The othering of a profession: The intriguing case of Australian psychology

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Othering allows an individual to both distance themselves from a reality which they may not feel resonates with them, and in some instances create a new reality which does. However, it also creates a space from which anyone perceived as deviating from the standard can be controlled or punished in subtle ways. Research into this phenomenon, generally comes from the perspective of the marginalised and oppressed. Less common is research exploring how othering impacts on those in the professional mainstream. Such research is important due to the power professionals may exert on shaping, and creating discourses which other individuals then live. Embroiled as it is in the trials, tribulations and political manoeuvrings of a fledgling discipline seeking to cement its place in society as both high status profession and 'science,' the practice of Australian psychology provides one microcosm in which to explore this space. Ten registered clinicians were interviewed using Hollway and Jefferson's method. Transcripts were read multiple times to identify use of normative terms, what was not said contradictions, ambiguities, slippages and key themes. It was revealed that professional othering may be experienced both retrospectively and contemporaneously, with the (new) status quo enforced by the establishment, peers, and curriculum, albeit in subtle ways. Othering may result in the loss of historically useful professional knowledge, and may effectively stultify creativity within a profession. Othering may impact negatively on professional's access to their guild's historical knowledge base, and obfuscate the creation of new practitioner-informed knowledge. Othering may also encourage the growth of professional hierarchies experienced as a form of personal control.

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Keywords: Australian psychology, professionals, professional norming, loss of expertise, stagnation

BACKGROUND

Since its formal inception in 1944, marked by the inaugural meeting of the Australian branch of the British Psychological Society (Cooke, 2000), Australian psychology has experienced the ongoing trials, tribulations and political manoeuvrings of a fledgling discipline seeking to cement its place in society as both a high status profession, and a science (Cooke, 2000; O'Neil, 1987; Shakow, 1965). At a practical level, recent legislatives changes have extended the financial outlay and study time required by trainee practitioners seeking professional registration[1] (Psychology Board of Australia [PsyBA], 2017). Types of practitioners are differentiated financially by governing bodies (Australian Psychological Society [APS], 2017), with those completing certain types of master's programmes, heavily laced with 'science' financially-preferred upon graduation, over those electing to study for example counselling. This is despite evidence showing minimal or no difference between these practitioners in terms of client outcomes (Pirkis et al., 2010). Clinicians or trainee practitioners seeking endorsement as the more highly paid 'clinical specialists' are required to apply for competitive master's programmes, with predilection awarded individuals with first class honours, and scholarly publication (e.g., Macquarie University, 2017). Yet the literature shows traits and skill sets in addition to (or even instead of) academic acumen, are necessary for positive client outcomes, arguably the mainstay of this professional role (Baldwin, Wampold, & Imel, 2007; Goldney, Bradley, & Selby, 2017; Slade & Longden, 2015).

More broadly, Western psychology, favours knowledge created within a 'scientific' framework, and informed by the results of randomised controlled trials (RCTs) (APS, 2010; Grenyer, 2017; Goldney et al., 2017), representing a movement away from the discipline's philosophical roots, and interest in the ontology of Being (Cooke, 2000; O'Neil, 1987). Yet some writers both contemporaneously and historically present such esoteric explorations as fundamental to wellness outcomes (Corcoran, 2009; Fromm, 1987; Heidegger, 1993). Theoretically, the aetiologies of mental illness proposed by academic psychologists, are both diverse and incongruous, positioning for example, causation as biomedical dysfunction occurring within the individual (McNally, 2011; Slade & Longden, 2015), as stemming from social/political policy and/or income inequity (Wilkinson & Pickett, 2010); or as the expected flow-on of an experience of oppression (Fanon, 2005; Oliver, 2004).

