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NECESSITY, NICE IDEA OR NUISSANCE? AN EXPLORATION OF CLINICAL PSYCHOLOGISTS' BELIEFS ABOUT, AND USES OF, DIAGNOSTICALLY DRIVEN NICE GUIDELINES

Section A: What arguments have been made within the UK clinical psychology community regarding the use of functional psychiatric diagnosis by clinical psychologists? A scoping review of the literature.

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Section B: Building on an existing framework of UK clinical psychologists' beliefs about, and uses of NICE guidelines, in adult mental health: A mixed-method investigation.

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Portfolio Summary

Section A is a scoping review, exploring UK clinical psychologists' beliefs about psychiatric diagnosis. Reviewed beliefs are considered in relation to associated leadership documents. Most literature critiqued the practice of diagnosis. However, some clinical psychologists considered diagnosis a helpful practice. This perspective was unrepresented in recent leadership publications. For many, the debate was not binary; empirical literature suggested clinical psychologists had concerns with diagnosis but considered complete withdrawal from diagnostic practices unfeasible. The review suggests that more empirical literature is needed to understand clinical psychologists' beliefs and practices regarding diagnostic practices in routine NHS work.

Section B presents the findings of a mixed-methodological investigation of clinical psychologists' (n = 55) beliefs about, and uses of diagnostically driven NICE guidelines. An integrated thematic map was produced, entitled: *Threat, useful guide and vital manual: the shades of grey within and between clinical psychologists' beliefs about, and uses of, NICE guidelines.* Participants were concerned about the medical-model basis of NICE guidelines and their implementation as 'rules', and managed these concerns in various ways. Some worried the guidelines threatened clinical psychologists' skills and jobs. A minority fully endorsed NICE guidelines. The need for clinical psychologists to feel safe to use their skills transparently is highlighted.

List of Contents

List of Tables

Section B: Empirical Paper

List of Figures

Section A: Literature Review

Section B: Empirical paper

List of Appendices

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Section A: Literature review

What arguments have been made within the UK clinical psychology community regarding the use of functional psychiatric diagnosis by clinical psychologists? A scoping review of the literature

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Abstract

UK clinical psychology leadership, the Division of Clinical Psychology (DCP), has published several documents taking a critical stance on psychiatric diagnosis. This scoping review examines the arguments for and against psychiatric diagnosis published by UK clinical psychologists. The extent to which these views are represented by leadership documents is then considered. A large amount of conceptual literature was found, the majority of which critiquing the practice of diagnosis and its use by clinical psychologists. However, some clinical psychologists considered diagnosis a helpful practice. This perspective was unrepresented in recent leadership publications. Empirical literature investigating this topic was scant. The three studies identified suggested that clinical psychologists had concerns with diagnosis but considered complete withdrawal from diagnostic practices unfeasible. The review considers that arguments by clinical psychologists supporting diagnostic practices might be underrepresented. The review suggests that more empirical literature is needed to understand clinical psychologists' beliefs and practices regarding diagnostic practices in routine NHS work. Doing so could help facilitate inclusive conversation and debate within the DCP and clinical psychology more broadly. It could help to inform DCP-sponsored publications regarding the role of clinical psychology and its relationship with, and uses of, diagnostic practices.

Key words: Psychiatric diagnosis, clinical psychology, medical model, beliefs, NHS

Introduction

Functional Psychiatric Diagnosis

Functional psychiatric diagnosis is a term used to denote mental health problems such as ‘schizophrenia’ ‘depression’ and ‘bipolar disorder’ where no underlying biological cause has been identified (DCP, 2013)[1]. The validity and utility of functional diagnoses is a contentious topic, both in general and within clinical psychology (CP).

Brief History of Psychiatric Taxonomy in UK Mental Health Provision

The formal and systematic recording of psychiatric diagnosis in the UK began in 1949 with the inclusion of ‘mental disorders’ in the sixth edition of the *International Classification of Diseases* (ICD-6) (Katschnig, 2010). Before this, orthodox psychiatry had shaped the development of institutionalised mental health provision in the first half of the 20th century, defined by its classificatory and custodial functions (Burton & Kagan, 2007). The use of classificatory systems for mental distress had, however, been a mainstay of UK mental health practice since the 18th century (Stein & Wilkinson, 2007).

In the 1950s, influential psychiatrists positioned mental suffering akin to physical illness by advancing the notion that mental distress results from brain abnormalities (Burton & Kagan, 2007). ‘Scientific naturalism’ - which Pilgrim (2010) referred to as ‘naïve empiricism’ - is the paradigm through which the study of human sciences was approached at this time. It assumes that mental distress is best understood using methods belonging to the natural sciences. That is, attempting to identify the reliable laws which govern distress (e.g. disease processes in the brain and associated behaviours) and seeking to describe, test and

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[1] Differentially, the dementias and learning disabilities are considered ‘organic’ diagnoses, due to established biological aetiologies (BPS, 2013).

explain them through the (ostensibly objective) scientific method (Aftab, 2016). The legacy of this epistemology is prominent today (Hall et al., 2015).

The ‘medical-model’- an evolved version of earlier disease-based accounts of mental distress - remains the principal conceptualisation of mental distress in western culture and has encompassed the development of associated diagnostic systems (Pilgrim & Rogers, 2009). The medical-model implicates biology, for example faulty neurotransmitter functioning (Kinderman, 2005) as the primary cause of mental distress.

Diagnostic practice is now the foundation of mental health provision and has shaped the beliefs and practices of the socio-cultural systems within which it operates (Randall-James & Coles, 2018). It forms the basis of referrals, assessment, outcome measures, service communication and entitlement to financial benefit (Coles & Pilgrim, 2009). Clinical research is also largely predicated on diagnostic categories, and accordingly, the National Institute for Health and Clinical Excellence (NICE) guidelines for evidence-based practice are founded upon, and organised by, this paradigm (Court, Cooke & Scrivener, 2016).

Development of British Clinical Psychology in Relation to Psychiatric Taxonomy and the Medical-Model

CP is a comparatively new profession in the UK, established in the 1950s alongside the NHS. It was thus heavily shaped by the dominant psychiatric context within which it developed (Hall, 2007a). Invited into the NHS by psychiatry, the original role of CP was to assist psychiatrists with psychometric testing to aid diagnosis (Hall, 2007b). This was mutually beneficial: it enhanced the perceived status of CP as a ‘hard science’ (Pilgrim, 2007) and strengthened psychiatry’s contention that brain abnormalities were causally linked to mental distress (Burton & Kagan, 2007). Thus, the use of diagnosis was originally harnessed by CP - assisted by the influence of Eysenck and the broader psychometric tradition (Hall, 2007a; Hall, 2007b) - at least in part to acquire credibility in institutions where power was held by psychiatry and legitimised by scientific status.

Since the 1950's, CP has continually developed its role in relation to NHS mental health provision (Cheshire & Pilgrim, 2004). The incremental development of therapies (e.g. behavioural and cognitive approaches) enabled CP to carve a principal role of delivering individual therapy in primary care and community settings (Harper, 2010). Increasingly, clinical psychologists (CPs) perform additional roles, including supervisor, teacher, consultant, researcher and manager (Cheshire & Pilgrim, 2004). These developments have been construed in various ways: attempting to gain autonomy from psychiatry's dominance (Hall et al., 2002); joining the perceived dominant narratives of the time, for example, scientific and managerial (Midlands Psychology Group, 2011); and carving a unique identity in services (Llewelyn et al., 2009).

Accompanying these advances, there appears to have been a shift in some CP's beliefs regarding psychiatric diagnosis. Facilitated by a spread of constructivist ideas in the human sciences (Pilgrim, 2010), the notion that human suffering can 1) be helpfully and reliably classified into discrete diagnoses, and 2) is caused by underlying biomedical pathology, has received marked criticism from commentators within and outside the profession (Allsopp, 2017). This apparent shift can be observed in the now common inclusion of the 'reflective-practitioner' (Schon, 1987) and 'critical-practitioner' (Cooke, 2017a) models in CP training programmes, alongside the traditional 'scientist-practitioner' model (Hall & Llewelyn, 2006). Many training courses also emphasise social constructionist ideas (Harper, 2010) and provide critical teaching on diagnosis (Peacock-Brennan et al., 2018; Salkovskis, 2014). Despite these changes, however, CPs still commonly use diagnostic terminology (May, 2007) and, arguably, scientific conservatism remains at the core of CP (Pilgrim, 2010).

It appears, then, that CPs might hold diverse views regarding diagnostic practices and their relationship to them (Cooke et al., 2019). Cheshire and Pilgrim (2004) suggested that internal division might have become more apparent with the increasing segmentation of CP, by dint of its diasporic sectors, specialisms and theoretical orientations. However, the CP's representative body, The Division of Clinical Psychology (DCP) of the British Psychological Society (BPS), has recently published several outward-facing documents presenting an unequivocally critical perspective on diagnosis and its use by CPs (DCP, 2013; Cooke, 2017b; Johnstone & Boyle, 2018).

View from Clinical Psychology's Representative Body

Historically, the DCP has adopted a neutral stance on psychiatric classification (DCP, 2013). However, surrounding the publication of the fifth edition of the *Diagnostic and Statistical Manual* (DSM 5) (American Psychiatric Association, 2013), it issued statements critical of it. In 2011, the DCP stated that diagnostic systems (*ICD* and *DSM*) fail to meet criteria for legitimate medical diagnoses and downplay the relational and social causes of distress. Subsequently, the DCP published a landmark 'position statement' (DCP, 2013), which called for a paradigm shift away from psychiatric diagnosis and the medical-model of distress. An accompanying document (DCP, 2015) offered CPs guidance regarding non-diagnostic ways of working in routine practice.

The 2013 statement listed profound limitations of diagnosis, including: inadequate reliability and validity, undue biological emphasis, decontextualisation from socio-political context, and the stigmatisation, discrimination and disempowerment of service-users. The statement argued that diagnostic classification provides a flawed premise for evidence-based practice, research and intervention guidelines, and could potentially harm service-users. It recommended a revised approach that acknowledges the mounting evidence for psychosocial causes of distress. A manifestation of this view was later embodied in the DCP-sponsored *Power Threat Meaning Framework (*PTMF) (Johnstone & Boyle, 2018)[2]. It called for CPs to renounce medico-diagnostic classification and unduly biological causal accounts of suffering.

The extent to which these DCP-sponsored documents are representative of the wider profession is not known. For example, Paul Salkovskis (2018), Director of the University of Oxford Clinical Psychology training programme, referred to the DCP's (2013) position statement as "professionally divisive" (para. 7) and criticised the *PTMF* for the authors' alleged unsystematic selection of evidence. While much literature has been published regarding the benefits and shortcomings of psychiatric diagnosis (Allsopp, 2017), there is no known review of this issue regarding CP. That is, arguments proposed by CPs about the use of diagnosis by CPs.

Aims of Review

This paper aims to review the theoretical and empirical literature regarding arguments proposed by CPs about the use of psychiatric diagnosis by CPs[3]. The review addresses the following questions:

i) What are the reasons presented by CPs for the use of diagnosis by CPs?

ii) What are the reasons presented by CPs against the use of diagnosis by CPs?

iii) What are the alternatives to diagnosis suggested by CPs?

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[2] The *PTMF* proposed that most forms of mental suffering are normal responses to abnormal situations. It argued that distress can be understood in the context of the social, economic, cultural, political, racial, biological and relational power operations to which, in various forms and fortunes, everyone is subject.

[3] While there are contributions to the diagnosis debate from other perspectives (e.g. psychiatry; Moncrieff, 2013 and sociology; Pickersgill, 2015) it is beyond the scope of this paper to review these.

iv) To what extent do the views of CPs in the literature appear to reflect the position represented in recent DCP-sponsored documents?

Method

The literature was selected and reviewed according to scoping methodology (Grant & Booth, 2009). Scoping reviews identify the size and scope of existing literature in broad topic areas, and identify gaps in knowledge and areas for future research (Munn et al., 2018). They do not aim to provide a critically appraised, synthesised answer to a question. They often produce large volumes of literature (Munn et al., 2018). Consequently, this review aimed to be thorough, not exhaustive. Several publications pertaining to scoping reviews (Grant & Booth, 2009; Levac et al., 2010; Munn et al., 2018; Peters et al., 2015; Tricco et al., 2018) were synthesised to develop the methodology used in the present review.

The following electronic databases were searched: PsychINFO, Medline, Web of Knowledge, ASSIA, PsychSource (BPS), Cochrane Library, Google Scholar and Google. Relevant issues of *The Psychologist* (the BPS magazine sent to all members) and *Clinical Psychology Forum* (CPF, sent to members of the DCP) were also searched manually. Additionally, reference lists of identified papers were searched to identify other relevant material. The ‘find similar’ and ‘find citing articles’ functions on electronic databases were also used (Grant & Booth, 2009).

The search terms used were: “Diagnosis” OR “Psychiatric Disorder” OR “Mental Illness” OR “Psychiatric Illness” OR “Disease” OR “Classification” OR “Medical Model” OR “Medicalisation” OR “Mental Disorder” OR “Psychodiagnosis” OR “Typology” OR “Taxonomy” OR “Abnormal Psychology” OR “DSM” OR “ICD” AND “Clinical Psychologists” OR “Clinical Psychology”.

Due to the vast amount of literature returned in initial searches, searches were limited to literature produced after 2007[4] . Empirical and theoretical literature was included. During the iterative search process (Levac et al., 2010), arguments advocating diagnosis were infrequently identified, and were found largely in less formal publications, such as blog posts and correspondence. These literature forms were therefore included. Literature from non-CP authors and/or samples, and non-UK literature, were excluded. Books were excluded on pragmatic grounds (see appendix A for further methodology details). Where database search results exceeded 300, only the first 300 results were scanned, considering time constraints. No quality assessment framework was employed as is usual in scoping reviews (Grant & Booth, 2009); a tabular results summary is neither required (Peters et al., 2015). Figure 1 portrays a search flow chart according to scoping review reporting criteria (Tricco et al., 2018).

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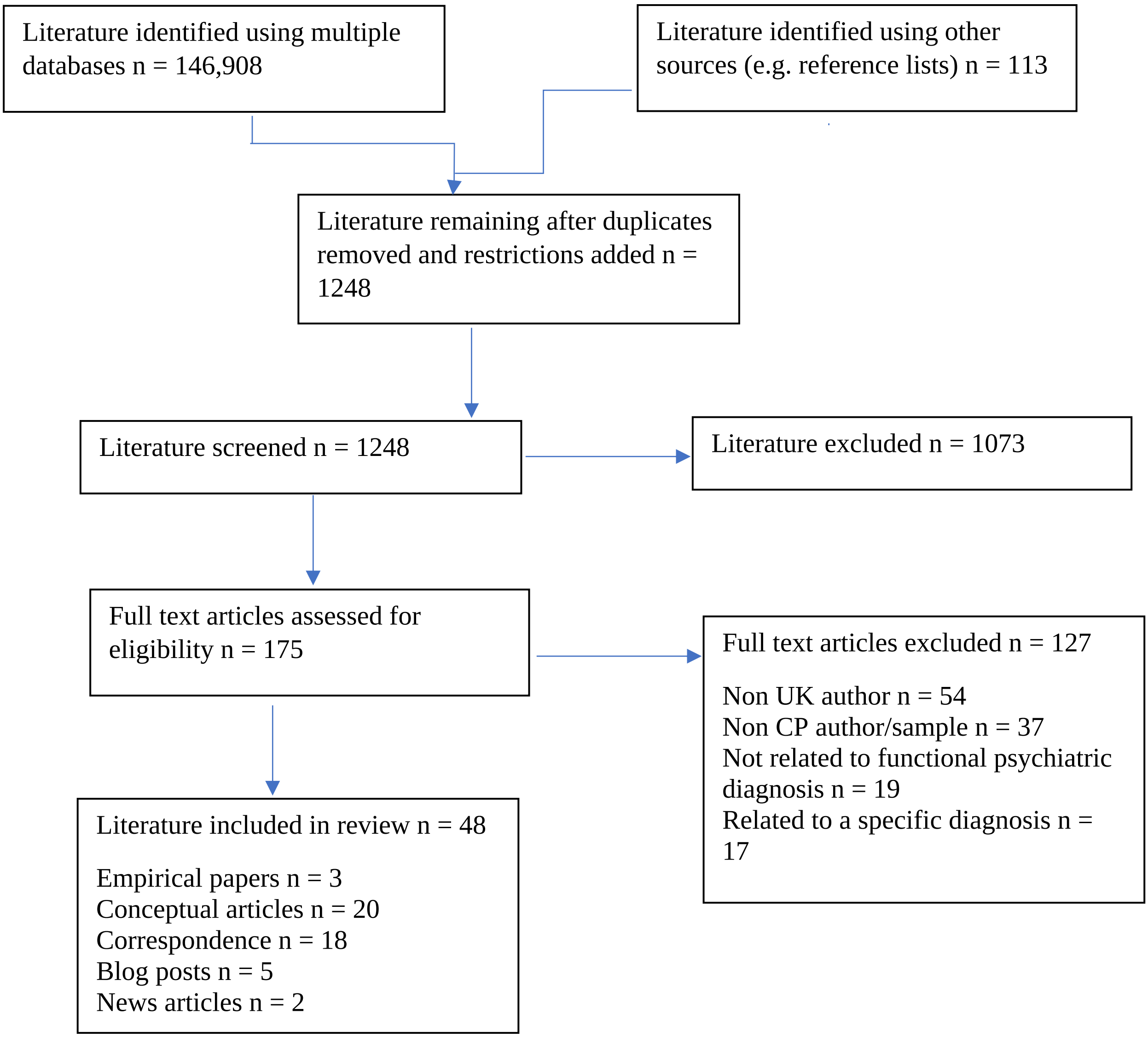
[4] In 2007 the BPS released a ‘Diagnosis Special Issue’ of *The Psychologist,* the first time a BPS publication foregrounded a critical stance on diagnosis. The publication sparked fierce public debate within the profession, clarifying the ambivalence about diagnosis within CP (Pilgrim, 2008)

Figure 1

Search flow diagram based on scoping review reporting criteria (Tricco et al., 2018)



The included literature was read and reread, while recording initial notes and codes pertaining to the research questions. Codes were subsequently grouped together into data-driven conceptual categories (Peters et al., 2015), which were named and renamed throughout.

Results

The search returned only three empirical papers: Court et al. (2016); Randall-James and Coles (2018) and Cooke et al. (2019). For a hotly debated topic (McGowan, 2013; Pilgrim, 2008; Salkovskis, 2018) this was striking, not least because of the pivotal role of CP's relationship to diagnostic practices in defining its purpose and identity (Hall et al., 2015). The review was thus largely comprised of theoretical literature. Forty-five such papers were identified, comprising conceptual articles (n = 20), correspondence (n = 18), blog posts (n = 5) and news articles (n = 2). Some authors authored/co-authored several papers, most notably: David Pilgrim (n = 7), Peter Kinderman (n = 5) and Anne Cooke (n = 4). Some sources referenced arguments both for and against the use of diagnosis. Arguments related to the benefits and costs of diagnostic practices for service-users, the profession, and wider mental health services.

Arguments for the Use of Diagnosis by Clinical Psychologists

Compared to CP perspectives dissenting from the dominant diagnostic paradigm, published arguments favouring diagnosis by CPs were scarce. Thirteen such publications were identified. Five were letters to *The Psychologist*, responding to the 2007 special issue regarding the DCP's 2013 position statement; others comprised blog posts, news articles and *CPF* articles. The three empirical studies also contained explanations for the use of diagnosis by CPs. A summary of reasons presented by CPs for using diagnosis is organised below into eight emergent thematic categories.

Diagnosis as Reflecting the Causal Role Played by Biology in Mental Distress

Whilst no authors advocated that CPs endorse entirely biomedical causal accounts of mental distress, some argued that biological factors are causally linked to distress, thereby justifying diagnosis. One CP (Bell, 2015), writing in *The Psychologist*, reasoned that since it is impossible to separate biology from experience, it necessarily plays a causal role in distress alongside psychosocial factors. Bell further suggested that, because debate regarding the causes of mental distress remains inconclusive, mental suffering cannot be clearly distinguished from physical illness.

Complementing this position, Vesey (2013), in *The Psychologist*, contended that there are an increasing number of conditions believed to have biological underpinnings. Further, responding to critical commentators (e.g. Boyle, 2007b; Johnstone, 2018) who position trauma and social adversity as primary causes of mental distress, Vesey highlighted that distress does not always have a root cause in psycho-social adversity, and psycho-social adversity does not always lead to mental suffering. Vesey concurred with Bamford (2013) - writing in *The Psychologist* - that disregarding diagnosis might be premature because increased evidence for biological understandings of particular conditions is anticipated. Likewise, Watts (2018) suggested that some diagnostic categories (e.g. ‘bipolar disorder’) have convincing neurological underpinnings and should not, therefore, be dismissed. These CPs saw diagnosis, and biological accounts of causality, as compatible with psychosocial accounts of distress.

Diagnosis as a Useful Atheoretical Tool

A second group of arguments acknowledged the lack of evidence for biological causation, but endorsed using diagnostic categories for clinical utility. Brewin (2013), a CP who contributed to the *DSM 5*, acknowledged in *The Psychologist* deficient evidence for biological causation, but noted that disorders are described according to symptomatology rather than supposed biological aetiologies. Accordingly, he argued that diagnoses are separate from explanatory frameworks of distress and cannot, therefore, be criticised on the grounds of biological reductionism. Divorcing the use of diagnosis from biomedical understandings of distress was also emphasised by Bell (2015) and Vesey (2013), who regarded diagnosis as a value-free tool.

Like other CPs (Egan, 2007; Vesey, 2013), Brewin noted the importance of classificatory systems to structure service provision (e.g. treatment, research and evaluation) and communicate ‘case essences’ shorthand, suggesting that diagnostic categories are the best tool in the absence of evidence-based alternatives. In fact, the need for a shared language for clinical, administrative and research tasks was universally accepted by CPs in the reviewed literature, including critical authors (Boyle, 2007a; Cooke et al., 2019).

Responding to some CPs’ suggestion that psychological formulation can supplant diagnosis, Berger (2013) noted that formulation (and the continuum model of distress more generally) does not enable the (pragmatically necessary, in his view) discrete organisation of problems that diagnosis affords. For example, clinical thresholds facilitate control of access to mental health provision, medication and social and financial support. For these CPs, diagnosis is a theoretically neutral pragmatic tool that exists comfortably alongside psychological formulation.

Diagnosis as the Foundation of Psychological Intervention and Research

Responding to *The Psychologist’s* special issue, Scott (2007) argued that diagnoses are essential to the development of evidenced-based knowledge about what works for whom. He noted that efficacious Cognitive Behavioural Therapy (CBT) interventions, as recommended in NICE guidelines, are anchored in their respective diagnoses (e.g. ‘obsessive compulsive disorder’ [OCD], ‘panic disorder’), which suggests that diagnoses represent valid and discrete cognitive processes. Scott questioned the ethicality of CPs use of ‘generic’ CBT, which elevates (allegedly unreliable) case formulation, over evidence-based diagnostically-driven approaches. Because CP funding is contingent on diagnostically-predicated clinical trials and evidence, Scott argued diagnosis is indispensable to the survival of CP. This sentiment was shared by Harpur-Lewis (2014), writing in *CPF*, who contended that diagnosis is crucial to inform CBT intervention and the development and evaluation of specific treatments for specific conditions. She concluded that diagnosis enables service provision enhancement via RCT-driven incremental advances in knowledge.

Congruently, many CPs have been involved in the development of specific psychological therapies for particular diagnostic populations (e.g. Brewin et al., 2010; Tai & Turkington, 2009). For example, Stephen Pilling, as the Director of the National Collaborating Centre for Mental Health (NCCMH) which produces NICE guidelines, has published several papers using diagnostic terminology without commenting on its contentious status (Pilling, 2008). Additionally, the NCCMH (which Pilling directs) requires that research is predicated on diagnostic categories for its inclusion in NICE guidance. Further, Salkovskis (2014) – who has developed specific CBT interventions for specific ‘anxiety disorders’ – asserted that the validity and reliability of discrete anxiety diagnoses is convincing, given the evidence base for associated CBT interventions. Whilst acknowledging that diagnostic categories are imperfect (Salkovskis, 2014), these CPs seemed to agree that (some) diagnoses can helpfully inform the development, research, implementation and evaluation of psychological therapies.

Diagnosis as Pragmatically Necessary in the Current Sociocultural Context

For some CP participants in empirical studies by Court et al. (2016), Randall-James and Coles (2018) and Cooke et al. (2019), diagnosis was viewed as having strategic, rather than intrinsic, value. These CPs acknowledged that the diagnostic paradigm pervades current systems, meaning labels are, therefore, sometimes necessary to enable people to access help. For example, many study participants acknowledged that diagnoses permit services-users’ access to psychological therapies which they might have otherwise been denied. These CPs also highlighted the need to use diagnosis in communication with external agencies to help service-users access benefits or other resources. While these CPs were sceptical of the scientific basis of diagnosis, they viewed the ability to work within the diagnostic paradigm as essential to help service-users within existing systems.

Diagnosis as Validating Service-users' Distress

Harpur-Lewis (2014) reasoned that conceptualising distress as diagnosable illnesses enabled the development of humane treatments in community medical settings, in the 1950s, for people who otherwise would have been consigned to asylums. She suggested that the medical diagnostic paradigm, therefore, enabled people to live meaningful lives. Relatedly, Watts (2018) suggested that less stigmatised diagnoses, such as 'OCD' and 'depression', can validate suffering. Bamford (2013) went further to reject entirely the association between diagnosis and stigma, arguing it is instead the behaviours associated with a diagnosis that stigmatise service-users (e.g. responding to unusual experiences in public). Accordingly, he suggested that stigma is a flawed argument upon which to criticise diagnostic practices. McGowan (2013) noted that illness labels sometimes facilitate compassion and understanding, particularly towards people in the criminal justice system, and enable self-forgiveness. Another CP, privately critical of diagnosis, concluded that if diagnosis is meaningful and validating for service-users, then it should also be considered so by CPs (Tan & McConvey, 2014).

Diagnosis as a Tool to Maintain Multi-Disciplinary Team (MDT) Relationships and CP Status

Some CPs cited in the empirical literature (Court et al., 2016; Randall-James & Coles, 2018; Cooke et al., 2019), who opposed the diagnostic paradigm, supported its expedient use to maintain relationships in MDTs via a shared language. The CP participants in Randall-James and Coles' (2018) study were cautious of openly rejecting diagnosis outright due to concern about causing friction in MDTs, and attracting 'outsider', 'trouble-maker' evaluations by colleagues. Using diagnosis was advocated by the CPs where deemed necessary to 'win people over' and preserve power in services, which they referred to as 'playing the diagnostic game'. This finding was echoed in Cooke et al.'s (2019) study. Pilgrim (2007) observed a similar conflict regarding diagnosis for CPs: wanting professional independence but simultaneously co-opting a medical knowledge base when convenient. Harper (2010) went further to position CP's reluctance to question diagnostic practices a principal reason for its growth.

