

# Health psychology: It's not what you do, it's the way that you do it

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## Abstract

Despite the growth in theoretical understandings of health behaviour and standardised approaches to health interventions (e.g. behaviour change taxonomies), health psychology has paid comparatively less attention to the importance of the implementation processes – ‘how to’ rather than ‘what to’ of such interventions. The clinical and interpersonal skills that often reflect these implementation processes are poorly defined within the health psychology literature. The level of proficiency in such skills expected of Health and Care Professions Council registered practitioner health psychologists is unclear and poorly documented within the UK training requirements. This article explores the potential impact of this and offers some pragmatic solutions.

## Keywords

clinical health psychology, critical health psychology, practice processes, public health psychology, treatment

## Introduction

The discipline of health psychology developed from the growing recognition of the contribution of psychological processes to health and illness. Its aim and focus being to generate and test theory, and translate these theories into practice (Ogden, 2012). At its core is the notion of a bio-psycho-social approach to understanding health and illness (Engel, 1977); a concept raised in prominent British medical journals more than 80 years ago (e.g. Billington, 1933). The primary intention of this approach is the recognition of the impact of a wide range of biological, psychological and social factors on wellness and chronic illness. These important features, which are often more broadly considered as the wider determinants of health (Dahlgren and Whitehead, 1991), are considered integral to the assessment and treatment of illness and disease (Andrasik et al., 2015).

Since the conception of health psychology, there has been a wealth of theoretical and empirical contributions to support our understanding of health behaviour as well as some (pre-existing) theoretical proposals that have been adopted to help understand health choice behaviours (e.g. smoking; physical activity). Such theoretical contributions include the Health Belief Model (HBM; Hochbaum, 1958; for example, Janz and Becker, 1984), the Theory of Planned Behaviour (TPB; Ajzen, 1991; for example, Kothe et al.,

2012) and the Transtheoretical Model (TTM; Prochaska and Velicer, 1997; for example, Armitage, 2010) all of which have been consistently utilised within a health psychology context.

Health psychology has been recognised as the most rapidly developing field in contemporary academic psychology (Kaplan, 2009). However, while the theoretical contributions continue to gain momentum, comparatively less is known about the clinical and interpersonal skills required to translate such theory into practice. Pavord and Donnelly (2015) and Clarkson (2003) provide a more detailed exploration of what is meant by clinical and interpersonal skills referred to throughout this article. Although, in brief, we refer to the importance of the specific skills and strategies utilised by the practitioner that help to enhance the collaborative and therapeutic relationship with patients – the repeated importance of attention to the therapeutic processes and interpersonal alliance integral to health

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consultations (Martin et al., 2000). As the 1980's pop band Bananarama and Fun Boy Three identified in their renowned record: 'it ain't what you do, it's the way that you do it (that's what gets results)' (Bananarama and Fun Boy Three, 1982). It is this important emphasis upon the implementation process that is currently lacking in the United Kingdom (UK) health psychology training and that we illustrate in this article. Metaphorically, it is as though health psychology has a range of food ingredients that appear to work well but little clarity about *how* these ingredients should be organised and implemented (i.e. detailed guidance regarding the method of *how to* combine and work with the ingredients).

### Contributions of health psychology to understanding behaviour change

A recent contribution to the field is the development of approaches to reducing ill-health choice behaviours through the use of behaviour change taxonomies (BCT) (e.g. Abraham and Michie, 2008; Michie et al., 2011). However, such BCTs are limited to a list of vague components regarding *what* may be effective in supporting someone through change (e.g. provide general encouragement) rather than providing specific strategies and examples. Furthermore, there is scant attention as to how these vague components should be *implemented* and by whom, under what conditions and why. This is rather akin to a chef being presented with a list of vague ingredients without access to specific quantities or a specific recipe. While a few expert chefs may be able to design an innovative recipe from such a vague list of ingredients, this is not likely to be sufficient for the vast majority of chefs training to work in practice (i.e. restaurants).