Australian psychology and othering

The othering literature predicts that individuals exposed to such polarity and contradiction, may experience conflict and alienation due to externally imposed 'processes that deny full inclusion and

[1]Within Australian psychology, there are currently three legal study pathways, whose successful completion results in registration. These are the 4+2, and 5+1 internship programmes, and an accredited professional degree (PsyBA, 2016). Heated discussion exists around these former two pathways because limited internships are available, and reporting requirements may be experienced as onerous by both the student, and supervising agency (Palmer, 2015). For example, within the two internship years of the 4+2 programme, students are required to participate in 1,114 direct client-contact hours, 1670 client-related activities, 176 supervisory hours, and 120 professional development hours (PsyBA, 2015). There are few, if any, paid positions available to facilitate this pathway, placing students in a bind as to how to support themselves while seeking registration. Additionally, students are generally expected to pay for their weekly supervision (two hours per week for a full-time load, and charged at around 150 AUD per hour). The final accredited professional degree pathway is also the site of marked contention, because psychologists with a clinical master's are more likely to be referred to by government agencies or insurance companies (AAPI, 2012). They also have greater access to a diverse range of jobs (e.g., APS Matters; and job search engines such as Trovit and My Career) and can access a substantially higher government rebate of 122.15 AUD per session (typically one hour) compared to all other psychologists who can only claim $83.25 per session back from Medicare under the Better Access scheme (APS, 2017). The Better Access scene allows individuals to access subsidised treatment by various medical professionals including psychologists.

membership' (Powell & Menendian, 2017), 'guided by and coupled up with...a public discourse' (Gulerce, 2014, p.245). The act of othering may then be used by an individual to both distance themselves from such a subjective reality, which they may not feel resonates with them, and in some instances create a new reality which does (e.g., Henry, 2003; Laplanche, 2005; Miller, 2008; Rief, 2009; Robbins, 2014). However, othering may also be used by an institution, to create a space from which anyone perceived as 'deviating from the standard' can be controlled or punished in subtle ways (Mullin-Jackson, 2009, p.1).

Generally research into the experience of othering explores the phenomenon from the perspective of marginalised and oppressed populations (e.g., Tuhiwai Smith, 2012). However, less common is research exploring how othering impacts on those in the professional mainstream. Even less common is research expressly exploring the experience of othering within the profession of Western psychology. However, I argue such research is important due to the power psychologists may exert on shaping, and creating discourses around what it means to be mentally well, to be a person, the process of recovery, and what constitutes effective mental health practice. For example, McNally (2011) highlights the political nature of some psychopathologies identified according to criteria outlined in varying versions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). He provides the historical example of homosexuality, initially included in the DSM as an aberration requiring diagnosis and treatment. Ongoing political activism on behalf of homosexual mental health practitioners saw its removal in the following DSM. Accordingly, the aim of this study is to provide an in- depth qualitative exploration of whether clinicians may characterise an othered psychology, whether they portray themselves as working in a way that differs from this characterisation, and whether such positioning represents attempts to navigate the larger contradictions in which their profession is embroiled.

METHOD

Due to the paucity of research into this experience, I employed a qualitative approach for this work. Ethics approval was awarded by Charles Sturt University. I conducted eight semi-structured interviews with 10 registered psychologists between September 2012 and August 2013 (one focus group with three participants, and seven individual interviews). Of these, six interviews including the focus group were conducted face-to-face. One interview was conducted using Skype, and another the phone. To participate, interviewees needed to be fully-registered and currently practicing psychologists.

Potential interviewees were sourced using 'snowball' sampling, and professional networks. The former approach involves participants introducing the researcher to their connections to find interested subjects.

Six of the participants (N = 10) were female, and four were male. Their ages ranged from 36 to 61 (M = 47.7, SD = 9.2). Eight participants were registered clinical psychologists, and two were generalists. Their years practicing within this profession spanned five through to 38 (M = 19.6, SD = 10.7). Clinicians' cultural background included Anglo (7), Greek (1), European (1), and the cultural background of one has been removed, to facilitate anonymity. Clinicians practiced across metropolitan Sydney (6), coastal New South Wales (NSW)(1), rural NSW (1), and Western Australia (1). Clinicians' theoretical preference encompassed mindfulness (1); psychodynamic (3); intensive short-term dynamic psychotherapy (1); eclectic (3); and cognitive behaviour therapy (CBT)(2). The names of all participants have been converted to pseudonyms.

