992) to a psychological trait in competent experts. It was also suggested in the analysis that the Psychologist is likely to be vigilant for signs that would be indicative of how the intervention is progressing. This use of dynamic feedback brings to mind the data gathering and hypothesis testing approach advocated by Stricker and Trierweiler (1995).

Quote 16 (Q16, p.78) provided a description of how the Psychologist viewed their role in managing the information presented to them in an assessment. The information is translated into a formulation of causal link between particular events and a specific symptom (feeling tense). This framework of the formulation is seen by the Psychologist to inform future decision making with regard to the Psychological intervention. Another type of framework, a model of therapy, is referred to as being helpful in understanding one's own behaviour in specific situations (Q18, p.79). It is stated in the analysis that the use of such a framework helps to provide clarity when the Psychologist is reflecting on decisions taken in session and perhaps to inform future decision making. It is suggested here that for both of these quotes decision making is being supported by the use of information frameworks; a formulation and a theoretical model which comprise explanations of behaviour.

Supported decision making was introduced at the beginning with reference to the use of actuarial methods to make clinical decisions so as to overcome difficulties such as biases in information attended to by individuals and a lack of prompt feedback with regard to the accuracy of decisions made. There was no discussion about the use of actuarial methods in any of the seven interviews and references to supported decision making relate to the use of Psychological formulations and theoretical models. Thus it would seem that actuarial methods are not employed and this was anticipated before the interviews were carried out. There was no mention of psychometric measures being used and data across groups of patients being collected in the interviews. This has been suggested as a useful tool in supporting decision making (*Lutz et al.* 2006). It is highly likely that the individual Psychologists are using psychometric measures for individual patients to guide the clinical work. As such, this is likely to be a gap in the research findings.

The analysis of quote 16 (Q16, p.78) highlighted the relationship the Psychologist has with the textbook sources of theoretical information. It was suggested that the textbooks represented a source of certainty and tool to boost one's confidence as well a straightforward source of information. As discussed before, developing competence in a specific area of work requires certain characteristics (Shanteau,

1992). The relationship with sources of information is clearly linked to the characteristics of having "sufficient knowledge of the domain" and having the "cognitive skills necessary to make tough decisions" (Shanteau, 1992, p252). The link with the former is obvious from the name given to the characteristic and can be related to the straightforward idea of the textbooks as an information source. The latter characteristic comprises a number of sub-characteristics, one of which is having an awareness of what is relevant. This is shown in quote 19 (Q19, p.80) when the psychologist refers to the texts as "bibles" and the sense of their need to go back to these sources now that they receive less intensive supervision. They have been trained for a specific profession which values certain sources of knowledge and these sources have become important for the individual Psychologist also.

D) Working through Decision Making Tasks

This theme reflects how the Psychologists described their approach to carrying out decision making tasks. It could quite easily have become a super-ordinate theme related to what influences the decision making tasks but the quotes selected seem to draw on the individual approaches adopted by the Psychologists more than general influential factors. The emphasis on approach over influence possibly reflects the use the use of IPA methodology which is designed to focus on the experiential concerns of each participants rather than conducting a content analysis of specific factors in the transcript.

The analysis of quotes 20 (Q20, p.81) and 21 (Q21, p.82) was focused on the direct approach adopted by the two Psychologists when in dealing with a problematic aspect of the Psychology sessions. In both cases the Psychologists have judged it best to broach the particular topic with the patient and have acted on the decision in a direct manner. For both quotes there was a sense of the Psychologist wanting to ensure that the patient had a clear understanding of how they viewed the situation. These scenarios are similar to that described in quotes 9 (Q9, p.74) and 10 (Q10, p.74), where the idea of there being a gap between making the judgement and acting on the decision, was introduced in the analysis. In the case of quotes 20 and 21 the

judgement has been made to broach the issue with the patient and they also have to decide how to act on this decision. In terms of the SIF framework (Baron, 2008), the Psychologists are clear with regard to what their goal is and have decided that addressing the issue is the best way to achieve that goal. However, the manner in which the issue can be addressed raises different possibilities and so the approach taken involves another decision. This is a speculative account of how the SIF may relate to the manner in which the decisions referred to in quotes 20 and 21. What it perhaps more certain is that the process of the interview led both of the Psychologists to reflect on the manner they approach these decisions; how they put into action the decisions they have made.