There is a growing demand within the health psychology professions (British Psychological Society (BPS), 2008) although there is a lack of clear clinical demonstrations of how to implement the skills required to work in practice. For example, the behaviour change wheel (e.g. Michie et al., 2011) has gained in popularity despite the tool being limited to characterising and designing behaviour change interventions rather than developing the sophisticated level of clinical skills and interpersonal processes required for practitioners to be able to support individuals through health behaviour change. In essence, the *where*, *when*, *why*, *who* and *how* of practice has been relatively ignored in favour of vague suggestions of *what* practice ingredients might include. Further, important characteristics such as empathy, warmth and positivity, for example have yet to be researched adequately within a BCT context (Marks et al., 2018). This is problematic because we know from the existing clinical literature that a key factor that makes a significant difference to the success of treatment is the strength of the therapeutic alliance (Roth and Fonagy, 2005). More than 30 years of psychotherapy research has

shown therapeutic alliance to be a consistent predictor of outcomes (Horvath and Bedi, 2002; Horvath et al., 2011; Horvath and Symonds, 1991; Martin et al., 2000).

The intention of such taxonomies and strategies is to offer some level of standardisation of techniques to facilitate the replication of interventions that have been shown to be effective (Abraham and Michie, 2008). However, there is a danger in ignoring all-important 'individual differences' and a call to limit this approach within health psychology has recently been made (Ogden, 2016). In a clinical context, what this means is that BCTs assume that the change behaviour(s) have been formulated in a way that tap into the specifics of the underlying causes. However, this often is not the case. The popularity of taxonomies is most likely because health psychology is a comparatively young discipline and, like many others before, may have succumbed to the tempting lure of standardisation as a method of scientifically and consistently predicting human behaviour – a demonstration of health psychology as a legitimate 'science'. However, this positivistic approach is ill-fitted to psychology because the complexity of human behaviour is such that it often cannot be studied and observed in a determined and regular manner as positivism would suggest (e.g. Collins, 2010). To return to the cooking analogy, more is needed regarding *how to prepare and combine* ingredients (e.g. formulation as a collaborative conceptualisation process; theoretical orientation of the therapist) and importantly *how* they should be cooked (clinical and interpersonal skills) to address important interpersonal processes (e.g. Teyber and McClure, 2009) and establish a strong collaborative therapeutic alliance (e.g. Norcross, 2005). The importance of the 'therapeutic relationship' and 'building alliance' is acknowledged in the BPS Qualification in Health Psychology (QHP) Stage 2 Candidate Handbook for trainee health psychologists (BPS, 2015a). Although no guidance on how this may be achieved is provided. This exemplifies how the health psychology discipline may be falling short of its potential to contribute more to clinical practice and reflect the aims of the discipline better in terms of *both theory and applied practice*.

A further complication to the growing interest in the identification of 'effective' behaviour change techniques is the publication of recent guidance that has been developed to support this aim (National Institute for Health and Care Excellence (NICE), 2014). This guidance lacks specific evidence-based recommendations as to the method and style of delivery (clinical skills and interpersonal processes) that are likely to initiate and sustain change behaviour. This lack of guidance available on *how to* implement behavioural counselling methods has been previously noted (Kaplan, 2009). This may have transpired because such guidance is often produced by academics and policy makers with typically limited or no experience of working directly with patients within a clinical health setting. This lack of implementation guidance is also aggravated by the fact that policy

documents are two-dimensional with no audio-visual demonstrations of the clinical and interpersonal skills required to deliver the practice recommendations. Given the integral role such guidance plays in shaping applied health (psychology) practice, this distinct lack of detail regarding the *how to* of supporting individuals through a process of behaviour change has undoubtedly contributed to the limited attention to skill development and lack of appropriate and ongoing supervision within the health psychology discipline.

### *Supervision and professional recognition*

The BPS requires that those who supervise health psychology doctoral trainees attend a series of four workshops to be included on the Register of Applied Psychology Practice Supervisors (RAAPS). These workshops are intended to assist supervisors to understand models of supervision and approaches to leadership. They provide mentoring in how best to manage and support students through an academic programme of study rather than how to provide clinical supervision of the interpersonal skills required for practice. This may contribute to the self-perpetuating cycle of clinical and interpersonal skill deficit of health psychologists which is particularly concerning given the eligibility for health psychologists to work in clinical practice. It is recognised that not all health psychologists lack the clinical skills required to work in practice; yet as a consequence of what has been outlined thus far, it is reasonable to suggest that many do.