Procedure

A digital recorder was utilised to record and transcribed each interview. The interviews ranged in length from 90 to 180 minutes. Participants were advised they were free to end the interview at any time should

they wish to do so. Additionally, the interview process has been outlined, including the use of silence to afford participants space to reflect (Hollway & Jefferson, 2013).
The interview commenced with the asking of an open-ended question, 'What is your experience of practicing as a psychologist?' Demographic data was also sought, either at the beginning of the interview, or at its end. Follow-up information was sought, using the language of the participant. For example, the interviewer would say, 'A moment ago you said (comment). Would you be happy to talk a bit more about that?'

Completed transcripts were emailed to participants, inviting validation, contradiction and comment. The completed study was also provided to interviewees seeking their feedback. Data were analysed using the method of Hollway and Jefferson (2013), and included a focus on contradiction, areas of ambiguity and emerging themes. More specifically, the transcripts were read a minimum of five times to uncover use of normative terms, what was not said, contradictions, ambiguities, slippages and key themes. During each reading extensive notes were created, with emerging impressions supported by substantive quotes. Counter-examples were actively sought-after to minimise confirmation bias and promote research rigour. Initial analysis was conducted, which was written around themes. Results were then discussed with the broader research team, who subjected these themes to thorough review including frequent return to the original interviews to ensure context- driven and accurate conclusions were reached.

RESULTS

The analysis identified a series of four themes relevant to this paper: 1.) Othering is experienced both historically and contemporaneously; 2.) The (new) status quo is enforced, albeit in subtle ways, by the establishment, peers, and educational curriculum; 3.) Othering may result in the loss of historically useful professional knowledge; and, 4.) Othering may effectively stultify creativity within a profession.

It should be emphasised I make no claim to generalise these results to all clinicians or professions. However, this research does provide evidence some registered psychological practitioners experience othering in this manner, and in their professional role. Moreover, the research highlights the oftentimes conflicting complexities faced by professionals, and the power such pressure can exert on both the individual and their sense of place, or power within the broader profession. My interest is in seeking to understand how this may manifest, as opposed to presuming to generalise results across the entirety of a population. In so highlighting experience, Western psychology may address and reflect on these dilemmas, and other professions may be afforded insight into areas for further exploration. I will now outline these themes in detail and then elucidate this conflict.

Othering is experienced both historically and contemporaneously

Anna is a 61-year-old, self-employed, clinical psychologist, with a part-time practice. Anna describes the current state of Australian psychology as a 'big schism', 'occurring uhm between general psychologists and the clinical psychologists, and the other postgrad psychs who aren't being recognised, in terms of the Medicare stuff'[2]. However, while the two end products have been a 'big schism' for Anna; its development has a history, spanning decades. She comments, that while '[she] did [her] clinical training back in 1990' she was aware even then that 'clinical psychs [were] favoured'. This is in contrast to her sense that 'everyone sort of seemed surprised, you know', that this was now the case. Her use of the word 'favoured' suggests that Anna, views this discrepancy as being based on institutional bias.

[2] Medicare is the Australian health insurance program (Australian Government Department of Health, 2017).

Anna speaks of how her perception that clinically trained psychologists were 'favoured…back in 1990', influenced her decision regarding 'what to do for post grad'. She states, '[I] thought, oh no, you know, it's probably going to be better career-wise if I do have the clinical 'cos even then there seemed to have been um……a ….a. um…realisation that that was ……..more …highly regarded'. Anna presents this 'realisation' as being in contrast with her then work focus, which at the time, was 'organisational psych'. However, it seems Anna experienced the pressure to 'have the clinical' as sufficiently powerful to shift her career path 'otherwise you weren't going to be uhm… you know in in… keeping up, you know…and have the expertise'. Anna reflects on that choice, commenting, 'I'm also so grateful that I chose clinical rather than organisational, although that might have taken me down another path, but I don't think I would have enjoyed it as much'. What is unclear here is whether her 'enjoyment' was informed by remaining 'within the fold' as it were, thereby allowing her access to, for example, the greater financial rewards and status that working as a clinician offer, as opposed to being required to operate on the fringe. Having chosen the more 'highly regarded' career path, Anna, to all outward appearances, operates within the 'favoured' elements of the 'schism'. Additionally, with her spoken emphasis on the phrase 'even then', Anna may be interpreted as understanding the expectation to practice within this frame as an even greater force now then it was 'then…back in 1990'.