The analysis of quote 22 (Q22, p.83) introduced the idea of the subtle judgements required for the timing of feedback. The Psychologist refers to the feedback provided by the patient and emphasises the role that a good therapeutic relationship plays in managing the situation and helping to progress with the therapy. This seems to fit with the BR perspective, (Girgenzer & Goldstein, 1996), in that the judgments made about sharing a comment are likely to be made on the spot in many instances and thus a limited amount of cues may be attended to. What it is interesting about the Psychologist's description is their awareness that opportunities can arise for addressing the impact of a miss-timed comment. In this case the Psychologist refers to times when the opportunity is instigated by the patient and instances where the miss-timed comment can lead to a positive outcome. This is an interesting example of the impact of a poor judgement being addressed and progress being made. The Psychologist is making judgments and decisions in the context of a dynamic relationship where information is passed back and forth between two people but the quality of the relationship helps these processes to lead to a positive outcome.

In quote 23 (Q.23, p.83) the Psychologist is regarded as experiencing comparisons of behaviour among peers as helpful. They use the words "normalisation" and "validation" when referring to the outcome of discussing the actions they decided to take with a colleague. As mentioned in the introduction, the Clinical Psychology profession is guided by standards laid out in documents such as the BPS Professional

Practice Guidelines (2001) and the HPC Standards of Proficiency for Practitioner Psychologists (2009). These documents outline the skills and behaviours expected of members of the profession. The idea of a comparable group of professionals is brought to mind here; one would expect similar skills and behaviours to be carried out by individuals trained for and working in a particular profession. In quote 23 we see this comparison across a smaller group of peers and the Psychologist experiencing this as being a positive factor in decision making. In quote 24 (Q24, p.84), we see a different perspective on this idea from another Psychologist. In this case the Psychologist is wondering how their "style" of clinical practice compares to that of others. They note that they will wonder at times how their Psychology colleagues approach the clinical work and refer to the idea of "magic behind doors". It seems as though they would welcome a closer comparison with their peers.

While it is possible to think and reason about shared characteristics among a group (e.g. Shanteau, 1992, BPS, 2001 & HPC, 2009), individuals are likely to perceive differences in the way they approach their work relative to their peers. Of course the manner in which one approaches their work is likely to be influenced by peer discussion and supervision (Lucock *et al.* 2006). The source of individual differences will vary and these have not been worked out in the present research. This is most likely due to an emphasis on experiences relating to difficult decision making rather than on specific influences on one's clinical work (interview schedule, Appendix 4). The gap here in the research was noticeable when going through the list of influences on clinical work cited by Lucock *et al.* (2006). Some of the factors that could lead to unique approaches to work (or style of working) could be personal philosophy, personal therapy, spirituality, friends and family (with mental health problems or just in general), major life events and activities and interests (Table 1). Again, this is speculative but it would be interesting to study the nature of these influences on clinical practice

5. 3 Research diary and the data analysis

The recording of reflections during the research process is recommended to help awareness of where and why decisions to take the research one way or another are taken (Dallos & Vetere, 2005) In addition this process can help one become aware of their own biases, which is an important step in being able to bracket out the a priori assumptions in order to engage fully with each participant's account (Smith *et al.* 2009). The following is a series of four extracts from the diary kept during this research.

A) *It seems like each quote, separated out from the transcript is like a small display of something larger and the description and interpretations around them are guides to what they represent. Feeling a sense of responsibility to provide an accurate and fair guide to the quotes.*

B) *Noticing styles of decision making at work more while analysing the data. Comparisons between style of allocation and review meeting between CMHTs.*

C) *Can empathise with experiences of concern re risk- have been worried re decision making when in session with distressed patients ….*

D) *Can also empathise with the sense of intuition mentioned in transcript 1 – interested in how it was described…..I have been previously advised to take note of intuitions as important pieces of information.*

While going though the data analysis process one was very conscious of the need to balance empathic and critical analysis (Smith, 2004). The diary did help with this but it is felt that the data analysis in the results section is possibly leaning towards an empathic analysis with a focus on describing each participant's experience and wondering as to what it means to them. Diary entry A does indicate a desire to remain close to and empathic towards the experiences discussed in the interviews. However, the analysis is more critical in the discussion which drew on a selection of

theories and models from the research literature as different ways to read and understand the data are provided, albeit in a speculative fashion. This part of the discussion was leading more towards the cognitive processes involved in each decision so it was important to remain aware that the analysis is speculative and that the primary concern is the experiential concerns of the participants.