The BPS does not formally recognise clinical health psychology through divisional membership although there is a Faculty of Clinical Health Psychology (see [www.bps.org](http://www.bps.org)). The BPS has published a briefing paper for ‘clinical health psychologists’ working in the National Health Service (NHS) (BPS, 2008) although this more accurately refers to clinical psychologists working within physical healthcare settings. A more recent survey of clinical psychology posts in physical health would suggest that the demand for this is growing (BPS, 2015b). While there is no formal division of clinical health psychology, that there is a BPS faculty and a briefing paper aimed at bridging the gap between clinical and health psychology demonstrates the close relationship between the two disciplines and necessity for clinical skills within healthcare practice.

### *Clinical skills deficit of health psychology*

The BPS (2008) briefing paper clearly demonstrates how the knowledge, training and experience of clinical psychologists is well suited to meeting the psychological healthcare needs of patients with physical health conditions in receipt of care through the NHS. Additionally, a recent publication from NHS Education for Scotland (NES) (2015) clearly maps the necessity for psychosocial interventions for people with persistent physical symptoms. Consequently, it is difficult to understand what the unique contribution of

a practicing health psychologist is, especially given the greater attention to clinical skills training within current doctoral training courses for clinical psychology in the UK. A closer look at what is required for health psychology chartered membership (BPS, 2015a) and registration with the Health and Care Professions Council (HCPC) (2015) as a practitioner health psychologist offers little clarity in this respect. For added context, what follows is an exploration of the current training requirements for health psychologists in the UK. In this review, we offer suggestions to demonstrate how the clinical skills training deficit within health psychology could be addressed by adopting elements from clinical psychology training. We argue that this offers the potential for the evolution of a new clinical health psychology discipline that is recognised as a formal division within the BPS. The potential benefits of doing so are also presented.

## **Training requirements for health psychologists in the United Kingdom**

In the UK, health psychologists undertake two stages of training: Stage 1 reflects what is described in the Stage 2 Handbook as ‘the underpinning knowledge base’ (BPS 2015a: 2) and is typically associated with an MSc programme of study. Trainees may then progress by completing either a BPS accredited Doctorate in Health Psychology or BPS (QHP) Stage 2. As part of the latter route, trainee health psychologists are required to undertake 2 years (or part-time equivalent) of assessed supervised practice and health psychology competencies are demonstrated through a portfolio of evidence and oral examination. The competencies are defined by five broad areas: generic professional competence (e.g. ‘sufficient professional experience to practice as an autonomous practitioner’ BPS 2015a: 26), behaviour change interventions competence, research competence, consultancy competence, and teaching and training competence (see BPS (2015a) for a full review). The distinction that is made between the underpinning knowledge base of Stage 1 and the demonstration of competence of Stage 2 would suggest that trainees progressing to Stage 2 are required to shift from ‘knowledge and knowing’ to ‘skills and demonstrating’. This distinction is a central consideration that the following critique of these required competencies will address. Specific questions include the following: how well defined are the competencies for clinical skills? Are clinical skills assessed in a way that requires the person to be able to demonstrate and implement the specific skill or simply to be able to describe/define it in a more theoretical, abstract or ‘academic’ way? How well does this actually prepare trainee health psychologists for applied clinical practice? The research and teaching and training competence have been omitted from the following critique because both are more clearly defined in the Stage 2 Handbook within the context of academic settings.

### Generic professional competence

To demonstrate the ‘generic professional competence’, the Candidate Handbook stipulates that ‘candidates must demonstrate that they have sufficient professional experience to practice as an autonomous practitioner’ (BPS, 2015a: 26). However, there is no clear guidance as to what is considered sufficient professional experience and the clinical skills that are required to practice as an autonomous practitioner. This lack of clarity is particularly apparent when candidates are advised that they are required to ‘use appropriate interpersonal skills (to establish rapport, empathy, engage in active listening skills, use of various type of questioning skills) to initiate, develop, maintain and end therapeutic and professional relationships with clients/service users’. (BPS, 2015a: 28). There is no suggestion of what established therapeutic micro-skills are deemed ‘appropriate’ to demonstrate these skills as there is within other skill assessments frameworks that are routinely used to assess ‘competency levels’ with a particular form of therapy (e.g. the use of the Cognitive Therapy Rating Scale (CTS-R) within skill assessment for cognitive behavioural therapy (CBT) or the use of the Motivational Interviewing Treatment Integrity (MITI) coding system for the assessment of practitioner competency within motivational interviewing (MI)). Furthermore, there is a lack of guidance regarding how many hours of direct client contact is required to demonstrate the implementation of such approaches or how much clinical supervision should be provided (i.e. number of supervision hours or contacts per client). The only guidance offered in the handbook in this latter respect is that candidates engage in ‘effective supervisory relationships for their professional practice’ but again, lack of clarity regarding what is considered an effective supervisory relationship and what exactly professional practice entails, means that opportunities for trainee health psychologists to enhance their clinical skills and have them appropriately assessed are potentially lacking. In addition, as mentioned previously, because the compulsory BPS supervisor workshops (for RAAPS registration) do not require clinical skill demonstration, this serves to perpetuate the problem because supervisors may be unable to facilitate the competency development of trainees in this respect.

