11

The scientist-practitioner and the reflective-practitioner

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This chapter explores two models that have been identified as appropriate for the training and ongoing practice and professional development of counselling psychology practitioners and researchers. These are the **scientist-practitioner** model and the **reflective-practitioner** models. An overview of both models is presented, as well as an exploration of the potential problems that arise out of their development. Finally, the chapter aims to discuss and consider how these two models might be integrated in order for them both to complement the training and ongoing practice of counselling psychologists.

The development of counselling psychology

Established within the humanistic movement, the emergence of counselling psychology was influenced by conceptualisations of counselling psychology as it is practiced in the United States (US), European psychotherapy, as well as mainstream psychology. In the US, the profession of counselling psychology has had a much longer history; it being established in 1946 at a time when numerous individuals returned from the Second World War needing additional psychological support. In the UK however, the inception of counselling psychology did not begin until the 1980s when an increasing number of individuals who had studied psychology were interested in applying their knowledge within the helping professions. A working party was set up, within the British Psychological Society, to consider the relationship between psychology and counselling (BPS, 1980). In 1994 counselling psychology achieved divisional status, according it equivalent status to other applied psychological disciplines and a corresponding outline of the defined area of theory and practice relevant to the profession. At the time of writing, counselling psychology is now the third-largest division in the BPS, after clinical and occupational psychology.

There exists a diversity of influence on the development of counselling psychology which some suggest has created a tension for the profession. The emphasis of counselling psychology on engagement with notions of subjectivity, inter-subjectivity, values, and beliefs is often considered to be at odds with the empirical-positivistic approach to ‘science’ which underlies scientific psychology, as it is traditionally defined. Ideas about ‘science’, especially within western psychology may not appear compatible with the concept of ‘the person’. Counselling psychology developed distinct from its fellow forms of applied psychology because of its philosophical underpinning. With an explicit focus on a humanistic value base, counselling psychology is built on the understanding of people as ‘relational beings’, and it is this conception of the human which informs the way in which counselling psychologists practise, adopting a strongly relational stance (Cooper, 2008). On this basis, practitioners seek to cultivate democratic, non-hierarchical client-therapist relationships, preferring to take a collaborative position alongside their client rather than positioning themselves as the expert over the client.

Counselling psychologists are required to negotiate diverse, and at times competing, ideologies which inform both their research activity and clinical practice. As a result, practitioners and researchers within the field of counselling psychology are tasked to *hold* this tension, and to form a professional identity which seeks to coherently integrate the thinking of the varied influences which have shaped its development. One key debate within the field of counselling psychology refers to the way in which counselling psychologists conceptualise their practice in relation to research. Strawbridge and Woolfe (2010), when considering this relationship, assert that counselling psychologists are **scientist-practitioner**s, and suggest that there should be an increasing recognition of what constitutes the scientific aspects of the counselling psychology identity. The next section aims to explore the implications of this label for counselling psychology practitioners and researchers, and to speculate whether the **scientist-practitioner** model is the only model suitable to guide the practice of counselling psychologists.

The scientist-practitioner model

The concept of the **scientist-practitioner** was originally conceived within the clinical psychology field. It was first introduced at the Boulder Conference on Graduate Education in 1949 in which it was proposed that clinical psychology training should provide an equal emphasis on both the research (science) and applied (practice) aspects of the discipline. This prompted a significant shift in the training of clinical psychologists, and later for those training as counselling psychologists. In 1951 the scientist-practitioner model was also endorsed by ‘The Division of Counseling and Guidance’ as a central model to inform counselling psychology training and practice, and has become the most popular model underpinning the development of the profession. More recently the BPS guidelines for the professional practice of counselling psychology state that the aim of the profession is to develop models of practice and research which ‘marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship’ (BPS, [2005](file:///C%3A%5CUsers%5Cafreitag%5CDesktop%5CTuesday%5C15031-0940%5CFrom%20CE%5C15031-0940-FullBook.docx#Ref_395_FILE150310940SV011), p. 1). A research attitude and commitment to conduct research is a key feature of the professional knowledge base of counselling psychology, and this professional practice guideline refers directly to the important requirement of ‘bridging’ the gap between practice and research. It is precisely this aim which the **scientist-practitioner** model fundamentally encapsulates. Corrie and Callahan (2000) suggest that those trained as scientist-practitioners should be equally capable of producing theoretical and research knowledge as they are at using it to inform their clinical practice. Research and practice should therefore be integrated into a coherent way of working, and expressed with a scientific attitude. In summary, counselling psychologists should have a ‘research-orientation in their practice, and a practice relevance in their research’ (Belar & Perry, 1992, p. 72).