Diary entries B, C and D provided a reminder that the research is influenced by my position as a Trainee Clinical Psychologist. I am working in the same discipline as the participants and am learning what good decisions are and how to make them. Having an awareness of my place relative to the research did enable me to acknowledge this and put aside temporarily while reading and analysing the data.

6.0 CONCLUSION

6.1 Research methodology and future research

Overall, the choice of IPA to study decision making is considered to have been appropriate in providing a description and analysis of the phenomenon based on first hand accounts from individual Clinical Psychologists (Starks & Brown Trinidad, 2007). Schottenbauer *et al.* (2007) have commented on the number of researchers who believe that the consideration of the context within which decisions are made is an important research area. This has been addressed to the extent that four super-ordinate themes from seven participants have been described and subjected to an interpretative analysis. The choice of IPA methodology allowed the researcher to attend to the experience of individual Clinical Psychologists before referring back to the theories and models provided in the research literature. It is posited here that this approach was a useful exercise in bridging the gap between the scientific research base and everyday clinical practice (Stricker & Trierweiler, 1995). The research was not designed to provide a normative or a prescriptive account of decision making but to take account of the way in which individual Clinical Psychologists experience and make sense of decision making.

With regard to the choice of research participants and research methodology it is suggested that Clinical Psychologists are well suited to reflecting and describing their experiences. By virtue of their training and the work they undertake one would one expect a high level of insight into experiences and an ability to articulate these experiences. Many of the participants fed back that it had been a challenging task to think about and discuss this topic but it was clear that most had considered the questions prior to the interview and the belief here is that a genuinely detailed account was provided by all seven participants.

Of course there will always be gaps in the research. Not every aspect of the topic will be covered in the research interview. While analysing the transcripts the researcher baulked at the hesitant fashion with which some questions were asked and noticed

his failure to follow up on some very interesting topics. In pursuing some interesting anecdotes others will be ignored and will not be realised in the research. On reflection there was not much use made of observations made during each interview. Observations may be more readily used in more emotive interviews when one is looking for signs of emotional expression while specific topics are addressed. Some of the gaps in the research have been identified in the discussion section; the limited range of factors influencing decision making relative to the Lucock *et al.* (2006) list (Table 1) and the limited range of research literature referred to. Readers will find more gaps and one of the reasons for this will be the research focus on the experience of a specific group of professionals. Each reader will have their own experience of difficult decision making and different factors relating to this phenomenon will come to mind. There is likely to be some common ground also but the IPA approach does not lead to results that are readily generalised to wider groups.

Also, it must not be assumed that the accounts provided in the interview transcripts equate to an exact description of decision making processes. They are dependant on memory and Nisbett and Wilson (1977) remind us that verbal reports are subject to various biases and are not an exact replication thought processes engaged in. One counter-argument to this would be that with IPA the aim is not to elucidate the exact thought process but to describe and analyse the experiential content of the verbal (in the case of this research) report and to try and understand how the participant has made sense of the experience (Larkin *et al.* 2006).

As mentioned in the discussion section the analysis provided in the results section is cautious in that it stays very close to the data. It is proposed that the analysis, which developed by discussing the four super-ordinate themes in relation to the research literature, is more interpretative. Thus, two analyses have been provided; the first of which remain close to the data with cautious interpretations and the second which is less close to the data and more interpretative.

Further research in decision making could be used to investigate the skills necessary for expert performance (as discussed by Shanteau, 1992 and Stricker & Trierwieler,

1995) in relation to specific scenarios that could arise in the clinical setting. This may take the form of a cognitive task analysis of specific aspects of clinical practice (e.g. Klein, 1998) or an analysis of questionnaire responses to a hypothetical clinical scenario (e.g. Schottenbauer *et al.* 2007). It is proposed that the rich information gathered in this study provides both a useful starting point for developing clinical scenarios for use in a study and for highlighting aspects of the decision making environment which clinicians may need to attend to.