Reasons Against the Use of Diagnosis by Clinical Psychologists

CP perspectives in the theoretical literature critiquing diagnostic practice were numerous (40 sources). Largely, these CPs were unequivocal in their critical positioning, arguing that the disadvantages of diagnosis far outweighed advantages**.** Most referenced the fundamental incompatibility of diagnosis with psychological, individualised, formulation-driven approaches (Boyle, 2007b; Bentall & Pilgrim, 2013; Coles & Pilgrim, 2011; Cromby, 2015; Hassell, 2013; Johnstone, 2017; Kinderman et al., 2013; Thompson, 2013). The empirical literature suggested that CPs in routine practice had concerns about diagnosis; however, unlike the theoretical literature, these concerns were often more nuanced**.** Arguments against diagnosis made by CPs across the literature were categorised into seven themes, which were demarcated according to the arguments presented in the BPS (2013) position statement.

Diagnosis as a Product of a (Discredited) Philosophical Position

Some CP commentators (Boyle, 2007a; Johnstone, 2017; Pilgrim, 2008) positioned the legacy of ‘scientific naturalism’ as the philosophical basis upon which the ‘fallacy of diagnosis’ still flourishes. Pilgrim (2011) suggested that diagnosis is underpinned by the ontological assumption of ‘medical naturalism’ - that naturally occurring, discrete mental pathologies can be discovered, understood and predicted through impartial empirical research. As the prevailing philosophy in the second half of the 20th century (when CP was establishing itself and fighting for credibility), it enabled the framing of diagnosis as an uncontentious fact, directly reflecting external reality (Pilgrim, 2008).

Pilgrim (2007, 2008, 2015) and Hassall (2007) rejected the very notion of objective science, arguing that scientific research, and past, present and future knowledge, is produced within cultural, societal and political climates of the time, and is necessarily value-laden. They both contended that fact-value separation is therefore impossible, and contested claims by CPs (e.g. Scott, 2007) that diagnoses are neutral artefacts of objective scientific processes. Similarly, McGowan (2013, para. 5) suggested that “sometimes labels tell us as much about ourselves as about the people we apply them to”.

To illustrate partiality in the production of ‘knowledge’, Pilgrim (2008) referenced the editorial policy of the *British Journal of Clinical Psychology*, which at the time disallowed publishing submissions that did not use clinical samples or were not randomised controlled trials (RCTs) or meta-analyses. Together with Boyle (2007a), Pilgrim also argued that since ‘diagnosed’ participants are essential for research publication, CP researchers are incentivised to conduct research premised on (flawed) ontology that psychiatric diagnoses represent a priori existing entities. Pilgrim asserted that privileging methodologies based on the scientific naturalist tradition (e.g. RCTs) further strengthens the diagnostic paradigm by implying that ‘truths’ about diagnoses are being discovered (e.g. patterns of symptomatology and behaviour, responsiveness to psychological therapies).

Pilgrim (2015) suggested that exploration of non-western understandings of mental distress highlights the errors of scientific naturalism. Pilgrim and Coles (2011) highlighted that diagnosis is based on one conception of distress (associated with a western cultural worldview). Hallucinations, for example, are considered extraordinary gifts in some cultures rather than symptomatic of underlying pathology. Parallel frameworks of distress would be unproblematic, and indeed welcomed (e.g. that of the Hearing Voices Movement; Longden & Dillon, 2013), argues Pilgrim and Coles (2011), were it not for the universal imposition of western diagnosis (and its assumptions) as value-free fact, without reflexivity of its epistemological ‘colonialism’.

Accordingly, Pilgrim (2010) and Boyle (2007a) argued that diagnosis was enabled, and is continually legitimised, by the ontic and epistemic fallacies of scientific naturalism when applied to human sciences. The ontic fallacy entails overlooking cognitive and social mechanisms by which knowledge is produced from preceding knowledge, while the epistemic fallacy is mistaking reality for what we call it. Pilgrim and Coles (2011) argued that CPs need to challenge western assumptions for CP to earn the scientific legitimacy and autonomy it seeks.

Pilgrim (2008) supposed that, because CPs work within systems that privilege the positivistic scientific paradigm, some CPs have wedded themselves to diagnosis and the discovery of diagnosis-specific evidence-based treatments (via RCTs) because doing so legitimises the profession.

Diagnosis as Bad Science

Several CPs (Bentall, 2007; Boyle, 2007a; Kinderman et al.; 2012; McGowan, 2013; Mollon, 2009) highlighted that heterogeneity within, and overlap between, diagnoses is so pronounced that allocation is almost arbitrary (e.g. between ‘anxiety’ and ‘depression’, and between ‘schizophrenia’, ‘schizoaffective disorder’ and ‘bipolar disorder’). Allsopp et al.’s (2018) study found evidence for this assertion in an empirical analysis of the DSM 5. The authors noted that without biomarkers, diagnosis relies on clinician interpretation of patient observation and self-report, leading to poor reliability. While the reliability of diagnosis has improved with successive versions of the DSM, Kinderman et al. (2013) and Rowe (2010) highlighted reliability is not sufficient for validity. Clinicians can agree on a label without that label corresponding to a ‘disorder’ or predicting the effectiveness of specific treatments.

The weak empirical and predictive validity of diagnosis was addressed by virtually all reviewed papers critiquing it (Boyle, 2007a; Coles et al., 2009; Hassall, 2013; Kinderman et al., 2013; Joffe, 2007; Johnstone, 2018; Pilgrim, 2015; Rowe, 2010; Soffe-Caswell, 2007). Thompson (2013), in a letter to *The Psychologist*, highlighted what he considered the paradox of CP colluding with diagnostic practice to gain scientific legitimacy, despite diagnosis being a manifestation of systematic failure to follow the scientific method. Several CP commentators (Bentall, 2007; Boyle, 2007a; Joffe, 2007; Kinderman et al., 2013) noted that, after years of biogenetic research attempting to evidence a biological basis of mental distress, no evidence has been found. Boyle (2007a) and Bentall (2007) argued that diagnostic practice has failed to: observe patterns of behaviour predicted by its underlying model, predict the course of a diagnosis, and indicate beneficial treatment and responses. Because of this, Joffe (2013) likened the *DSM* to ‘maps of wonderland’. Kinderman et al. (2013) and Pemberton and Wainwright (2014) argued that the validity problem has meant diagnosis has hampered research into causes of mental distress, because it is impossible to find causes of invalid constructs.

Pilgrim and Coles (2011) suggested that weak reliability and validity of diagnostic practice is foregrounded in the discriminatory way that certain diagnoses are applied to people from particular demographic groups. For example, black people are more likely to receive ‘schizophrenia’ diagnoses compared to their white counterparts, even in the absence of other differences. The authors invited CPs to consider the ethicality of their practice whilst failing to challenge diagnosis - a concept that, once interrogated, they argued fails to meet basic scientific criteria.

Because diagnoses do not demonstrably correspond to discrete physical pathologies, Allsopp et al. (2018) contended that mental health diagnoses cannot be considered explanatory in the way physical health diagnoses are. For example, in the latter field, a diagnosis of Type 1 diabetes explains the death of someone failing to receive an insulin injection (Pilgrim, 2015). Congruently, Pilgrim (2008) added that diagnoses do not add new explanatory knowledge to ordinary language descriptions of distress (e.g. madness, sadness and fear). Rather, he argues, diagnosis merely serves to (unnecessarily) medicalise understandable behaviour and mask the psychosocial context in which it manifests. These criticisms point to the circular logic on which diagnosis relies[5] (Rowe, 2010). Pilgrim and Coles (2011) concluded that, if CP aspires to be a reputable, scientific discipline, it can no longer partake in psychiatric diagnosis.

Diagnosis as Biological Reductionism

Considering the alleged problems with the scientific integrity of diagnosis, many CPs have argued that the implication of a biological cause by diagnostic labels is misleading and therefore unethical. As Boyle (2007a) and Coles and Pilgrim (2011) noted, psychiatric diagnosis is an attempt to apply a system intended to classify bodily dysfunction to people’s experiences. This conceptualisation is problematic, argued Roberts (2013), given what he considered grave methodological problems in biogenetic research, such as faulty interpretation of twin studies (e.g. underestimating the role of shared environment in MZ

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[5] E.g. Why do people hear voices? Because they have schizophrenia. How do you know someone has schizophrenia? Because they hear voices.

twins). Roberts contended that recent ‘breakthroughs’ in genetic research have explained between just 1 and 2 percent of variance in people diagnosed with ‘bipolar disorder’, ‘schizophrenia’ and ‘major depression’, which, in conjunction with result inflation due to diagnostic overlap, likely amount to zero clinical significance. Soffe-Casswell (2013) suggested that undue focus on biogenetic research leads to other research being ignored, for example, research demonstrating that the brain responds and develops according to the environment to which it is subjected.

Responding to the contention that some critical CPs unduly deny the role of biology in mental distress (e.g. Vesey, 2013), Pemberton (2013) and Boyle (2013) argued that they rather seek to redress the balance between the role of biology and that of psychosocial context. These CPs suggested that trauma and social factors have long been obscured by biology (which, they acknowledged, enables and mediates all human behaviour). Johnstone (2007) and Pemberton (2013) suggested that looking to biology for primary causes of distress is a farcical endeavour, akin to investigating biogenetic causes of bereavement.

While some CPs (Brewin, 2013; Vesey, 2013) suggested that diagnosis is atheoretical and therefore divorced from biogenetic conceptualisations of mental distress, Hassall (2013) argued that the term ‘diagnosis’ sits within medical vernacular and cannot, therefore, be disentangled from its conceptualisation as an illness with biogenetic aetiology. Hassall highlighted that, in the *ICD 10*, the classification of mental disorders occupies one chapter among other taxonomies of physical diseases, clearly positioning the former as a subset of the latter.

Diagnosis as Ignoring Trauma and Socio-Political Causes of Suffering

Some CPs (Bentall, 2016; Coles et al. 2009; May 2007) argued that diagnosis detracts from the causal role of trauma and socio-political factors in mental suffering, and exhort CPs to abandon it. Coles et al. (2009) suggested that mental health services and the pervading diagnostic discourse perform ‘conjuring tricks’ which make service-users’ contexts disappear. For example, the framing of externally caused damage of sexual abuse as an internalised, naturally occurring illness (e.g. schizophrenia). McGowan and Cooke (2013) referred to this phenomenon as the ‘myopic’ consequences of diagnosis. This notion was echoed by CP participants in Cooke et al.’s (2019) empirical study, who criticised diagnosis’ focus on putative individual deficits rather than people’s context. These CPs considered that colluding with this obscuration of context is incongruent with the scientific and the ethical foundations of CP.

Pilgrim (2008) suggested that CP has traditionally located problems within individuals to justify the provision of therapy. Because of this, Coles et al. (2009), Mollon (2009) and Pilgrim (2008) argued that CP is unavoidably complicit in the obscuration process (with Coles et al. referencing CP as ‘the magician’s assistant’). For example, Coles et al. noted that diagnosis-driven CBT interventions (the dominant therapy recommended by NICE) minimises biographical and social context through a focus on the ‘here and now’ and individuals’ ‘maladaptive’ cognitions. Toates (2007) suggested that CP voices have too long been ‘feeble’ in asserting that inequality, alienation and poverty have toxic effects on mental health, and Coles and Pilgrim (2011) implored CPs to step outside the therapy room paradigm (which he called a ‘vanishing apparatus’). Bentall (2016), Boyle (2007a), Kinderman et al. (2013) and Pemberton and Wainwright (2014) concluded that CPs are complicit in practices which disguise the fundamental causes of distress, thus impeding prevention and maintaining suffering.

Diagnosis as Stigmatising and Disempowering Service-Users

May (2007) argued that the only valid assessment of diagnosis is how it is received by, and impacts, those diagnosed. Even when taken as an atheoretical tool, some CPs questioned the extent to which service-users can make informed choices about the meaning attributed to their diagnosis, given medical, illness-based narratives occupy the discursive space (Bentall, 2007; Watts, 2018). Thus, regardless of whether individuals value their diagnosis, one view is that it is inherently disempowering due to the restriction of individual choice and thought by the power of diagnostic discourse.

May (2007) and Rowe (2010) suggested that the power of diagnostic practice facilitates the ‘alienation’ and ‘disappearance’ (respectively) of service-users. May (2007), for example, suggested that spiritual experiences described in diagnostic terminology (e.g. as delusions) can be experienced as undermining. Boyle (2007a) argued that diagnosis privileges experience form (e.g. hearing voices) over content (e.g. voice characteristics), which prevents service-users from sharing rich, contextual accounts of their difficulties. The determinism of diagnosis led McGowan (2013) to surmise that diagnosis might hamper an individual’s belief in their own resources to change.

Allsopp et al. (2019) suggested that an inevitable product of systematic disempowerment is stigma. Watts (2018) proposed that stigma attaches itself disproportionately to ‘personality disorder’ and ‘schizophrenia’ diagnoses, likening the application of these labels to “structural violence” (para. 8). The sentiment was shared by Salkovskis (2014), who argued there exist vast differences in therapeutic benefit between being diagnosed with an ‘anxiety disorder’ and a ‘personality disorder’. Johnstone (2018) contended that the damage incurred through prejudice can render stigmatised diagnoses life-destroying.

May (2007) suggested that the neglect of service-user expertise is complicit in the disempowering and stigmatizing process. Relatedly, Court et al.'s (2016) empirical study suggested that CPs were concerned that delivering CBT interventions stipulated by diagnostic based NICE guidance can harm service-users due to reduced scope for collaborative intervention.

Diagnosis as a Threat to the Profession of Clinical Psychology

While 'colluding' with diagnosis has been construed as the key to legitimacy for CP (Johnstone, 2017), many CP commentators asserted that diagnostic practice is fundamentally incompatible with the role, identity and philosophy of the profession. Harper (2010), Johnstone (2017) and Pilgrim (2008) argued that CP cannot be psychological and formulation-driven (i.e. exploring meaning in distress through contextually situating behaviour, biographically and socially) and simultaneously collude with diagnostic practice; the approaches are ideologically and ethically irreconcilable. Relatedly, Mollon (2009) argued that diagnostically-driven practices impede CPs' innovation and thought. Many commentators (Harper, 2010; Pilgrim, 2010; Soffe-Caswell, 2014; Toates, 2007) viewed CPs' co-opting of diagnostic practices as a quest for status and privilege at the expense of the profession's integrity. For example, Thompson (2013) contended that because diagnosis is not a 'real' science, CP collusion undermines the core claim of CPs as 'scientist-practitioners'.

Many authors in the theoretical literature saw colleagues' 'playing of the diagnostic game' (Randall-James & Coles, 2018) as evidence of status being prioritised over integrity and identity (Boyle, 2007b; Coles, et al., 2009; Pilgrim, 2008; Soffe-Caswell, 2007). Soffe-Caswell (2007) and Coles et al. (2009) suggested that the increasingly business-driven paradigm of mental health services has penetrated CP to the extent that self-interest in a competitive market outweighs CPs stakes in social justice and intellectual integrity. Thus, CPs collusion with diagnosis has been understood as a survival mechanism, but one that comes at ideological and ethical cost (Pilgrim, 2007). Pilgrim (2007) suggested that the more diagnosis is used by CPs in MDTs, the more credibility diagnosis accrues; CPs gather relational currency as they lose their professional core. These CPs called for CPs to end complicity in diagnostic practices.

The empirical papers, however, suggested that the negotiation of CPs' identity in relation to diagnosis is, in practice, more complicated. Participants in Court et al.'s (2016) study believed that diagnostically-driven NICE guidelines threatened the profession, due to the perceived devaluing of their 'level 3 skills' (Mowbray, 1989). Mowbray considered these the ability to integrate diverse psychological theories to deliver interventions according to idiosyncratic service-user need. Court et al.'s (2016) participants worried that the devaluing of these skills entailed the replacement of CP with posts for cheaper therapists trained in unimodal, diagnosis-driven, NICE-recommended therapies. However, because CPs experienced pressure to be seen by teams and management to employ diagnostically-driven approaches, they sometimes did so to protect their reputation, and therefore profession. For these CPs, diagnosis was both a threat and a lifeline. A similar picture emerged from Randall-James and Coles' (2018) study: the CP participants construed diagnosis as incompatible with their CP role, yet regarded their complete withdrawal from diagnostic practices unfeasible while working within NHS teams and systems.

Diagnosis as Only One Way of Many to Understand and Record Distress

Pertaining to the third research question, CPs suggested several alternatives to diagnostic practice. While many CPs noted the role of diagnosis in providing a shared language, Johnstone (2017) and Coles and Pilgrim (2011) argued that context-specific psychological formulation can perform this function while restoring the ‘meaning in madness’. To engender a shared culture of psychosocial thinking, Johnstone noted that formulation can be undertaken by teams, and ‘case formulations’ are increasingly mandated on electronic record keeping systems.

Responding to CPs who have suggested that formulation is hindered by administrative systems requiring diagnostic codes, Cooke and Kinderman (2017), Kinderman and Allsopp (2017) and Allsopp and Kinderman (2018) have encouraged clinicians to use newly available psychosocial and phenomenological codes in ICD 11, instead of diagnostic codes. These codes enable the quantitative recording of psychosocial adversities (e.g. low income, childhood sex abuse) and associated phenomenological difficulties (e.g. anger, low mood), and allow the national data capture of these links. This means a person’s specific difficulties (e.g. hearing voices or intrusive thoughts) can be recorded without imposing a medical diagnosis, while providing communicative ease through short-hand shared language.

Summary

CPs presented various reasons for and against the use of diagnosis by CPs. Literature outlining arguments against the use of diagnosis by CPs was significantly more abundant than CPs’ perspectives in favour. Some CPs’ viewpoints were situated unequivocally on one side of the debate (largely CP commentators in conceptual or opinion pieces), while other CPs’ perspectives straddled both positions (largely practising CPs in empirical studies). For example, some CPs suggested that diagnostic practices invariably harm (Coles et al., 2009), or benefit (Scott, 2007), service-users, while others reasoned that the value of diagnosis is context dependent (Court et al. 2016; McGowan, 2013; Watts, 2018). CPs who understood diagnosis as an atheoretical classificatory tool were more approving of the practice compared to CPs who considered diagnosis inseparable from medicalised conceptualisations of distress.

All CPs valued psychological formulation but differed in the extent to which they construed this compatible with diagnostic approaches. Some saw diagnosis and formulation as evidentially inseparable (Harpur-Lewis, 2014; Scott, 2007), while most CPs saw them as fundamentally irreconcilable, understanding collusion with diagnosis as threatening CP (Johnstone, 2017). Divergence here, to some extent, corresponded to the differing philosophical starting points taken by CPs. A small minority of CPs appeared to accept the ontological a priori assumption of the existence of diagnoses, and subsequent epistemological endeavours to ‘discover’ the laws by which diagnoses are governed. Most CPs, however, adopted a questioning approach aligned with critical realist and/or constructionist philosophies. Accordingly, CPs also held different viewpoints regarding the relationship between CPs’ involvement with diagnosis on the one hand, and CP status and credibility on the other. Some CPs suggested that association with diagnosis historically and presently assists CP to harness power within services and teams due to its perceived status as a ‘hard science’. Other CPs suggested that the perpetual failure of CP to abandon collusion with diagnosis has undermined the autonomy, and scientific and ethical legitimacy of CP. CPs in the empirical literature drew on both arguments.

The CPs advocating diagnosis fell into two broad groups. The first argued that diagnosis is a valid and useful practice. The second acknowledged its invalidity but advocated its strategic use to achieve outcomes for service users and/or CP, given the current context. Overall, the literature suggests that CPs hold various perspectives towards diagnostic practice (although critical voices were more prevalent). Smail’s (1995) observation appears to remain applicable to CP today: “What CP has not done...is develop a consistent theoretical position of its own, i.e. one which accurately reflects its practice” (p.3). This prompts the question of how a divided profession can address this task.

Discussion

The Relationship Between the Views Expressed by CPs and Those of the Profession's Representative Body (DCP)

The DCP's position statement and subsequent publications (e.g. the *PTMF*) comprehensively capture CPs' arguments against diagnostic practices in the reviewed literature. This is unsurprising, since several critical CP commentators referenced herein contributed to these DCP documents. In fact, most CP commentators who affirmatively opposed the use of diagnosis were contributors; CPs who were equivocal in their positioning, or advocated diagnosis, were not. Accordingly, documents published by the DCP could be said to represent the views of a powerful grouping of critical CPs, rather than those of the wider profession (Salkovskis, 2014). However, while the position statement and *PTMF* publicly affirmed the need to move beyond a 'disease' model, they did not suggest that CPs should end involvement with diagnostic practices entirely, despite the call for this in some literature reviewed (written by some of the same CPs). This might represent a BPS effort to ensure their documents are (relatively) representative. Indeed, Bamford (2013) and Pemberton (2013) concurred that the (2013) position statement is far more balanced than reported in the media.

Importantly, the CPs who offered critical perspectives in the literature reviewed, as well as in DCP publications, largely occupied senior clinical (e.g. consultant CP) or academic posts. CPs who were ambivalent in their positioning were largely CPs in routine practice. This suggests that senior clinical and academic posts might enable more forthright, unequivocal takes on diagnosis (both for and against). This could be because (due to reduced clinical contact and extant seniority) these positions entail scarcer negotiation of issues which led CPs in routine practice to express mixed feelings about diagnosis (e.g. recognising problems but needing to draw on diagnostic discourse within MDTs, for example to secure therapy for service-users).

The DCP published an accompanying inward facing document (DCP, 2015), which suggested alternative language CPs could use to describe experiences and difficulties typically referred to diagnostically (e.g. attachment difficulties instead of 'personality disorder'). It did not feature guidance, however, regarding the negotiation of: working within diagnostically-driven NICE guidelines, communication ease in MDTs, and the impact of affirmatively rejecting diagnosis on CPs' relationships with other MDT members (e.g. Salkovskis, 2014). The DCP documents, then, do not adequately reference the empirically indicated need in the current system for CPs to use diagnostic language in particular contexts to secure favourable outcomes for service-users and CP (Cooke et al., 2019; Court et al., 2016; Randall-James & Coles, 2018;). Neither do DCP documents represent the perspective that binary viewpoints about diagnosis (e.g. entirely good or entirely bad) are problematic, since many CPs consider the value of diagnosis dependent on service-user preference, context, and the specific diagnosis received (Watts, 2018).

More apparent is the irreconcilability of the DCP documents with the views of CP commentators (Bell, 2015; Brewin, 2013; Egan, 2007; Harpur-Lewis, 2014; Scott, 2007; Vesey, 2013) who appeared largely satisfied with a diagnostic approach. If the reasons presented by CPs favouring diagnostic practices are representative of many CPs (which, empirically, is yet to be studied), the DCP faces a question: does it accept the apparent diverse perspectives as equally valid, and if so, how does it represent these perspectives? This would presumably entail accommodating difference within DCP publications or facilitating constructive debate to achieve agreement on compromise statements.

Limitations

There were several published critiques of diagnosis and little published literature in support. It would be premature to assume this represents the distribution of views among the profession. This review was limited by scant empirical research (three studies) into CPs' perspectives regarding diagnostic practices working in routine practice. The review largely comprised conceptual literature, which is more likely to feature perspectives dissenting from the dominant paradigm (diagnosis) than perspectives that acquiesce. Further, some CPs critical of diagnosis authored several of the included papers (e.g. Pilgrim). It is possible, then, that CP perspectives advocating diagnosis are underrepresented in the literature. Most literature was written by senior and academic CPs. For reasons previously hypothesised, these may not be representative of the view spectrum within the profession. These limitations were, however, largely anticipated and a principal reason for using scoping methodology: to provide an overview of the literature and identify gaps, rather than arrive at a definitive conclusion.

The three reviewed empirical papers also had limitations. Court et al. (2016) and Cooke et al. (2019) employed small samples of CPs (11 and 19, respectively) and may have been unrepresentative. While Randall-James and Coles (2018) garnered 305 responses to their online survey (76% of which were from CPs), the research assumed that CPs were 'questioning diagnosis in clinical practice'. This means it is likely that self-selecting bias was operative in recruitment, such that critics of diagnosis might have been more likely to respond. Similarly, Cooke et al. (2019) stipulated 'critical of the medical-model' in their inclusion criteria for CP recruitment. Therefore, empirical evidence pertaining to CPs' beliefs about diagnosis is likely based on unrepresentative samples.

This review also had methodological limitations. Due to a large volume of literature returned in searches, and the various search engines used, limits were imposed (see Appendix A). The exclusion of relevant literature in this review is, therefore, likely. Further, an assessment of bias in the evidence was not systematically performed. However, the author actively sought literature representing various perspectives to minimise bias in data selection.

Overall, the literature suggests that there are diverse perspectives among CP in relation to diagnosis: we know some CPs are wholly against it, some wholly in favour, some ambivalent, and some are resolutely critical but prepared to ‘play the diagnostic game’ in particular circumstances. What the literature does not tell us is the distribution pattern of these beliefs among the wider profession. We are only just starting to learn how difficulties relating to diagnostic practices are negotiated in routine practice, and two of the three extant studies on this topic only investigated CPs who identified as critical of it. (Cooke et al., 2019; Randall-James & Coles, 2018). More empirical research is needed with a representative sample of CPs to understand the spectrum of beliefs about, and use of, psychiatric diagnosis among UK CPs.

Avenues for Future Research

Empirical research investigating the beliefs and actions of CPs relating to diagnostic practices is scant. The existing empirical data suggests that, compared to the polarised CP perspectives portrayed in conceptual literature, CPs in routine practice might hold varied beliefs and use diagnostic practices in various ways, the latter not always being consonant with their underlying views.

One reason for this, indicated in the literature, might be the rise of the critical psychology movement alongside the increasingly intertwined relationship between diagnosis and psychological therapy provision (e.g. NICE guidelines). This is likely a contradiction that CPs in routine practice negotiate more frequently than their senior or academic peers. In Court et al.’s (2016) small-scale study, the 11 CPs considered NICE guidelines simultaneously beneficial (e.g. allowing people diagnosed with ‘schizophrenia’ to access psychological therapy) and fraught with dangers (e.g. the possibility of harm both to service-users and CP). Accordingly, the CPs had a flexible relationship with NICE guidelines, reporting using them selectively when they judged it was in service-users' interests and protective of CP.

Interestingly, NICE acknowledges limitations of its diagnostic approach: "the most significant limitation is with the concept of depression itself…it is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment plans" (NICE, 2007, p.10). However, NICE continues to publish, and monitor the uptake of, evidence-based recommendations for psychological therapy predicated on diagnostic categories. Additionally, cheaper therapist posts (e.g. Psychological Wellbeing Practitioners and CBT therapists) are increasingly being commissioned to deliver protocol-driven therapies as per NICE guidance (Llewelyn & Aafje-van Doorn, 2017). These factors raise questions regarding the role and identity of CP relating to the evidence-base, diagnosis and therapy provision in services – contentions that have plagued the profession for much of its history (Pilgrim, 2010).

Future research could helpfully explore CPs' beliefs and actions regarding the diagnostically-driven guidelines among a larger sample of CPs in routine practice. Doing so would address some limitations of the present review, and anchor the diagnosis debate in core CP roles: the development, provision, communication and evaluation of psychological therapy; and encouraging psychological thinking within teams, services and systems.