In seeking to extend the potential of research to inform clinical practice, the question surfaces of *what research* should be conducted and applied within the profession. The professional practice guideline for counselling psychologists, provided by the BPS, uses the terminology ‘rigorous empirical enquiry’. So, what constitutes rigorous research, and how is the quality of research into therapy assessed? Policy initiatives in the area explicitly stress the importance of basing therapeutic practice on ‘evidence’, a viewpoint that has become commonly known as ‘**evidence-based practice**’ (EBP).

Focus box 11.1 Evidence-based practice and practice-based evidence

In an effort to enhance the effectiveness of psychological therapy, two different, and sometimes considered competing, paradigms have developed which adhere to different models of research. ***Evidence-based practice*** refers to the use of current best evidence when making decisions about the care of individual clients. The best evidence is often considered to be that which develop psychological interventions via the testing of their efficacy in well-controlled and randomised trials; known as randomised controlled trials (RCTs). The comparison of the experimental condition versus the control group takes place under tightly controlled conditions in order to extrapolate a generalisable conclusion from the study. Outcomes of these research studies are then sought to be disseminated and applied in practice.

In contrast, ***practice-based evidence*** (PBE) seeks to study the effects of psychological therapy as they are delivered in routine clinical practice. In these studies, allowance is made for variation in the client’s presentation, therapist competence and different therapy contexts. Unlike the controlled conditions which are sought within RCTs, in PBE real world practice is documented and measured, just as it occurs. It could be said that this type of research does not readily accept the ‘cause and effect’ model of science. Instead, research is understood to flow out from practice.

Since the advent of the EBP movement in the 1990s, and adoption of EBP as a key paradigm within the National Health Service (NHS) in the UK, professionals working in the field of counselling psychology have been confronted by the growing demand that they produce and utilise research which has a high level of scientific rigour; thus, they seek to employ exclusively those therapeutic practices that have empirical support (Barkham & Mellor-Clark, 2003). In the UK, clinical guideline groups, such as the National Institute for Health and Care Excellence (NICE), have an increasingly influential role in the commissioning and delivery of psychological therapies. NICE offer guidance on conducting good quality research that can be used in the NHS, viewing the quality of research evidence in a hierarchical manner. Quantitative research approaches are favoured. Systematic reviews and RCTs are considered to be at the top of this hierarchy of evidence, as research participants are allocated to different interventions, including a control group, in a randomised fashion. Qualitative research, on the other hand, is considered much lower down in the levels of evidence deemed suitable to inform therapeutic practice.

Focus box 11.2 Research methods

A well-known RCT conducted by King et al. (2000) set out to compare the efficacy of up to 12 weeks of non-directive counselling with usual general practitioner (GP) care for adults experiencing depression. A total of 467 individuals took part in the research. They asked participants to complete the Beck Depression Inventory (BDI; a common measure of depression, in which a higher score means a higher number of depressive symptoms) at the assessment and then again after 4 and 12 months. The results showed psychological therapy was a more effective treatment for depression than usual general practitioner care in the short term. However after 12 months there was no difference in outcome.

As a discipline, counselling psychology adopts a critically minded position when considering the validity and utility of evidence produced by RCTs. The limitations of RCTs on methodological and ethical grounds have been explored (Cartwright, 2007).

Focus box 11.3 Ethical Issues

Counselling psychologist Alexandra works in an acute inpatient setting. She is keen to carry out an evaluation of the mindfulness group she runs weekly on the ward. As a result she decides to conduct a service evaluation. Before members begin the group, and at each mindfulness session for the next nine weeks, she invites group members to complete a batch of questionnaires relating to their wellbeing and understanding of mindfulness. She also asks individuals to complete a feedback form asking questions about what they found most/least helpful about the session. At the end of each group Alexandra collects the questionnaire and feedback forms from group members, scores them and inputs the data into statistical software which she will later use to analyse the results.

What ethical problems might arise when considering conducting an evaluation of this sort?

Consider the following:

• The dual role of researcher and practitioner

• Conflicts of interest

• The storage of questionnaire and feedback forms

As well as examining the relevance of outcomes of RCTs for their practice, counselling psychologists have also questioned the assertion that the **scientist-practitioner** model is the only model capable of relating practice to evidence. The **reflective-practitioner** model provides an alternative framework for counselling psychologists to consider, and it is that which we turn to now.

The reflective-practitioner model

In the previous section, the vast professional knowledge base of counselling psychology began to be explored. Among the areas of knowledge which counselling psychologists are expected to grasp, including knowledge pertaining to psychological and philosophical dimensions, and awareness of ethical and professional issues, is reflexive knowledge. Reflexivity is a key characteristic of the counselling psychology profession, and has been referred to as one of the defining features distinguishing it from other applied psychology professions. Emergence of the **reflective-practitioner** model has provided counselling psychologists with an alternative model to the **scientist-practitioner** model, within which to establish their professional identity. Being a reflective-practitioner requires the individual to consider, and analyse, how they were impacted by the interaction within the therapeutic relationship, and how it may have been experienced by the client. Engaging in reflective practice therefore requires practitioners to assume the perspective of an external observer of their own assumptions and feelings which underlie their behaviour. It is then the responsibility of the reflective-practitioner to consider how these assumptions and feelings may have affected their practice. Where a lack of self-awareness may cause practitioners to be more likely to use their own values and assumptions to make judgements about the presenting problems of their clients, a practitioner’s increased awareness of their subjectivity and the way their personal lenses may impact their decision-making indicates an increase in successful interpersonal understanding.

