The perceptions of clinical psychology: A focus on the different ethnic groups

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Declaration

This work has not been submitted to any other institution or for any other qualification.

ABSTRACT

Introduction: The under-representation of minority ethnic staff groups within the clinical psychology profession has been a serious area of concern for some time. Central to these concerns has been the questionable ability of the profession to adequately address, provide for and meet the needs of an increasingly diverse multi-racial and multi-ethnic society, for whom the utilisation of clinical psychology services are extremely poor. ***Literature review:*** The literature review indicated that minority ethnic groups were generally marginalized and excluded from clinical psychology services on a number of different levels, due to a combination of: referral conventions, professional misunderstandings of psychological distress, the limitations of conceptual frameworks and cultural factors. ***Research report:*** Given the profession's lack of success in attracting and recruiting staff from minority ethnic groups, this thesis was undertaken to: (a) explore the perceptions of clinical psychology held by different ethnic groups, using psychology undergraduates as the target population and (b) investigated their intention or otherwise to pursue a future career in clinical psychology, using the Theory of Planned Behaviour (TPB) as a model. The results showed the TPB to be predictive of intention in all cases. However, for the minority ethnic groups, there were significantly more perceptions of disadvantage in pursing clinical psychology, as there were the factors that would deter them from entering the profession. Methodological limitations of the study, practical implications and directions for future research are discussed. ***Critical appraisal:*** An appraisal of the research process is presented, concluding with salient learning points for the future.

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Finally, I would like to thank my family for always believing in me and for their unconditional love and support.

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[1] Currently known as South Yorkshire Workforce Development Confederation.

Word Counts

Literature Review	5068
Literature Review References	2105
Literature Review Total	**7173**
Research Study	11965
Research Study References	1408
Research Study Total	**13373**
Critical Appraisal	2523
Critical Appraisal references	115
Critical Appraisal Total	**2638**
Full Thesis (excluding Appendices)	**23184**

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Clinical psychology and the diversity of service provisions in the UK: A review of the literature

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Abstract

Objectives: There is substantial evidence to suggest that clinical psychology services are failing to meet the psychological and clinical needs of people from minority ethnic groups. This paper reviews and extends current knowledge and understanding of some of the possible factors that may be contributing to this, by examining the diversity of clinical psychology service-provisions for minority ethnic groups in the United Kingdom (UK).

Method: Research concerned with the poor utilisation of clinical psychology service provisions among minority ethnic groups were identified and the limitations assessed against the conventional models and frameworks offered by mainstream psychological services. References to developments from the United States (US) were also included, where they enhanced understanding of the current situation affecting minority ethnic groups in the UK.

Results: The findings showed that minority ethnic groups were generally marginalized and excluded from mainstream clinical psychology services on a number of different levels. These were often influenced by referral conventions, professional misunderstandings of psychological distress and a reliance on ethnocentric and Eurocentric conceptual frameworks. Cultural factors were also implicated.

Conclusions: This review illustrates that the profession needs to be more considerate in their provisions of services for minority ethnic users, although an exploration of how the profession is perceived by the different ethnic groups would also seem pertinent.

Introduction

Clinical psychology in the UK is becoming an increasingly prolific profession. The last 10 years has witnessed the following important developments: advancements in both the science and practice of clinical psychology; growth in the scope and depth of psychological knowledge; inter-professional utilisation of psychological principles and skills to inform a variety of psychological and psychiatric problems; a plethora of clinical approaches, psychological therapies and interventions of increasing specification that are in constant demand; and successive increases in the demand for and availability of places on clinical psychology training courses (Kinderman, 2001; Knight & Llewelyn, 2001). Never before in the profession's history has clinical psychology received so much acclaim. Hailed as a welcomed success for the profession and the wider psychology fraternity, the status of clinical psychology has reached new realms (Frankish, 2000). The profession is increasingly considered an essential part of current government policy, with the modernisation of the new National Health Service (NHS) plan (e.g. Department of Health & Home Office, 2000), and is now widely perceived as being analogous to other 'powerful' professions such as psychiatry.

However, just like psychiatry, clinical psychology is also regarded by many as being a relatively exclusive profession. That is, exclusively White, middle-class and predominately female (Fatimilehin & Coleman, 1998; Fernando, 1991, 1995; Fernando, Ndegwa & Wilson, 1998). Whilst its' training and practice is widely acclaimed to be

universal, flexible[1] and 'integrative', many critiques also believe that far from being ubiquitous, its' historical foundations and knowledge-base means that it is eminently biased towards Eurocentric and ethnocentric ideals[2] (Alladin, 1993; Coleman, Brown, Acton, Harris & Saltmore, 1998; Fernando, 1991; Lokare, 1992; Meldrum, 1998; Nadirshaw, 1992). However, considering that the UK is now an increasingly diverse, multi-cultural, multi-racial and multi-faith society, how universal and ethnically diverse, is the profession of clinical psychology?