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Section B: Empirical paper

Building on an existing framework of UK clinical psychologists' beliefs about, and uses of NICE guidelines, in adult mental health: A mixed-method investigation

Word count: 7927 (229)

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

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Abstract

Recent small-scale empirical research suggested clinical psychologists (CPs) have concerns about NICE guidelines and use them flexibly in their practice (Court et al., 2016). The present investigation used mixed methodology to explore beliefs about, and uses of, NICE guidelines using a larger sample of CPs. Fifty-five adult mental health CPs completed an online survey. A thematic map was produced, comprising integrated quantitative and qualitative findings. The map was entitled: *Threat, useful guide and vital manual: the shades of grey within and between CPs' beliefs about, and uses of, NICE guidelines.* Participants were concerned about the medical-model basis and scientific integrity of NICE guidelines, and the implementation of guidance as 'rules'. Participants sometimes experienced pressure to report formulation-driven, integrative practice as unimodal and NICE-backed. Some participants worried NICE guidelines restricted CPs' specialist skills and identity, and that clinical psychology jobs were being replaced with NICE-sanctioned unimodal therapy posts. A minority fully endorsed NICE guidelines and believed CPs should feel pressure to use them. Findings provided support for, and developed, Court et al.'s framework of CPs' guideline use. The study highlights the need for CPs to feel able to use their specialist skills transparently, and considers avenues for action and future research.

Key words: NICE guidelines, clinical psychologists, beliefs, mental health, diagnosis.

Introduction

The National Institute for Health and Care Excellence (NICE) opened in 1999 to develop independent, evidenced-based guidance for UK NHS health professionals. The guidance intends to help practitioners deliver the most effective interventions and reduce inequality in clinical practice (Department of Health [DH], 1998). However, evidence suggests that guideline adherence is low (Michie et al., 2007). Guidelines pertaining to psychological intervention are large and increasing, and service adherence is growingly monitored (NICE, 2017).

Clinical psychologists (CPs) arguably contribute significantly to how NICE guidance is used in services, considering their roles in delivering therapy, disseminating research and contributing to service design (British Psychological Society [BPS], 2007). Accounts of prominent CPs suggest that there are mixed views about NICE guidelines among the profession (Clark, 2011; Mollon, 2009; Pilling, 2008). However, empirical understanding of CPs' beliefs about, and uses of, NICE guidelines is in its infancy. The first of its kind, a recent small-scale study suggested that CPs have concerns about NICE guidelines and use them flexibly in their NHS clinical practice (Court et al., 2016). Court et al.'s theory of guideline usage, grounded in the experiences of 11 CPs, supported a mounting body of theoretical literature highlighting a tension between the assumptions and implementation of NICE guidelines, and the philosophy and practice of clinical psychology (CP) (Cromby et al., 2013; Johnstone & Boyle, 2018; Midlands Psychology Group, 2010; Nel, 2011; Smail, 2006).

The Nature of Distress

One tension raised by CPs relates to the nature of distress on which NICE guidance is based. NICE guidelines are driven and organised by diagnostic categories[6], and appear to assume their validity (Johnstone & Boyle, 2018). Diagnosis has been positioned as reliant on a ‘medical-model’ of distress, a model that pervades political, societal and service-level structures (Pilgrim & Coles, 2011; Randall-James & Coles, 2018) within western societies (Mills & Fernando, 2014). Kinderman (2005) argued that this model presents mental health problems as predominantly biomedical conditions caused by brain dysfunctions. Many CPs (Boyle, 2007; Pilgrim & Coles, 2011; Thompson, 2013; Toates, 2007) suggested that this view of distress is incompatible with psychosocial, trauma-informed conceptualisations. Writing about NICE guidelines, Mollon (2009) argued that therapeutic intervention should not be predicated on ‘symptoms’ listed in diagnostic manuals, but on the often-complex suffering underlying them. By partaking in diagnostically informed guidance, Smail (2006) suggested CPs were “selling [their] souls”.

However, other CPs see benefits to diagnosis. Brewin (2013), for example, argued diagnosis is a pragmatic tool to reliably organise mental distress and need not involve aetiological claims. Likewise, Scott (2007) contended that because evidence-based psychological therapies are diagnosis specific, diagnoses must be valid constructs.

Despite this apparent diversity within CP, the Division of Clinical Psychology (DCP) of the BPS has been critical of diagnosis, stating that its use is not consistent with the practice and philosophy of CP (DCP, 2011; DCP, 2013). The DCP-sponsored *Power Threat Meaning Framework* (PTMF) (Johnstone & Boyle, 2018) proposed psychosocial alternatives to diagnostic practices, including NICE guidelines. While it was welcomed by many CPs

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[6] Diagnosis refers to functional psychiatric diagnosis (DCP, 2013) and excludes diagnoses with established organic origins (e.g. the dementias)

(Aherene et al., 2019; Griffiths, 2019), the framework was criticised by others (Salkovskis, 2018).

The Nature of Therapy

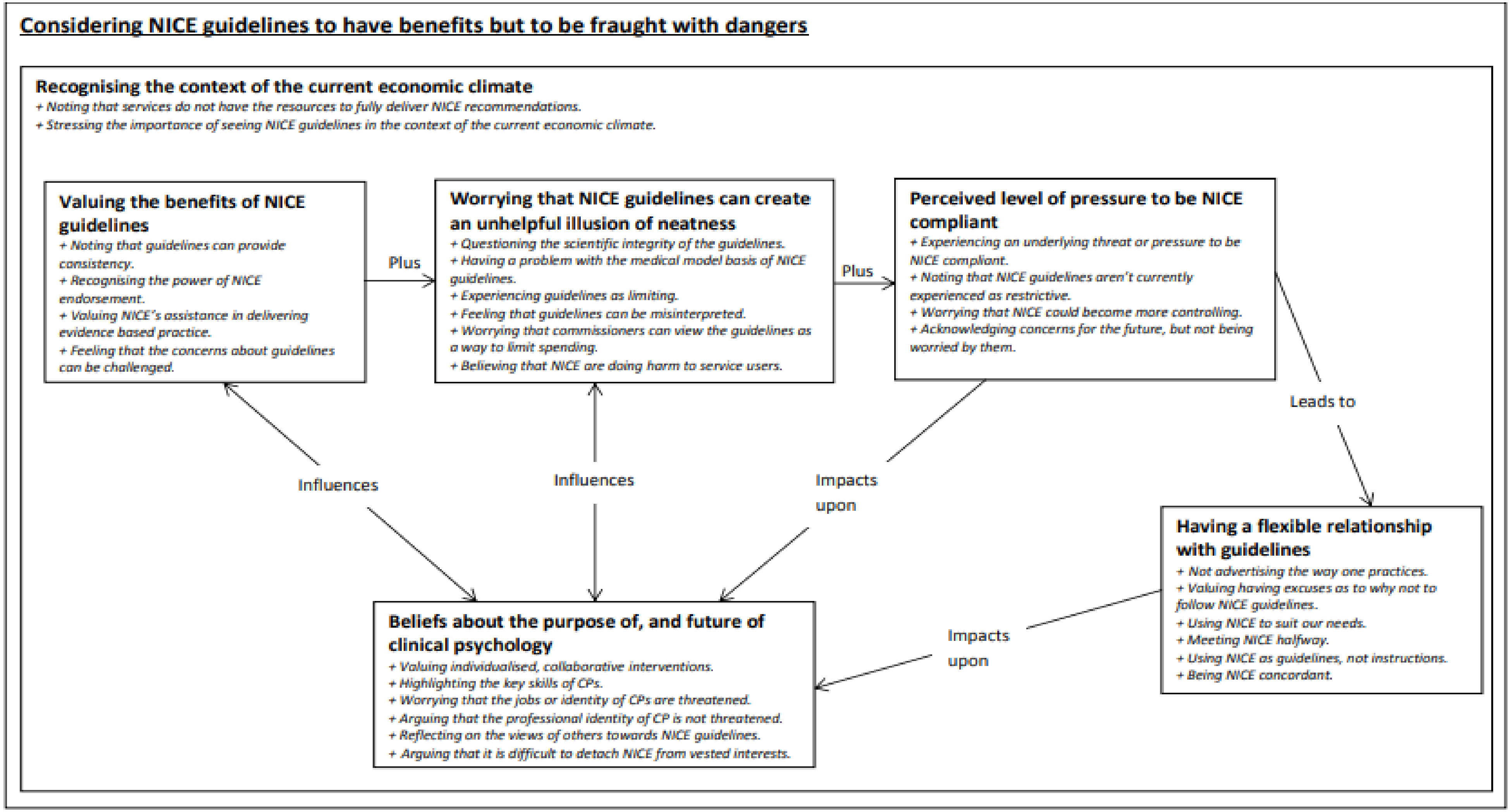
Psychiatric diagnosis has informed the development, research and delivery of psychological therapies (Cromby et al., 2013). Accordingly, a further tension for some CPs is the representation of, and assumptions underpinning, the nature of therapy in NICE guidance (Mollon, 2009). NICE guidelines rely heavily on evidence from Randomised Controlled Trials (RCTs), which it considers the ‘gold standard’ of research (NICE, 2018). Pilgrim (2010) proposed that RCT methodology is rooted in the positivist epistemology of ‘scientific naturalism’ – which seeks to uncover impartial, reliable truths - which he considered a flawed framework through which to study complex and subjective human experience. Guy et al. (2012) argued that RCT use has led to the prioritisation of unimodal therapies as ‘simple systems’ that can be standardised and uniformly operationalised for each ‘disorder’. The authors argued that this obscures the impact of therapist and service-user variation. This approach is also juxtaposed with the nature of therapy outlined in the Leeds Clearing House (2019, “General description of the job”) trainee CP job description, which states “individualised formulation-driven psychological interventions” should be “informed by a broad range of potentially conflicting clinical, theoretical and conceptual models; the empirical, experimental and clinical literature base and the results of assessment”. Mowbray (1989) defined these abilities as ‘level-3 skills’. Highlighting the limits of ‘level-2 skills’ - the manualised delivery of unimodal therapies - authors proposed therapy is inherently unpredictable (Bohart & House, 2008), requiring a “disciplined, improvisational artist, not a manual driven technician” (Bohart et al., 1998, p. 145). Prescribed therapies have also been considered at odds with service-user collaboration and empowerment (Court et al., 2016), for example, service-users’ right to make informed choices about their treatment (World Health Organisation, 2010). However, many CPs have contributed to the production of NICE guidelines (Clark, 2011; Pilling, 2008), suggesting they might endorse the paradigm of therapy represented in the guidance.

Empirical Research

The interrelated concerns regarding the nature of distress and therapy for CPs were evidenced empirically in Court et al.’s study (see Figure 1 for diagrammatic depiction of grounded theory). The 11 CPs interviewed saw several benefits of NICE guidelines but considered them ‘fraught with dangers’ that could harm service-users. They felt that NICE guidelines created an unhelpful illusion of neatness and ignored the complexity of clinical practice. The CPs questioned their medical-model basis and their prioritisation of RCTs. CPs worried that pressure to adhere to the guidelines would increase. Given these interacting concerns, CPs used the guidelines flexibly in their practice. For example, some drew selectively on the guidelines to help service-users access psychological therapy. Others continued to use their specialist level-3 skills but reported integrative, formulation-driven interventions as unimodal ‘NICE-compliant’ therapies. However, they worried doing so threatened their professional identities and jobs, pointing to the increased delivery of unimodal therapies by cheaper, single-modality therapists (Llewelyn & Aafje-van Doorn, 2017). These findings were supported by Randall-James and Coles (2018) and Cooke et al.’s (2019) subsequent research. Both studies suggested that CPs use creative strategies (e.g. using diagnostic terms to help a service-user access therapy) when managing tensions between their professional practice, skills and identity, and medically dominated mental health services.

Figure 1

Court et al.'s (2016) grounded theory



Considering NICE guidelines to have benefits but to be fraught with dangers

Recognising the context of the current economic climate
+ Noting that services do not have the resources to fully deliver NICE recommendations.
+ Stressing the importance of seeing NICE guidelines in the context of the current economic climate.

Valuing the benefits of NICE guidelines
+ Noting that guidelines can provide consistency.
+ Recognising the power of NICE endorsement.
+ Valuing NICE's assistance in delivering evidence based practice.
+ Feeling that the concerns about guidelines can be challenged.

Worrying that NICE guidelines can create an unhelpful illusion of neatness
+ Questioning the scientific integrity of the guidelines.
+ Having a problem with the medical model basis of NICE guidelines.
+ Experiencing guidelines as limiting.
+ Feeling that guidelines can be misinterpreted.
+ Worrying that commissioners can view the guidelines as a way to limit spending.
+ Believing that NICE are doing harm to service users.

Perceived level of pressure to be NICE compliant
+ Experiencing an underlying threat or pressure to be NICE compliant.
+ Noting that NICE guidelines aren't currently experienced as restrictive.
+ Worrying that NICE could become more controlling.
+ Acknowledging concerns for the future, but not being worried by them.

Having a flexible relationship with guidelines
+ Not advertising the way one practices.
+ Valuing having excuses as to why not to follow NICE guidelines.
+ Using NICE to suit our needs.
+ Meeting NICE halfway.
+ Using NICE as guidelines, not instructions.
+ Being NICE concordant.

Beliefs about the purpose of, and future of clinical psychology
+ Valuing individualised, collaborative interventions.
+ Highlighting the key skills of CPs.
+ Worrying that the jobs or identity of CPs are threatened.
+ Arguing that the professional identity of CP is not threatened.
+ Reflecting on the views of others towards NICE guidelines.
+ Arguing that it is difficult to detach NICE from vested interests.

Court et al.’s model departed from extant theories of guideline use and implementation. Cabana et al. (1999), for example, positioned guideline adherence versus nonadherence as a dichotomous dependent variable, impacted on linearly by independent variables (e.g. knowledge, resources and external factors). This theory prompted the development of training aimed to increase guideline adherence (NICE, 2009). Conversely, Court et al.’s model theorised circular, reciprocal interactions between beliefs and use which were contextually adaptive. This is consistent with recent research (Greenhalgh & Papoutsi, 2018), which emphasised the need for a shift to non-linear causal models when studying complex health services. The authors argue that this is necessary to capture behaviour in its contextual, dynamic and interactive richness, and the changing interrelationships between parts of systems.

It is unclear, however, whether Court et al.’s model is generalisable to a larger number of CP’s. The publication attracted diverse and impassioned comments from several CPs (Court & Cooke, 2017) and the finding that CPs deviated from NICE recommendations was controversial. Exploring the beliefs and practices of a wider number of CPs is therefore pertinent, to understand potential diversity of beliefs and practises within CP.

Rationale and Aims

The present study aimed to explore beliefs about, and uses of, NICE guidelines in a larger sample of CPs, examining potential relationships between the two using a thematic map (Castleberry & Nolen, 2018). Doing so, it aimed to investigate and develop the conceptual framework outlined by Court et al. (2016). As the first known framework modelling CPs beliefs about, and uses of, NICE guidelines, it was considered important to ground the present research in this model to explore the extent to which it represents CPs’ NICE guidelines beliefs and uses more widely. Because Court et al.s model is grounded in only 11 CPs' perspectives, the present study sought to develop a methodology to also permit the identification of novel findings.

The study intended to explore benefits and limitations of NICE guidelines, without promoting or discouraging adherence. It was hoped that the study would further understanding of the range of CPs' beliefs and practices, relating to NICE guidance and its impact within current NHS contexts. It aimed to examine these findings in view of extant literature regarding the practice and philosophy of CP and how CPs negotiate these within broader systems and institutions. Accordingly, it aimed to further discussion regarding the best use of guidelines in services, including by CPs.

Research Questions

The study aimed to answer the following questions:

1. Do the findings of Court et al.'s (2016) study of CPs' views about, and use of NICE guidelines appear in a larger sample of CPs
    i. In response to open questions?
    ii. In ratings of agreement with statements derived from Court et al.'s model?
2. Which of Court et al.'s findings are identified most frequently in the larger sample of CPs?
3. Are further findings identifiable in a larger sample of CPs in addition to those found by Court et al.?

Method

Design

A mixed-methods concurrent design was used. Quantitative and qualitative elements were integrated through design, methods and reporting (Fetters et al., 2013). Regarding design, participants were invited to complete both open-ended (qualitative) and closed (quantitative) questions, derived from the findings of Court et al. (2016), on an online survey. Regarding method, qualitative questions were devised to thematically match with the quantitative subscales, to allow ‘merging’ of the data (Fetters et al., 2013). Merging followed the separate, parallel analyses of quantitative and qualitative data (Meurer et al., 2012) using descriptive statistics and Thematic Analysis (TA) (Braun & Clarke, 2019; Fereday & Muir-Cochrane, 2006), respectively. Regarding reporting, the merged data were narratively ‘weaved’ according to themes (Fetters et al., 2013).

A mixed-method approach was chosen to investigate the replicability of Court et al.’s grounded theory (2016), while allowing for the identification of novel themes. This sought to enable an ‘assessment of fit’ at the point of data integration to confirm, expand or suggest discordance between quantitative and qualitative data sets (Fetters et al., 2013).

TA, a tool developed to identify, analyse and report patterns in data, was selected due to its flexibility in analytic options and epistemological cohesion with quantitative approaches (Braun & Clarke, 2006). This study adopted a critical realist epistemological position (Bhaskar, 2013), which sits at the interface between ‘real’ and ‘observable’ worlds. Considering social processes (e.g. socially desirable responding) and sociocultural contexts, the present study assumed that participant responses imperfectly reflected participants’ ‘real’ beliefs and actions.

Ethical Considerations

This study was approved by Canterbury Christ Church University Salomons Institute Ethics Panel (Appendix B) and complied with the BPS (2014) human research ethics code. Participants were informed of the study’s purpose (Appendix C) before consenting

(Appendix D). Participants completed the survey anonymously and were informed of their right to have their data destroyed.

Participants

Participants [n = 55] were CPs who had worked in an NHS adult mental health setting within the past year. CPs from other specialisms (e.g. CAMHS, learning disability, older adults) were excluded because the NICE guidelines are qualitatively different across clinical populations[7]. Restricting recruitment in this way helped ensure that participants were responding to the same group of NICE guidelines, for theoretical clarity. Sampling was therefore non-random, purposive and theory-driven and followed a concurrent, identical sampling design (Onwueqbuzie & Collins, 2007).

Sample size was determined by the research questions and the respective methodologies of the quantitative (descriptive statistics) and qualitative (TA) components (Onwueqbuzie & Collins, 2007). The restricted timeframe also affected sample size considerations. The research sought to test and develop Court et al.'s (2016) findings, rather than make statistically inferential generalisations. This meant power analysis was not necessary (Onwueqbuzie & Collins, 2007) and recruitment ceased when novel codes no longer produced significant changes to thematic structures.

Recruitment was conducted by advertising the research, and its website, in *Clinical Psychology Forum,* a monthly publication for DCP members (Appendix E). The survey link was also shared by the research team on social media platforms, such as Twitter and the Clinical Psychology Facebook page. On Twitter, the link was shared by numerous CPs, many of whom considered to have potentially differing perspectives towards NICE guidelines to

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[7] E.g., adult mental health guidelines are more specific than guidelines for the learning disability population

that of the research team (Appendix F). CPs who were thought to hold varied perspectives on NICE guidelines were also contacted and asked to share the link in their networks (Appendix G). The possible perspectives of these potential participants were hypothesised based on research and literature output, as well as any involvement in producing NICE guidelines or evidence-based therapies. Because of the anonymous nature of responding, it is not known how many participants were recruited via each respective method. Participants' characteristics are presented in aggregate form (Table 1).

Table 1

Participant characteristics

Characteristic	***n***
Level of current care provision	
Primary	1
Secondary	35
Tertiary	6
Secondary and primary	2
Secondary and tertiary	2
Centre of Excellence	1
Private practice	1
Not disclosed	7
Band	
7	10
8a	18
8b	8
8c	7
8d	2
9	1
No longer in NHS	2
Not disclosed	5
Year of qualification	
1987-1999	5
2000-2009	11
2010-2015	15
2016-2019	17
Not disclosed	7

Preferred therapeutic modality	
Integrative	19
Several	19
CBT (including 3rd wave)	5
Systemic	2
Psychodynamic	3
Not disclosed	7

Procedure

The survey was distributed and completed online at a time and location of participants' discretion between November 2019 and January 2020. First, six open-ended questions (Appendix H), based on the interview schedule of Court et al. (2016) were presented to participants. Subsequently, 32 closed statements were displayed (Appendix I), with which participants were asked to rate their agreement on a 7-point Likert scale, ranging from 'strongly agree' (1) to 'strongly disagree' (7). The statements were based on codes and subcategories from Court et al. (Appendix J). To limit the impact of Court et al.'s findings on responding, statements were not presented until participants completed the open-ended questions.

Quantitative Measure

The 32 statements presented to participants for quantitative rating were derived from the coding framework of Court et al.. Codes were selected from each subcategory of the grounded theory to ensure it was represented comprehensively. Due to time and length considerations, not all codes were included. Further, some statements were edited following piloting to minimise value-laden language and potential for social desirability responding. Thus, the statements can be considered based on Court et al.'s findings, rather than an identical depiction of them.

Data Analysis

Likert scale responses to the statements were analysed using descriptive statistics. Table 2 displays the steps taken during TA of the qualitative data, and the subsequent 'merging' of quantitative and qualitative data. Rather than completing the analytic stages linearly, analysis was flexible, fluid and iterative (Braun & Clarke, 2019).

Table 2

Phases of analysis, adapted from Braun and Clarke (2006).

Phase	Description
Familiarising with data	The data was read and reread, and analysed line by line. Initial ideas were noted.
Generating initial codes	Interesting features of the data were coded systematically. To address the research questions, a hybrid approach to TA was used, combining top-down and bottom-up approaches (Fereday & Muir-Cochrane, 2006). To investigate the replicability of Court et al.'s model, the qualitative data was initially coded theoretically and deductively, using the coding, categories and sub-categories from Court et al.. To allow for novel insights, inductive, data-driven coding was used when codes were identified that could not be accommodated in Court et al.'s model. Coding was therefore performed inclusively to retain accounts that departed from the dominant story (Braun & Clarke, 2006).
Searching for themes	Codes were collated into themes, and data pertaining to each theme was gathered. Themes were identified on a semantic level according to the surface meanings in the data. However, response patterns and their wider implications were also theorised (Patton, 1990), drawing on existing theory (Court et al., 2016) to do so. Analysis aimed to ensure that data within themes cohered together and neat demarcations were kept between themes (Patton, 1990).
Reviewing themes	A thematic map was produced, building on and adapting Court et al.'s conceptual framework, according to the differences and similarities that were identified in the development of codes, sub-themes and themes in the data. This interpretative phase involved considering the interconnections between themes (Braun & Clarke, 2019; Castleberry &

	Nolen, 2018) and the way in which they fit together (Nowell et al., 2017).
Defining and naming themes	Some identified themes and codes were iteratively changed to sub-themes, to structure large and complex themes (Braun & Clarke, 2006). Names of codes, themes and sub-themes were defined and refined throughout, referencing the raw data to ensure integrity (Braun & Clarke, 2019).
Merging qualitative and quantitative findings to produce the report	‘Merging’ was enabled by comparing and synthesising quantitative data sub-scales with qualitative themes (Fetters et al., 2013). Taking the approach of Meurer et al. (2012), quantitative endorsements were compared to codes, sub-themes and themes to ensure that endorsed statements were represented in the thematic map. During this process, some statements were altered to assimilate insights identified in the qualitative data, which then formed codes, subthemes or themes. Likewise, some codes identified in the qualitative data were updated and/or reworded to accommodate quantitative insights. Statements that were endorsed quantitively but not initially identified in the qualitative data were added to the theme and code table. Qualitative data was subsequently rechecked to identify these codes. These integrative steps helped to achieve ‘confirmation’ of the two data sets and enhance credibility of the findings (Fetters et al., 2013). At the reporting level (see Results), the integration of the quantitative statistical analysis and qualitative analysis was presented through narrative ‘weaving’, such that quantitative and qualitative findings were synthesised (according to the procedures described) and presented thematically (Fetters et al., 2013) based on the merged thematic map. Herein, quantitative descriptors were used to substantiate qualitative themes and subthemes, and vice versa (Meurer et al., 2012). Here, attention was focussed on relationships between themes and more global findings (Castleberry & Nolen, 2018).

Quality Assurance

Castleberry and Nolen (2018) suggest that data do not ‘speak for themselves’ and researcher interpretation in TA should be highlighted. Several measures were used to ensure transparency and reflexivity in analysis. A research diary documented the researcher’s decision-making rationale and reflected on potential impact of the research team’s beliefs (Appendix K). A bracketing interview (Fischer, 2009) was conducted between the principal researcher and a colleague to consider the impact of the researcher's assumptions on data collection and interpretation, to inform a positioning statement (Appendix L). Coding and theme development extracts were discussed with the researcher's supervisors and within a qualitative analysis discussion group (Nowell et al., 2017). Participant quotations are presented in the results, and examples of coded qualitative data is presented in Appendices O and M. This transparency increases the integrity of findings (Hill et al., 2005).

Results

The analysis led to the identification of five themes, 21 subthemes and 72 codes. This study builds on Court et al.'s (2016) conceptual framework modelling how CPs use NICE guidelines and the factors associated with this. First, quantitative data is reported. Next, a summary of the integrated ('merged') thematic map is displayed. Finally, thematic 'narrative weaving' of the integrated data is presented (Fetters et al., 2013).

Descriptive Statistics

Response numbers varied from n = 49 to n = 51 for each statement. Not all respondents who completed the open-ended questions completed the closed questions. The statements in Table 3 are displayed according to numbers of participants who agreed with each statement, from highest to lowest. Agreement was defined as endorsing 'strongly agree' (1) or 'agree' (2) on the seven-point Likert scale. Undecided was defined by the responses 'somewhat agree' (3), 'neither agree nor disagree' (4) and 'somewhat disagree' (5). Disagree was defined by selecting 'disagree' (6) or 'strongly disagree' (7) on the response scale. Responses were grouped for clarity and comprehension. Further descriptive statistics (e.g. standard deviations) are displayed in Appendix N.