The term ‘reflective practice’ was initially developed by Schön (1983), who identified two types of reflection; reflection-in-action and reflection-on-action. The first, reflection-in-action, refers to the reflection of the practitioner on their behaviour as it occurs (e.g. within a therapy session); the reflexive process informs their immediate action. Reflection-on-action occurs after the situation has taken place (e.g. sometime after the therapy session), in which the practitioner may review, describe, analyse and/or evaluate the event in order to gain insights for the future. It is considered very important that practitioners understand why their practice was either productive or unproductive within the therapeutic context. It enables the promotion of effective, competent and ethical practice (Furr & Carroll, 2008), and permits an ‘anticipatory reflection’ process (Conway, 2001), which refers to the way in which the reflexive activities of the practitioner act to inform their subsequent practice.

Focus box 11.4 Applying the science: reflection-in-action and reflection-on-action

Reflection-in-action

During a family therapy session counselling psychologist Aisha was facilitating with daughter Elise, and her parents James and Joanne, Elise’s father James began to cry. Aisha felt unsure why James had become emotional at that moment, as there appeared to be no immediate and obvious cause. She wondered how best to manage the situation, and noticed that Elise had turned her gaze away from her parents. Aisha noticed her urge to acknowledge James’ expression of emotion, however also recognised a felt-sense that the family may benefit from sitting with this experience before it was explored further. Aisha facilitated silence for another minute, and as a result witnessed Joanne take the hands of both her daughter and husband in what appeared to be a comforting gesture.

Reflection-on-action

Emma is reflecting on a role-play which she participated in earlier in the day, as part of a training course. The role-play involved various professionals, including the role of a psychiatrist and social worker. Upon reflection she recalled the events and processes which took place during the role play, including the way she responded to the other participants, particularly the psychiatrist, whose opinions she did not entirely agree with. Emma decided to take notes of the specific interaction, including how it made her feel, and how it could have been done differently.

If reflective practice requires the practitioner to include themselves within the frame in which they view their work, then in order for counselling psychologists to engage with subjectivity, intersubjectivity and the values and beliefs of the clients they work with, they too must be open to explore their own value base and implicit dimensions of their thinking and practice. With that in mind, learning the skills required to become a reflective-practitioner is often understood as stemming from participation in personal therapy and experiences in clinical supervision. The requirement to undertake personal therapy during training is one component that sets counselling psychology apart from other applied psychologies within the BPS. It is also an element that helps to demonstrate the discipline’s commitment to viewing reflexivity as an essential skill for the work of psychologists. Please refer to Chapter 10 for further exploration of the personal development component of the profession.

Focus box 11.5 Supervision to support reflective practice

The supervision of clinical work is a requirement for counselling psychologists in training and after qualification, and is part of the ethical framework for practice. Clinical supervision offers a space to reflect upon our therapeutic practice, and as a result to support the development of skills essential to a reflective-practitioner. What factors make supervision effective? Driscoll (2007) consider the use of experiential learning to develop further knowledge as one function of supervision. In addition they suggest that the exploration of personal feelings that can surface as a result of client work also serves an important feature. These appear to be particularly appropriate to the reflective-practitioner.

There is a recognition that counselling psychology sits within a more creative realm than other psychologies, emphasising the importance of reflexivity and self-awareness. Perhaps this is why Woolfe (2012) considers the reflective-practitioner model to offer counselling psychology a ‘narrative arc’ which differentiates the discipline from the rest of the applied psychology family. However, insight from Joyce Scaife (2010), a clinical psychologist, about her understanding of reflexivity demonstrates the extent to which the **reflective-practitioner** model has successfully developed as a supplementary model to the **scientist-practitioner** across other areas of applied psychology too:

My personal reactions are important and useful. I need to engage with the issues with energy and resourcefulness. In this context my feelings and thoughts are information and my task is to monitor these and generate ideas from among which I choose in deciding what next to do and say. I might jot down some of my ideas and return to these later if the direction of the work does not seem optimally useful. Successful analytical reflection on practice should lead to learning and skill development because it involves maintaining a stance of curiosity and questioning automatic responses. Instead of doing things in the way that they have habitually been done or according to a manual or technical prescription, the worker feels, thinks and modifies what he or she is doing responsively to the ongoing process. No wonder Schön referred to this as professional artistry. The creative element is forefront.