There is now a rapidly extensive and convincing body of evidence, from both the UK and abroad, which significantly shows that members of minority ethnic groups are generally excluded from, marginalized and are either unable to or unwilling, to access clinical psychology services (Bender & Richardson, 1990; Fatimilehin & Nadirshaw, 1994; Nadirshaw, 1993; Fernando, 1991; Meldrum, 1998; Patel, Bennett, Dennis, Dosanjh, Miller & Nadirshaw, 2000; Webb-Johnson & Nadirshaw, 1993). There are an insurmountable number of reasons for this, but chief amongst these has been the questionable ability of the profession to adequately offer and provide an appropriate range of clinical and psychological services that are aptly sensitive to, attractive, respectful of and relevant to the ethnic, cultural, spiritual and religious needs of a multi-cultural society. This paper seeks to develop and extend current knowledge and understanding of these issues, by offering a review of the diversity of clinical psychology service-provisions for minority ethnic groups in the UK.

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[1] In terms of adaptability.

[2] Ethnocentric refers to the inherent tendency to view one's own culture as the standard against which other are judged (Senior & Bhopal, 1994). Eurocentric refers to a reliance on European/Westernised world views.

This paper will be structured into four main parts. The first will provide a brief overview of terminology and address the current situation with regards to possible causes for the poor utilisation of clinical psychology services by minority ethnic groups. This will then be preceded in section two, by an examination of some of the cultural factors that may affect service up-take. Section three will provide an exploration of alternative psychological models of mental health and tentatively draw on parallels to those offered in mainstream psychological services. The final section will address the clinical, professional and personnel implications of these findings for the provisions of clinical psychology services to minority ethnic groups in the UK, outline the limitations of current knowledge in this area and offer suggestions for further research.

Method of literature search

A combination of search methods was used to identify research articles in this area. In the first instance, computerised literature searches were undertaken of the relevant health and social science databases. These included: PsychINFO, HMIC (Health Management Information Consortium), ASSIA (Applied Social Sciences Index and Abstracts), CINAHL (Cumulative Index of Nursing and Allied Health Literature – part of the OVID bibliographic records) and Medline. The search period ranged from 1st January 1981 – May 2002, using the following key terms: clinical psychology, ethnic minority/minorities, minority ethnic(s), service(s), user(s), patient(s), client(s), perception(s), uptake, access(ing), use/utilisation, experience(s), United Kingdom/UK, British, culture/cultural, difference(s), different, provision(s).

Some studies were also identified through citations in research articles, telephone and e-mail dialogues with writers in this area, and through contacts with specialised organisations (e.g. NAFIYAT Inter-cultural Therapy Centre and the Black Mental Health Resource Centre in Leeds). Finally, the Department of Health website was used to identify relevant circulars and government reports on the Internet.

Use of terminology and conceptual frameworks

Throughout this review, references will be made to published literature that can be challenged on both methodological and conceptual grounds. The latter pertaining to fundamental issues of interpretive frameworks based on Eurocentric and ethnocentric ideals (alluded to earlier), which may question the appropriateness of some of the conclusions derived, and like the former, can make comparisons between studies difficult. Similar limitations emerge in the use of studies where terms can acquire different meanings in other cultures (e.g. in America, 'Asians' refers to persons of East Asian origin and therefore differs to the term 'Asians' as used in the UK), therefore where this occurs, reference will be made to this in the text. Also for the purpose of clarity, the terms minority ethnic(s) and ethnic minorities may be used interchangeably in this review, to refer to people of predominately African, Caribbean and South Asian origin (Bangladeshi, Indian, Pakistani)[3]. Occasionally, the term 'Black' may also be used in the literature as a collective term, to describe the common experiences of discrimination, racism, marginalization and oppression which usually occurs on the basis of skin colour.

[3] By definition, this therefore excludes the White minorities (e.g. those of Irish origin) and persons with origins from East Asia (e.g. the Chinese). The heterogeneity that exists within the minority ethnic groups described, is acknowledged.