Table 3

Agreement with statements

Statement	**Agree *n* (%)**	**Undecided *n* (%)**	**Disagree *n* (%)**	**Total *N* (%)**
I think it is important to acknowledge and highlight the limitations of NICE guidelines	41 (82)	9 (18)	0 (0)	50 (100)
There are problems with NICE guidelines	38 (76)	9 (18)	3 (6)	50 (100)
I question the validity of the medical basis of diagnostic categories	37 (74)	11 (22)	2 (4)	50 (100)
I use NICE as guidelines and not instructions	37 (74)	11 (22)	2 (4)	50 (100)
Whether or not therapies are recommended by NICE depends on whether they fit the research paradigms favoured by NICE	36 (74)	9 (16)	5 (10)	49 (100)
I would like NICE to review its approach to creating guidelines for psychological intervention	34 (68)	12 (24)	4 (8)	50 (100)
Services do not have the resources to fully deliver NICE guidelines	34 (68)	15 (30)	1 (2)	50 (100)
I worry that less-well researched but potentially effective therapies are left out of NICE guidelines	33 (66)	11 (22)	6 (12)	50 (100)
There are difficulties in researching the effectiveness of psychological therapies	33 (66)	15 (30)	2 (4)	50 (100)
I worry that therapists who deliver manual-driven brief therapies are seen as a cheaper alternative to CPs	31 (62)	13 (26)	6 (12)	50 (100)
It is important for NICE guidelines to distinguish the role of CPs from single-modality therapists	29 (59)	14 (27)	7 (14)	49 (100)
I believe there are alternatives to diagnoses that can more helpfully inform clinical practice	29 (59)	19 (37)	2 (4)	50 (100)
NICE guidelines over-simplify clinical decision making	29 (58)	16 (32)	5 (10)	50 (100)

I worry that commissioners sometimes view NICE guidelines as a way to limit spending	28 (56)	10 (20)	12 (24)	50 (100)
NICE guidelines can prevent CPs offering the individualised, formulation-driven therapy that service users need	28 (56)	10 (20)	12 (24)	50 (100)
I believe vested interests (e.g. government political aims) have a significant impact on NICE guidelines	25 (50)	14 (28)	11 (22)	50 (100)
I am open regarding my views about NICE guidelines where I work	25 (50)	24 (48)	1 (2)	50 (100)
NICE guidelines can help the public know what to expect regarding psychological treatment	24 (48)	23 (46)	3 (6)	50 (100)
NICE guidelines can help provide consistency in psychological intervention	22 (44)	26 (52)	2 (4)	50 (100)
Some CPs may follow NICE guidelines without being familiar with the evidence it is based on (e.g. using a guideline based on evidence from a non-adult population in an adult setting)	21 (42)	26 (54)	2 (4)	50 (100)
NICE guidelines are a useful guide to the evidence base for psychological intervention	18 (36)	28 (56)	4 (8)	50 (100)
Adhering to NICE guidelines can cause harm to service users	18 (36)	21 (42)	11 (22)	50 (100)
At work, I sometimes label interventions as single-modality when they are integrative (e.g. drawn on a range of psychological theories and models)	18 (36)	20 (40)	12 (24)	50 (100)
I feel that NICE guidelines provide a safeguard against bad therapeutic practice	17 (34)	23 (46)	10 (20)	50 (100)
I sometimes experience pressure from management to be NICE compliant	17 (34)	21 (42)	12 (24)	50 (100)

I do not feel NICE guidelines restrict how I practice	17 (34)	23 (46)	10 (20)	50 (100)
I follow NICE guidelines in my practice	15 (30)	33 (66)	2 (4)	50 (100)
I believe that the professional identity and specialist skills of CPs are threatened by NICE guidelines	14 (28)	20 (40)	16 (32)	50 (100)
I would welcome a more instructive use of NICE guidelines in the future	13 (27)	24 (49)	12 (24)	49 (100)
I value the shared language regarding mental health and intervention that NICE guidelines provide	11 (22)	35 (70)	4 (8)	50 (100)
Diagnostic categories can be a useful way to conceptualise mental distress	8 (16)	31 (62)	11 (22)	50 (100)
I welcome the prioritisation of Randomised Controlled Trials (RCTs) by NICE	8 (15)	28 (55)	15 (30)	51 (100)

Integrated Framework Summary

The merged thematic map was entitled: *threat, useful guide and vital manual: the shades of grey within and between CPs beliefs about and use of NICE guidelines.* Figure 2 displays this map, comprising qualitative and quantitative data, of proposed connections between themes (Nowell et al., 2017; Castleberry & Nolen, 2018). Themes are displayed in bold, upper-case text, with their properties (subthemes[8]) in lower-case. Grey shading represents the range of beliefs and practices reported by CPs, with lighter grey indicating more critical perspectives. The proposed framework is active and interconnected, representing differences between and within CP perspectives as they appraised and negotiated beliefs, context and practice.

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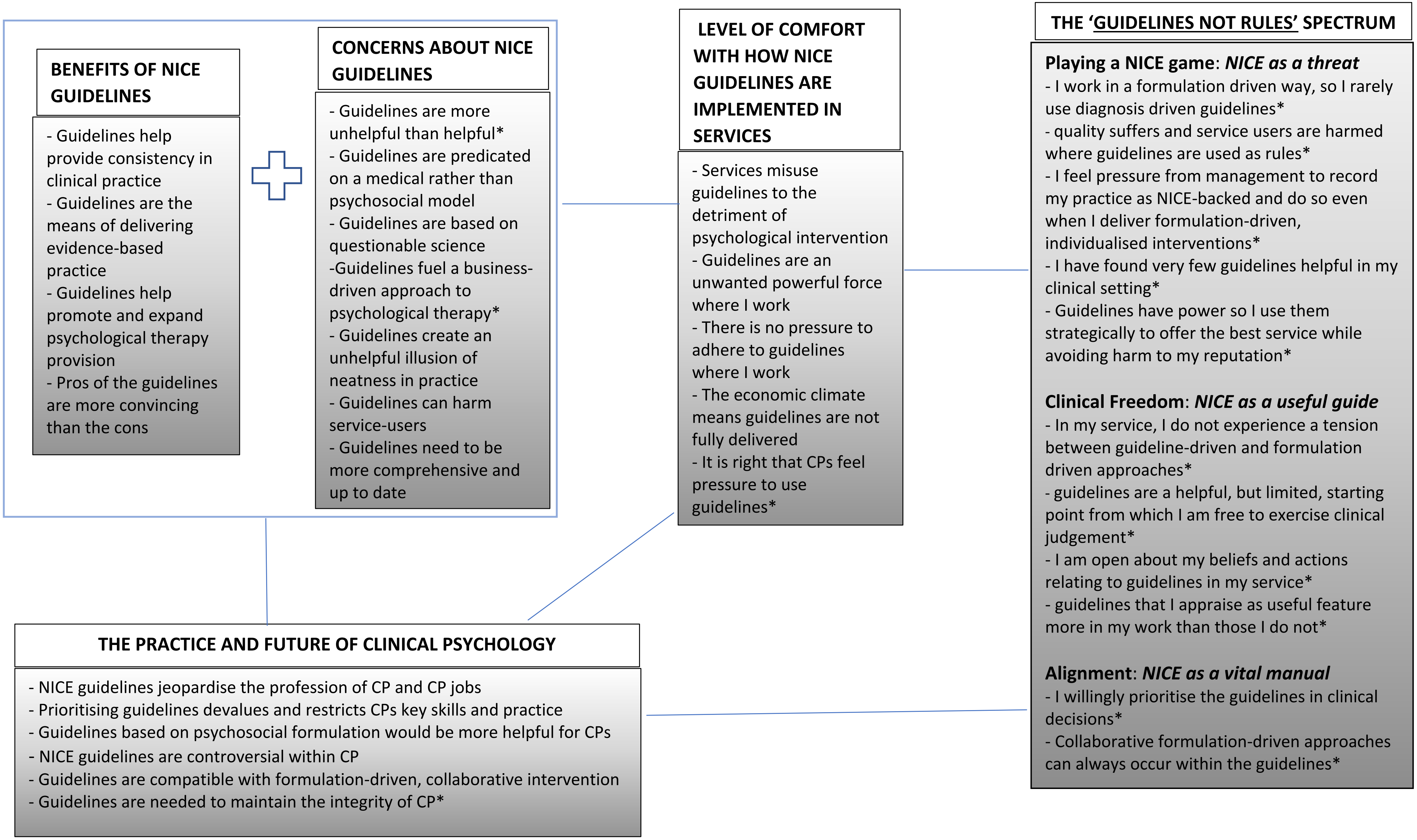
[8] *denotes a code

Figure 2

Merged thematic map



Threat, useful guide and vital manual: the shades of grey within and between CPs' beliefs about, and uses of, NICE guidelines

BENEFITS OF NICE GUIDELINES

- Guidelines help provide consistency in clinical practice
- Guidelines are the means of delivering evidence-based practice
- Guidelines help promote and expand psychological therapy provision
- Pros of the guidelines are more convincing than the cons

CONCERNS ABOUT NICE GUIDELINES

- Guidelines are more unhelpful than helpful*
- Guidelines are predicated on a medical rather than psychosocial model
- Guidelines are based on questionable science
-Guidelines fuel a business-driven approach to psychological therapy*
- Guidelines create an unhelpful illusion of neatness in practice
- Guidelines can harm service-users
- Guidelines need to be more comprehensive and up to date

LEVEL OF COMFORT WITH HOW NICE GUIDELINES ARE IMPLEMENTED IN SERVICES

- Services misuse guidelines to the detriment of psychological intervention
- Guidelines are an unwanted powerful force where I work
- There is no pressure to adhere to guidelines where I work
- The economic climate means guidelines are not fully delivered
- It is right that CPs feel pressure to use guidelines*

THE 'GUIDELINES NOT RULES' SPECTRUM

Playing a NICE game: ***NICE as a threat***
- I work in a formulation driven way, so I rarely use diagnosis driven guidelines*
- quality suffers and service users are harmed where guidelines are used as rules*
- I feel pressure from management to record my practice as NICE-backed and do so even when I deliver formulation-driven, individualised interventions*
- I have found very few guidelines helpful in my clinical setting*
- Guidelines have power so I use them strategically to offer the best service while avoiding harm to my reputation*

Clinical Freedom: ***NICE as a useful guide***
- In my service, I do not experience a tension between guideline-driven and formulation driven approaches*
- guidelines are a helpful, but limited, starting point from which I am free to exercise clinical judgement*
- I am open about my beliefs and actions relating to guidelines in my service*
- guidelines that I appraise as useful feature more in my work than those I do not*

Alignment: ***NICE as a vital manual***
- I willingly prioritise the guidelines in clinical decisions*
- Collaborative formulation-driven approaches can always occur within the guidelines*

THE PRACTICE AND FUTURE OF CLINICAL PSYCHOLOGY

- NICE guidelines jeopardise the profession of CP and CP jobs
- Prioritising guidelines devalues and restricts CPs key skills and practice
- Guidelines based on psychosocial formulation would be more helpful for CPs
- NICE guidelines are controversial within CP
- Guidelines are compatible with formulation-driven, collaborative intervention
- Guidelines are needed to maintain the integrity of CP*

Participants' beliefs about the purpose, identity and future of CP were associated with their evaluations of the benefits and limitations of NICE guidelines, and also with their level of comfort with how the guidelines are implemented in services. These evaluations were associated with a spectrum of guideline use among CPs, entitled *guidelines not rules*. In turn, use appeared to be associated with beliefs about purpose, identity and future of CP.

The *guidelines not rules* spectrum represented the range of use within and between CPs. Whilst spectra are by definition continuous, the following three positions (subthemes) were demarcated to render the data digestible and useful (Braun & Clarke, 2006). The positions represented multiple thematically aggregated views rather than those of individuals.

Table 4

Overview of 'guidelines not rules' theme

Subtheme	Description
Playing a NICE game: NICE as a threat	The first position was a focus on the limitations of NICE guidelines. Pressure from managers to adhere to NICE guidelines appeared to link to CPs feeling they had to report formulation-driven, integrative practice as unimodal, NICE-backed therapies. Some CPs reported using NICE guidelines strategically to suit professional interests and service-user needs, having recognised the power of NICE in their service. CPs worried, however, that *playing a NICE game* posed a longer-term threat to the profession (e.g. the replacement of CP posts with unimodal therapy posts) and to service quality (e.g. the unavailability of formulation and level-3 skill driven therapy).
Clinical Freedom: NICE as a useful guide	The second position was that NICE guidelines were a useful practice guide, which CPs were able to adapt or deviate from according to clinical judgement. CPs might not have felt pressure to adhere to NICE guidelines in their service and felt able to be honest about the complexity of their practice. They felt less tension between their identity and skills as a CP, and using the guidelines. This linked to more positive evaluations of the guidelines.

Alignment: NICE as a vital manual[9]	A rarer position, described by few participants, was the view that NICE guidelines were a vital manual, essential to maintain the integrity of the profession. Here, CPs always prioritised the guidelines in clinical decision making. While they still considered them *guidelines not rules*, these CPs endorsed the core assumptions of the NICE guideline approach and felt that their specialist skills could invariably be exercised within the guidelines.

All codes, subthemes and themes with quotation examples are tabularly presented in Appendix M.

Thematic Data Integration through 'Narrative Weaving'

Each theme in the merged thematic map is discussed alongside qualitative participant quotes and quantitative descriptive statistics. The analysis focusses on key elements.

Benefits of NICE Guidelines

Participants highlighted several benefits of NICE guidance. Most CPs thought guidelines were "a nice idea".

> In principle they are a fantastic thing and provide useful guidance on practice.[10]

Participants suggested that NICE guidelines help deliver evidence-based practice and validate clinical decisions.

> [NICE] backed up my impression that the time frame was too soon to commence therapeutic work [trauma focussed therapy] for the person's presentation and could be quoted back to the GP who accepted the decision.

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[9] The three positions are referred to as 'Threat', 'Freedom' and 'Alignment' hereon.

[10] Quotes are not attributed to participants due to participant volume. Several quotes are presented for each code in Appendix M to demonstrate that codes were derived from several participants' data.

Most CPs recognised the role of NICE guidelines in expanding psychological therapy provision.

> [NICE] has been helpful in making the case to introduce or increase psychological provision in areas where that hadn't been any.

Some participants felt the pros of NICE guidelines outweighed the cons.

> There are flaws that need to be addressed. But a complete overhaul is unnecessary. Other approaches have their own problems.

A minority of CPs appeared to value the NICE approach to guideline production as it is.

> I fully support and endorse them. They offer clarity in mental health provision that can end ineffective and harmful treatment and empower patients and families to seek and receive the treatments with best evidence of effect. It is a myth that they are rigid or don’t apply in adult mental health secondary care contexts.

Concerns about NICE Guidelines

Many CPs believed that the limitations of NICE guidelines needed highlighting. This was the most frequently endorsed statement (86%[11] agreement; 0% disagreement) with the lowest response variance[12]. Qualitatively, many CPs felt the guidelines were more unhelpful than they were helpful.

> I think they can generally be unhelpful as they are reductionistic.

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[11] Percentages are given instead of absolute n, to prevent the reader from referring back to the total N for each statement.

[12] See Appendix N for standard deviations.

Most CPs (74%) questioned the validity of diagnostic categories upon which NICE guidelines are based. Qualitatively, many participants felt that it was problematic that NICE guidelines are predicated on medicalised understandings of distress, rather than a psychosocial model.

> I believe they perpetuate a diagnosis led service as well as research and all the problems that entails. In addition to funding for research being offered for a particular diagnosis, now we have therapies for "SMIs' and I have concerns that this is ensured as needing to be provided, thereby further perpetuating a model of diagnosis and ignoring the role of trauma.

Participants highlighted that a system designed for physical health care is not necessarily appropriate for mental health care.

> In physical healthcare [NICE guidelines] might make sense but mental health is entirely different so this is a gross category error and we are in effect being forced to offer treatments for which there is a poor evidence base, at the expense of offering things which might be more helpful to people referred to us.

Most CPs also felt NICE guidelines were based on questionable science, suggesting that NICE's prioritisation of particular research paradigms results in the prioritisation of particular therapies (74%).

> Models, such as CBT, receive much more funding for research and are better suited to trials which means there is "more evidence" for them, however this does not actually mean they are necessarily the best.

Participants appeared concerned that this came at the expense of other forms of evidence, such as “qualitative research” and “practice-based evidence”, relating to a “wider range of therapies” (66%).

CPs also suspected that vested interests, such as political and business agendas, interfered with the scientific legitimacy of the guidelines (50%). There was high variance between responses to this statement, suggesting diverse opinions among CP’s.

> NICE guidelines are reflective of the power of particular lobby groups within psychology rather than a reflection of evidence and best practice. When you evaluate who was on the board … biases and conflicts of interest are clear. E.g. psychologists making a career out of selling CBT for psychosis, recommending CBT for psychosis and turning a blind eye to research and evidence that counters their favoured area.

Participants worried that NICE guidance fuelled a “brand name”, business-driven approach to psychological therapy.

> The profession does not appear to be interested in giving proper scrutiny to the NICE guidelines and it is likely that it uses NICE to further its own interests (i.e. the continued sale of psychological therapies) rather than upholding standards of rigorous science and truth.

Participants were concerned that NICE guidelines created an unhelpful illusion of neatness in practice (58%) and were inapplicable to clients with more complex difficulties, where “integrative approaches are necessary”. Additionally, participants worried that restrictions on practice that NICE guidelines can entail can harm service-users (36%), by denying them the most helpful support.

> They become unhelpful when clinicians view them as the only way to work and are unable to think critically about them... I see this frequently in other services, and ultimately, it is clients/patients who pay the price.

Level of Comfort with how NICE Guidelines are Implemented in Services

Qualitative data suggested CPs were concerned that services misuse NICE guidelines, with many participants frustrated that guidelines were interpreted uncritically by management.

> We know any research trial only works for x% of people (and those who clearly met a specified diagnosis), yet at an organisational level the interpretation can be as though 100% of people under the trial showed clinically significant improvement, and therefore that is what should be offered in the service.

Participants were concerned where NICE guidelines were interpreted as “facts”, “rules” and “the truth” by services, teams and commissioners, and some worried that this generated inappropriate psychological therapy referrals.

> They contribute to an over simplified understanding of mental health. Psychiatrists have referred to me requesting CBT for anxiety, EMDR for trauma and long-term therapy for difficult relationships with parents for the same person, suggesting someone’s needs can be separated and packaged to different therapy approaches.

These concerns engendered a desire for the limitations of NICE to be made transparent service-wide.

> More training is required so people understand the pros and cons of the guidelines as this would give them a more nuanced view.

Qualitatively, many CPs reported experiencing NICE guidance as an unwanted powerful force. Participants felt pressure to use NICE guidelines in their service (34%), where doing so conflicted with their clinical judgement. This statement had a comparably high response variance, suggesting participants had varied experiences in this regard.

> [NICE guidelines have been unhelpful] when my supervisor has suggested I should do a pure CBT approach because NICE guidance indicates that…my formulation would suggest a more integrated approach.

Some participants acknowledged pressure is hard to resist because of the guidelines' ubiquity.

> The pressure then builds for all psychologists working in adult mental health to support these programmes. It's very difficult to challenge when so many psychologists all over the country are going along with it. And people going on the training … get told that if they don't get with the programme they need to go and find another job.

As implied by the high response variance, many CPs reported not experiencing pressure to use NICE guidelines in their service (24%) and did not feel their practice was restricted (34%).

> Thankfully our service recognises that our clients don't fit neatly into guidelines. We see people with multiple presenting problems early childhood trauma and neglect and attachment issues. It would be impossible to know which guideline to follow first as there would probably be at least 5 relevant to our clients…I haven't felt under pressure to use or not use them.

However, some participants worried that they would begin to experience pressure to use the guidelines.

> Not currently [experiencing pressure] but the IAPT SMI agenda will considerably change this to target driven interventions as within EIT teams, leaving practitioners to fudge data or provide ineffective interventions.

A minority of CPs who endorsed NICE’s approach to guideline production suggested that CPs should feel pressure to follow NICE guidelines.

> I think that it is right and ethical that clinicians should be pressured to deliver interventions which offer people something which we know works effectively and maximises the patient’s chance of clinical improvement.

Some CPs worried that managers used NICE guidelines to limit spending (56%).

> In the name of providing NICE recommended interventions, with scant financial provision, some services seem to boil it down to the barest of bones. Take IAPT as an example of "providing CBT" to the masses. I'm not sure that the guidance was conceived with 30-minute telephone sessions by minimally qualified practitioners reading from a script in mind.

Beliefs about the Identity, Purpose and Future of CP

CPs worried unimodal therapists were considered cheaper alternatives to CP (62%). Qualitatively, some CPs who experienced NICE guidance as a powerful force believed that it threatened CPs jobs.

> Our workforce is entirely based on numbers of CBT therapists based on the guidance for psychosis, there is no formally recognised role for psychologists who use wider approaches (they are just seen as people who can do CBT). This has led to having hardly any psychologists in the workforce in EIP.

Participants felt that NICE restricted (56%) and threatened (28%) CPs' specialist formulation and integrative skills.

> I am aware that some services won't allow their practitioners to provide therapies that are not outlined in NICE guidance, which I think means we are completely undermining the clinical skills of our practitioners, and are not providing our service-users with the most individualised, clinically effective treatments.

Some participants felt NICE guidelines restricted their choice regarding professional development, and some stressed the need for CPs to use their specialist knowledge, where indicated by formulation, to work beyond guidelines.

> We use our knowledge to inform formulation. We should be drawing upon that knowledge to use individually tailored interventions that meet the needs of the individual. Just because a therapy approach isn't in NICE guidance, doesn't mean it's not well researched and we have the skills to read and appraise research papers.

CPs welcomed a revision of the NICE guideline approach (68%). The response variance for this statement was low, indicating relatively consistent agreement. Qualitatively, participants suggested that psychosocial "formulation based" and "trauma-informed" guidelines could replace medically-oriented guidance.

Some CPs, for example those who not did not experience pressure to use the guidelines, believed that NICE guidelines were compatible with CPs’ specialist skills in collaborative, formulation-driven intervention.

> They are just guidelines. So if I’m working with someone who has what you might heuristically label depression, I can include in my thoughts and discussion with my clients the guidelines - but that might include saying ‘and what about this therapy approach which isn’t NICE recommended but you might benefit from because of XYZ that we have discussed’.

A minority of CPs considered NICE guidelines essential to maintain the integrity of the profession.

> The Guidelines provide a transparent framework. Fear [without NICE] would return to old power dynamics of I know best masquerading under the guise of formulation and patient centred care.

Qualitatively, participants acknowledged that NICE guidelines are controversial among CP.

> Some champion NICE guidelines as the only way forward, a pious road that cannot be detoured from…others completely reject guidelines and see them as stifling specialist practice. I am somewhere in the middle.

Some CPs supposed that CPs’ beliefs about NICE guidelines might depend on the extent to which they appraise the guidelines as supporting their professional interests.

> Many psychologists have their own interests at heart and it is in their interests that psychological therapies are promoted by NICE. I just don't like lying to myself or anyone else about this.

CPs also thought views might vary according to CPs' relationship with the diagnostic approach.

> I understand that some CPs believe the NICE guidelines are unhelpful, too diagnosis focused and too restrictive. Where CPs do not diagnose it would be harder to use the NICE guidelines as they are based around diagnoses.

Epistemological stance was also understood as informing attitudes towards NICE guidelines. CPs suggested that those who adopt "constructionist" positions and are critical of "positivist evidence" are less likely to value NICE.

The 'Guidelines not Rules' Use Spectrum

Playing a NICE Game: NICE Guidelines as a Threat to CP. Some CPs who felt formulation-driven approaches and guideline-driven approaches were incompatible rarely adhered to NICE guidelines.

> CPs are trained to formulate and intervene from multiple perspectives. I find it impossible to rigidly work within one approach and not draw upon all my knowledge.

Many CPs felt that practice was hindered where NICE guidelines are understood as rules.

> They are constantly unhelpful when our organisations are expected to comply with, and measure their compliance with NICE guidelines.

A conflict between the dominance of NICE in services and CP level-3 skills meant some CPs felt pressure to report NICE-discordant interventions as NICE-backed (36%).

> I have felt under pressure to be delivering CBT to the majority of my caseload and felt pressure to label it as such when in practice we have been using a different approach.

Likewise, linked to the power of NICE endorsement in their services, some CPs reported that they strategically co-opt NICE guidelines to "suit" clinical needs, often to benefit service-users.

> NICE guidelines tend to be more helpful when they have aided me in advocating for a service-user...I.e. getting treatment.

These CPs reported finding little inherent value in NICE guidelines in their clinical settings.

> I don't find them helpful for the population I work with- secondary care. All (or almost all) my clients have complex and comorbid difficulties, so trying to work out which guideline to follow feels useless.

Clinical Freedom: NICE as a Useful Guide. CPs who did not feel under pressure to adhere to NICE guidelines did not appear to experience a tension between delivering formulation-driven and guideline-driven interventions in their service.

> The guidelines themselves make clear that they should be used interpreted by clinicians with some degree of flexibility. We seem to have a sensible position in our Trust: evidence + clinical judgement + client informed choice.

These CPs saw NICE guidelines as a useful, but ultimately limited, guide to practice, upon which they could exercise clinical judgement, even if that meant working beyond NICE guidelines.

> I consider NICE guidelines to be a valuable tool to guide my work, but they are just that-a tool for me to use. In my area, the guidelines only suggest one type of therapy for everyone, and I disagree with a one size fits all approach.

These CPs felt able to deviate from guidelines when they felt the situation required it.

> I only deviate from them for one of the following reasons i) I don’t have good skills in the intervention recommended, ii) the person opts for something different…or iii) the formulation suggests a different approach.

The relative freedom that these CPs experienced also enabled honesty within their services about their use of NICE guidelines (50%).

Alignment: NICE as a Vital Manual. A rarer position was the fundamental endorsement of the NICE guideline approach. These CPs prioritised NICE guidelines to guide their interventions. They felt that collaborative and formulation-driven practice was invariably possible within the parameters of NICE guidelines. This position is represented quantitively by a minority endorsement of ‘pro-NICE’ statements and disagreement with statements criticising NICE (Table 2).

> Follow them. They’ve been reviewed by experts in the field...I don’t understand why we wouldn’t follow guidelines.

Discussion

This study used qualitative and quantitative methodology to test and develop a pre-existing account of CPs’ beliefs about, and uses of, NICE guidelines (Court et al., 2016) using a larger sample of CPs. The results are discussed relating to the research questions, extant literature and clinical and research implications.

Main Findings

Firstly, key findings are discussed in relation to the research questions.

Clinical Psychologists' Beliefs about NICE Guidelines

The hypotheses regarding CPs' beliefs about NICE guidelines, derived from Court et al., were supported by the integrated data. Like Court et al., beliefs varied within and between CPs. Most CPs questioned core assumptions of the guidance, such as its diagnostic premise. This supports commentary from critical CPs (e.g. Boyle, 2007) and suggests the issue of diagnosis concerns more than a critical few. Similar to Court et al.' findings, most CPs simultaneously valued the power of NICE in increasing psychological therapy provision and access.

Like Court et al., CPs' assorted evaluations appeared related to CPs' level of comfort with how the guidelines were implemented within their respective services. Where there was unwanted pressure to adhere to the guidelines, perceived costs were salient, such as believing that guidelines restrict individualised, integrative and collaborative formulations (level-3 skills). This is consistent with the DCP (2011) statement and trainee CP job description (Leeds Clearing House, 2019) highlighting the core role of formulation for CPs. These findings support Court et al.'s theory, which suggested that pressure to be NICE-compliant impacts on CPs' beliefs about the purpose and future of CP. For example, participants in both studies worried that pressure to deliver unimodal, NICE-backed interventions jeopardised CP jobs, citing the increasing prevalence of CBT therapists in their services.

However, the present findings, in part, depart from Court et al.'s model. Qualitative findings suggest that a minority of CPs welcomed pressure for CPs to use NICE guidelines. Additionally, not all CPs believed that *NICE guidelines create an unhelpful illusion of neatness*. One participant, for example, described this a as "myth". Accordingly, associated themes, subthemes and codes were newly identified, adapted or removed compared to Court et al.'s model.

Clinical Psychologists' Use of NICE Guidelines

The hypotheses regarding CPs' uses of NICE guidelines, derived from Court et al., were also supported by integrated data. Firstly, most CPs had a 'flexible' relationship with the guidelines, using them as *guidelines not rules*. Further, CPs sometimes felt pressure to report integrative, NICE-discordant interventions using level-3 skills as NICE-backed. CPs sometimes used the guidelines selectively to help service-users access psychological intervention. Like Court et al., the present study suggests that how CPs use NICE guidelines relates to their beliefs about the pros and cons of the guidelines, how they are implemented – and therefore their effect on – services, and their implications for the practice and future of CP.