(p. 5)

Conceptualisation of reflective practice, such as the one offered here by Scaife (2010) does not aim to deny the importance of theory and technique in conducting adept therapeutic practice. Instead, it encourages processes of reflection as a way in which to improve the practitioner’s ability to adapt and improvise in accordance with what the therapeutic situation may demand, all the while working from a consolidated theoretical and practical knowledge base.

Focus box 11.6 Case example: responding to the client’s changing needs

Kasimir has been working with his client, Gerard, for seven weeks. Gerard initially sought psychological therapy as he had been experiencing what he called ‘unbearable performance anxiety’ in relation to his work life. Gerard works as a manager of a restaurant and is often called upon to deliver series of training sessions for staff. When he came to see Kasimir, he was clear that his life on the whole was fine, all except his recurring anxiety in the weeks leading up to his training sessions. Gerard made it clear to Kasimir that what he wanted from counselling was to achieve his goal of ‘being able to stand in front of staff without feeling so panicked’. Kasimir introduced Gerard to a cognitive model of panic and over the course of the first five sessions, after devising a formulation, they began to focus on how Gerard might be able to begin challenging some of his unhelpful thoughts and beliefs in order for him to gradually begin to make changes in his behaviour. During the sixth session Kasimir invited feedback from Gerard on how he thought the therapy was progressing. Gerard reported feeling more able to challenge his negative thoughts, since being able to apply the ‘fact or opinion’ skill that he and Kasimir had discussed in session. However, Gerard also expressed that he had recently started to wonder where his negative thought patterns first originated. As the session continued, Kasimir acknowledged that Gerard may also benefit from developing an understanding of the problem and how it developed, and that this may go some way in preventing it from reoccurring in the future. Following the session Kasimir reflected on the benefit of therapists requesting feedback from clients to ensure that they are working collaboratively with them to decide on how the therapeutic work should proceed. In the seventh session, Kasimir and Gerard begun to talk in more depth about his early life experience, beginning to make links between the past and present, including these insights into the formulation as they went.

Exploring the tensions

The consumption and production of research has been identified as an important component in the formation of the identity of counselling psychologists. In addition to this, the notion of reflexivity has also been recognised as a central process to inform the good practice of counselling psychologists. The next section explores some of the tensions which exist as a result of our commitment to being both scientist- and reflective-practitioners.

What is evidence?

Practice-led enquiry has been strongly endorsed by counselling psychology, despite it posing a number of challenges to the positivistic methodological framework which currently dominates. At the root of scientific enquiry is the underlying assumption that only objectively observable phenomena can be considered as evidence. Therefore, **evidence-based practice** and **practice-based evidence** are often viewed as opposing one another. However, there are ongoing debates between practitioners and academic researchers about what kind of knowledge counts as evidence, and counselling psychologists have been active in this discussion. While the notion of ‘good’ research is valued within counselling psychology regardless of which research method is used, practitioners have challenged the way in which more value is placed on particular research approaches over others (Hanley, Cutts, Gordon & Scott, 2013). For instance, one argument is that the use of quantitative methods in **evidence-based practice** has been developed entirely independently of practice in the caring professions. Such work commonly prizes the concept of *statistical significance*, where the change reported during a period of therapy is greater than that expected by chance, despite this potentially having little explicit relationship to peoples’ lives. The *relevance* of such research findings for practice can therefore be open to question. In response, researchers have adapted quantitative methodologies to consider more practically applicable concepts. For example the concept of *clinical significance*, where the change reported during therapy reduces symptoms of distress below a pre-set threshold. This might be viewed as more meaningful to the therapeutic process.

Focus box 11.7 The generalisability of randomised controlled trials

The central goal of conducting an RCT is to test whether an intervention works by comparing it to a control condition, which means either no intervention is received by participants or an alternative one. In this kind of research, participants are randomly allocated to either treatment or control conditions. Procedures are sought to be controlled to ensure that all participants in all conditions are treated the same except for the factor that is unique to their group. However, how generalisable are the results to routine clinical practice? In order to operationally define the independent variable (the therapy) in RCTs, treatment manuals for therapists to follow are produced as an attempt to ensure that participants receive the same therapeutic treatment. However in clinical practice, the way psychological interventions are provided may (appropriately) vary between clients and between therapists. Furthermore, client characteristics such as capacity to form an alliance with the therapist and initial functioning have also proved to be important in predicting treatment outcome, and may not be easily accounted for within an RCT (Krupnick et al., 1996).

The scientist is considered to be concerned with knowledge that is rigorous, objective and generalisable. It could be said that the priority of the scientist is on the *product*. In contrast, the practitioner emphasises knowledge that is subjective, holistic and relevant to the individual. Therefore, it could be said that the emphasis for the practitioner is on the *person*. For this reason, some would argue that the **scientist-practitioner** model is an unsustainable model for counselling psychologists as it is unable to capture the essence of the therapeutic relationship. Barkham and Mellor-Clark (2003) recommend more research is needed that truly examines the applied clinical issues which psychologists come across daily in their practice. However, this need exists within a context of an increasing demand for **evidence-based practice**. Therefore, from this position, it is argued that practice must be grounded in the evidence which is available, even if this evidence appears less sensitive to diverse populations and unique contexts of delivery.