6.2 Decision making in Clinical Psychology

As stated previously the aim of the research was to provide a descriptive account of decision making within a Clinical Psychology context. The development and analysis of the four super-ordinate themes necessitated the exclusion of a lot of other data but even so there were many interesting points raised.

We were provided with insights into how the decision making environment can be perceived. Of particular interest was the nature of professional relationships and how this can influence decision making. Specific features of the Decision Making Environment were perceived to make the process more difficult (e.g. lack of feedback information and not having control over a decision). The descriptions of the Experience of the Decision Making Environment were based on emotions and uncertainty (within the individual and the CMHT team), which remain with the Psychologist even after the decision had been made. A full account of how emotions influence decision making is outwith the scope of this research. However, in the analysis an interesting idea of there being a type of gap between making a judgement and acting out the decision was introduced. The gap appears to have been related to a particularly difficult decision making experience characterised by concern about the consequences of the judgment made. The possibility of a conflict of beliefs complicating decision making was also raised in the discussion.

In the theme Managing Information we saw how individual Psychologists used frameworks of information (such as a psychological formulation or a theoretical model) and an example of the relationship an individual can have with sources of theoretical information. In the theme Working Through Decision Making Tasks the requirement to attend to the feedback available while working in a dynamic environment emerged. In addition two Psychologists reflected on comparisons made with peers, and in one case, the sense of a comparison being elusive. Although there are shared experiences discussed among the Clinical Psychologists, there is a sense that some aspects of one's practice will remain unique and form part of one's style of clinical practice.

It is suggested that, while one must be careful about generalising the findings summarised above to a wider group of Clinical Psychologists, this research may be useful in prompting readers to reflect on their own experience. It may be that the findings can be used to focus attention on particular aspects of one's decision making in clinical practice. The four themes emerging from this research reflect various features of decision making such as emotions experienced, approach taken to difficult decisions, use of information sources, comparisons with peers and the influence of professional relationships on decision making.

As such, the present research elucidates specific features of decision making and focuses on how the individual perceives them in the context of their professional practice. This adds to the research on the performance of experts in real world, dynamic scenarios (Klein, 1997). Issues such as how Clinical Psychologists perceive and respond to the decision making environment and the skills required by Clinical Psychologists are raised in the present research. Firstly, we have seen how decisions are rendered difficult for an individual if they perceive their team to be "floundering" and the onus being on them to solve a problem. Secondly, the idea of there being a gap between making a judgement and acting out the decision highlighted the requirement to manage competing thoughts and difficult emotions elicited during the decision making process. It is proposed that in highlighting such issues this research provides the reader with an opportunity to reflect on their own experience of clinical

practice. Stricker and Trierweiler (1995) state that being aware of and reflecting on specific aspects of one's clinical practice (which may be unique to their current work context) is a necessary factor in working as a scientist-practitioner.

In addition, it may that the links made between the data and the research literature will prompt individuals to make use of a particular model in their own decision making. The influence of a wide range of factors on decision making and the value placed on justifying one's decisions makes decision making in Clinical Psychology an important phenomenon to investigate. It is hoped that the reader can make use of the in-depth description of decision making provided in reflecting on their own practice. Whether we attend to the accounts of individuals or theoretical models or both it is proposed that it is worthwhile attending to the process and experience of decision making in relation to one's own clinical work. In discussing the aims of human science, Rennie (1994, p. 235) stated that "achievement of an understanding as opposed to the demonstration of the truth" is a key emphasis of this form of research. It is hoped that this study on decision making will help toward the reader achieving a more complete understanding of this phenomenon.

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Appendix 1:

Email contact with area Research Ethics Service (in reverse chronological order).

-----Original Message-----
From: [redacted]
Sent: 26 February 2009 14:30
To: [redacted]
Subject: RE: NHS ethics for research project

Dear [redacted]
Thanks for your email.

After review of the project with the Vice Chair of Commitee 2, we both feel that this is a service evaluation looking at the decisions made by therapist and it would not require an ethics application.

If you require any further information, please don't hesitate to contact the office.

Kind regards
[redacted]

[redacted] Research Ethics Service

From: [redacted]
Sent: 24 February 2009 11:16
To: [redacted]
Subject: FW: NHS ethics for research project

Hi [redacted]

Could I have your opinion about whether this project needs formal ethics approval.