These findings suggest that the extent to which CPs perceived the guidelines as *guidelines not rules* varied between CPs. For example, most CPs believed that CPs should be able to deviate from NICE guidelines where indicated by formulation. A minority, however, believed that NICE guidelines should be prioritised and formulation-based adaptation was invariably possible within the guidelines. This suggests that CPs might subscribe to different conceptualisations of distress. For example, diagnostic, categorical conceptualisations might engender the view that distinct theories can sufficiently formulate each diagnosis; formulation is integrally wedded to diagnosis and can therefore always be used within the parameters of NICE guidance (e.g. Scott, 2007). However, viewing distress as idiosyncratic and multifactorial might engender the view that incorporating various theories is essential to provide individualised formulation-driven interventions (e.g. Mollon, 2009). This diversity supports arguments that CP has struggled to carve a clear identity in the NHS (Pilgrim, 2011) and lacks a cohesive theoretical core (Cheshire & Pilgrim, 2004; Parsloe, 2012). The present study modifies Court et al.’s framework to foreground diverse guideline uses among CPs, and their relationship to beliefs, with the variation and *shades of grey* featuring in the title.

Theoretical Integration

Below, key findings are considered in relation to relevant theoretical literature.

Guideline Implementation Theory

The present findings support Court et al.’s theory modelling ‘reciprocal’ and ‘circular’ relationships between beliefs, context and guideline use. This aligns with emergent complexity theory in health care settings (Greenhalgh & Papoutsi, 2018), which questions the validity of representing guideline adherence as a categorical, dichotomous variable (e.g. (Cabana et al. 1999). For example, this study emphasised the creative and adaptive solutions to complex problems, which made sense to CPs in their respective, dynamic systems (Greenhalgh & Papoutsi, 2018). CPs appeared to negotiate between their professional self-identities and skills, the pros and cons of NICE guidelines, and the implementation of NICE in their service settings. These negotiations were associated with CPs using the guidelines adaptively, such as practising using level-3 skills but not reporting this, and using NICE guidelines selectively to meet professional and service-user needs. These uses defied dichotomous categorisation (e.g. adherence versus nonadherence). The *guidelines not rules* spectrum positions the complex guideline uses of CP as the ‘central plot’ rather than the ‘footnotes’ - where complexity is typically relegated (Greenhalgh & Papoutsi, 2018).

Practice and Future of Clinical Psychology in NHS Systems

CPs acknowledged positivism, the medical-model and business-driven marketing of curative, targeted therapies, as powerful discourses that give legitimacy to NICE guidelines. Foucault (1980) suggested that discourses embody power/knowledge relationships that constitute reality. Accordingly, CPs sometimes drew on powerful discourses to achieve particular outcomes. For example, despite concerns about NICE guidelines, CPs used them selectively to validate arguments for service-users' access to psychology provision. Additionally, CPs felt they had to downplay level-3, formulation-driven practice to protect their reputation in teams. This accords with the findings of Court et al. (2016), Cooke et al. (2019) and Randall-James and Coles (2018), which suggested that CPs will 'step' into the medical-model, or 'play the game' when doing so supports service-user or professional interests. Paradoxically, the present findings support Court et al.'s theory that downplaying specialist skills leads CPs to worry that their professional identity and jobs are at risk. This double-bind aligns with Pilgrim's (2007) suggestion that co-opting dominant discourses amasses power for CP at the expense of their professional identity.

Similarly, CPs suspected that some CP colleagues might align with NICE guidelines if their preferred therapeutic modality is NICE-endorsed, recognising the powerful discourse of therapies as marketable commodities (Soffe-Caswell, 2007). The present framework suggests that this is a common conflict for CP's. NICE guidelines might simultaneously increase the provision of unimodal psychological therapies (affording some CPs power and status) while broadly devaluing the level-3 identity, and therefore profession, of CP. Likewise, the guidelines' role in increasing therapy provision might benefit service-users, while the restriction of level-3 interventions might harm them. CPs working within NHS discourses might therefore find themselves in various double-binds, accounting for their nuanced beliefs about, and uses of NICE guidelines represented in the present framework.

Clinical Implications

Working within NHS Systems

The double-binds reported by CPs suggest that CPs might benefit from more guidance from representative bodies (e.g. BPS) relating to working within, and challenging, dominant discourses. This might include developing ways for CPs to safely demonstrate their unique worth to teams without fear of reprisal. Importantly, some CPs felt their identities did not clash with the discourses surrounding NICE guidance. The present framework suggests this is linked to some CPs experiencing dominant discourses as less powerful (*freedom*) and a minority seeing no conflict *(alignment).*

Guidelines not Rules

While a small minority of CPs welcomed pressure for CPs to follow NICE guidelines, most CPs were concerned by the implementation of NICE guidelines as rules. CPs believed that this restricted and obscured CP level-3 skills and lowered intervention quality. They worried that this harmed the profession and, therefore, service-users. Concern that the guidelines were implemented rigidly was linked to negative evaluations of NICE guidelines. These negative evaluations could be understood as an unintended consequence of the confluence of NICE guidelines and service context (e.g. the rigid implementation of NICE due to stakeholder monitoring, medical-model dominance and resource pressures). Indeed, guidance uptake is expected to be increasingly monitored (NICE, 2017), a development that could entail the increased delivery of unimodal therapies by unimodal therapists (Llewelyn & Aafje-van Doorn, 2017). These concerns suggest that implementing guidance as *guidelines not rules* is key, to: improve the perceived usefulness of guidelines for CPs; allow CPs to draw on their specialist level-3 skills, and for these skills to be valued by teams; protect the profession of CP; and, ultimately, provide the most helpful interventions for service-users.

Addressing this might involve adapting BPS supervision guidelines and contracts, and developing training for teams and service managers about NICE guidelines and CP. The BPS, DCP and Association of Clinical Psychologists (ACP) could also consider addressing this issue more assertively, for example by making a renewed effort to publicly articulate the identity and skills of CPs. This might involve foregrounding the present study and Court et al.’s (2016) finding: mandating guidelines could impede and devalue CP skills, threaten the profession, and potentially harm service-users.

A NICE Review

Further to concern regarding the implementation of NICE guidance in services, CPs had concerns about aspects of NICE guidance per se. While a minority of CPs supported the core assumptions of NICE guidance, most CPs felt that guidance based on a diagnostic framework and a narrow range of evidence limited its relevance to CP intervention. Accordingly, CPs were keen for a review of NICE guidelines. There have been mixed messages from the BPS regarding NICE guidance. While the BPS has criticised diagnostic practices (DCP, 2013), it has seemingly welcomed NICE guidance (BPS, 2007), often considered a diagnostic practice (Mollon, 2009; Johnstone & Boyle, 2018). Recently, however, the BPS issued a position statement outlining concern with the ‘depression’ guideline (BPS, 2020), featuring many concerns identified in the present study. The call for a NICE review among CPs raises the role of the BPS in highlighting discordancy between NICE guidelines and the nature of distress and therapy as understood by CPs.

A NICE review might include increasing the types of evidence and therapies selected, and emphasising the role of individual formulation. More fundamentally, the diagnostic premise could be revised, thus developing trauma-informed, psychosocial guidelines in which particular ‘symptoms’ (e.g. hearing voices) are linked to adversity (e.g. sexual abuse) rather than a ‘disorder’ (e.g. schizophrenia) (Kinderman & Allsopp, 2018). However, like some study participants, the *PTMF* (Johnstone & Boyle, 2018) advocates replacing guideline-based practice entirely, emphasising the idiosyncrasy of distress. This raises the question of whether decision making should be located primarily at a service and/or guideline level, or within individual CP and service-user dyads. The latter might entail highlighting CPs as scientist, reflective practitioners trained to draw on assorted theoretical knowledge and empirical evidence to inform individualised interventions. Service-wide acknowledgement of these skills might enable CPs to report their practice more transparently. Indeed, the assumed role of guidelines in increasing practice transparency is queried in the present findings because the guidelines' dominance meant some CPs falsely reported their practice.

Research Implications

Repeating the study with CPs working in non-adult, specialist and primary care settings, to explore the extent to which findings and framework are replicable, would provide important clinical and theoretical insights. Quantitative research could employ correlational techniques in a large adult mental health dataset to test suspected relationships between identified beliefs and practices in the current study[13].

The present findings also suggest CP is not a unified profession regarding views on NICE guidance and its assumptions. This appears partly linked to CPs' different experiences of NICE guidance and service context confluence. However, different perspectives also related to underlying diversity in the self-identity and philosophies of CP, an under-researched area (Parsloe, 2012). Accordingly, a vocal few CPs' views are at risk of being considered proxy for the profession. This warrants further exploration of the self-identities of

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[13] E.g., CPs who endorse the medical-model will view NICE more favourably than those who do not; CPs who feel unwanted pressure to use guidelines will conceal integrative practice more than those who do not; CPs whose preferred therapeutic modality is NICE-backed will favour NICE guidelines more so than CPs whose is not.

CP and their negotiations of these within dominant discourses (e.g. scientific naturalism, business-driven manufacturing of therapies, and the medical-model).

The findings also suggest research is needed to investigate formulation, level-3 skills-based practice. CP is obliged to evidence its specialist skills; however, this is complex and, arguably, cannot be achieved using methodologies suited to medical interventions (e.g. RCTs). This raises the role of professional bodies in securing funding for such research.

Limitations

The principal researcher's active role in identifying themes is acknowledged. While the quantitative component helped to mitigate researcher effects due to reduced researcher interpretation, the statements were derived from, rather than a direct reflection of, Court et al.'s findings. Thus, the researcher's role in *constructing* the statements limits the extent to which endorsement of the statements can be considered direct endorsement of Court et al.'s findings. However, steps were taken to enhance the transparency and integrity of the researcher's decision making (see Quality Assurance).

Recruitment methods were also limited. Sampling was non-random, and CPs with strong views about NICE guidelines might have been more inclined to participate. Further, social media advertising was conducted by Court et al. (2016) authors, some of whom's views regarding discourses associated with NICE guidance (e.g. the medical-model) are known publicly. CPs with consonant views might have therefore been more likely to take part, for example by being more likely to see the survey advertised on Twitter. However, the research team encouraged the retweeting of the survey by numerous other CPs. The spectrum of findings suggests that CPs with mixed beliefs were not deterred from participating.

Additionally, the sample size was smaller than hoped given time constraints. No national database was available to check participant demographic information, and the sample was predominantly comprised of band 8a CPs working in secondary care. This limits representativeness claims. Finally, a safeguard against non-CPs completing the survey was absent. However, response content suggested it was unlikely that participants were not CPs.

Conclusion

The present conceptual framework largely supported, and built upon, Court et al.'s (2016) framework regarding CPs' beliefs about, and uses of, NICE guidelines and their nonlinear connections. Beliefs about NICE guidance varied within and between CPs and CPs used NICE guidelines as *guidelines not rules* to varying degrees. Whilst most CPs thought NICE guidance was "a nice idea", they were concerned about its often "rigid" implementation and its core assumptions. For example, most CPs considered the diagnostically-informed nature of distress and therapy portrayed by NICE guidance incongruent with formulation-driven, individualised interventions of CP. The study suggests that CPs would welcome a NICE review from professional bodies. However, a minority of CPs aligned with the assumptions of NICE guidance. This diversity suggests further self-examination of the profession is warranted.

Some CPs described double-binds. For example, reporting integrative formulation-driven practice as unimodal and NICE-backed to preserve their reputation within teams, and simultaneously worrying doing so threatened CP's practice and future. This contributes to recent discussion (Cooke et al., 2019; Randall-James & Coles, 2018) regarding the negotiation of CPs' practice within NHS systems that are constituted by discourses with which they might disagree. This raises the role of CP representative bodies in highlighting the specialist skills and practice of CP, so CPs feel able to transparently deliver quality level-3 interventions to service-users without reprisal.

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HANNAH BROWNLEE BA (Hons) MSc PgDip

Necessity, NICE idea or nuisance? An exploration of clinical psychologists' beliefs about, and uses of, diagnostically driven NICE guidelines

Section C: Appendices of supporting information

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

June 2020

SALOMONS INSTITUTE
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Appendix A - Further Details of Literature Review Methodology

Initial literature searches were exploratory, conducted using various search terms in several electronic databases. When relevant papers were identified, keywords and referenced articles were examined. These keywords informed a structured search strategy in November 2019. Due to the vast amount of literature returned in searches, results were limited to literature produced after 2007. It was thought that the time frame selected would capture arguments mobilised by CPs in recent years.

Search Terms

"Diagnosis" OR "Psychiatric Disorder" OR "Mental Illness" OR "Psychiatric Illness" OR "Disease" OR "Classification" OR "Medical Model" OR "Medicalisation" OR "Mental Disorder" OR "Psychodiagnosis" OR "Typology" OR "Taxonomy" OR "Abnormal Psychology" OR "DSM" OR "ICD"

AND

"Clinical Psychologists" OR "Clinical Psychology".

Electronic Databases Used

PsychINFO (for psychological literature), Medline (for biomedical literature), ASSIA (for health and social science literature), Cochrane Library (for reviews), Psychsource (for articles and correspondence published in BPS journals, *The Psychologist* and *Clinical Psychology Forum*), Google (for blogs and news articles) and Google Scholar (for a wide search).

Additional Manual Searching

Due to the vast array of keywords used to reference the psychiatric diagnosis debate, ensuring that all relevant literature had been located via structured search methods was not possible. Considering this, the reference lists of relevant articles were scanned to identify other relevant studies. The ‘find similar’ and ‘find citing articles’ functions on electronic databases were also used. Further, because there was very little returned by way of arguments supporting the use of diagnosis by CPs, these perspectives were manually sought by referencing CP figures in search engines who have been publicly involved in diagnostic practices (e.g. the production of diagnostically-driven therapies; Bevan, Oldfield & Salkovskis, 2010; Pilling, 2010).

Inclusion Criteria

Publications between 2007 – 2019

Empirical literature (qualitative or quantitative)

Conceptual literature (peer reviewed articles, editorials, opinion pieces, correspondence, news articles, blog posts)

Literature written by UK CPs or involving UK CP participants

Literature written in English

Literature pertaining to functional psychiatric classifications (e.g. schizophrenia, bipolar disorder, the anxiety disorders, depression, personality disorders)

Exclusion criteria

Literature published before 2007

Literature written by non-CPs, or involving non-CP participants (e.g. counselling psychologist, educational psychologist, academic psychologist, forensic psychologist)

Literature produced by CP representative/leadership bodies – BPS, DCP, ACP.

Literature focussed on arguments regarding the use of specific diagnostic categories (e.g. there is a wealth of literature focussing solely on the ‘personality disorder’ diagnosis). This was excluded due to the large amount of literature returned, and to keep a broad focus on the common benefits and drawbacks of diagnoses.

Literature pertaining to diagnoses not considered functional, such as ASD, the dementias and moderate to severe learning disabilities and difficulties. These conditions have identified biological aetiologies and their diagnostic classification has been less controversial (BPS, 2013).

It was a pragmatic decision to exclude books in the review. The search returned a large quantity of literature. When running initial scans of the books returned, the arguments presented tended to be referenced by the same author elsewhere (e.g. in articles and comment pieces). It was therefore reasoned that excluding books would not entail the exclusion of relevant and novel arguments in relation to the use of psychiatric diagnosis by CP.

Results

Titles and abstracts were reviewed, and full articles were scanned to assess the relevance of literature. Three peer reviewed empirical articles were found in the literature, which investigated the beliefs and actions of CPs in relation to diagnostic practices in routine NHS work. Forty-five conceptual documents were drawn upon in the review, including: peer reviewed journal articles, editorials, opinions pieces, blog posts, letters and news articles. A vast amount of literature was found via reference list searches. Most reasons for the use of diagnosis by CPs were found in less formal forms of literature such as correspondence and blog posts, while reasons against the use of diagnosis by CP were represented in all types of literature.

Full details of the results produced from each electronic database (before assessing relevance) are below:

Database	Number of results
PsychINFO	1473
Medline*	496
ASSIA	59000
Cochrane library*	48
Google Scholar	38965
PsychSource (BPS)	1539
Google	45387

*Medline – returns narrowed to 496 from 1829 once relevant mesh headings were used

*Cochrane Library – due to limited initial returns (n = 8) the term ‘clinical psychology’ and ‘clinical psychologist’ were removed from the search

Except for Cochrane Library, database searches returned an unmanageable amount of literature. Given the time constraints of the study, the first 300 results in each database were screened. Database results were organised crudely according to ‘relevance’ in attempt to capture appropriate literature.

Appendix B – Salomons Institute for Applied Psychology Ethics Approval Letter

This has been removed from the electronic copy

Appendix C – Online Information Sheet for Participants

INFORMATION SHEET FOR PARTICIPANTS

Study: Clinical Psychologists' beliefs about and use of NICE Guidelines.

Researchers: Hannah Brownlee, trainee clinical psychologist, Salomons Institute for Applied Psychology, Canterbury Christ Church University (CCCU), Anne Cooke, Joint Clinical Director for CCCU Clinical Psychology Doctoral Progamme, and Dr Alex Court, Clinical Psychologist in Kent and Medways NHS Partnership Trust (KMPT).

I (Hannah) am carrying out this study as part of my doctoral qualification in clinical psychology, supervised by Anne Cooke and Alex Court. The study follows on from an earlier one which interviewed a small number of clinical psychologists about similar issues (Court, Cooke & Scrivener, 2016). It has been approved by the university and by the Salomons Institute Ethics Committee.

You are invited to take part in a research study. Before deciding whether or not to take part in the study, it is important to understand why the research is being carried out and what it will involve. Please read the following information carefully.

What is the purpose of the study?

NICE guidelines were introduced in 1999 with the aim of improving clinical effectiveness and reducing variation in practice across NHS Trusts. There is evidence that NICE guidelines are not implemented consistently by a range of NHS mental health professionals. There is also evidence to suggest that clinical psychologists (CPs) hold a range of views about the guidelines.
The present study aims to investigate what CPs think about NICE guidelines and how this might impact their use of the guidelines. The aim of the study is neither to promote the use of NICE guidelines nor to dispute them. We hope this will further discussion regarding the benefits and limitations of NICE guidelines, and how they can be best used by clinical staff in services, including CPs.

How is the study being carried out?

The study involves responding to an online survey. The survey will ask you a series of open and closed questions seeking to understand your views about NICE guidelines and your relationship with them in your work. The survey should take between 15 and 30 minutes to complete. Data from open questions in the survey will be analysed using the qualitative method of thematic analysis, which seeks to identify themes in the textual data. Participants' levels of agreement with statements (closed questions) pertaining to NICE guidelines will be described using percentages and frequencies.

Why have I been invited to participate?

The researchers are interested in the views of CPs working in adult mental health settings in routine clinical practice in the NHS.

Do I have to take part?

It is your decision whether or not to take part. If you do decide to take part you will be asked to consent on the next page. You will still be free to withdraw at any time without giving a reason. You also have the right to withdraw consent retrospectively and to ask that your data be destroyed. You will be asked to provide a codename so that in the event you request to withdraw I can identify your questionnaire, as all answers will be anonymised.

Is anyone excluded from participating?

Only qualified CPs who have worked in working age adult NHS mental health services within the last year are invited to take part.

What are the possible disadvantages and risks of taking part?

A disadvantage is that this study requires you to give up between 15 to 30 minutes of your time. It is up to you whether you wish to share a lot or a little information in the survey questions. Depending on how much you wish to write in open-ended questions it may take a longer or shorter time.
A potential risk is that participants might feel it is implied that they should be using NICE guidelines either more or less than they currently are. This is not the implication – rather, we hope to garner thoughtful perspectives in order to inform ongoing service and professional development. We hope that you will feel the survey enables you to provide honest responses.

What are the possible benefits of taking part?

This study could provide you with the opportunity to reflect upon your own views about NICE guidelines and how you utilise them, giving you the opportunity to think through your position and opinions.
Overall, the study is a chance to further our understanding of how NICE guidelines are used by CPs. This study could provide valuable information on how CPs practice and the skills that the profession can offer to services. The study may also provide information that could be taken into consideration in the production, distribution and use of future NICE guidelines, as well as the development of policy in the field of clinical psychology.

Will what I disclose in this study be kept confidential?

All information collected from you will be kept strictly confidential. The survey asks for information such as professional banding, years since qualification and specialist area, but not names or other potentially identifying information. The demographic information collected will only be presented in aggregated and anonymous form. Following the conclusion of the study, the anonymous data will be kept according to Canterbury Christ Church University’s policy. Data will be kept electronically on a password protected CD in the Clinical Psychology programme office of the

Salomons Institute for Applied Psychology, CCCU (1 Meadow Road, Tunbridge Wells, Kent, TN1 2YG) and on the encrypted memory stick in a locked drawer in the researcher's residence for 10 years. After 10 years all data will be destroyed.

What will happen to the results of the research study?

The results of the research will be used for a thesis as part of a doctoral course in clinical psychology and will be submitted for publication. Findings will only be presented in aggregated form (i.e. based on themes rather than participants) meaning there is no risk of participant identification. We hope the findings will inform important debates in the profession and more widely in mental health services. If you wish to receive a copy of the results of the study you may request this by contacting the researcher at h.k.brownlee444@canterbury.ac.uk.

Who is organising and funding this research?

Hannah Brownlee is conducting the research as a trainee clinical psychologist on the Clinical Psychology Programme, Salomons Institute for Applied Psychology, CCCU. This organisation is funding the research.

Who has approved this study?

The study has received approval through the Salomons Institute for Applied Psychology ethics approval process.

Concerns?

If you have any concerns or wish to make a formal complaint about the way in which this research has been carried out, you can do so by contacting me in the first instance. If you are still not satisfied, you may contact the research project's lead supervisor at: anne.cooke@canterbury.ac.uk, or for someone independent of the project, Dr Fergal Jones, the Research Director at Salomons Institute for Applied Psychology, CCCU, at fergal.jones@canterbury.ac.uk.

If you have any questions you can contact Hannah Brownlee, trainee clinical psychologist for further information at h.k.brownlee444@canterbury.ac.uk

Thank you for taking the time to read the information sheet.

To take part in the study please progress to the next page.

If you would like more time to consider the above information and/or ask questions, you can exit the survey and complete it at a later date, should you wish.

Appendix D – Online Participant Consent Form

CONSENT STATEMENT

Please read the statements below. If you choose to consent to the following you will proceed to the questionnaire.

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. If I do take part in the survey, I agree to the information being analysed using thematic analysis and descriptive statistics.

4. I understand that the data from the survey may be seen by other people involved in the research, other than the lead researcher. I understand that these people will be informed of, and required to respect, the confidential nature of the data.

5. I agree that anonymised quotes from the survey may be used in the write up and in any subsequent publication. I understand that all personal identifiable will be removed from these.

I consent to the above and agree to take part in the present study.

I consent
I do not consent

Appendix E – Recruitment Advert in Clinical Psychology Forum*

Canterbury
Christ Church
University

NICE GUIDELINES: HOW DO CLINICAL PSYCHOLOGISTS USE THEM, AND WHY?

Are you a clinical psychologist working in NHS adult mental health services?

If so, we want to hear what you have to say!

I'm Hannah Brownlee, a trainee clinical psychologist at the Salomons Institute for Applied Psychology, Canterbury Christ Church University (CCCU). I'm interested in clinical psychologists' attitudes towards NICE guidelines and how they draw on them in their practice.

Why is this study important?

NICE guidelines are ubiquitous and increasingly endorsed by service management. A previous study interviewed a small number of clinical psychologists regarding their views of NICE guidelines and found that attitudes were varied. Whilst participants saw benefits to guidelines, many also considered them to be fraught with dangers.

It is not known whether the range of views expressed in the initial study are shared more widely among clinical psychologists in adult mental health services. This current study seeks to explore this, with the aim that this will further discussion about the ways in which clinical psychologists can most helpfully relate to NICE guidelines.

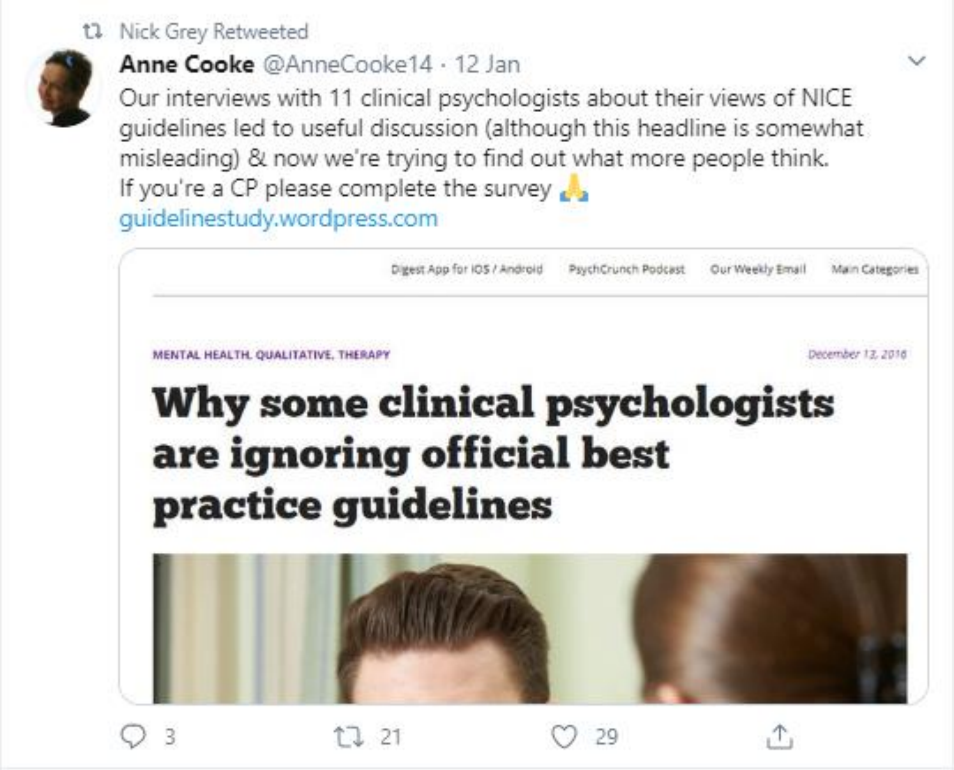
What would taking part involve?

You can take part in the study at a time and place that is most convenient for you, as it involves responding to a series of questions in an online survey. The survey duration will depend on how much or little you chose to write, but it shouldn't take more than 30 minutes. All responses will be anonymised.

To take part or if for any questions, visit **hannahbrownlee.wordpress.com**

*Minor amendments were made to this draft before submission. The website was changed to guidelinestudy.wordpress.com; the email address of the researcher was added.

Appendix F – Example of Social Media Recruitment



Anne Cooke @AnneCooke14 · 12 Jan

Our interviews with 11 clinical psychologists about their views of NICE guidelines led to useful discussion (although this headline is somewhat misleading) & now we're trying to find out what more people think.
If you're a CP please complete the survey 🙏
guidelinestudy.wordpress.com

Why some clinical psychologists are ignoring official best practice guidelines

Appendix G – Examples of recruitment correspondence with CPs with potentially different perspectives

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Appendix H – Open-ended Survey Questions

1. What are your views about NICE guidelines? Do any pros and cons of the guidelines come to mind?
2. Can you describe a time when you felt a NICE guideline was helpful to you, what the guideline was and how or why it was helpful?
3. Can you describe a time when you felt a NICE guideline was unhelpful to you, what the guideline was and how or why it was unhelpful?
4. Do you think other clinical psychologists might hold different opinions to you about when and how to use the guidelines? If so, what are these opinions and why do you think this is?
5. Are there alternative ways of working to using NICE guidelines? What would be the advantages and disadvantages to these?
6. Have you ever felt under pressure to use, or not to use the guidelines? Please explain your answer.