What influences therapeutic practice?

Before we think further about this question, have a go at completing the activity in Activity box 11.1.

Activity box 11.1 Seeking the therapist for you

Imagine you are just beginning your professional training in counselling psychology and as a result are required to undertake a minimum of 40 hours of personal therapy. What expectations would you have of your therapist? What would be the most important factors for you? Rate the following therapist characteristics in order of importance (1 being unimportant and 5 being essential).

An ability to develop a warm and responsive therapeutic relationship

Over 20 years’ experience as a therapeutic practitioner

A non-judgemental attitude

A knowledge of the most up-to-date research findings

Experience of conducting research on the effectiveness of therapy

A thorough knowledge of CBT techniques

The knowledge that the therapist reflects upon their practice in clinical supervision

Consider your ratings in relation to what you now know about the **scientist-practitioner** and reflective-practitioner model. Which of the models do the elements you chose resonate most with?

Meier and Davis (1997) claimed that ‘in no other profession does the personality and behaviour of the profession make such a difference as it does in counselling’ (p. 61). Therefore there is an ongoing debate about the utilisation of knowledge counselling psychologists acquire throughout their training and ongoing professional development, and their subsequent behaviour within their clinical practice. What does influence the decision-making of therapists? Whilst **evidence-based practice** encourages the implementation of those therapies with the greater evidence base, the practice of counselling psychologists may be informed by a broader range of aspects than just research. Activity box 10.1 invited you to reflect on what elements would be most important to you when seeking out a therapist. Perhaps a clear knowledge of the most up-to-date evidence was considered most important to you, or maybe you felt it was more important that your therapist had a significant number of years’ experience in therapeutic practice? It might be interesting to consider a piece of research conducted by Lucock, Hall and Noble (2006) which aimed to find out what is considered as most influential on the practice of psychotherapists and trainee clinical psychologists in the UK. What do you think the results demonstrated? The survey showed that professional training, clinical supervision and three related factors, client characteristics, client feedback and psychological formulation, were rated as the most influential factors for both the qualified psychotherapists and trainee clinical psychologists. Cognitive-behaviour therapists rated evidence-based guidelines, research-based journal articles and electronic journals higher than the other groups in the study; however on the whole, evidence-based factors including treatment manuals and evidence-based guidelines were rated less highly overall. Perhaps this is particularly surprising for clinical psychologists in training, who are primarily supported by the **scientist-practitioner** training model. Do you think this result would be the same for qualified and trainee counselling psychologists?

What makes therapy effective?

Focus box 11.8 *Efficacy* and *effectiveness*

Roth and Fonagy (2005) draw attention to the important distinction between **efficacy studies** and the effectiveness of routine therapeutic practice, and the different purposes of each. **Efficacy studies** demonstrate outcomes achieved in the context of highly controlled research trials, where the aim is to discover the benefits or harm of an intervention. Effectiveness, on the other hand, refers to the performance of an intervention under real world conditions, with more heterogeneous populations and less standardised protocols of therapy.

With the above in mind, efficacy and **effectiveness studies** might be viewed as existing at opposite ends of a continuum of decision-making in research. Therefore, a focus on either efficacy or effectiveness will affect the research study design. How might the terms ‘efficacy’ and ‘effectiveness’ relate to those researchers/practitioners engaged in working within the paradigms of **evidence-based practice**, or **practice-based evidence**?

Systematic reviews have shown that, when compared, different mainstream therapies are actually as effective as each other (Cooper, 2008). This has given rise to phrase ‘the dodo bird verdict’, which references a story in Lewis Carroll ’s *Alice in Wonderland.* In the story, a group of animals run a chaotic race, which is brought to an end when the Dodo bird declares ‘*everybody* has won, and all must have prizes’. In the context of psychological therapy, this result suggests that there must be effective components of practice that are common to all therapeutic approaches. To reflect upon what these active ingredients of therapy might be the American Psychological Association assembled a task force to review the empirical research. They discovered that the specific techniques associated with certain types of therapy are less important than non-specific factors such as positive qualities of the therapeutic relationship. Focus box 11.9 provides more detail on the findings of this seminal work.

Focus box 11.9 Research methods: common therapeutic factors

In a book entitled *Psychotherapeutic Relationships that Work* by Norcross (2011), the elements of the therapeutic relationship that work were investigated. The common therapeutic factors considered as demonstrably effective in individual therapy were highlighted as follows:

• Alliance in individual psychotherapy

• Alliance in youth psychotherapy

• Empathy – communication of the therapists understanding of the client’s emotional experience

• Collecting client feedback – asking for the client’s views on their experience of therapy

It is important to note that the term *alliance* is often understood as consisting of a shared agreement between the therapist and client on the goals and tasks of therapy, as well as referring to the emotional bond between the therapist and client (Bordin, 1994).