Unfortunately, the methods of assessment for the generic professional competence unit do not allow for the consideration of the candidates’ clinical and interpersonal process skills. A logbook documenting ‘professional practice’ and the experiences that have enabled candidates to develop an understanding of the ‘substantial body of knowledge within health psychology’ is required alongside a reflexive report summarising personal and professional development as a health psychologist and a short (1000 word) report that documents the inclusion of service users and carers within the candidates training activity. Again, a logbook and reflexive report are arguably only able to demonstrate knowledge, not skills. There is no opportunity for candidates to demonstrate

a level of clearly defined clinical competencies sufficient to work in practice.

### Behaviour change interventions competence

Health psychology trainees are advised that the behaviour change competency is underpinned by the Health Behaviour Change Competency Framework (HBCC; Dixon and Johnston, 2010). The HBCC is represented by three domains: foundation competencies (e.g. knowledge of professional and ethical guidelines), behaviour change competencies (e.g. ability to take a generic assessment) and behaviour change techniques (e.g. reassurance, general information and verbal persuasion); these techniques are categorised into low-, medium- and high-intensity interventions. However, the HBCC suffers from the same critical limitation as BCTs referred to earlier (e.g. Abraham and Michie, 2008) and the recent NICE (2014) guidance in that there is no specificity regarding *how* these competencies should be implemented and the clinical skills required to do so. Furthermore, it is generally accepted that providing ‘reassurance’ is ineffective therapeutically because it is reliant upon external support (Westbrook et al., 2007). Similarly, verbal persuasion has been considered ineffective in supporting behaviour change as early as 1983 (Miller, 1983). Accordingly, it is difficult to understand what the evidence-base is for the proposal of such competencies. While the HBCC makes reference to the use of MI (Miller and Rollnick, 2012), rather than more accurately being acknowledged as a behaviour change counselling approach, it is cited within the context of a behaviour change technique. Again, no specific details that reflect the clinical skills required to deliver MI are identified (i.e. *how* to do it rather than *what* to do).

The HBCC guidance states that ‘the Stages of Change Model provides the theoretical model of behaviour change’ (Dixon and Johnston, 2010: 41) but then explains how the model does not adequately account for how individuals change behaviour and instead proposes a new model upon which the competency framework is based. While it is acknowledged that the competency framework is not an academic document, without adequate supporting citations to published literature, it is difficult to understand how such assertions have been derived. One can only assume that the ‘Stages of Change Model’ that is cited refers to a single component of the integrative TTM (Prochaska and Velicer, 1997). Crucially, the TTM also includes self-efficacy, decisional balance, and 10 cognitive and behavioural processes of change as critical components of the change process (see Hutchison et al., 2009). These other critical components of the TTM appear to have been completely overlooked by the HBCC.