Captain (54-year-old, self-employed, clinical psychologist with 33 years practice experience) talks about the 'war… in APS between clinical psychologists and non-clinical psychologists; saying that it's around money'. Captain presents this 'war' as comparable to the historical delineation between psychiatry and psychology, with the medical title of 'doctor' in his recollections, easily trumping qualifications gained within the latter degree.

Captain defines the 'entirely arbitrary' differentiation between registered and clinical practitioners, as being based on self-interest and varied 'belief systems'. He presents this differentiation as being unrelated to 'science' (conversely suggesting that this is how it is presented to the profession), and instead, as a reflection of the fact that (according to him), 'we can't stand to be with people who don't share our, uhm belief systems'. He presents the case of 'let's say CBT' in contrast to 'psychodynamic psychotherapy', arguing that practitioners who subscribe to one point of view are "not going to criticise the methodology' of articles which support their team. He comments that 'we're not really interested in empirical outcomes'; 'you just want to know whether your team is winning'. With these statements, Captain appears to refer to a predilection within psychology (he uses the all-encompassing pronoun 'we') which seeks to present itself as informed by 'empirical outcomes', when in fact (according to Captain), it is actually informed by intergroup ('team') rivalry, based on 'belief systems', which are riddled with 'prejudice', and motivated by 'self-interest'. For Captain, this state of affairs is the antithesis of 'empiricism'. The suggestion is that this split within the profession is not based on evidence even though it is presented as such.

The (new) status quo is enforced – albeit in subtle ways

Anna presents the 'big schism' in psychology as 'causing… hardship' for practitioners who do not work within its frame, and as 'favouring' those who do, which Anna presents primarily as the 'clinical psychologists'. Anna articulates that acquiescence to the clinical frame is necessary for 'keeping up', and that it is 'better career-wise', because ultimately it is 'more highly regarded'. Conversely, Anna says 'hardship' is experienced by 'general psychologists… and the other postgrad psychs who aren't being recognised, in terms of the Medicare stuff'. Here, 'hardship' appears to be understood by Anna as both financial 'in terms of the Medicare stuff' (viz. differential pay scales), and in terms of status, namely that clinical psychologists are 'more highly regarded'. Exactly who has made this decree is presented as an esoteric, albeit divisive (suggested by her choice of the word 'schism'), generic force which 'was always there'.

However, Anna, despite having chosen the more 'highly regarded' career path and thereby operating within the 'favoured' elements of the 'schism', provides evidence that she still experiences her practice as alternative to the edicts of the establishment. She can be seen as having her sense of professional competence and judgment undermined. As evidence of this claim, Anna describes her approach as 'a mishmash, and [she doesn't] know whether to be embarrassed about that or not'. Later in the interview, Anna provides some insight into her experience of 'embarrassment', presenting it as coming from outside her. She states, 'some people think it ("sticking to a model and doing it perfectly") is important, and that's when I think I say I'm a bit embarrassed'. Yet, Anna expresses a sense of conflict around what she perceives is expected of her versus how much she 'should' allow her experience to inform her practice.

Despite being a practitioner who has enjoyed professional longevity, she states:

> *I don't know anymore... how... you know whether you should be sticking to a model and doing it... perfectly... uhm... or whether... experience actually shows you that... it doesn't matter what model you use, what's important is that you relate effectively with the client, and that they have a good experience, and that they are finding insights into what's happening for them.*

Here Anna appears to express juxtaposition between her experience of effective practice, which tells her one thing, and 'other people' who according to Anna expect you to 'stick to a model and do it... perfectly'. Moreover, with her use of the word 'should', according to Brown and Gilligan (1992), Anna may be understood as referring to a moral voice in psychology, experienced as both external to her, and requiring her to practice in a mode at odds with both her preference (which is a 'mishmash') and what her 'experience' has 'shown' her.