Exploring the opportunities

Expanding the notion of evidence

We have identified that the creation of research that can be translated into practice is not a simple matter. The question of what type of knowledge and created by whom, in what context should be considered legitimate, still remains. The concept of ‘**methodological pluralism**’ (Kasket, 2013) offers one way in which to reconcile the tension between assumptions underlying more positivist approaches with the humanistic and intersubjective concerns of counselling psychology. The concepts of **methodological pluralism** suggests that there are numerous research methods that can be useful in addressing a research question. The position is therefore opposed to the idea that there is only one valid way to approach the inquiry of any given question. By expanding the notion of what constitutes ‘science’ and ‘valid evidence’, an increasing inclusion of diverse methodological perspectives with different epistemological underpinnings can be appreciated and valued. Key concepts within counselling psychology such as meaning, values and insight are less amenable to be tested via strictly quantitative methods. Instead, they may be better explored via qualitative research approaches which provide rich and detailed pictures of human experience. A pluralistic approach to evidence enables more inclusive methods for the synthesis of evidence and highlights the useful contribution to counselling psychology practice from a diverse array of research approaches (Hanley & Winter, 2016). In the case of **evidence-based practice** versus **practice-based evidence**, seeing the two paradigms as complementary rather than competing may be the most appropriate way forward for counselling psychologists. Barkham, Stiles, Lambert and Mellor-Clark (2010) suggest that both are needed in order to build a relevant and rigorous science of the psychological therapies. Barkham and Mellor-Clark (2003) suggest that ‘no single research paradigm can deliver all the requirements of rigorous and relevant research’ (p. 320). Therefore it is suggested that practitioners and researchers should seek to value diverse research approaches which in combination enable a richer foundation of knowledge on both the process and outcomes of psychological therapy.

Forming a relationship with research

The findings from the Lucock et al. study (2006), which was mentioned earlier, showed the high ratings for client-centred factors and notions of intuition and judgement on the influence of practice. This would appear to support the idea that effective practice might be best seen as a combination of evidence-based practice guidelines with reflective practice elements such as clinical judgement and flexibility, in order to adjust the therapy to the individual. A conclusion from the Lucock study suggested that practitioners using predominantly CBT were more inclined to view the importance of **evidence-based practice**. However within CBT there have been developments of integrative training strategies which aim to enable practitioners an experiential learning process to facilitate the acquisition of therapeutic skill in a number of cognitive-behavioural therapy (CBT) competencies (Bennett-Levy, Lee, Travers, Pohlman & Hamernik, 2003). The self-practice component of the process involves the practitioner’s engagement in a structured experience of using CBT on themselves, either in the form of self-guided completion of a manualised workbook of typical CBT tasks or the initiation of limited co-therapy with a colleague (Bennett-Levy & Lee, 2014). The therapists’ self-reflection is encouraged on both the experience of the process of self-practice and the perceived implications of their experience on their subsequent understanding of CBT theory and practice. Within this paradigm, reflexivity is considered to play an essential role in therapist skill development, as it acts to mediate how knowledge is used in practice, and vice versa. Furthermore, reflection on clinical practice is also understood as having potential to consolidate or modify current declarative knowledge and, hence, contribute to new learning. Perhaps this particular approach provides one way in which to combine technical knowledge informed by research evidence, and reflective knowledge informed by the experience of its application.

Focus box 11.10 Beyond the frontier: a research-informed approach

As has been discussed counselling psychologists commonly advocate the use of the **scientist-practitioner** model to inform how practice relates to evidence. As a result, taking account of current research findings is considered important and useful for their practice. We have also discussed some of the potential tensions that may exist between the discipline’s philosophical basis and what is currently considered appropriate research evidence to inform practice. A research-informed approach, as opposed to research-directed one, may be one way in which counselling psychologists can acknowledge the many things, including research, which can impact on the decision we make for each individual client we meet in therapy.

Conclusion

[A counselling psychologist must] be able to use professional and research skills in work with clients based on a **scientist-practitioner** and **reflective-practitioner** model that incorporates a cycle of assessment, formulation, intervention and evaluation.

(HCPC, 2015, p. 22)

The identity of the counselling psychology profession could be defined as one which seeks to hold tensions, rather than necessarily resolve them. The same could be said for the potential tension which exits between the two models presented in this chapter. The diverse forms of knowledge which constitute the counselling psychology profession may make it difficult to conform solely to the principles of **evidence-based practice**. However it is our continued engagement with the tensions which this debate generates that has the most potential to enable the formation of a distinct professional identity.