Appendix I – Closed statements presented to participants for agreement rating

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NICE guidelines can help provide consistency in psychological intervention

NICE guidelines can help the public know what to expect regarding psychological treatment

NICE guidelines are a useful guide to the evidence base for psychological intervention

I feel that NICE guidelines provide a safeguard against bad therapeutic practice

There are problems with NICE guidelines

Some CPs may follow NICE guidelines without being familiar with the evidence it is based on (e.g. using a guideline based on evidence from a non-adult population in an adult setting)

I worry that less-well researched but potentially effective therapies are left out of NICE guidelines

Whether or not therapies are recommended by NICE depends on whether they fit the research paradigms favoured by NICE

I worry that commissioners sometimes view NICE guidelines as a way to limit spending

Adhering to NICE guidelines can cause harm to service users

I welcome the prioritisation of Randomised Controlled Trials (RCTs) by NICE

There are difficulties in researching the effectiveness of psychological therapies

I question the validity of the medical basis of diagnostic categories

Diagnostic categories can be a useful way to conceptualise mental distress

I believe there are alternatives to diagnoses that can more helpfully inform clinical practice

NICE guidelines over-simplify clinical decision making

I sometimes experience pressure from management to be NICE compliant

I do not feel NICE guidelines restrict how I practice

I would welcome a more instructive use of NICE guidelines in the future

I worry that therapists who deliver manual-driven brief therapies are seen as a cheaper alternative to CPs

It is important for NICE guidelines to distinguish the role of CPs from single-modality therapists

NICE guidelines can prevent CPs offering the individualised, formulation-driven therapy that service users need

I believe that the professional identity and specialist skills of CPs are threatened by NICE guidelines

I believe vested interests (e.g. government political aims) have a significant impact on NICE guidelines

I am open regarding my views about NICE guidelines where I work

I follow NICE guidelines in my practice

At work, I sometimes label interventions as single-modality when they are integrative (e.g. drawn on a range of psychological theories and models)

I think it is important to acknowledge and highlight the limitations of NICE guidelines

I value the shared language regarding mental health and intervention that NICE guidelines provide

I would like NICE to review its approach to creating guidelines for psychological intervention

I use NICE as guidelines and not instructions

Services do not have the resources to fully deliver NICE guidelines

Appendix J – Court et al. (2016) Grounded Theory

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Appendix K – Abridged research diary

January – May 2018

I initially wanted to do a project on the impact of the medical model on people's recovery, or something about the epistemological and ontological assumptions behind the medical model. I don't believe fact-value separation is possible, and therefore I see this model as value laden and not a truth, as it is widely perceived. I always wanted to do philosophy, so I'm always drawn to questions about the nature of things, how experiences/knowledges come to be, and people's beliefs systems. I see NICE as rooted in the medical model and positivistic epistemology, so I was instantly drawn to this project. I also worry about the prevalence of CBT and pressure to deliver CBT; I did not train as a CP to become a CBT therapist. I would never have trained as a PWP because I don't really find being taught how to deliver protocol interesting. I'm more interested in being encouraged to use my training to deliver person centred, perhaps integrative interventions, and reflect critically on current practices and unquestioned assumptions. So really, I came into this project with some views. I am sceptical of NICE. I query the ontological assumption that there exists discrete naturally occurring mental disorders. I query that RCTs are the 'gold standard' of research. Part of me wants to find that other people have these concerns about NICE. I quite wanted Anne to be my supervisor. I was aware of her work well before training and I know she shares some of these reservations.

Telephone conversation with Alex. I am coming to understand Alex's positioning a bit more. I initially assumed he might share similar views to Anne. He is more balanced, however, and I don't think he has a deep-rooted scepticism of NICE in the way I do. I think this will be helpful to keep assumptions in check.

I am worrying about doing a quantitative project. We had a lecture that said quantitative methods typically link to positivistic epistemologies which I do not identify with. I worry about this tension.

Meeting with Alex and Anne. It was suggested at outset that we would use quantitative methodology. This was in order to test Alex's theory with a larger sample. However, none of us feel confident in quantitative methods. We think about doing mixed methods. I think it is important to have a qualitative component to see if anything emerges that did not in Alex's study. It feels a bit too soon to do a large scale quant project on the basis of 11 CPs, I think more bottom up investigation is needed first, then move on to a quantitative project. I feel reassured that it is not entirely quantitative because this felt out of my depth, and not really aligned with my thinking.

We meet with Sue Holtumn and we consider the qualitative element could use thematic analysis. It coheres better with quantitative approaches than other qualitative methods because it is not fixed in a particular epistemological position. Approaching research from critical realist perspective, which I think reflects the methodological choices.

June 2018

Viva. Julie is very concerned the statements are biased and will rub people up the wrong way. I explain that this a top-down element, based on the findings from Alex's study. They are not the researchers' views. Julie and Sue think the wording needs to be changed. I am feeling a tension between wanting to be faithful to Alex's codes in order to theory test, but not wanting to have the study be perceived as biased. I think Julie might like the NICE guideline approach. I felt she reacted quite strongly to the proposal. She works in LD where NICE is not very prescriptive, so perhaps the statements that suggest NICE guidance restricts CPs' practice is a bit jarring; it does makes sense. This is a helpful response because I imagine lots of CPs will feel like this too.

Reflecting on viva makes me think I should keep sample to adult mental health. I'm leaning towards adult MH because I'm looking through the guidelines and they are vastly different across clinical populations, ranging from prescriptive to actually quite vague (e.g. LD), and I suppose this reflects the extent of research in each area. It feels odd to ask people about guidelines generally as if they are a homogenous group – I just don't think it makes sense theoretically.

I speak with through with trainees in a research group and they agree. I speak with Anne on the phone and she agrees. Especially as there is very little research in this area, it feels more appropriate to start with a restricted population and expand sampling in subsequent research.

April – May 2019

Working on ethics form. It's helping me to consolidate important parts of the project. Particularly recruitment. I am emailing lots of potential stakeholders: the psychosis and complex mental faculty of the DCP, and regional DCP meetings, to see if recruitment is possible here. Social media advertising will be used to cast the net wider. And I am hoping to advertise in Clinical Psychology Forum if I can get funding.

Salomons Ethics has given approval first time which is a relief.

October 2019 – Jan 2020

Sadly I have not been able to recruit through BPS avenues, excepting the CPF, which I am submitting an advert to; it will come out in November issue. Will recruit via twitter and CP facebook page.

Making final additions to online survey. Doing lots of piloting with trainees; it's quite a political project and I don't want the statements to put people off from proceeding through with the whole survey. Julie's response in the viva stays with me. I think it's important to make clear in the survey that the statements are derived from previous research rather than representing the researchers' views. Trainees helped me with lots of changes for clarity, but the fundamental essence of each statement is kept, I think. Piloting helped me realise that It's difficult to say 'this project seeks to fully explore benefits and limitations of NICE, rather than advocating or criticising use' if all the statements I present about NICE are negative. For this reason, I reverse some of the statements e.g. 'I welcome the prioritisation of RCTs by NICE' was changed from 'I have concerns about the prioritisation of RCTs by NICE': they are similar enough to retain the conceptual core of the statement, but worded in a way to balance the number of negative statements about NICE.

I make a website for the research to advertise on social media. Survey is released.

Part A. I decided to do a review on CP perspectives on psychiatric diagnosis, in conversation with Anne. I wanted to do something that spoke to potential tensions CPs might face working within systems and practices informing and legitimising NICE guidelines with which CP philosophy and practice might contradict. I also wanted to do something that explored different beliefs held by CPs about key properties of NICE guidance, because I have always felt CPs are so diverse (e.g. modality; clinical population; unimodal therapies vs manualised therapy vs integrative; view on diagnosis; positivism vs, constructionism; manager, teacher, leader, consultant, therapist…I could go on), and I am always thinking, what is it that ties this profession together? I am always interested in how the BPS represent diversity among CP too. I think diagnosis is a key premise of NICE guidelines, and clearly premises research into psychological therapies. I don't even think this is just a perspective – it just is. I think it is important to understand diversity among CP regarding diagnosis, which the NICE guideline debate can then be situated in.

I spend all of November and December writing part A. I take no days off except Christmas day and some of boxing day. It takes forever to search digest and assimilate literature. Alex thinks it's important to thicken arguments in favour of diagnosis for it to be a balanced and interesting read, but this is the problem – there are so few in the literature!! However, I do not think this is necessarily representative (there are probably many more CPs out there who favour diagnosis), and I seek to emphasise that more research is needed in the review.

January 2020- March 2020

Initial survey responses are very thorough which I find reassuring. It suggests people have a lot to say about the topic and we are tapping into a very useful and pertinent conversation. I was worried lots of research just gets lost and sits on virtual shelves, but this make me feel motivated to continue.

Scanning responses so far. They appear much like Alex's at face value. No CPs seem particularly devout in following guidelines, seeing them as a helpful summary but not at all prescriptive. They acknowledge LOTS of problems with NICE. Some experience pressure to use them – these people seem to feel more angry about NICE and don't have the same relaxed attitude about them compared to those who don't feel pressure. Some are really strongly written, I am picking up a lot of emotion and fear. The people who are saying they are free to use NICE how they like don't necessarily want NICE urgently replaced, as long as it's seen as a 'guide', that they can override when they need to.

Prof Paul Salkovskis has commented on CP facebook page that our research is likely to attract a biased sample because Anne has been advertising the survey on social media using the research digest article (summarising Alex's research) with the inflammatory heading 'CPs are ignoring best practice guidelines'. This made me think of the crucial difference between ignoring and choosing not to follow NICE. I feel like Alex's research made clear that some CPs were not following NICE following thoughtful consideration rather than ignorance. I regret the title of this article. Perhaps Prof Salkovskis has a point, CPs sceptical of NICE might be more likely to complete the survey. But surely if people felt strongly against this message and strongly supported NICE, they might in fact feel more inclined to complete the survey – to 'set the record straight'?

Speaking with Alex, I choose to email Prof Salkovskis. I validate his concerns and politely suggest that the representation of the sample might be improved if he were to post the survey link on his twitter. This might attract more CPs who support NICE because Prof Salkovskis does not appear to be critical of NICE.

Prof Salkovskis has not replied. I wonder what he feels he has to lose by posting the link? Perhaps that if he posts the link and the responses are still critical of NICE, he can no longer say the sample is unrepresentative? Maybe he just didn't read my email.

I'm worried one statement in survey is unclear 'I welcome a more instructive use of NICE'. This could be interpreted in different ways – that people want NICE to be clearer, relevant and useful, OR that people want NICE to have more power and control over our interventions (i.e. more like instructions). This is VERY different. I'm annoyed I didn't spot this. Data pertaining to this statement won't have much meaning due to ambiguity, which is a shame. The definition of instructive is 'useful and informative'. I think I wanted to tap into whether people would prefer NICE to become more like instructions, which is really not the same. I wonder how participants interpreted this. I am annoyed at myself.

Prof Paul Salkovskis is posting on twitter under Anne's post of the survey link. He says we are clearly hoping to see a desired outcome, by saying that we want to know 'the extent to which these views are shared by CPs more generally'. I think this is an unfair comment. We do want to know the extent – whether large or small, either way. I am pleased with how Anne responds to this. I feel annoyed that Prof Salkovskis hasn't responded to my email which offers a productive solution to his concerns.

A few CPs who appear to strongly favour NICE, and have very few, if any concerns, have responded to the survey. I wonder if this has something to do with Prof Salkovskis involvement on twitter, and if he himself has completed the survey. Regardless, I am pleased to have some more diversity. I know these beliefs are out there and I want to understand them. This is exciting because I feel these types of responses are departing from Alex's findings a little, which might entail some difference in my eventual thematic map.

I have 55 responses. I email Prof Stephen Pilling in hope that he might share our link. He obviously directs the body that produces guidelines, so his posting might increase the share of CPs responding who favour NICE.

Prof Pilling hasn't replied. I am thinking about closing survey, I need to get analysis underway. I think 55 responses is ok; I aimed for 40-70. I feel I have tried my best to encourage a wide range of CPs in adult mental health to respond. I am happy that there is some diversity in responses.

Reading through responses and thinking about initial codes. Struggling between the top down approach (based on Alex's themes and categories) which might help test his theory, and a bottom up approach, which might produce a model entirely different. This makes me think about inevitable impact of values and assumptions in qualitative analysis, such that different methods of coding might produce entirely different frameworks. Thinking I need to speak to Anne and Alex about this, to decide on the best approach to coding. I think it will be impossible to perform coding in a completely bottom up way, because I will implicitly be influenced by Alex's codes because I am familiar with them. I decide to code using top down approach initially, because to suggest I am doing entirely bottom up would be impossible. I will then do data-driven coding when data does not fit with Alex's codes. This will be iterative rather than linear, I imagine.

Reading some literature and thinking about how CBT could be seen as an extension of western medical model. It is congruent with diagnosis and can internalise problems through focus on 'maladaptive cognitions' and focussing on the here and now.

March – April 2020

Thoughts on analysis: NICE guidelines are ok IN PRINCIPLE – KEY WORD. But many problems with core properties (e.g. narrow research used, bias, diagnosis) and the way that NICE guidelines are used factually and implemented dogmatically. This leads to a whole host of problems with MDT working – inappropriate referrals, having to challenge team members who see NICE as fact, compromising relationships, having to falsely advertise practice. So, some people aren't necessarily opposed to guidelines per se – but they would find them more useful and less stifling if they addressed perceived flaws in their fundamental properties (e.g. diagnosis, narrow evidence, favour CBT) and CPs were given explicit permission to override NICE with formulation.

And interestingly, those who seemed to feel threatened by NICE were also those who felt unwanted pressure to use NICE – by people interpreting NICE factually.

Recurrent theme – can be helpful when viewed as guidelines not rules, dangerous when viewed as rules and not guidelines.

Recurrent theme – using guidelines to argue for psychological therapy provision/access as people recognise the power and currency of NICE and diagnosis, while privately being sceptical of these things. Tension for CPs who do not align with medical approaches. Makes me think of Randall James' 2018 study and Cooke et al.'s 2019 study and theories of how CPs negotiate NHS discourses – 'playing a game' and 'strategically' using medical model to suit needs.

I feel like its tapping into something very important. Most CPs are sceptical of NICE but have to play the game for a number of reasons: pressure from teams, professional interests (provision of psychology), power of NICE and diagnostic language, legitimising arguments. Relates to Court et al 2016. Relates to Cooke et al 2019. Relates to Randall James 2018. Tells us that internally consistent views and actions are rare, as is perhaps made out in theoretical literature. Relates to diagnosis literature review. Bps need to give guidance about these complexities? Feels like an exciting budding branch of CP research, these tensions.

Big message in data about compatibility of formulation with NICE. Some say nice undermines formulation, some see as compatible. Again, this seems to be linked to the pressure felt by CPs to use NICE guidelines -if pressure is there, formulation and NICE feel incompatible. It feels like there is a separate, small group of CPs who favour NICE entirely. This is interesting and moves on from Alex's theory. I want to protect and showcase this novel finding.

Really wish I'd asked p's to provide training course and philosophical orientation. Realise survey doesn't include basis demographic info.

Worked out percentages on excel. Noticing most people agree with all statements, which suggests people hold complex beliefs about nice I.e. don't view as entirely good or entirely bad. Lots of support for Alex's model, upon which statements were derived, on a cursory view.

Conversation with Alex. Helpful conversation about needing to be transparent. Talked about combining top down and bottom up approaches and literature I have read to support this. Agreed to send coding extracts to Anne and Alex where discrepancies emerged. I shared my trainee consultations, which he thought was a good thing because they will have fresh eyes and not be implicitly biased by Alex's model. Talked about reader having more respect for model if I do apply it critically to current findings.

Statement that has received the most 'strongly agrees' is need to highlight limitations of nice. Second to questioning medical/diagnosis. Nice link to part a, which is reassuring.

Feel like there is a theme emerging among all empirical literature re: medical model in practice – having to play the game, far more complex than portrayed to be by cp commentators who hold polarised views.

Wanting to draw on need for certainty to defend against complexity.

Data is making me feel like particular models/techniques are just the tip of the iceberg regarding what delivers a successful intervention. What about personality, relationship, race, class etc? NICE does not mention this and seems to imply therapy outcome is dependent entirely on modality used.

The things that are really interesting me in these findings 1) what is CP – is there a core, philosophy – consensus? Does seem to be a clear majority but certainly not whole story, there are outliers which are very interesting 2) how does CP work within systems, teams, institutions which are pervaded by discourses (medical, diagnostic, positivist ideas of science e.g. nice) which many CPs see incompatible with the profession??

Feeling a little pulled between Alex and Anne's views on my thematic map. Alex seems to be suggesting I stick to his model unless there is strong evidence to change it, and I will be need to be able to justify every small change in viva. This feels a little odd because surely it is obvious why I have made changes – because I have different data. Anne is saying fine to go completely from afresh, and stay close to the data in front of us, or what is the point? I've been trying to simultaneously occupy both these positions, as per my methodology. I coded the data with Alex's codes in mind, but If I felt something novel was there, or the wording or the emphasis of a code or theme needed altering to better fit the data, then I would change it. The point is to test Alex's model, update, improve and refine it, on the basis on new data, so this seems sensible to me. Because of this I have tried to make my decision making in analysis explicit - so top down codes, then bottom up coding when I felt existing codes weren't the best fit, or when completely new ideas were identified.

Thinking about the three use positions I have identified, threat, freedom and alignment. I feel including the three use positions on a spectrum (as subthemes within guidelines not rules theme) is warranted because 50 people responded so I feel I am in a better position to identify different positions compared to a smaller sample. I feel keeping 'nice guidelines not rules' as one homogenous theme misses the opportunity to do more with data, and it flattens out clear nuances that I am identifying. If I feel like it's there, so I should draw it out, or what's the point? Important findings will get lost if I feel constrained by Alex model. Alex isn't so sure about these three positions. Anne thinks it's important to keep them. I think it's important to keep them. I want to foreground the diversity, perhaps using this in a title.

An example of a change is that some CPs welcome pressure for CPs to use NICE guidance in this data, which is a novel finding. Accordingly, my theme to represent the use of NICE guidelines in services departs from Alex's associated category - *level of pressure experienced to adhere to NICE guidelines*- assuming that participants perceived 'pressure' as undesirable. My themes is: *level of comfort with how NICE guidelines are implemented in services.* Alex agrees this is good new theme when I show him data extracts and codes.

Beyond percentages, I would like to see if responses to items are correlated with responses to other items, but from Sue's email, this does not seem possible without grouping the items in to broader constructs, which is problematic because the items that comprise each construct are not necessarily cohesive/consistent, which, in part, is the key message of the model. Has been very hard to get support from other members of research team, have sent several emails with no reply. Sue did reply in the end, which was helpful. I know everyone is so busy.

I have made the decision to stop quant analysis after using SSPS to calculate standard deviations. In conversation with Alex, we thought that checking the relationships between subscales was not warranted because of the diversity within the subscales and responses were not normally distributed. We were not interested in seeing if subscales are related, because of diverse statements within subscales. We are interested in relationships between items within subscales (assessing which cannot be done) rather than subscales per se.

Thinking about 'threat', 'freedom' and 'alignment' spectrum. I am categorising a spectrum of beliefs, but that is in some ways the nature of research. I stand by this decision I just need to make it clear that I have simplified it into these three positions for digestibility. Also, I need to emphasise that they are thematically aggregated rather than representing views of individuals (though in some cases they do, particularly 'alignment'). I use the trainee quantitative analysis discussion group to share these parts of coding, and other differences between mine and Alex's framework. Really encouraging and gave me confidence that my identified codes and subthemes were aligned with data, and working too closely with Alex's model might mean missing importance new messages in data. I think highlighting this spectrum of diversity is very important. I reflect this in the title of the thematic map: *Threat, useful guide and vital manual: the shades of grey within and between CPs' beliefs about, and uses of, NICE guidelines.* This is a key change from Alex's model – emphasising the diversity in the title.

Having difficulty with the claims that TA permits me to make. I am doing lots of reading and it doesn't mention anything related particularly explicitly, which I find unhelpful. It seems I can make claims about relationships between themes but not say the direction of causation. I remove the arrow directions from the model. Anne and Alex comment that I need arrows, but I don't think I can keep them because of TA methodology. It's a bit of a shame because participants do seem to say quite clearly that particular things lead to other particular things – but at the end of the day my methodology can't support these claims. Making me think of future research to test correlations between particular beliefs (not between themes but between particular subthemes and/or codes).

Anne and Alex's feedback for part B I am noticing have very different emphases. Alex seems keen on discussion regarding the relationship between my framework and his theory in the discussion, and theoretical integration with guideline implementation theories. Anne is saying I should talk less about the model and more about the findings, and focus more on clinical implications. Part of me feels this is linked to their respective interests, and I'm not sure what is best to pass. Alex's MRP was very much rooted in theories of behaviour and guidelines implementation, and probably sees my project as an extension of that, hence his interest in linking to theories of guideline use, and Greenhalgh's work in complexity theory. Anne doesn't seem so interested in this and seems to want me to emphasis the impact of NICE on CP more (e.g. restrictions on the profession and implications of that). I am worried about the latter because I think the study will attract criticism from those who favour NICE (there were a few in the present study). But concern with NICE was the majority view in the data, so I do think it is fair on the other hand. However, I worry that focussing more on the clinical implications comes at the expense of theoretical, which is essential to pass the MRP. Kind of feeling I can't please everyone? I don't have enough words to. Hard to separate out what is essential and what is a perspective…….im confused!

Nearing the end… having to remove lots of paragraphs. Really thinking hard about what the key messages are. I could write a discussion that is 30000 words. It's difficult because there was diversity in beliefs among CPs so I cannot fully thicken implications of all CP viewpoints. The majority of CPs had strong concerns about fundamental aspects of NICE guidance. These concerns were less threatening when guidelines were not implemented as rules in their services. It makes me feel it is important to represent this majority viewpoint, over the minority viewpoint that NICE guidelines are wholly valuable in their current form (bar needing updating more frequently). This is because this view is already supported by the dominant discourses, so doesn't need thickening so much. It is also the minority view in the data, by quite a margin.

I had to delete this paragraph on safe uncertainty. I think using guidelines for certainty is a key point, but was perhaps more latent than explicit in the data, so I thought it would be more representative of the data to present more clearly grounded implications. "Bohart and House (2008) argue that therapy is necessarily and constitutively uncontrollable. This means that, despite best efforts, therapy precludes standardisation by 'modernist control agendas', of which NICE guidelines could be considered an example. For instance, Court et al (2017) positioned NICE guidelines as a quest for certainty (Court et al, 2017). CPs in the present study used NICE as guidelines not rules, which reinforces the idea that being guided, but not bound by, the guidelines represents a position of 'safe uncertainty' within Mason's (1993) theoretical framework. However, the present theoretical model suggested that CPs might have different ideas regarding where 'safe uncertainty' lies in practice. For example, CPs occupied different positions on the 'guidelines not rules' spectrum, with CPs making different appraisals regarding the most helpful balance of clinical judgement (uncertainty) versus evidence-based protocol (certainty). These appraisals are modelled in the 'threat', 'clinical freedom' and 'alignment' positions."

Appendix L - Positioning Statement

I conducted a bracketing interview with a trainee colleague to reflect on and understand what some of my motivations might have been for doing a project in this area and what assumptions I might hold. I am a trainee at Salomons CCCU. Salomons is a clinical training course known for its attention to ‘critical practitioner’ and ‘reflective practitioner’ models of CP, as well as the more traditional ‘scientist practitioner’ model. We have a lot of teaching with a social constructionist emphasis and community psychology principles are valued. We are encouraged to think critically and examine taken for granted assumptions (e.g. the nature of distress, the nature of therapy, and what might constitute ‘good science’). Teaching involves lots of peer reflection, rather than being taught how to do things. I definitely applied to Salomons for these reasons. I remember, before the course, I was interested in the idea of therapy being the ‘opium of the people’, and whether therapeutic efforts would be better directed at changing society. I remember feeling put off a few courses that seemed, from my reading of their websites, to accept things as they are and interested in producing trainees that will follow the ‘evidence’ and ‘rules’ in the delivery of therapy and more broadly. (This was probably an inaccurate and unfair reading but it did go through my mind). I just reread my personal statement on the clearing house application, and all this stuff is there, I haven’t changed at all. I wanted to be a philosopher when I was growing up, so I think that part of me has meant I have a strong dislike being told what to do and what to think, especially when opinion or convention is presented as fact.

I saw this project advertised in the MRP project options booklet. I reflected that It probably got my attention because I understood NICE guidelines as a manifestation of diagnostic and positivistic practice, which I had scepticisms about. These scepticisms had a lot to do with attempts to organise complicated, context-dependent mental distress into discrete, neat categories, at which specific, curative therapies could be targeted – i.e. ontological and epistemological issues, from my perspective. I have also never really liked making decisions, because everything (not just mental health) has always felt very idiosyncratic, complex, nuanced and contingent of other things. So, the idea of a set of decisive guidelines just felt jarring to me – like attempt to cover up and streamline whatever is really going on, and removing one’s own ability to think.

That said, I didn’t feel that I wanted to promote or to dispute NICE guidelines in this project and I was genuinely interested in CPs’ views. I think this comes from a desire to understand the nature of the profession and the breadth of views within it. It has always struck me that CP is difficult to define, and training courses have such different identities. I think part of my motivation was also to elucidate this perhaps at times disparate, hard to pin down, professional identity. So I am genuinely curious to attract the breadth of views out there to help my own understanding about what CP is. However, while I do genuinely want to understand and capture a range of CPs views, I don’t think I would be happy if a recommendation of the project, borne out the data, was that NICE guidelines are best understood as rules and their use enforced. I think that comes from an assumption that guidelines, if understood as instructions, are limiting and undermine original thought. I think having enforced guidelines would also raise my own anxieties, because I would feel guilty, like I am doing the wrong thing if I do not follow the NICE recommended protocol, and I don’t like being told off, either. It would also make me feel like a bad psychologist? Like there is this robust evidence that I am just not following, for no particular reason. So perhaps

I do want CPs have permission to not follow guidelines, so I feel less anxious about not following them.

My main supervisor is Anne Cooke, a public figure with lots of output on critical psychology. She is vocal on issues such as diagnosis, the nature of distress and therapy and critical of the medical model. I supposed that Anne might be interested in this project to highlight the limitations of NICE, because it is embedded in the medical model and can be seen to imply that 1:1 unimodal therapies are the best type of intervention for all. However, in conversations with Anne I got a real sense that she wanted to foreground other perspectives, if they were out there. Alex, my second supervisor, and the lead author of Court et al. (2016) I think has a more balanced view on the guidelines. In his own research diary, he said that he had traditionally favoured rules and struggles sometimes that they aren't followed, but equally he has found NICE guidelines more limiting as he has amassed clinical experience. I got a strong sense from Alex that he sought to be balanced, fair and representative. That said, because he published the Court et al. paper that could be said to have an anti-NICE message, he probably cannot be seen as entirely neutral on the issue, as presumably he has some stakes in his findings being replicated to support his theory. In all, the research team tips towards a critical view on NICE, which must be acknowledged. However, I think the interview allowed me to see that I genuinely wanted to understand what other CPs are like, borne out of a curiosity of wanting to understand humans and our beliefs and decision making more generally (something that has always interested me). I think these things will mean that my assumptions will not cloud my analysis. I plan to see what is in the data and code accordingly. I plan to pay particular attention attend to data that does not fit with my beliefs. Trainee colleagues and I have set up a coding group to check each others codes, and I plan to bring data that jars with my beliefs to this group.