It is noteworthy that the QHP Stage 2 Candidate Handbook specifically refers to the requirement that trainees ‘formulate a working hypothesis/model of the interactions between biological, medical, psychological, social and



cultural factors relevant to the target health behaviour (gained from the evidence base and the assessment process)' (BPS 2015a: 31). Indeed, the notion of a candidate's ability to formulate runs throughout the behaviour change interventions competency, which is also referred to as a 'psychological intervention competency'. However, what is consistent throughout the handbook is that there is no guidance regarding *how* a formulation should be done (e.g. a collaborative process of formulating and reformulating *with* the client/patient to help engage and to ensure that both parties are working together on a set of often linked problems or issues). There are no proposed examples of suitable processes involved (e.g. formulation and re-formulation diagrams; detailed assessment and interim reports in therapy) or the function of and specific methods involved (i.e. the 5 Ps approach to formulation (see Hutchinson and Johnston, 2013; Johnston and Hutchinson, 2016); or different theoretical approaches to formulation such as those promoted within different schools of therapy (see Johnstone and Dallos, 2014)). The BPS has published good practice guidelines for the use of psychological formulation (BPS, 2011) and there is no cross-referencing or signposting to this seminal document. Crucially, there is always a risk within areas of clinical health practice that interventions prematurely focus on a single medical (physical) consequence (e.g. obesity) without a fuller appreciation of underlying and maintaining biopsychosocial causes (see Hutchison and Johnston, 2013; Johnston et al., 2017; Watt et al., 2016a, 2016b).

Different clinical/applied approaches to therapeutic formulation (see Johnstone and Dallos, 2014, for a comprehensive review) are largely ignored within health psychology texts and clinical health texts tend to favour pre-defined condition specific models (e.g. Nikčević et al., 2006). Consequently, to return to the earlier cooking analogy, trainees are provided with a list of pre-defined ingredients for a set menu with no guidance regarding how to prepare and cook the meal, whether the client/patient actually wants the meal, how many courses they require, if they wish to eat in (self-help), have a take away (online), go to a restaurant (groups/manualised approaches) or pay for a personal cooking lesson to enable them to make the meal again and again (1-to-1 therapy). If the patient does decide they want to eat (engage in therapy), there is very little choice of restaurant (approach to therapy or theoretical orientation) and the skill level of those who are cooking is not known or closely supervised by people who can actually cook. Access to a personal cooking lesson (therapist) is often costly or involves a long wait and the special ingredients associated with a top coach (therapeutic alliance factors) is a rare commodity that is often ignored completely.

### Consultancy competence

Health psychology consultancy is defined in the Stage 2 Handbook as 'the use of specialist health psychology skills

and knowledge to provide a service to an external business client, for example, public, private or third sector organisations' (BPS, 2015a: 37). An example of a consultancy request provided in the handbook includes an NHS Trust who may wish to improve the outcomes of a diabetes programme and therefore requests psychology informed training for staff, although the details of what this may comprise are unclear. A further example suggests a consultant to support a minority group to improve their exercise levels. Given the lack of focus and guidance within the UK training requirements, programmes designed by health psychologists that aim to support individuals manage chronic conditions and change behaviour (e.g. exercise) are at risk of being limited in their capacity to utilise the very clinical skills that often lead to better outcomes (e.g. Horvath and Bedi, 2002). The training requirements of health psychologists may well enable those offering consultancy to enhance the theoretical and epidemiological knowledge of those requesting the service but as it currently stands, health psychologists are arguably poorly equipped to fully implement clinically/therapeutically informed training and consultancy.

### Assessment of qualified health psychologists

The assessment of health psychology trainees further reflects the emphasis on the *what* (knowledge focused) at the expense of the *how* (skill demonstration/implementation focused) because candidates are assessed via a portfolio of competence and an oral examination. Other than (as part of the behaviour change competency) the requirement for a trainees supervisor to observe face-to-face sessions conducted with clients, there is no opportunity for the demonstration, observation, supervision and appropriate assessment of clinical and interpersonal process skills. Candidates are advised that 'more than a single session of observation may be required' (BPS, 2015a: 30) which seems extremely limited with respect to what is normally required to support the development of clinical and interpersonal process skills. For example, those undertaking the BPS counselling training route are required to demonstrate 'client contact hours and supervision showing 450 hours of supervised practice with supervision at a minimum ratio of one hour of supervision for every eight hours of client contact' (BPS, 2014a: 17) and standards for doctoral programmes in clinical psychology in the UK reflect similar requirements (BPS, 2014b). Of course, the quality of supervision received and its capacity to support the treatment fidelity of a therapeutic approach is also somewhat dependent upon the supervisors level of proficiency which again given the lack of specificity for Stage 2 training is likely to be limited for health psychologists.