At present, evidence-based practices, primarily developed through the amalgamation of randomised control trials, dominate guidelines instructing what therapeutic approach should be utilised for whom. In contrast, counselling psychologists commonly advocate a broader understanding of how evidence is used to inform practice. From this perspective, the relationship between research and practice appears best seen as bi-directional, where research has a role in informing practice, as does practice in informing areas where further research is required to be conducted. In order for practitioners to respond to client needs, therapists will always be in a position whereby they are required to devise innovative methods. As practitioners gain experience, and more important reflect on that experience, they become better equipped to combine theoretical concepts and techniques with their clinical wisdom in order to serve the needs of their clients. Counselling psychology seems able to form a dual alliance with both the **scientist-practitioner** model and the **reflective-practitioner** model. As scientist-practitioners we can seek to both consume and produce research, and as reflective-practitioners we seek to always remain alert to the uniqueness of each practice situation as it develops.

This chapter has highlighted that the articulation of what constitutes practice knowledge appears hard to define. Training, and continued professional development models which support the experiential learning and reflexivity skills of counselling psychologists, as well as their suitable use of psychological research to inform their practice, offers one way in which to achieve a coherent integration of theory, research and practice. As a result, the models are seen as increasingly complementary rather than opposing forces. Counselling psychologists can therefore locate themselves in a position whereby they remain as both scientist- and reflective-practitioners (HCPC, 2015).

Learning outcomes

To outline the key elements of the scientist-practitioner model and its relationship to the discipline of counselling psychology.

To outline the key elements of the reflective-practitioner model and its relationship to the discipline of counselling psychology.

To highlight the differences between EBP and PBE and their relevant contribution to counselling psychology practice.

To critically engage with the debate on what constitutes as suitable research evidence to inform therapeutic practice.

Key concepts

Scientist-practitioner

Reflective-practitioner

Efficacy studies

Effectiveness studies

Evidence-based practice

Practice-based evidence

Methodological pluralism

Sample essay titles

Critically discuss the reflective-practitioner model.

What challenges and opportunities do randomised control trials pose for counselling psychologists?

Describe and discuss a situation when it is appropriate for a psychologist not to use a recommended evidence-based practice.

Further reading

**•** Barkham, M., Hardy, S. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies*. London: John Wiley & Sons.

• Hanley, T., Cutts, L., Gordon, R., & Scott, A. (2013). A research informed approach to counselling psychology. In G. Davey (Ed). *Applied psychology* (pp. 1–23 supplementary material). London: BPS Wiley Blackwell.

• Kasket, E. (2013). The counselling psychology researcher. In G. Davey (Ed). *Applied psychology* (pp. 1–19 supplementary material). London: BPS Wiley Blackwell.

• Wessley, S. (2001). Randomised controlled trails: The gold standard? In C. Mace, S. Moorey, & B. Robert (Eds). *Evidence in the psychological therapies: A critical guide for practitioners* (pp. 46–59). Hove: Brunner-Routledge.

**•** Lane, D., & Corrie, S. (2006). *The modern scientist-practitioner: A guide to practice in psychology*. Sussex: Routledge.

• Scaife, J. (2010). *Supervising the reflective practitioner: An essential guide to theory and practice*. Sussex: Routledge.

Useful journal articles

**•** Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology. *Counselling Psychology Review*, *25*(4), 19–30.

• Cartwright, N. (2007). Are RCTs the gold standard? *BioSocieties*, *2*(1), 11–20.

• Jones, J. L., & Mehr, S. L. (2007). Foundations and assumptions of the scientist-practitioner model. *American Behavioral Scientist*, *50*(6), 766–771.

• Myers, D. (2007). Implication of the scientist-practitioner model in counselling psychology training and practice. *American Behavioural Scientist*, *50*(6), 789–796.

• Rennie, D. L. (2004). Reflexivity and person-centered counseling. *Journal of Humanistic Psychology*, *44*, 182–203.

Web resources

The NICE website provides an overview of the recommended evidence-based guidance for recognised mental health issues – www.nice.org.uk

References

Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology & Psychotherapy*, *10*(6), 319–327.

Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge-base for the psychological therapies. In M. Barkham, G. Hardy & J. Mellor-Clark (eds). *Developing and Delivering Practice-Based Evidence: A Guide for the Psychological Therapies* (pp.21–61). London: Wiley & Sons.

Belar, C. D., & Perry, N. W. (1992). The national conference on scientist-practitioner education and training for the professional practice of psychology. *American Psychologist*, *47*(1), 71-75

Bennett-Levy, J., & Lee, N. K. (2014). Self-practice and self-reflection in cognitive behaviour therapy training: What factors influence trainees’ engagement and experience of benefit? *Behavioural and Cognitive Psychotherapy*, *42*(1), 48–64.

Bennett-Levy, J., Lee, N. K., Travers, K., Pohlman, S., & Hamernik, E. (2003). Cognitive therapy from the inside: Enhancing therapist skills through practising what we preach. *Behavioural and Cognitive Psychotherapy*, *31*(2), 143–158.