Appendix M – Theme, subtheme and code table with qualitative and quantitative data examples

Theme	**Sub-theme**	**Code**	**Examples from data**
BENEFITS OF NICE GUIDELINES	Guidelines help provide consistency in clinical practice Agreement with quantitative statement 44%	NICE guidelines help standardise interventions	NICE guidance on social anxiety disorder helped me to know how long the intervention should be (using CT-SAD), which could be communicated to the client. It also reminded me of elements of the intervention which I should think about employing. [Guidelines] give indication of length / type of therapy and areas of assessment needed and possible risk or problems that might complicate treatment, and then what would be indicated then
		NICE guidelines can help organise services	[NICE guidance is a] useful indicator for service planning and provision [The guidelines are] generally [useful] to structure service provision and pathways of care, to communicate with commissioners about clinical provision and to support rationale for first line therapeutic intentions
		NICE guidelines help provide transparency for service users	Agreement with associated quantitative statement 44% (NICE guidelines can help the public know what to expect regarding psychological treatment) It [NICE guidelines] also allows those who use services to understand what should be provided and why I think the guidelines are helpful for sharing with our clients, more so those unfamiliar with therapy, where the therapist is able to explain that different therapies have been researched, and help someone make an informed choice

			NICE guidelines introduce a degree of standardisation, which has its benefits in terms of what we can expect of services when we need to access further support for psychological distress [NICE can] empower patients and families to seek and receive the treatments with best evidence NICE guidelines have been helpful to me when seeking appropriate care for family members - without them i wouldnt know where to start. i admit that this has been outside of the question of AMH, but i then consider the people and their families seeking AMH help and where do they go for guidance and what guidance do we give them
		I value the shared language regarding mental health and intervention that NICE guidelines provide	Agreement with quantitative statement 22%
	Guidelines are the means of delivering evidence-based practice	It is a good idea to have a summary of the evidence base	Agreement with associated quantitative statement 36% (NICE guidelines are a useful guide to the evidence base for psychological intervention) I think it’s helpful to be collating evidence and drawing on research about what works to develop guidelines of best practise I think guidelines are needed that take account of evidence and treatment effectiveness Generally, a useful synthesis of current evidence with input from service users and professionals In principle they are a fantastic thing and provide useful guidance on practice NICE guidelines present appropriate interventions based on the best, most rigorous research evidence of effectiveness. They are straightforward and easy to read for any clinician (even those without extensive training) and ensure that, as a profession, we are

			offering clients interventions that we know work (which is ethical, in line with hopes of service users as we know they prefer interventions that work, and ensures best use of taxpayer money). I think that the NICE guidelines provide a useful indicator as what type of therapy may be most effective for particular presenting problems most of the time As a positive they help practitioners across all levels understand some of the evidence into diagnosis-based difficulties & as such provide a framework to apply to services in terms of treatment I value the health economic element - we are massively under resourced in my team and having some research base for cost benefit of different treatments is helpful.
		NICE guidelines help safeguard against bad practice and harm to service users	Agreement with associated quantitative statement 34% (I feel that NICE guidelines provide a safeguard against bad therapeutic practice) The disadvantage to this [absence of NICE] is you may have some professionals who are not performing effectively and how can this be monitored The disadvantages [of using clinical judgement instead of NICE] are that it probably wouldn't work, and might actually make things worse [Without NICE] the level of harm could be increased as unevidenced interventions could be adopted without evaluation and be prone to Clinician bias They offer clarity in mental health provision that can end ineffective and harmful treatment … It is a myth that they are rigid or don't apply in adult mental health secondary care contexts. This myth is harmful to patients

			It is very worrying and unethical that people are being treated for certain difficulties where there is no evidence of effectiveness and where the psychodynamic theories/models are entirely false (e.g. OCD).
		NICE guidelines help validate decision making	[NICE] backed up my impression that the time frame was too soon to commence therapeutic work [trauma focussed therapy] for the person's presentation and could be quoted back to the GP who accepted the decision
	NICE guidelines help promote and expand psychological therapy provision	NICE guidelines support arguments made to other professionals regarding psychological therapy access	To be able to justify the use of psychological approaches for people with psychosis in a system that is still somewhat sceptical about this. Has influence on powerful people in the system like psychiatrist [The guidelines are helpful when] used to make argument for why someone should receive psychological treatment or support when a service might not have been providing it
		NICE guidelines help expand psychological provision	I think that having psychological interventions clearly recommended within NICE guidelines leads to services believing that these must be offered, so provision is put in place to support this Has been helpful in making the case to introduce or increase psychological provision in areas where that hadn't been any. When discussing with service leads the importance of offering service provision via interpreters, the NICE guidelines for PTSD explicitly state that interventions should not be denied on account of language In my service they have been used to get funding to increase therapy provision, providing an alternative to just medication for many Sadly it is necessary to argue for resources and funding. NICE guidance has been helpful in providing substance behind such arguments Guidelines can be helpful for making cases to commissioners to get money and resources allocated. Some guidelines like NICE on

			‘challenging behaviour’ have wide definitions that can enable creative interpretations and inventive requests for funding. I’ve been able to use them to try and highlight gaps in provision or to guide better practice. So for instance in the Long Term Conditions guidelines
	The Pros of NICE guidelines are more convincing than the cons	Acknowledging problems with NICE guidelines but we would be worse off without them	There are flaws that need to be addressed. But a complete overhaul is unnecessary. Other approaches have their own problems. Of course, the main disadvantage [of having a more relaxed approach to guideline adherence] would be the risk of people ignoring them completely Flexibility and response to individual [would be an alternative to NICE]. However, my main concern would provide a large lottery of care no clear understanding of what is provided or how competently Without them we truly are either in the dark or anything goes It may seem contrary to my points above, but the complete absence of any guidance/evidence summary does seem a confusing and unhappy vacuum.
		NICE’s current approach to producing guidance is a good one	I do believe that CBT should be prioritised as an intervention due to the high quality and quantity of evidence for CBT models and its therapeutic effectiveness and efficacy (evidenced by well-controlled RCTs). NICE guidelines help augment the best evidence and RCTs to compare types of treatment NICE guidelines are an incredibly helpful summary of the available evidence. Even in their production they embody evidence based practice by including clinical expertise and service users views and preferences. I think there is only one valid way, which is to employ them [NICE guidelines] as useful synthesis of research evidence leading to

			professional consensus statement. Some may believe they are something else, but these beliefs are in my view mistaken Diagnostic categories can be a useful way to conceptualise mental distress – Quantitative agreement 16% I welcome the prioritisation of Randomised Controlled Trials (RCTs) by NICE – Quantiative agreement 15%
		Mistrust of NICE guidance is based on misunderstanding	[arguing scepticism of NICE can be based on a misunderstanding of CBT] when I got properly trained in CBTp I realized I actually held huge misconceptions about the approach and it was my lack of adequate training in CBT and CBTp that accounted for my reluctance to offer this model to people as I assumed it was about reducing symptoms, pathologizing distress, too based on realist notions etc. etc. - turns out I was poorly trained and led to hold a straw man of the approach. With a good formulation and careful discussion of what someone wants from therapy I was able to use the model in a helpful and compassionate way focused on function and distress not symptom reduction I think [some CP don’t favour NICE] because some CPs are unaware of what guidelines state or how they come to be. There is also a strong mistrust of evidence based practice among a specific group of psychologists which can be very undermining and unhelpful [arguing scepticism of NICE can be rooted in an overestimation of CP research skills] many clin psychs, despite our long years of training, are actually not overly skilled at research. For example, I often hear people spout about 'common factors in therapy' to justify why it's fine not to use one model or why it's fine to ignore evidence base - but if you actually read that material on common factors - it's based on people properly adhering to a model (that we see that one approach is not necessarily superior) - the common factors research didn't account for people working integratively

CONCERN ABOUT NICE GUIDELINES		NICE guidelines are more unhelpful than helpful	I'm actually finding it difficult to think of a time when it was helpful Not really..no [not being able to think of a time nice was helpful] More downside tend to come to mind. I think they can generally be unhelpful as they can be reductionistic I don't find them helpful for the population I work with- secondary care/long term mental health. All (or almost all) my clients have complex and comorbid difficulties, so trying to work out which guideline to follow feels useless
	Guidelines are predicated on a medical rather than psychosocial model	Concern with diagnostic premise of NICE guidelines	Agreement with associated quantitative statement 44% (I question the validity of the medical basis of diagnostic categories) But the processes in which one reaches [the NICE recommendations] is question, given what can often appear to be a very diagnostic-driven, rather than needs driven, process. Recently, I heard a radio discussion refer to such clear-cases of diagnostic presentations as 'the unicorn of services' - as such clear instances just do not exist within real life working environments. More downside tend to come to mind. The guidelines rely on reified concepts of diagnoses, clinicians are then expected to put clients through a 'shape sorter' in selecting the guideline: some clients fit in the slots, other do not They are based around diagnostic categories, increasing the prominence of the medical model and limiting consideration of a formulation-based understanding of clients. In essence, I believe they perpetuate a diagnosis led service as well as then research and all the problems that entails. In addition to funding for research being offered for a particular diagnosis, now we have therapies for "SMIs' and I have concerns that this is ensured as

			needing to be provided, thereby further perpetuating a model of diagnosis and ignoring the role of trauma This is the case with the majority of NICE guidelines for mental health difficulties, due to epistemological problems with all diagnoses, but is even more of a problem with more contentious diagnoses [I have found the guidelines unhelpful] - basically throughout my career - making a false association between single medicalised conditions and single medicalised approaches
		The physical health paradigm doesn’t work in mental health	I am concerned about the lack of psychological thinking and decision making [NICE guidelines] leads to as mental health is not directly comparable to physical health despite the best efforts of the DSM... a both/ and position appears to be getting lost! While it’s important to evidence base what we do, I fear we don’t evidence the right things and use research frameworks that come from physical health and not ones that work for mental health. In physical healthcare it might make sense but mental health is entirely different to physical health so this is a gross category error and we are in effect being forced to offer treatments for which there is a poor evidence base, at the expense of offering things which might be more helpful to people referred to us
		NICE recommended therapies ignore the contextual origins of distress	Feels like being forced to use a model which doesn't address the causes of distress Not representative of the lived experience of people’s lives that are complicated, messy and grounded in political and social context If we accept the Power Threat Meaning Framework and the contribution of environmental and social factors towards mental health problems arising from the misuse of power - then the intervention must also be social, environmental and stem from a human rights based approach

			[NICE guidelines] tend to focus on overly simplified models of difficulties and ‘treatment’ without taking any of the complexity of human lives, interactions, relationships into consideration i.e. social difficulties (housing, benefits) or multiple complex trauma leading to difficulties trusting/ engaging with therapy.
	Guidelines are based on questionable science	Concern with research paradigms prioritised by NICE	There was only 15% agreement with the quantitative statement: I welcome the prioritisation of Randomised Controlled Trials (RCTs) by NICE CBT is the 'treatment of choice' for the area I work in, yet, no one really talks about effect sizes, or questions the norming populations. While it’s important to evidence base what we do, I fear we don’t evidence the right things and use research frameworks that come from physical health and not ones that work for mental health they only refer to RCT evidence which doesn’t allow for novel approaches I'm mindful that the guidelines are limited, based on a narrow range of research studies that often exclude a large number of people we may work with, for example comorbidity. They assume value of evidence in the same way as for medical trials which I don’t think apply in the same way to mental health ie RCTs not being an equivalent ‘gold standard’. I am concerned that the evidence presented is (I) often weighted to CBT (however widely defined) over other approaches in part because CBT has enjoyed much of the research funding in the past (and I believe still does), (II) we know from moderation analyses of group-based trials that not everyone gets on with CBT but this evidence seems to get lost in NICE guidance because of group-level relied upon, (III) much of the evidence is often specific to one illness group or a single diagnostic category as eligibility criteria, which means the people evaluated in the evidence do not reflect the

			people I see in working age adults who have lots of problems intersecting However [the research that informs NICE is] often limited to studies that are designed with very specific client groups, very specific ways of measuring change and difficulties and often do not capture real life scratch the surface of a lot of research and it doesn't pass muster: vested interests, publication bias, demand characteristics, fidelity, numbers needed to treat etc. etc. the list goes on
		NICE guidelines exclude other meaningful forms of evidence	I consider it my ethical responsibility as a Clinical Psychologist to offer support informed by recommendations for practice based on multiple strands of research. NICE guidelines may not include all evidence available such as qualitative research or small N design Perhaps if NICE guidelines drew on multiple forms of evidence and respected qualitative research, actively funded research into a much wider range of therapies and so on they would be more useful I value practice based evidence as well as evidence based practice so emerging research is of interest to me. New and innovative practices will rarely be included in the guidance Often they are based on studies that are artificial and so do not reflect the reality of work at the coal face, so to speak. I think as a consequence they can be over-valued whilst practice based evidence is under-valued
		Therapies than can be manualised fit well with the NICE paradigm and are therefore recommended in the guidelines	Agreement with associated quantitative statement 74% (Whether or not therapies are recommended by NICE depends on whether they fit the research paradigms favoured by NICE) Particular models, such as CBT, receive much more funding for research and are better suited to trials which means there is "more evidence" for them, however this does not actually mean they are necessarily the best

			Not all evidence is treated equally and there is an over emphasis on CBT which perhaps is easier to measure Sometimes treatments aren’t NICE recommended not because of negative outcomes but because there are simply not enough studies using that method to back it in NICE guidelines. Also the research behind NICE guidelines is not always strong. For example it is definitely skewed to more ‘easily researchable’ psychological approaches such as CBT even though CBT has very mixed evidence based despite being often promoted as the gold standard. Massive bias towards CBT at exclusion of all other ideas (probably due to trial and funding bias)
		Less-well researched but potentially effective therapies are left out of NICE guidelines	Agreement with quantitative statement 66% There is also the issues about the validity of evidence based on manualised therapy approaches rather than integrative or formulation driven approaches. Also people who are not aware of their limitations can sometimes be unaware of some even basic criticisms of the notion of an 'evidence base' i.e. that some models are simply more studied and therefore more evidence as opposed to equal amounts of research on various interventions available
		Political, business and professional interests limit the scientific integrity of NICE guidelines	Agreement with associated quantitative statement 50% (I believe vested interests (e.g. government political aims) have a significant impact on NICE guidelines) When it comes to psychology, NICE guidelines are reflective of the power of particular lobby groups within psychology rather than a reflection of evidence and best practice. When you evaluate who

			was on the board for particular guidelines, the biases and conflicts of interest are clear. E.g. psychologists making a career out of selling CBT for psychosis, recommending CBT for psychosis and turning a blind eye to research and evidence that counters their favoured area They can often feel biased by who worked on them - e.g. in my opinion the evidence for CBT in ARMS is overstated. I despair about them. In my mind they are akin to some sort of pyramid scheme, where everyone is trying to make money out of something that essentially doesn't exist (in this case the confidence in the effectiveness of the intervention). It is also recognising that there is a political agenda to which research studies gain funding and therefore produce the evidence needed for what works. There may be a political agenda to supporting cheaper, shorter-term interventions like CBT over longer-term interpersonal/dynamic therapy models aware of one example where a CBT study gained funding for a particular condition and the psychodynamic study for the same condition did not. Therefore you have a heavily biased pot of research to extrapolate from when developing guidelines
		NICE guidelines side-line research into common therapeutic factors	The DODO Bird Conjecture indicates that it does not matter what therapy you use as the strongest correlation with success is within the therapeutic relationship neglects literature about individual therapist variation in outcomes and common factors in outcomes - sees therapies as like medications
		NICE fuels a business- driven approach to psychological therapy	I despair about them. In my mind they are akin to some sort of pyramid scheme, where everyone is trying to make money out of something that essentially doesn't exist (in this case the confidence in the effectiveness of the intervention). Cons - based on diagnosis, don't deal with co-morbidity (eg. 50% overlap with bipolar and BPD), fuel 'brand name' approach to therapy rather than formulation-driven, tailored approaches

			The cons are that the guidelines prevent more original thinking and practice based evidence and encourage a one size fits all approach and the branding of treatments rather than allowing greater practitioner flexibility and autonomy The profession does not appear to be interested in giving proper scrutiny to the NICE guidelines and it is likely that it uses NICE to further its own interests (i.e. the continued sale of psychological therapies)
	Guidelines create an unhelpful illusion of neatness in practice	NICE guidelines restrict the interventions that can be offered to service users	When CBT was recommended treatment but it did not fit for persons formulation or needs. Can sometimes mean limiting support for people. They can be used to exclude provision of therapies that might have a building evidence base but are not quite up to the monolith that CBT has become I terms of my area of specialty, I feel that the guidelines are at risk of being used to narrow what we are permitted to provide and being used to provide watered down versions of therapy The way of summarising the evidence is very 'medical model', biased toward short-term manualised treatments that increases access to research grant funding. This means that more sophisticated process-oriented psychotherapy models tend to be excluded.
		NICE guidelines cannot be used prescriptively for clients with complex difficulties	The relative lack of guidance around complex presentations is a challenge. So you can be under pressure to stick to x sessions when that may not be clinically appropriate In secondary care, clients have multiple problems/diagnoses and my reading of some guidelines (e.g. dual diagnosis of psychosis with drug/alcohol problem) just cross reference each guideline which rather ducks the complexity issue and the conceptual leap in drawing this conclusion as appropriate

	They are a useful starting point but I often find my clients don’t fit (e.g. complexity, comorbidity) or interventions take much longer than suggested by guidelines. They are not helpful for secondary care. The prescribed models in secondary care population are not effective.. For individuals with complex developmental trauma, diagnoses of personality disorders, psychosis. These therapies are not suitable and integrative approaches are necessary.
Research participants are not representative of service users	Also, the majority of RCTs out there have not adequately taken personality disorders and complex trauma into account - and these more complex presentations have largely been excluded. Therefore, generalisability of findings quoted in the NICE guidelines to real settings is limited. I'm mindful that the guidelines are limited, based on a narrow range of research studies that often exclude a large number of people we may work with, for example comorbidity. III) much of the evidence is often specific to one illness group or a single diagnostic category as eligibility criteria, which means the people evaluated in the evidence do not reflect the people I see in working age adults who have lots of problems intersecting
One size does not fit all	Agreement with associated quantitative statement 58% (NICE guidelines over-simplify clinical decision making) I think most psychologists and clinicians agree that one size does not fit all The guidelines prevent more original thinking and practice based evidence and encourage a one size fits all approach and the branding of treatments rather than allowing greater practitioner flexibility and autonomy NICE tells you about populations, not individuals I 'hold them lightly' as people are unique and one size does not fit all

	Adhering to NICE guidelines can cause harm to service users Agreement with associated quantitative statement (36%)	NICE guidelines prevent service users receiving the most helpful interventions	They become unhelpful when clinicians view them as the only way to work and are unable to think critically about them, or question them. I see this frequently in other services, and ultimately, it is clients/patients who pay the price. When CBT was recommended treatment but it did not fit for persons formulation or needs. Can sometimes mean limiting support for people. I've certainly felt pressured to adhere to eg doing CBT rather than a narrative or counselling intervention where that was more appropriate for the client. I know of clinical leads who will only allow their practitioners to provide nice recommended therapies. I do not believe this is in the best interests of our service users.
		NICE guidelines can lead to service users being blamed if a NICE backed intervention is unsuccessful	I do worry that, as with medication, the client then gets labelled 'treatment resistant' and can ejected from the service without any reflection on this I work mainly with nurses delivering DBT and they will often cite the guidelines when making a case against a service user, something along the lines of "well if it's not working then it must be because they are choosing to not use"
	Guidelines could be more comprehensive and up to date	Some guidelines need updating	NICE could engage more with NHS organisations to ensure new guidance is disseminated to clinical services NICE should publish guidance and review evidence more regularly. Some guidance dates back to the early 2000s, but research evidence has moved on The NICE guidelines are updated roughly every 5 years (I believe) which means that there is the potential for them to become out of date. However, I understand that NICE regularly tracks publications, particularly key events and key studies

		Some guidelines are limited or vague	NICE guidance could be more specific in providing guidance. For example, for complex PTSD, it is not clear how the intervention may differ and how the intervention may be adapted Of course there are limits and we are usually seeing people where we may need to consider more than a single guideline or where guidelines haven’t been developed - usually because there isn’t the available evidence.
LEVEL OF COMFORT WITH HOW NICE GUIDELINES ARE IMPLEMENTED IN SERVICES	Services misuse guidelines to the detriment of psychological intervention	Frustration when managers interpret NICE guidelines uncritically	When commissioners and managers don’t get that we need to be flexible and develop from the ground up, NICE guidelines can kill development and service provision We know any research trial only works for x% of people (and those who clearly met a specified diagnosis), yet at an organisational level the interpretation can be as though 100% of people under the trial showed clinically significant improvement, and therefore that is what should be offered in eth service I work mainly with nurses delivering DBT and they will often cite the guidelines when making a case against a service user, something along the lines of "well if its not working then it must be because they are choosing to not use" this is unhelpful as it puts me in the difficult positon of challenging the model and nurses that I in place to support. It often makes me feel angry and a bit desperate Also people who are not aware of their limitations can sometimes be unaware of some even basic criticisms of the notion of an 'evidence base' i.e. that some models are simply more studied and therefore more evidence as opposed to equal amounts of research on various interventions available There is poor understanding from higher management about why cbt might not be appropriate in all cases and that non cbt therapy might be valuable
		Frustration when guidelines interpreted as facts or rules	I think those interpreting the guidelines can unfortunately become quite dogmatic and rigid

	They are helpful to a degree. But they are guidelines and I think people/ services/commissioners implement them as if they were the truth and will cure everybody. I don't believe this is the case. The frustration as a clinical psychologist is having a deeper and critical view of the guidelines than many of the people I work with. They are often cited to excuse what we do and are often considered as fact
NICE guidelines lead to inappropriate referrals for psychological therapy	The guidelines - or their interpretation at service level - also can imply everyone is ready for therapy. This is of course is because research participants volunteered themselves and were in some ways selected for their readiness. The reality in secondary care MH services is that we are often having to provide tiers of intervention/stepped care to make therapy accessible, and understand a client's readiness – I think they contribute to an over simplified understanding of mental health. psychiatrists have for example referred to me requesting CBT for anxiety, EMDR for trauma and long term therapy for difficult relationships with parents all for the same person, suggesting someone’s needs can be separated and packaged to different therapy approaches Often medical staff will tell clients that they will refer them for interventions based on diagnosis when the client is either not at the right stage for treatment or the treatment is completely inappropriate. They have been weaponised against us as a service as a rationale for accepting inappropriate referrals by non therapists e.g. "nice guidelines state this person should access talking therapies for their ocd" regarding a client with deeply entrenched difficulties who has had little impact in previous therapy and limited motivation
Some CPs may follow NICE guidelines without being familiar with the evidence it is based on (e.g. using a guideline based on evidence from a non-	Agreement with quantitative statement 42%

		adult population in an adult setting)	
		The limitations of NICE guidelines need to be highlighted	Agreement with associated quantitative statement 82% Being honest and open about the shortcomings of the evidence base in the guidelines would also be useful More training is required so people understand the pros and cons of the guidelines as this would give them a more nuanced view I think that there should be acknowledgement of the limited role of manualised therapy, and more understanding that for some people therapy needs to be adapted (and that this is over and above minimum nice expectations, not less good than)
	NICE guidance is an unwanted powerful force in my service	Experiencing pressure to use NICE guidelines	Agreement with associated quantitative statement 34% (I sometimes experience pressure from management to be NICE compliant) [Feeling pressure] All the time! Forced by my manager to do additional training in CBT when I really didn't want to do it. Was openly told I would not be able to progress in my career in my Trust without it I have felt under pressure to be delivering CBT to the majority of my caseload and felt pressure to label it as such when in practice we have been using a different approach I think when my supervisor has suggested that I should do a pure CBT approach because NICE guidance indicates that. When in reality than my formulation would suggest that a more integrated approach during from a range of other evidence-based psychological therapies Increasingly both the Trust and NHSE are expecting NICE to be the basis of what is offered. Most strongly seen in IAPT, bit starting to come in Early Intervention for Psychosis and early discussions

			taking place around SMI in generalist services (psychosis, bipolar and personality disorder
		It is hard to challenge NICE guidance	I think a lot of psychologists feel that the guidelines get too much attention, but aren't sure about what to do to resist the pressure of having to use them Formulation based ways [would be an alternative to NICE guidelines] Such as PTM framework. However these are hard to apply in a medically focussed world I work mainly with nurses delivering DBT and they will often cite the guidelines when making a case against a service user, something along the lines of "well if its not working then it must be because they are choosing to not use" this is unhelpful as it puts me in the difficult positon of challenging the model and nurses that I in place to support. It often makes me feel angry and a bit desperate The pressure then builds for all psychologists working in adult mental health to support these programmes. It's very difficult to challenge when so many psychologists all over the country are going along with it. And people going on the training for things like this get told that if they don't get with the programme they need to go and find another job
	There is no pressure to adhere to guidelines where I work	Not currently experiencing NICE guidelines as restricting clinical practice	Thankfully our service recognises that our clients don't fit neatly into one or other nice guidelines. We see people with multiple presenting problems early childhood trauma and neglect and attachment issues. It would be impossible to know which guideline to follow first as there would probably be at least 5 relevant to our clients. So no I haven't felt under pressure to use or not use them They are seen as guidelines in my service, rather than as strict rules to follow [Not feeling pressure] Nice guidelines don’t feature much in my work

		We are science professionals so should both value and critique them… It is a tool to use wisely. Add long as you give a good rationale and evidence progress, you are not under pressure No [not feeling pressure]. I do use them but I 'hold them lightly' as people are unique and one size does not fit all
	Pressure to use NICE guidance is increasing	Not currently [experiencing pressure to use NICE guidelines] but the IAPT SMI agenda will considerably change this to target driven interventions as within EIT teams, leaving practitioners to fudge data or provide ineffective interventions
The economic climate means NICE guidelines are not fully delivered	Services don't have the resources to fully deliver NICE guidelines	Agreement with quantitative statement 68% Some of what is stipulated is just not available in clinical services right now with the way that the NHS is functioning. People often can't access alternative psychological treatments (possibly as a consequence of limited training funding after qualification in the NHS and the CBT plus 2 training model
	Managers use NICE guidelines to limit spending	Agreement with quantitative statement 52% The durations of therapy mentioned in the guidelines have also led to quite rigid interpretations at a service level, and this perhaps relate to economic imperative that is there with NICE The local, organisational interpretation of NICE that - heavily influenced and framed by under resourced services with high demand - becomes rigid and dogmatic In the name of providing NICE recommended interventions, with scant financial provision, some services seem to boil it down to the barest of bones. Take IAPT as an example of "providing CBT" to the masses. I'm not sure that the guidance was conceived with 30 minute telephone sessions by minimally qualified practitioners reading from a script in mind Guidance might state a minimum number of sessions but managers can take that as a maximum