There is no requirement to demonstrate proficiency in *how* to formulate collaboratively with a patient/client or to demonstrate therapeutic clinical skills via the use of video-taped

submissions of a trainees practice. In disciplines where health professionals are required to demonstrate the specific skills required to work with patients in practice (e.g. clinical psychology), it is typical that both real-time observation of practice or observations of recorded consultations will be assessed. A range of established coding tools have been developed within some areas of therapeutic work. For example, the CTS-R is commonly used for assessing trainees practice within CBT (James et al., 2001); while the MITI (4.2.1) (Moyers et al., 2015) is one of several coding tools used within MI (see [www.interviewing.org](http://www.interviewing.org) for alternatives). While such coding approaches to the assessment of interpersonal process skills can be somewhat reductionist (Hilton et al., 2016), they provide a measure of skill proficiency more accurately and transparently than a knowledge-focused portfolio or oral examination.

If we accept that there is a necessity for health psychology and psychologists to have *both* a theoretical *and* an applied component (Ogden, 2012), then we need to consider how to better reflect this through the process of training and supervision. Without the requirement to develop, demonstrate and assess their clinical and interpersonal skills, we need to consider exactly what it is that we are training health psychologists to actually do? The challenge of equipping practicing psychologists with adequate applied clinical skills is not exclusive to health psychology. For example, similar difficulties have been observed within the sport and exercise psychology discipline (Hutchison and Johnston, 2013). Indeed, it is reasonable to suggest that *all* practicing psychologists would benefit from the requirement to undertake training to enable them to more fully demonstrate and implement clinical and interpersonal skills with ongoing supervision as part of their core training and continued professional development. Regardless of the discipline, practicing psychologists are in the business of working *with* people; often with complex needs and within complex environments and contexts. Therefore, improving opportunities to develop clinical and interpersonal skills has the capacity to enhance practicing psychologists' ability to create a therapeutic alliance with individuals (regardless of the context) which has been consistently demonstrated to improve outcomes (e.g. Horvath and Bedi, 2002; Horvath and Symonds, 1991; Martin et al., 2000; Norcross, 2005).

## HCPC requirements

Qualified health psychologists who complete Stage 2 training are eligible for registration as a practitioner psychologist with the HCPC. There are 15 standards of proficiency that the HCPC require to be registered as a practitioner psychologist (see HCPC, 2015) and supplementary discipline-specific guidance is also provided. For example, all practitioner psychologists are required to 'understand the key concepts of the knowledge base relevant to their profession' (HCPC, 2015:

13) and supplementary guidance is provided for clinical, counselling, educational, forensic, health, occupational and sport and exercise psychologists. Health psychologists are advised that within this proficiency context they are required to 'understand the epidemiology of health and illness', 'understand applications of health psychology and professional issues' and 'understand healthcare in professional settings' (HCPC, 2015: 18). While it is acknowledged that these are all relevant to health psychology as a discipline, they seem far removed from what would be required to work therapeutically with an individual in practice. In this respect, the supplementary guidance for the clinical psychology discipline: 'understand psychological models related to how biological, sociological and circumstantial or life-event-related factors impinge on psychological processes to affect psychological wellbeing' (HCPC, 2015: 14) and the counselling psychology discipline: 'understand the therapeutic relationship and alliance' (HCPC, 2015: 15) seem far more applicable to practitioner health psychologists.

Similarly, practitioner psychologists are 'to be able to draw on appropriate knowledge and skills to inform practice' (HCPC, 2015: 20). Health psychologists are advised that they should 'be able, on the basis of psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting problem, and to the psychological and social circumstances of the service user' (HCPC, 2015: 23) and 'be able to integrate and implement therapeutic approaches based on a range of evidence-based psychological interventions' (HCPC, 2015: 27). However, as we have seen Stage 2 training requirements for health psychologists are lacking in this respect. Without specific training or requirement to demonstrate therapeutic approaches to formulation (e.g. 5 Ps as outlined earlier), psychological therapy or therapeutic approaches, it is difficult to understand how health psychologists would be deemed 'fit to practice' without any additional training and appropriate skill assessment other than that required for QHP Stage 2. It is interesting to note that clinical psychologists are required to demonstrate the use of CBT as part of this HCPC proficiency yet no such approach is specifically detailed for health psychologists who as practicing psychologists may often find themselves working with individuals to help them manage persistent physical symptoms (see NES Scotland 2015 Matrix Tables); all of which have similar clinical and interpersonal skill requirements to that of clinical psychologists. The necessity for practicing health psychologists to have a similar level of clinical and interpersonal skill proficiency to those of clinical psychologists is perhaps further magnified when we consider that approximately 80 per cent of general practitioner (GP) appointments relate to persistent physical symptoms and that those with such conditions are 'two to three times more likely to experience mental health problems than the general population' (NES, 2015: 4). Thus, chronic physical ill-health conditions commonly

present alongside psychological co-morbidities such as anxiety and depression (Qin et al., 2014).