Captain constructs an experience of psychology in which clinicians such as him are provided professional and political permission to afford themselves higher status relative to non-clinically endorsed peers. His vignette provides an illustration of a divisive element within the profession. He states:

> *I find myself acting with the same sort of smugness around people who don't have Medicare rebates, as psychiatrists used to do with me... cos you know, you might have a psychiatry colleague who might also be a psychotherapist, but at a particular point they'll say oh yes yes, we're doctors... and that's what I do with people who call themselves psychotherapists, at a particular point, or out loud... like, 'Yes, but you're not... there's a reason why we have Medicare and you don't.'.*

On the one hand, Captain claims that different knowledge bases do not have merit, stating the debate is 'entirely arbitrary', and driven by people who 'dress that up as something other than self-interest [laughs]' driven by a desire for more 'money'. Yet he concurrently comments, 'as a clinical psychologist I naturally take the side of people who say "Well we're special, we should be paid more money."' Here, we have a further account of what is perceived by some therapists as being behind the schism experienced by Captain and others within the discipline.

Conversely, 36-year-old, self-employed Michelle expresses an inability to speak about 'orientations [other than] a theoretical framework of cognitive behaviour therapy [informed by] the biopsychosocial model', 'because I don't think I'm really familiar with other orientations, and ways of doing things'. Nevertheless, ongoing education seems to be integral to Michelle's work ethic. When speaking about her internship process she shares:

> *I'd come across issues I hadn't dealt with before and so I would have to go home and read and... buy books, and accumulate knowledge in various ways and do a lot of research there all the while doing some sort of formal treatment, without knowing exactly what I was dealing with.*

Michelle appears to simultaneously present herself as 'unfamiliar' with 'other orientations' while being forced to 'read', 'accumulate knowledge in various ways' and 'do a lot of research' to effectively 'treat' her clients. What is unclear here, is why Michelle only 'accumulated knowledge' which reinforced her 'theoretical framework of cognitive behaviour therapy', thereby rendering her 'unfamiliar' with 'other orientations'. One interpretation may be that Michelle feels constrained 'under the general health system' to 'provide' her clients with 'sufficient strategies' within the '6–12 sessions, or 10 sessions now'[3]. Consequently, she turns to 'cognitive behaviour therapy' which presents as being able to work effectively within a short-term frame, as opposed to other therapeutic options.

As evidence for this interpretation, Michelle seems compelled in 'most instances', to very quickly identify if she is going to 'go beyond that 10–12 sessions'. The implication seems to be, that therapies which do go beyond 10–12 sessions are synonymous with incompetence. Furthermore, Michelle's professional identity, and evaluation of therapeutic approaches applied within her rooms, appears to be entangled with her need to provide 'sufficient strategies' for her clients to 'manage effectively in those 6–12 sessions, or 10 sessions'. If Michelle is able to provide therapy within a 10-12 session timeframe, she has 'done good'. Conversely, if she cannot, she feels compelled to re-evaluate the efficacy (or not) of her practice approach. With reference to Hollway and Jefferson's (2013) defended subject, Michelle may be understood here as defending against incompetence (her own and others), using time as a measure. Additionally, she may be viewed as experiencing almost a third presence within the room with her as she works with her clients, which inform how she views her practice, and pivots within it.

Othering may result in the loss of historically useful professional knowledge

As the interview progresses, Anna talks about the 'boom years of psychology' in the 'late 60s and early 70s' where she was exposed to 'the best of all possible worlds... all the bright minds, and all the you know, the different attitudes, whereas now you only get what you get at CSU or what you get at Macquarie, you don't get, you know everybody's perspective'. Anna appears to find the access to intellectual and theoretical diversity of training that used to be available to psychology, inspiring and exciting. Furthermore, she states, 'I got a really good grounding in counselling skills, and that I think... has held me in good stead'. It appears for Anna, psychology was better in the '60s and early 70s' when 'everybody's perspective', and 'grounding in counselling skills' was available. The converse implication is that diversity within contemporary psychology has been replaced by only some people's 'perspective', a de-emphasis on 'counselling skills', and a shift towards homogeneity and standardisation of what constitutes the endorsed practice-base.