		CPs should feel pressure to use guidelines	I think there should be a greater expectation to make use of these [NICE] across services and use relevant systematic review or meta-analyses where specific nice guidelines might not yet exist I think that it is right and ethical that clinicians should be pressured to deliver interventions which offer people something which we know works effectively and maximises the patient's chance of clinical improvement
THE PURPOSE, IDENITY AND FUTURE OF CLINICAL PSYCHOLOGY	Guidelines jeopardise CP jobs and profession	The skills CPs have beyond uni-modal therapists are devalued by NICE guidelines	I'm also dismayed when I see job adverts for CBT therapists or Clinical Psychologists as CPs do a lot more than therapy and I think that has a negative impact on wider services Can be unhelpful when trying to promote the value of clinical psychology vs single-modality therapies. Fuels sense of all of you need is a CBT therapist in psychosis for example. I think that it is an unfortunate consequence that linking NHS mental health service delivery to the NICE guidelines has inevitably led to a decline in the profession of Clinical Psychology as integrative approaches are seen as less robust and undermined at the expense of manualised evidence based treatment which can be delivered far cheaper.
		CP posts are being replaced with CBT therapists	Agreement with associated quantitative statement 62% (I worry that therapists who deliver manual-driven brief therapies are seen as a cheaper alternative to CPs) Agreement with associated quantitative statement 59% (It is important for NICE guidelines to distinguish the role of CPs from single-modality therapists) I think the pressure is more subtle and pervasive, and at the level of: does our performance data show we are offering lots of CBT, and do we have therapists who are qualified to offer CBT (sadly devaluing those that do not, or who offer other approaches). Our workforce is entirely based on numbers of CBT therapists based on the guidance for psychosis, there is no formally recognised role

			for psychologists who use wider approaches (they are just seen as people who can do CBT). This has led to is having hardly any psychologists in the workforce in EIP
	NICE guidelines restrict and devalue CP key skills	NICE guidelines restrict and devalue integrative practice	I feel like a relatively average clinical psychologist but one who would like to use a variety of models, but I've essentially being directed to become a CBT therapist There is also the risk that it deskills psychologists - why bother with a long, pluralistic training if we are only ever meant to be delivering CBT. I'm concerned the team may rigidly stick to these recommendations, but hopefully they will allow me to use my integrative skills as a clinical psych. Likewise with the number of sessions available, I hope clinical judgement can be used rather than sticking to this rigidly The guidelines prevent more original thinking and practice based evidence and encourage a one size fits all approach and the branding of treatments rather than allowing greater practitioner flexibility and autonomy I think that it is an unfortunate consequence that linking NHS mental health service delivery to the NICE guidelines has inevitably led to a decline in the profession of Clinical Psychology as integrative approaches are seen as less robust and undermined at the expense of manualised evidence based treatment which can be delivered far cheaper.
		NICE guidance restricts formulation-driven, individualised collaborative practice	Agreement with quantitative statement 56% Many people are not aware that evidence based practice is a three-legged stool: therapist skills, best available evidence, client wishes/values. NICE could do better to emphazise this and to also to highlight the role of formulation in selecting approach

			NICE's focus on RCTs as evidence and the dominance of CBT in RCTs undermines the knowledge and expertise of CPs and patients, who I feel are together best placed to decide on the therapeutic approach that should be use I find that my training (UEL) supported me to develop formulation-based/individualised ways of working, rather than working to specific guidelines. As far as I know, this isn't reflected in the guidelines. They are rigidly interpreted to the detriment of creative or idiosyncratic approaches that may help people, especially in a population that does not mirror those used for research trials. I work with a lot of trauma and PD. The guidance from NICE in this area is limiting and if I adhered to it all the time then I wouldn't be using my formulation to inform the work, I would be using NICE guidance I am aware that some services won't allow their practitioners to provide therapies that are not outlined in NICE guidance, which I think means we are completely undermining the clinical skills of our practitioners, and means we are not providing our service users with the most individualised, clinically effective treatments
		Dominance of NICE limits choice regarding professional development	Without the NICE guidelines I wouldn't have developed my CBT skills (i.e. done additional training) which wouldn't have been my first choice…. Forced by my manager to do additional training in CBT when I really didn't want to do it. Was openly told I would not be able to progress in my career within my Trust without it
		CPs should be permitted to prioritise formulation over NICE guidelines	Any competent clinician can surely be allowed to deviate from the guideline if they are well able to justify with reason for deviation and able to document said justification - if they can do this then I see no problem We use our knowledge to inform formulation. We should be drawing upon that knowledge to use individually tailored interventions that meet the needs of the individual. Just because a therapy approach isn't in NICE guidance, doesn't mean it's not well

			researched and we have the skills to read and appraise research paper I think they should be considered "guidelines" which we are able to deviate from using our clinical experience and expertise, rather than strict rules which must be always be followed Clinical psychologists are trained to formulate and intervene from multiple perspectives. I find it impossible to rigidly work within one approach and not draw upon all my knowledge
	Psychosocial, formulation-oriented guidelines would be more helpful for CPs	There are alternatives to diagnoses that can more helpfully inform clinical practice	Agreement with quantitative statement 59% Formulation based guidance, trauma informed guidance incorporating neuroscience and trauma sequelae [would be an alternative to NICE guidelines]. [It would be good to have] more on common factors research and approaches which monitor the alliance between therapist and client. Looking at outcome at a therapist level rather than at a treatment level. This allows more flexibility, isn't bound by diagnosis and can cope with co-morbidity It would be better if they were less diagnostically focused / organised and instead formulation Some guidelines assume that all professionals follow a diagnostic understand of mental distress. Recommendations could be made about specific psychological mechanisms that should be targeted, and which models are best suited to do that. It would also be nice to have some sort of document (no idea what) which could support commissioning of services which is not an add on the medical guidelines for particular diagnoses
		Wanting NICE to review its approach to creating guidelines for psychological intervention	Agreement with quantitative statement 68%

		Guidelines could incorporate evidence for a broader range of therapies	However, it could be possible to have listed a range of models/interventions which are all appropriate, despite some having more stringent research backing them up. This would allow for clinicians to use their judgement, skills and experience to determine which is most appropriate for the client It would be lovely to have regular systematic reviews as a full document and a summary version of evidence for a wider range of therapies.
	NICE guidelines are controversial within CP	CPs might use/favour NICE guidelines if they believe the guidelines support their professional interests	I think we range from those who are more rule following to others who are more flexible in their approaches. Both have their uses. If you’re trained in an evidence based therapy you might be more likely to use the guideline to justify your position, . Also not having a range of experiences in different settings can limit your view. The profession does not appear to be interested in giving proper scrutiny to the guidelines and it is likely that it uses NICE to further its own interests (i.e. the continued sale of psychological therapies) rather than upholding standards of rigorous science and truth. I have trained and practiced as an integrative therapist, my colleagues with unimodal training, especially CBT, tend to take a more rigid view of implementing the guidance Depends on who is buttering your bread. Many psychologists have their own interests at heart and it is in their interests that psychological therapies are promoted by NICE. I just don't like lying to myself or anyone else about this Some psychologists stick a lot more to the evidence base than others. I actually think this comes done to two key things: the politics of the psychologist, and how much vested interest they have in promoting the efficacy of psychology

			I think there are some clinical psychologists that perhaps only feel comfortable working within one model and use the guidelines to legitimise this The issue is often that they are tied to diagnostic categories and tend to recommend things with an actual evidence base, so those with a favourite approach that of not in there will be anti the guideline
		CPs have different beliefs about NICE guidelines	Yes. Some might use them more closely than me... Yes, I think some find them helpful. Perhaps they have been trained in a way I haven't, where they identify specific diagnostic categories and address those based on the guidelines? Yes of course. I think we range from those who are more rule following to others who are more flexible in their approaches. Both have their uses I think there is a lot of variability amongst clinical psychologists. My sense is that within the CP profession there is likely to be mixed views as to use of the NICE guidelines depending on clinical training course and orientation They do indeed - in both ways. Some champion NICE guidelines as the only way forward, a pious road that cannot be detoured from. Whereas some others completely reject the need of such guidelines and see them as stifling specialist practice. I am somewhere in the middle, and I suspect many people are. I think some psychologist see the guidance as gospel to be honest. My impression has it always been that they are guidance not necessarily binding policies Yes - I feel like I am in a minority. so many clin psychs have, what I believe to be, limited and limiting views of NICE. as a professional

			group we are an extraordinarily entitled and self-satisfied bunch, thinking we know best. I imagine opinions vary widely
		CPs who use diagnosis might value NICE guidelines more than CPs who don’t	I understand that some clinical psychologists believe the NICE guidelines are unhelpful, too diagnosis focused and too restrictive. Where clinical psychologists do not diagnose it would be harder to use the NICE guidelines as they are based around diagnoses My guess is because they haven’t had adequate teaching, discussion and reflection on ontology and epistemology. Some courses appear to be run by psychologists who’ve adopted the medical model uncritically and have a Masters or undergraduate understanding of science I can imagine those who are anti diagnosis or non medically focussed may have a more negative view of NICE guidance. And there will be others who want to use them more rigidly I think some find them helpful. Perhaps they have been trained in a way I haven’t, where they identify specific diagnostic categories and address those based on the guidelines? However I feel that working that way is more suited to clients with less complex and longstanding difficulties I think some CPs are more comfortable with a diagnostic frame, and also some are invested and/or leading in a particular model. This aligns well to a NICE approach and they tend to work in specialist areas. Other CPs see diagnosis itself as fundamentally flawed and therefore don't like NICE guidance Many are very medicalised in their thinking so are happy
		CPs might use NICE guidelines more when they are anxious or inexperienced	I think sometimes, when anxiety comes into play, or standards, clinicians can become too attached to guidelines and lose their ability to think in a detached analytical way

		Epistemological stance might impact CPs' views about NICE guidance	the clinical psychology profession seems infused with beliefs that nice guidance is irrelevant in some contexts. I think this is because training courses are not all strong enough on the scientist practitioner model and overly prioritise more critical psychology framework I feel like I am in a minority. So many clin psychs have, what I believe to be, limited and limiting views of NICE. as a professional group we are an extraordinarily entitled and self-satisfied bunch, thinking we know best. we need to learn from others and NICE is one way in which we do this, but certainly not the only way Often those with a heavy emphasis on a social constructionist view point Some psychologists reject ideas of positivist evidence Imagine your study will get a skew in that most responders will likely be critical of NICE guidelines and identify as critical psychologists who will be more likely to be skeptical of evidence based approaches due to acute awareness of limitations It would be interesting to see if where people studied e.g. UEL versus IOPPN and how that influences their regard for NICE guidelines I think that this also comes from devaluing quantitative, RCT evidence, in favour of qualitative research
	Guidelines are compatible with collaborative, formulation-driven interventions	NICE guidance helps facilitate collaborative practice	I always show interest in the guidelines and discuss with people what approach we should take together based on their wants, guidelines, my skills and the formulation To hold existing evidence in mind and use this, along with our knowledge of theory, our understanding of the client and the clients' wishes, to form a plan that leads to an alleviation of distress or improvement of difficulties They are just guidelines. So if I'm working with someone who has what you might heuristically label depression, I can include in my

			thoughts and discussion with my clients the guidelines - but that might include saying and what about this therapy approach which isn’t NICE recommended but you might benefit from because of XYZ that we have discussed Thinking about how [NICE] might compliment a proposed care plan, listening to client voices, values and wishes, understanding best principles of working and adapting them to meet the needs of a client group
		NICE guidelines are compatible with formulation	They are there to guide our practice, rather than be hard and fast rules. Within the interventions suggested by NICE, there is still the opportunity to formulate with a client and adapt the therapy to meet their individual need Individual formulations take NICE into account but allow for flexible use of evidence based on patient choice and specific circumstances
		Guidelines are needed to maintain the integrity of CP	If I was a person struggling I would want my clinician to be ethical and to consider what reportedly it most helpful according to NICE before checking with me if it fits with my wishes [As an alternative to NICE guidelines] we can ignore them and say anything goes. homeopathy here we come! [Without NICE cps would use] their own biases, stances and reliance on intuition Guidelines provide a transparent framework. Fear would return to old power dynamics of I know best masquerading under the guise of formulation and patient centred care You could simply ignore all of the evidence and its implications (which are neatly summarised in the NICE guidelines) and do what 'feels right', based simply on your experience. The advantages are that it would be easy to not have to worry about what actually is

			effective, the disadvantages are that it probably wouldn't work, and might actually make things worse
THE ‘GUIDELINES ARE NOT RULES’ SPECTRUM	PLAYING A NICE GAME: *NICE as a threat*	I work in a formulation driven way so rarely use diagnosis-driven NICE guidance	As a highly qualified clinician, I use personalised formulation to decide what interventions will be helpful for my individual client. Sometimes those interventions are not specifically mentioned in the guidance as they will be designed for the masses and cannot take individual circumstances into account, but in my professional opinion, they will be appropriate. I therefore would not wish to be limited by the guidance. I find that my training (UEL) supported me to develop formulation-based/individualised ways of working, rather than working to specific guidelines. As far as I know, this isn’t reflected in the guidelines I am concerned about the lack of psychological thinking and decision making [NICE guidelines] lead to as mental health is not directly comparable to physical health despite the best efforts of the DSM... a both/ and position appears to be getting lost! clinical psychologists are trained to formulate and intervene from multiple perspectives. I find it impossible to rigidly work within one approach and not draw upon all my knowledge There is no space in the guidelines for clinical judgement and critical evaluation which are so important to our roles. guidelines don’t feature much in my work I work using a formulation driven approach. It doesn't mean the NICE guidelines are ignored but they do not guide me. Perhaps pre

			qualification I might have used them more as a guide to my practice. They are generally based on a CBT approach which is not my primary mode of working either
		Practice is hindered and service users are harmed where guidelines are used as rules	I know of clinical leads who will only allow their practitioners to provide nice recommended therapies. I do not believe this is in the best interests of our service users NICE guidelines can kill development and service provision [NICE guidelines are unhelpful] when used as a rule rather than a guide, when it feels like it works against a client getting the care I believe they need. They are constantly unhelpful when our organisations are expected to comply with, and measure on their compliance with NICE guidelines
		I feel pressure from management to record my practice as NICE-backed and do so even when I deliver formulation-driven, individualised interventions	Agreement with associated quantitative statement 36% (At work, I sometimes label interventions as single-modality when they are integrative (e.g. drawn on a range of psychological theories and models)) [There was] strong pressure in my last service to use the guidelines, and to even "tick the right box" on the electronic system, whether I did the NICE recommended therapy or not! I suppose our targets are driven by NICE guidance. As a result of this, I have been instructed by management to record every session I do as CBTp (CBT for Psychosis) as this is a key target to meet. This is unhelpful as it is inaccurate recording and has wider implications. The guidelines have sometimes been used by senior professionals to blanket restrict the number of sessions offered to clients, but some clients due to a variety of factors clearly need more. Most colleagues (and me) find a subversive way to get around it

			You could always lie about your clinical practise! Advantages are that everyone thinks you're doing NICE guideline recommended interventions and thus 'supports' the 'evidence base'! I have felt under pressure to be delivering CBT to the majority of my caseload and felt pressure to label it as such when in practice we have been using a different approach.
		I have found very few guidelines helpful in my clinical setting	I think the guidelines around CBT for anxiety disorders is helpful as we know this treatment works over other approaches. Outside of this I can not recall a time when the guidelines where particularly helpful in the working age population Basically throughout my career [I have found guidelines unhelpful] making a false association between single medicalised conditions and single medicalised approaches I don’t find them helpful for the population I work with- secondary care/long term mental health. All (or almost all) my clients have complex and comorbid difficulties, so trying to work out which guideline to follow feels useless I think they can generally be unhelpful as they can be reductionistic They are helpful for non complex presentations, for example within primary care or individuals not in services. They are not helpful for secondary care. The prescribed models in secondary care population are not effective
		Because of the guidelines’ power, I use them selectively to protect my reputation or help a service user	NICE guidelines tend to be more helpful when they have aided me in advocating for a service user...I.e. getting treatment, appropriate response Only [helpful] when arguing for a particular intervention that’s already NICE recommended.

			Well, I feel a little sheepish saying this, but when the guidelines suit me then I will cite them - to bolster an argument for instance. similarly, when it suits me to challenge them then I do so I frequently quote nice guidelines for depression etc to pressurise CMHTs to accept referrals that they have declined I think also ACT (and its advocates) itself 'swings both ways' - if it suits to say it is CBT as that is mentioned in NICE guidance then it rolls with that, but when it comes to distinguishing itself from (second wave) CBT and being critical of CBT then it rolls with that.
	CLINICAL FREEDOM: *NICE as a useful guide*	In my service, I do not experience a tension between guideline-driven and formulation driven approaches	The guidelines themselves make clear that they should be used interpreted by clinicians with some degree of flexibility. We seem to have a sensible position (statement) in our Trust: evidence + clinical judgement + client informed choice Individual formulations take NICE into account but allow for flexible use of evidence based on patient choice and specific circumstances If you stick to the fact that they are GUIDELINES, they are rarely unhelpful. I use them as a guide but am mindful of biases and restrictions as to what is considered ‘evidence’ by NICE so always consider the formulation, needs, and wishes of each person when considering interventions CPs and patients, who I feel are together best placed to decide on the therapeutic approach that should be used.
		Guidelines are a helpful, but limited, starting point from which I am free to exercise clinical judgement	I think holding them lightly and constant critical reflection on practice is a useful way forward They are guidelines therefore amazingly useful as guidelines. If you try to use them as something else, a bible or a straw man, then you’ll be disappointed

			I tend to use formulation driven with NICE as a starting point but weighting goes to my assessment The NICE Guidelines are exactly what they say they are. They are 'nice' in that they are a neat package of practice implications based on the best available evidence, and they are 'guidelines' - not prescriptions to be stuck to in every circumstance with every client with a particular difficult I consider NICE guidelines to be a valuable tool to guide my work, but they are just that - a tool for me to use. In my area, the guidelines only suggest one type of therapy for everyone, and I disagree with a one size fits all approach. Therefore, I use the guidelines to inform and guide my approach Any competent clinician can surely be allowed to deviate from the guideline if they are well able to justify with reason for deviation and able to document said justification - if they can do this then I see no problem I think they should be considered "guidelines" which we are able to deviate from using our clinical experience and expertise, rather than strict rules which must be always be followed Either way, I make my own decisions. I think it is irresponsible to simply ignore them without considered reasoning. If the guideline is sound and appropriate to context, we should start with their recommendations before going off piste We are science professionals so should both value and critique them… It is a tool to use wisely
		Guidelines that I appraise as useful feature more in my work than those I do not	PTSD - helped me to think about a client's drug use and whether I should pursue intervention for PTSD or try to get the drug use sorted first

			They are helpful for non complex presentations, for example within primary care or individuals not in services….For OCD and non complex or enduring anxiety, single trauma PTSD PTSD guidance really helpful. Aided choice of therapy for individual patients, and aided selection of approach to managing trauma following major incidents within the service. Nice Guideline for treatment of single trauma - it was very specific and easy to operationalise. A helpful guideline for me is the recommendation to use psychodynamic approaches when working with EUPD. My team mainly uses DBT and so in order to promote psychodynamics I usually return to the evidence base.
		I can be open about my beliefs and actions relating to guidelines in my service	Agreement with quantitative statement 50% As long as you have a rationale for why you have designed an intervention based in a unique formulation with the patient and are evidencing progress decision is good Any competent clinician can surely be allowed to deviate from the guideline if they are well able to justify with reason for deviation and able to document said justification - if they can do this then I see no problem
	ALLIGNMENT: *NICE as a vital manual*	I prioritise the guidelines in clinical decisions	Follow them. They've been reviewed by experts in the field….I don't understand why we wouldn't follow guidelines.
		Collaborative formulation-driven approaches can always occur within the guidelines	Within the interventions suggested by NICE, there is still the opportunity to formulate with a client and adapt the therapy to meet their individual need NICE guidelines should be used to guide our practice and highlight the interventions to offer as a first line treatment. Formulation and

			individual adaptation of therapy can still be used working within the framework of the NICE guidelines

Appendix N – Further descriptive statistics

Statement	N	Minimum	Maximum	Mean	SD
NICE guidelines can help provide consistency in psychological intervention	50	1.00	6.00	2.7400	1.30634
NICE guidelines can help the public know what to expect regarding psychological treatment	50	1.00	7.00	2.7800	1.55563
NICE guidelines are a useful guide to the evidence base for psychological intervention	50	1.00	7.00	3.0400	1.56440
I feel that NICE guidelines provide a safeguard against bad therapeutic practice	50	1.00	7.00	3.7400	1.79353
There are problems with NICE guidelines	50	1.00	6.00	2.1600	1.29929
Some CPs may follow NICE guidelines without being familiar with the evidence it is based on (e.g. using a guideline based on evidence from a non-adult population in an adult setting)	50	1.00	6.00	2.9000	1.31320
I worry that less-well researched but potentially effective therapies are left out of NICE guidelines	50	1.00	7.00	2.4600	1.88669
Whether or not therapies are recommended by NICE depends on whether they fit the research paradigms favoured by NICE	49	1.00	7.00	2.3265	1.76054
I worry that commissioners sometimes view NICE guidelines as a way to limit spending	50	1.00	7.00	3.0600	2.18912
Adhering to NICE guidelines can cause harm to service users	50	1.00	7.00	3.5800	1.90692
I welcome the prioritisation of Randomised Controlled Trials (RCTs) by NICE	51	1.00	7.00	4.3137	1.76057
There are difficulties in researching the effectiveness of psychological therapies	50	1.00	7.00	2.3400	1.36442
I question the validity of the medical basis of diagnostic categories	50	1.00	7.00	2.0800	1.46858
Diagnostic categories can be a useful way to conceptualise mental distress	50	1.00	7.00	4.0000	1.56492

I believe there are alternatives to diagnoses that can more helpfully inform clinical practice	50	1.00	7.00	2.2600	1.32187
NICE guidelines over-simplify clinical decision making	50	1.00	7.00	2.6200	1.73664
I sometimes experience pressure from management to be NICE compliant	50	1.00	7.00	3.7600	2.02595
I do not feel NICE guidelines restrict how I practice	50	1.00	7.00	3.5200	1.90852
I would welcome a more instructive use of NICE guidelines in the future	49	1.00	7.00	3.8571	1.74404
I worry that therapists who deliver manual-driven brief therapies are seen as a cheaper alternative to CPs	50	1.00	7.00	2.4200	1.77385
It is important for NICE guidelines to distinguish the role of CPs from single-modality therapists	49	1.00	7.00	2.5510	1.90461
NICE guidelines can prevent CPs offering the individualised, formulation-driven therapy that service users need	50	1.00	7.00	3.2400	2.27282
I believe that the professional identity and specialist skills of CPs are threatened by NICE guidelines	50	1.00	7.00	3.9800	2.12363
I believe vested interests (e.g. government political aims) have a significant impact on NICE guidelines	50	1.00	7.00	3.1000	2.07266
I am open regarding my views about NICE guidelines where I work	50	1.00	6.00	2.6400	1.22491
I follow NICE guidelines in my practice	50	1.00	7.00	3.1200	1.30368
At work, I sometimes label interventions as single-modality when they are integrative (e.g. drawn on a range of psychological theories and models)	50	1.00	7.00	3.5200	1.86526
I think it is important to acknowledge and highlight the limitations of NICE guidelines	50	1.00	5.00	1.7400	0.96489
I value the shared language regarding mental health and intervention that NICE guidelines provide	50	1.00	7.00	3.6600	1.34938
I would like NICE to review its approach to creating guidelines for psychological intervention	50	1.00	7.00	2.3400	1.59860

I use NICE as guidelines and not instructions	50	1.00	7.00	2.1200	1.34983		
Services do not have the resources to fully deliver NICE guidelines	50	1.00	6.00	2.0600	1.13227		
Valid N (listwise)	48						

Appendix O – Examples of coded qualitative data

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Appendix P- End of Study Summary Report for Salomons Ethics Committee

Necessity, NICE idea or nuisance? An exploration of clinical psychologists' beliefs about, and uses of, diagnostically driven NICE guidelines

Background: Recent small-scale empirical research (Court et al., 2016) suggested that, while clinical psychologists (CPs) see many benefits to NICE guidelines, they consider them fraught with dangers. To manage these perceived dangers, the 11 CP participants used NICE guidelines flexibly in their practice, such as selectively drawing on the guidelines to meet professional and service-user needs. These findings sit amidst a backdrop of conceptual literature written by CPs, which suggests that there is a tension between the nature of distress and therapy as portrayed by NICE guidance, and conceptualisations of distress and therapy by held by clinical psychology and clinical psychologists. The present investigation aimed to fully explore the benefits and limitations of NICE guidelines among a larger sample of CPs working in NHS adult mental health settings. Doing so, the study aimed to build on Court et al's (2016) grounded theory of CP guideline use, by creating a thematic map.

Method: Mixed methodology was used to analyse the responses of 55 clinical psychologists, to open and closed questions about their beliefs and practices pertaining to NICE guidance, on an online survey. Thematic analysis and descriptive statistics were used for qualitative and quantitative data, before the findings were merged in an integrated thematic map.

Results: The integrated thematic map was titled: *Threat, useful guide and vital manual: the shades of grey within and between CPs' beliefs about, and uses of, NICE guidelines.* Most participants simultaneously saw several benefits and several limitations to NICE guidance. They recognised the power of NICE guidance in expanding psychological therapy provision and valued having a summary of evidence to guide their practice. Participants were concerned about the medical-model basis and scientific integrity of NICE guidelines. Participants felt guidelines should not be implemented as rules, and were concerned where they were interpreted as such. Some participants experienced unwanted pressure to use NICE guidance from teams and managers. To provide the best clinical interventions - using formulation and integrative skills - while maintaining their reputations in teams, many CPs reported formulation-driven, integrative practice as unimodal and NICE-backed. Doing so, however, participants worried NICE guidelines devalued CPs' specialist skills and identity, and that clinical psychology jobs were being replaced with NICE-sanctioned unimodal therapy posts. CPs who did not report to feeling pressure to use NICE guidelines experienced less tension between using their specialist skills and the guideline approach. A small minority of participants fully endorsed NICE guidelines and believed CPs should feel pressure to use them.

Clinical and research implications: The findings of this study suggest that some CPs experience a tension between the dominant discourses surrounding NICE guidelines (e.g. medical model, business driven approach to psychological therapy, positivism) and their beliefs and identity as clinical psychologists. Considering the power of NICE guidelines in many participants' services, these CPs did not see open non-compliance as a feasible option. To maintain their reputation in teams and help service-users access therapy, these CPs felt they had to sometimes draw on the guidelines and downplay their formulation-driven and integrative practice. Doing so, however, CPs worried that their unique skills were devalued on a service level, and their jobs might increasingly be at risk of replacement with cheaper, unimodal therapists. These CPs were therefore in a double-bind. This finding suggests that ways for CPs to feel able to practice openly according to their specialist skills need developing, to allow CPs to continue to provide the highest quality service to patients without fear of reprisal from teams and managers. One way to do this might be highlighting the role of the Division of Clinical Psychology in making a renewed effort to clarify the role and skills of clinical psychologists to teams and managers. This might entail explicitly permitting CPs to prioritise their formulation and clinical judgement over the guidelines. The present findings also suggest a review of NICE guidelines is endorsed by CPs. This might entail using alternative methodologies to those currently prioritised by NICE (RCTs) to generate an evidence base for CPs formulation-driven, integrative practice. The present findings also suggest that a minority of CPs fully endorse NICE guidance and its assumptions, which suggests more self-examination of the profession is needed, to understand the apparent diversity of perspectives within.

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