## Recommendations for health psychology training and practice

There is a need to re-address the purpose and agree the practice boundaries of the health psychology discipline within the UK. This is particularly important given that BPS chartered membership for health psychology provides eligibility for HCPC registration and enables those qualified to work directly with patients in practice. However, if the skills to do so are not a requirement of Stage 2 training and are not demonstrated by trainees or assessed adequately we have no way of knowing whether health psychologists are fit to practice in this specific respect. What follows are some training and practice recommendations derived from the current challenges and shortfalls within health psychology.

### *Enhance clinical and interpersonal skills: formulation and MI*

Health psychologists would benefit from clearly documented competency-based clinical and interpersonal skills training, appropriate supervision and the requirement to demonstrate these skills through appropriate approaches to assessment throughout Stage 2. Health psychologists are required to formulate although there is a lack of guidance within the QHP Stage 2 Candidate Handbook (BPS, 2015a) or mainstream health psychology literature as to what should be expected when they formulate. MI is also specifically referred to within the documents that are designed to support health psychology trainees achieve the required competencies (BPS, 2015a; HBCC; Dixon and Johnston, 2010) and it is also referred to in the popular BCT developed by Abraham and Michie (2008). However, again there is no guidance in any of these documents that details what it is, how to do it, how to access appropriate training and supervision, and how to assess proficiency and treatment fidelity (i.e. that a practitioners skills accurately demonstrate the approach). If it is deemed that health psychologists are to demonstrate these clinical skills in practice, appropriate training and assessment of skills needs to be incorporated into the QHP Stage 2 requirements.

Formulation, or what is also referred to as case formulation or case conceptualisation (cf. Kuyken et al., 2011), was initially developed for use within a clinical psychology context. However, the approach has been extended to a range of health contexts such as obesity, Type 1 diabetes, cancer treatment and chronic pain management (see Nikčević et al., 2006). Central to case formulation is the notion of a collaborative approach between the client and practitioner to mutually generate plausible explanations for the problems experienced. One generic formulation model

which is widely used within clinical psychology is referred to as ‘the five Ps’; defined as: presenting issues, predisposing factors, precipitating factors, perpetuating factors and protective factors (see Johnstone and Dallos, 2006, 2014; Macneil et al., 2012). The practical skills of health psychologists could be enhanced by specifically including the requirement to *demonstrate* formulation skills in this way as part of QHP Stage 2 training or exclusively for those who wish to register as a HCPC practitioner psychologist. Indeed, a checklist of best practice characteristics of formulation is already available (BPS, 2011: Appendix 1) and could be utilised as part of the assessment for health psychology trainees.

Similarly, if health psychologists are expected to utilise MI, then appropriate training is required. MI is a complex behaviour change counselling method that was initially developed to support individuals with problem drinking and unhealthy addictive behaviours (Miller, 1983). MI has been conceptualised as ‘a collaborative conversation style for strengthening a person’s own motivation and commitment to change’ (Miller and Rollnick, 2012: 12). Since its initial conception, MI has grown in popularity and has been used to both reduce ill-health behaviours (e.g. smoking cf. Efrainsson et al., 2012) and promote health-enhancing behaviours (e.g. physical activity cf. Gourlan et al., 2013). Training in MI varies in duration although typically a 3-day course with follow-up supervision that is tailored around eight stages of learning is considered a good starting point to provide trainees with a grounding in the approach (see Miller and Moyers, 2006). However, what is noteworthy is that it is the interpersonal skills of the practitioner that are deemed critical to predicting outcomes for MI consultations (Moyers, 2014). To develop proficiency, attendance at more advanced workshops and ongoing supervision are recommended alongside the assessment of practitioner skills via observation of MI practice. The use of the MITI 4.2.1 (Moyers et al., 2015) is recommended to offer a transparent approach to coding and coaching and to aid the development of proficiency. This is a critical consideration if MI continues to be integrated into the development of taxonomies and continues to be suggested as a useful approach for health psychologists working in behaviour change. Yet, both BCTs and the current training/assessment requirements of UK health psychologists do not reflect what is required to be proficient in MI.