Thanks

[redacted]

-----Original Message-----
From: Hickey John
Sent: 23 February 2009 17:41
To: [redacted]
Subject: NHS ethics for research project

Hello [redacted]

I was in contact with you last year about ethical approval for a project. I'm now doing some more research as part of my training in Clinical Psychology.

The project is being conducted with [redacted]

I've attached details of the project here so that it can be reviewed and a decision made with regard to ethical approval. Do you provide research and development approval also or should I contact [redacted] about this separately?

Kind regards
John Hickey

Appendix 2:
Participant Information form

Decision-making in clinical practice: the individual therapist's perspective

Information for participants

John Hickey
[redacted]

What is the study for?

This research is to investigate the decision-making process in the course of clinical practice. In order to find out about this process interviews will be conducted on a one to one basis. In doing so your experience and thoughts on clinical decision-making will be discussed.

The information from these interviews will be studied and interpreted by the researcher who will be striving to provide both a description and a detailed analysis of phenomenon of decision-making within the therapeutic encounter, while putting to one side his own assumptions and a priori beliefs about what is happening.

Who is carrying out the study?

John Hickey, who is training as a Clinical Psychologist, is carrying out the study. I am carrying out this research as part of this training. The study has been reviewed by an NHS ethics committee to ensure it is carried out safely and appropriately.

What will I have to do?

If you would like to participate in the study you will have an initial meeting with me. This will be to discuss the research and to organise a time to meet for the research interview.

The research interview will last between 1 and 1-½ hours and will follow a conversational format. I will have some general questions, which I will ask to frame the conversation but mostly I am interested in what you have to say. The interview will be audio-recorded.

At a later stage you will be contacted by myself to check that you are happy for the information from this interview to be included in the study. In all, it is expected that participation in the study will take a maximum of 2-½ hours.

Is this the same as clinical supervision?

No, the interview should feel more like a conversation about your experiences. I will not provide any advice or opinion on specific pieces of clinical work. My role is to start the conversation and to follow up on the points raised during the interview.

Is this a test of my theoretical knowledge or my expertise as a therapist?

Not at all! You have been selected for this study as someone who has received professional training in therapy and has experience in providing therapy. This isn't a forum for testing or assessing clinical skills or knowledge. Rather it is an opportunity to discuss your experiences and take part in a qualitative research study.

Is my information confidential?

I will be the only person who will be aware of your participation in the study. The information gathered in the study will be anonymised.

Your name will not be used in the study and while a true account of your experiences will be recorded, every effort will be made to minimise the amount of information, which may make you or your patients identifiable, used in the study.

You will be given an opportunity to review the written account of your part of the research before the work is submitted. At this point you can choose to have information removed if you wish.

A note on unprofessional/unethical conduct

Confidentiality will not be maintained if unprofessional conduct is disclosed during the course of the interview. In this case the researcher is ethically obliged to discuss the issue of unprofessional conduct with the appropriate manager ([redacted]) and my own line manger ([redacted]).

Should a research participant be concerned about or unhappy with the conduct of the researcher they should contact my line manager, [redacted].

How will the information be used?

The write up of this study will be submitted to the University of Edinburgh as part of the academic requirement for my course of study. I will report my findings back to the services involved and am hopeful that the work may be published in a peer reviewed research journal.

Can I change my mind about being part of the study?

You are free to choose whether or not you wish to participate in the study. The details of who has participated will not be shared with any third party.

If you do participate in the study you can change your mind at any time and need not give a reason for this. You can request for the information gathered form your participation in the study to be destroyed.

What do I do now?

I am more that happy for you to contact me via telephone, email, or in person to discuss the research.

What do I do if I decide to participate?

Please contact me and we can discuss the research further and organise a time for the research interview.

Thank you for taking the time to read this information form.