Annette, (58-year-old, self-employed, clinical psychologist, of Anglo descent, with 38 years practice experience) while talking about the content of workshops that she organises for 'colleagues about various things', laughs as she states that, as a result of 'the requirements that we have', some of that content is 'evidence-based'. This is immediately followed by the comment 'so lots of it is CBT', which seems to imply that Annette understands the 'evidence-based' practice 'required' of her, and other psychologists (her use of the collective 'we') is 'CBT'. However, within the context of this interview, Annette's laughter does not seem to be disparaging of 'evidence-based' therapies (i.e., 'CBT'). Rather, it seems indicative of a sense of irony at the weight given to this 'required' approach, when she views others as also 'valuable'. She posits, 'but also, uhm we get people to come and talk about... anything that we think would be really valuable... we've had, you know, art therapy, and music therapy, and

[3] Medicare, under the Better Access Scheme will subside 10 sessions per annum with a psychologist.

psychoanalytic therapy'. Thus, instead of indiscriminately accepting 'the requirements', placed on her and her 'colleagues', Annette, and those she associates with, seek out 'anything' they interpret as 'really valuable' to their practice, as suitable material for their 'workshops'. Yet neither art nor music therapy are included on the Australian Psychological Society's (2010) listing of what treatments constitute best practice in psychology, yet they are viewed by Annette, and apparently others (she refers to 'we') as 'really valuable'.

Othering may effectively stultify creativity within a profession

During her interview, Michelle hints at an interest in, or an awareness of something other to mainstream psychology, which she terms 'the gut of what's going on [for her clients]'. She presents this as being converse to the 'very high level, cognitive level, cerebral level', 'reactions' which 'psychologists' 'tend to' focus on, thereby 'distancing [themselves]' from the 'gut of what's going on', which is the 'intense emotion'. One interpretation here is that CBT-practicing Michelle may experience her training as insufficient for dealing with "intense emotion" which is in fact what her therapy oftentimes requires her to do.

As Michelle speaks about these concepts, she appears to struggle to find words with which to present her thoughts. When asked to 'talk a bit more about… the very core of being human', concept Michelle injects into the interview, she begins by saying, Yeah, well, so I can't think exactly myself what I'm meaning by that…'. Additionally, Michelle repeats herself, uses long pauses between disjointed phrases, restates words, and finally seeks acknowledgement from me asking, 'Does that make sense?' Furthermore, the language she employs to articulate her thoughts may be regarded as more colloquial, more confused, and less professional, than her listing of what is her practice, which I will outline in the following paragraph. For example, she states that, 'We [psychologists] think through emotions a lot to ahh, a lot and uhm… do it at a very uhm… think, think, think about reactions that are very high level, cognitive level, cerebral level'.

In contrast, Michelle's articulation of what is her practice, presents as scripted and pre-determined, with minimal use of pause. This is suggestive of an ease of accessing associated concepts with which to explicate her meaning and experience. She clearly delineates her process to me, presenting this in almost checklist form which she describes as a 'comprehensive assessment', and including 'biological factors', 'symptoms', 'family history of mental health issues', 'previous history of mental health issues', 'biological factors that might be an issue', 'current situation', 'social situation', the contribution of 'role modelling', 'workplace', 'stress', and 'protective factors that may be present'.

Another clinician, Callithump (42, male, Anglo, registered psychologist with 18 years practice experience) questions the validity or usefulness of evidence-based practices which have been deemed as such, based on statistically significant findings in randomised controlled trials (RCTs). He comments:

> *You can't apply the same technology…to two different people and expect to get… if you do it to 100 people, it'll average out, and you know 55% of them will get better, and you'll go, ace that's what we're looking for…that's an improvement?… but it doesn't… what about the other 45%?*