[Bolton](file:///C%3A%5CUsers%5Cafreitag%5CDesktop%5CTuesday%5C15031-0940%5CFrom%20CE%5C15031-0940-Ref%20Mismatch%20Report.docx#LStERROR_51), G. (2010). *Reflective practice: Writing and professional development*. London: Sage.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & L. Greenberg (eds). *The Working Alliance: Theory, Research, and Practice* (pp.13-37), New York: Wiley & Sons

British Psychological Society (1980). *Counselling: The report of a working party*. Leicester: BPS.

British Psychological Society Division of Counselling Psychology (2005). *Professional practice guidelines*. Leicester: BPS.

Cartwright, N. (2007). Are RCTs the gold standard? *BioSocieties*, *2*(1), 11–20.

Conway, P.F. (2001). Anticipatory reflection while learning to teach: From a temporally truncated to a temporally distributed model of reflection in teacher education. *Teaching and Teacher Education, 17*(1), 89-106

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly*. London: Sage.

Corrie, S., & Callahan, M. M. (2000). A review of the scientist – practitioner model: Reflections on its potential contribution to counselling psychology within the context of current health care trends. *Psychology and Psychotherapy*, *73*, 413.

[Driscoll](file:///C%3A%5C%5CUsers%5C%5Cafreitag%5C%5CDesktop%5C%5CTuesday%5C%5C15031-0940%5C%5CFrom%20CE%5C%5C15031-0940-Ref%20Mismatch%20Report.docx%22%20%5Cl%20%22LStERROR_52%22%20%5Co%20%22Goto%20error%20report), J. (2007). *Practising clinical supervision: A reflective approach for healthcare professionals*. (2nd edition). Philadelphia, PA: Elsevier.

[Furr](file:///C%3A%5CUsers%5Cafreitag%5CDesktop%5CTuesday%5C15031-0940%5CFrom%20CE%5C15031-0940-Ref%20Mismatch%20Report.docx#LStERROR_54), S. R., & Carroll, J. J. (2003). Critical incidents in student counselor development. *Journal of Counseling & Development*, *81*(4), 483–489.

Hanley, T., Cutts, L., Gordon, R., & Scott, A. (2013). A research informed approach to counselling psychology. In G. Davey (Ed). *Applied psychology* (pp. 1–23 supplementary material). London: BPS Wiley Blackwell.

Hanley, T., & Winter, L. (2016). Research and pluralism. In M. Cooper & W. Dryden (Eds). *The handbook of pluralistic counselling and psychotherapy* (pp. 337–349). London: Sage.

Health and Care Professions Council (2015). *Standards of proficiency* – *practitioner psychologists*. London: HCPC.

Kasket, E. (2013). The counselling psychology researcher. In G. Davey (Ed). *Applied psychology* (pp. 1–19 supplementary material). London: BPS Wiley Blackwell.

King, M., Sibbald, B., Ward, E., Bower, P., Lloyd, M., Gabbay, M., & Byford, S. (2000). Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care. *Health Technology Assessment*, *4*, 1–83.

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, *64*(3), 532.

Lucock, M. P., Hall, P., & Noble, R. (2006). A survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. *Clinical Psychology & Psychotherapy*, *13*(2), 123–130.

Meier, S., & Davis, S. (1997). *The elements of counseling*. (2nd edition). Pacific Grove, CA: Brooks/Cole.

Norcross, J. C. (Ed) (2011). *Psychotherapy relationships that work: Evidence-based responsiveness*. (2nd edition). Oxford: Oxford University Press.

Roth, A. & [Fonagy](file:///C%3A%5C%5CUsers%5C%5Cafreitag%5C%5CDesktop%5C%5CTuesday%5C%5C15031-0940%5C%5CFrom%20CE%5C%5C15031-0940-Ref%20Mismatch%20Report.docx%22%20%5Cl%20%22LStERROR_53%22%20%5Co%20%22Goto%20error%20report), P., (2005). *What works for whom? A critical review of psychotherapy research*. (2nd edition). New York: Guilford Press.

Scaife, J. (2010). *Supervising the reflective practitioner: An essential guide to theory and practice*. London: Routledge.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.

[Strawbridge](file:///C%3A%5C%5CUsers%5C%5Cafreitag%5C%5CDesktop%5C%5CTuesday%5C%5C15031-0940%5C%5CFrom%20CE%5C%5C15031-0940-Ref%20Mismatch%20Report.docx%22%20%5Cl%20%22LStERROR_56%22%20%5Co%20%22Goto%20error%20report), S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds). *Handbook of counselling psychology* (3rd edition, pp. 3–22). London: Sage.

Woolfe, W. (2012). Risorgimento: A history of Counselling Psychology in Britain. *Counselling Psychology Review, 27*(4), 72-78