### *Assess clinical and interpersonal skills appropriately*

Clearly, the current assessment requirements for QHP (written portfolio and oral examination) are unsuitable and inappropriate to establish a candidate’s level of proficiency in the skills deemed essential for applied health psychology practice (i.e. as stipulated by the HCPC). Therefore, the

current approaches to the assessment of trainee health psychologists in the UK require updating to allow for adequate consideration of a candidate's demonstration of clinical and interpersonal skills (rather than level of knowledge and understanding alone).

Practitioners interested in developing their clinical and interpersonal skills often do so by attending appropriate training and engaging in opportunities to assess skills via ongoing coaching, critical self-reflection, audio-video analysis of mock (and where ethically viable, real) consultations and assessment via appropriate coding tools such as the MITI (Moyers et al., 2015) or CTS-R (James et al., 2001). However, as mentioned previously, such scales are rather reductionist in that they do not fully capture the complexity of the clinical processes involved in a therapeutic interaction. Therefore, the use of Computer Assisted Qualitative Data Analysis Systems such as NVivo ([www.qsrinternational.com](http://www.qsrinternational.com)) has recently been encouraged to aid this process of clinical skill development (Johnston et al., 2015).

### *Formalise a new clinical health psychology discipline*

If health psychologists are required to work directly with patients and individuals with complex physical illness that often present with mental ill-health co-morbidities (Qin et al., 2014) and also support individuals through the behaviour change process, then one of the following changes to the QHP training requirements must be implemented: (a) that health psychology trainees intending to practice, and become HCPC registered as a practitioner psychologist, are required to demonstrate clinical interpersonal skills (e.g. collaborative case formulation/CBT and MI) and are assessed through appropriate qualitative (i.e. coaching, clinical supervision and clinical process assessment via NVivo, for example) and quantitative (i.e. established coding tools, for example, MITI and CTS-R) methods, or (b) that the discipline of clinical health psychology is officially recognised by a formal division of the BPS and that the necessity to demonstrate clinical interpersonal skills becomes the requirement of this discipline and not that of health psychology. It is reasonable to suggest that the current QHP requirements would be suitable for health psychologists working in academic settings or those that do not require direct contact with patients.

From a feasibility perspective, it may be more reasonable to suggest that the formal recognition of a new clinical health psychology discipline/division would enable academic institutions to respond well. For example, it is likely those UK universities that offer postgraduate programmes in health psychology and clinical psychology (e.g. MSc, Prof Doc, PhD) need only share modules from these programmes to develop new postgraduate programmes of study in clinical health psychology. Doing so would also facilitate clarity of

the professional boundaries of both health psychology and the newly recognised clinical health discipline.

## **Conclusion**

Enhancing the clinical and interpersonal skills of health psychologists and/or clinical health psychologists in the manner outlined has the capacity to meet the Stage 2 requirements and HCPC requirements of practitioner health psychologists more thoroughly and transparently. There is a critical necessity to address the current shortfall in such skills for health psychologists who are trained in the UK to avoid health psychology becoming too heavily theoretically weighted and assessed via means that only allow for the demonstration of knowledge rather than applied skills. The current approach to training and assessment leaves practicing health psychologists ill-equipped to work directly with patients. In short, if health psychologists wish to work in practice, then they need the clinical skills to do so. 'It ain't what you do, it's the way that you do it – that really is what gets results and this has been consistently demonstrated in the literature (e.g. Rogers, 1961; Roth and Fonagy, 2005; Schöttke et al., 2016). The current training and assessment requirements for health psychology need to be updated accordingly. Alternatively, we propose that the BPS to recognise a new Division of Clinical Health Psychology that would respond to this need and to amend the current QHP Stage 2 requirements such that they are solely focused upon the requirement for candidates to work epidemiologically, theoretically and academically (and for there to be no requirement to work clinically).

## **Author's Note**

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