In context here, Callithump appears to position formalised psychology as requiring 'pre-packaged' responses to treatment, suggesting almost a fear of uncertainty within the therapeutic space. He provides the metaphor of 'a flowchart, with little yes, no, no's'. Yet, in contrast, Callithump presents the lack of access to 'sheets that will change the past', or that will change the client's 'thinking' as almost necessary for an efficacious process. He argues the therapeutic alliance is always about working with 'different patients… different therapists [and]… different histories', and 'what worked for you', can be 'experienced in a totally different way' by someone else. Yet Callithump mitigates this by suggesting that

the main tenets or philosophy of one therapy can transfer across to other patients, for example, 'trying to find a common language with somebody' which 'resonates for them'. The 'difference' for Callithump is that, in 'good practice', even if a clinician does apply a 'technique' with a client, they do not then continually position themselves as the expert, or remain rigid in their interpretation. Instead, they 'go on to accept the feedback' from the client and 'listen to what happens afterwards'. If the technique works it is not 'because you know, I read the right page on the text book'. Conversely, if it does not work, it is not 'because they're just being resistant [today], and I'll try it again next week [when they may no longer be]'.

CONCLUSION

In this article, I have used data from a number of interviews to illustrate clinicians' experience of a psychology, which is other to them. Within the theoretical frame provided by Hollway and Jefferson (2013), and in the context of this research, othered psychology may be understood as that psychology (as perceived by the individual) which minimises their capacity to embrace a professionally-agent subject position. It concurrently works against, or calls into question the individual's belief systems and professional observations, and is experienced as imposed. Hollway and Jefferson's theory, predicts that individuals who experience anxiety or emotional discomfort within a particular discourse will seek out alternative discourses which minimise 'anxiety and therefore support identity' (p.21). I have provided illustrations of clinicians who do this, presenting two psychologies; one which they articulate as being restrictive and undermining, and another, which is their alternate, and according to them, superior version.

Additionally with reference to Captain's experience, and giving consideration to Hollway and Jefferson's (2013) theory of the defended subject, one can argue that the profession of psychology is defending against its own anxiety, motivated by perceptions of what constitutes status (financial reward for the provision of scientifically derived therapies). On the one hand, the discipline presents best practice as being the application of knowledge generated by science, and published in peer-reviewed journals. On the other hand, the decision to split the profession along training lines draws on 'prejudice', motivated by 'self-interest'. Captain presents this split as comparable to what occurred historically between psychology and psychiatry. Thus psychiatry, embedded as it is in medicine, is afforded greater status than psychology. Similarly, within psychology, clinically trained psychologists are afforded greater status than alternatively trained psychologists.

Othered psychology may be presented by some participants as a divisive force existing between those who practice in accordance with its expectations, and those who do not. The external expectation to practice within this model is presented as being imposed on the individual by mainstream psychology. However, clinicians working within the frame of othered psychology may also be experienced as imposing this expectation on their colleagues who do not so work. Therapists may present this imposed experience as reflective of a prejudiced, professional stratum, or hierarchy created by the auspice of mainstream psychology, which facilitates for some psychologists, an apparent entitlement to sanction peers who they perceive are not practicing accordingly. The motivation behind the imposition of othered psychology onto clinicians is sometimes presented by the clinicians interviewed as stemming from a desire by some elements within the profession, to facilitate their personal financial gain, as opposed to emerging from an objective, evidence-based discussion. Additionally, practitioners may position othered psychology as obfuscating their professional role and capacity to facilitate effective treatment outcomes for their clients.

Further to these findings, clinicians also articulate an experience of anxiety resulting from their decision to practice in a manner counter to how they understand they are expected to by the othered psychology (irrespective of years of practical experience, or the existence of a substantive evidence-base for their preferred approach/es). Practitioners may also express concern at their perception, that formalised

psychology is moving away from the embrace of diverse practice approaches and towards requiring therapeutic homogeneity.

Clinicians may critique the application of APS endorsed treatment approaches (particularly CBT), and present these as being insufficient for their needs at the coal face. Additionally, while some practitioners may articulate a lack of awareness of methodologies alternate to CBT, they may concurrently express a valuing of concepts external to their practice of CBT, but struggle to adequately express these ideas. Clinicians may also express a valuing of ongoing education, yet only draw on those resources which re-affirm the philosophical stance perpetuated by othered psychology. A better understanding of how clinicians navigate working within the conflicted profession of psychology is important due to the rise in incidents of mental un-health (reference), and the power psychologists may exert on shaping, and creating discourses around what that experience both is, and how it will be treated.

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