John Hickey

Appendix 3:
Consent Form

Identification Number for this research interview:

CONSENT FORM

Title of Project:

Difficult decision-making in clinical practice: the individual therapist's perspective

Name of Researcher: John Hickey

Please initial box

1 I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3 I understand that my participation in this study is confidential such that my name will not be revealed in the text or to any third party and that the researcher does not have access to the clinical case notes that I keep as part of my work. ☐

4 I understand that I will have the opportunity to go through the analysis of the data gained from my participation before the work is completed and that I can ask to have information removed. ☐

5 I agree to take part in the above study. ☐

Name of Clinician Signature Date

Researcher Signature Date

Appendix 4:
Interview Guide

Semi-Structured Interview Guide

Note: questions designed to direct the conversation to the process of decision-making in clinical practice. Once this has been achieved the researcher will be responding to the content brought up by the participant.

How would you describe your therapeutic approach?
- Which therapy have you had training in?
- What types of clinical work do you carry out?

Can you describe what impacts on the choices you make in how to approach working with a new client?

How might these change over the course of therapy?

What are the easy decisions you routinely make?

What kinds of decisions do you find challenging?

What overriding factors influence the decisions you make?
- How are these influenced by your clinical practice?
- What is the impact of other people that you work with?
- How far does your formal training influence them?

Is there anything that you would like to add?

Appendix 5:
Emerging themes from Transcript one; prefixed by numbers from paper copy of transcript.

Therapy Models

10. Model of therapy experienced as sufficient/insufficient

67, 70, 74. Therapy as having potential to help patients

73, 101. Model of therapy directing therapist's attention

13, 26, 39, 77, 79, 100. Match between therapy and patient presentation

Searching for and working toward common ground with patient

11, 38, 48, 75, 78. Enquiries in the context of minimal information

4, 6, 12, 14, 25, 31, 35, 54. Searching for common ground

36. 40, 57. 76. Scope of information sources

5, 91. Meeting half-way – common ground

15, 36, 45, 64. Power balance – patient's voice

33, 51, 58, 90, 92. Negotiation and clarification re therapy work

Certainty and uncertainty in carrying out the work

23, 24, 27, 28, 33, 92 93 Deciding what therapy is for/not for

47, 49, 50, 52. 97, 102. Evidence intangible (more to be uncovered)

55, 60, 61, 80. Progress in therapy is tentative

103. Building a coherent account from available information

98. More information gathered as therapy progresses

46. Uncertainty leading to creative problem solving

Making a decision or judgement call

32, 44. Having to decide what action to take

63. Online/continuous decision making

89. Value placed on ability to justify a statement (considered response)

94. Managing the decision making by being direct

Appendix 6:
List of over-arching themes from each transcript (N = 7)

Transcript one (CP1)
7. Therapy Models
8. Searching for and working towards common ground
9. Certainty – uncertainty
10. Judging and deciding

Transcript two (CP2)
11. Framework for decision making
12. Sources of information
13. Responsibility
14. Pressure
15. Uncertainty
16. Nature of Psychology work

Transcript three (CP3)
17. Progressing the work
18. Decision making environment
19. Decision making tools
20. Emotions
21. Judging

Transcript four (CP4)
22. Managing information
23. Emotions
24. Decision making context
25. Judging the therapeutic intervention

Transcript five (CP5)
26. Emotion
27. Changeable decision making environment
28. Working towards clarity
29. Working through judgment and decision making tasks

Transcript six (CP6)
30. Working towards clarity
31. Managing information
32. Deciding on approach to therapy

Transcript seven (CP7)
33. Decision making environment
34. Managing information
35. Managing in the decision making environment

Appendix 7:
Super-ordinate themes (A to D) with sub-themes

(A) Decision making environment:

Decision making environment (CP3)
Decision making context (CP4)
Changeable decision making environment (CP5)
Decision making environment (CP7)

(B) Experiencing the decision making environment:

Certainty – uncertainty (CP1)
Responsibility (CP2)
Pressure (CP2)
Uncertainty (CP2)
Nature of Psychology work (CP2)
Emotions (CP3)
Emotions (CP4)
Emotions (CP5)

(C) Managing information:

Searching for and working towards common ground (CP1)
Framework for decision making (CP2)
Sources of information (CP2)
Decision making tools (CP3)
Managing information (CP4)
Working towards clarity (CP5)
Working towards clarity (CP6)
Managing information (CP6)
Managing information (CP7)

(D) Working through decision making tasks:

Judging and deciding (CP1)
Progressing the work (CP3)
Working through judgment and decision making tasks (CP5)
Deciding on approach to therapy (CP6)
Managing in the decision making environment (CP7)