Service-utilisation by minority ethnic groups

There is now a substantial body of psychological and other evidence, which suggests that the healthcare needs of minority ethnic groups are under-served and inadequately addressed in the UK (Fatimilehin, 1989; Roach, 1992; Smaje, 1995; Webbe, 1998). Whilst general debates and speculations remain about the specificity, variability, causation, prognosis and general outcome of certain mental health difficulties amongst minority ethnic groups e.g. rates of depression amongst South Asian females (Bhui, 1999) and the excess diagnosis of schizophrenia and other psychosis among people of African Caribbean origin (Harrison, Owens, Holton, Neilson & Boot, 1988), there is nevertheless significant evidence to suggest that minority ethnic service-users are over-represented in psychiatric and forensic services, but grossly under-represented within clinical psychology services (e.g. Fernando et al, 1998; Iiahi, 1980; Nadirshaw, 1993; Patel, 1992; Webb-Johnson & Nadirshaw, 1993). There are no clear reasons for why this may be the case, although research focussing on the role of the general practitioner (GP) as a possible gate-keeper to other pathways or sources of care (Goldberg & Huxley, 1980) and the institutional frameworks (i.e. policies, procedures and practices) of healthcare providers (Ross & Hardy, 1999), has shed considerable light on the unequal access to and diversity of clinical psychology and other service provisions for minority ethnic groups in the UK.

Most of the research undertaken on the role of the GP in this context has tended to specialise on the experiences of people from South Asian communities relative to other minority ethnic groups. The earlier studies focussed mainly on ethnic group differences

in GP consultation rates, certified sickness absence requests and the recognition rates of psychological distress in patients by GPs' (e.g. Boardman, 1987; Johnson, Cross & Cardew, 1983). However, although they were generally consistent in finding significantly higher rates of GP consultations among persons of South Asian origin, especially Pakistani GP attenders, relative to those of Caribbean and Indian origin (e.g. Balarajan, Yuen & Raleigh, 1989; Gillam, Jarman, White & Law, 1989), they tended to lack specificity with regards to definitions of ethnicity (due to the absence of standardised criteria prior to the 1991 Census) and often utilised inappropriate diagnostic tools for the classification of 'mental' and other related disorders, which were rarely normed on minority ethnic groups (Marsella & Kameoka, 1989). There was also a tendency to routinely use practice attendance rates for White ethnic groups as a standard benchmark in which to make comparisons with the other ethnic groups (Bhui, 1999) and they frequently failed to report on the context, content and outcome of these consultations for the different minority ethnic groups (Marsella & Kameoka, 1989).

Subsequent research undertaken on the nature and types of GP presentations by the different minority ethnic groups and the referral routes taken thereof, have broadly fallen into one of two camps, based on the differential experiences of mainly African Caribbean and South Asian ethnic groups. Thus regarding the former, GP presentation rates of common mental health disorders (such as anxiety, alcohol abuse and depression) among people of African Caribbean origin, were generally found to be either similar to or lower than prevalence rates found in the general population (Lloyd, 1992; McKeigue & Karmi, 1993). However, although the results of two national surveys which showed excess rates

of depression among Caribbean adults later disputed these claims (Nazroo, 1997; Office for National Statistics, 1995)[4], what was more significant, was the finding that Caribbean adults were less likely to be referred onto other services by their GPs', unless at crisis point (e.g. Commander, Sashi Dharan, Odell & Surtees, 1997; Fernando et al, 1998; Smaje, 1995).

Conversely, while there is thought to be a greater preponderance of alcohol misuse, stress-related/neurotic and depressive-type symptoms among 'Asian' GP attendees (e.g. Bhui, 1999; Cochrane & Bal, 1989), there is some debate about the undiagnosed rates of depression or other common mental health disorders for this ethnic group, and the subsequent impact this may have on GP referral rates to other agencies (Odell, Surtess, Wainwright, Commander & Sashi Dharan, 1997; Shaukat, deBono & Cruichskank, 1993; Smaje, 1995; Wilson & MacCarthy, 1994). Interestingly, although cross-cultural comparisons of research in Pakistan and India appear to demonstrate that rates of depression and other common mental health disorders (e.g. anxiety) to be equally prevalent in these countries as well (Mumford, Nazir, Jilanic, et al, 1996; Mumford, Saeed, Ahmad, et al, 1997; Sethi, 1986) a significant proportion is also thought to remain undiagnosed by GPs' there, as in the UK.

However, given the relatively high GP attendance rates and the differential presence of severe and less common mental health disorders among the different ethnic groups (as noted above), there is also evidence to suggest that although most minority ethnic groups tend to seek access to care directly through their GP (Gater & Goldberg, 1991; Goldberg

[4] NB: These studies referred to community-based samples rather than consultations with GPs'.

& Huxley, 1980; Wilson & Francis, 1997), so far as clinical psychology is concerned, the pathways taken thereon, are more likely to be influenced by patterns in referral conventions (Commander, Sashi Dharan, Odell & Surtees, 1997; Goldberg & Huxley, 1992; Shaukat et al, 1993) and factors related more specifically to their ethnic group (Nadirshaw, 1993; Ndegwa, 1998; Webb-Johnson, 1991).

References in the psychological literature to 'Asians' being 'psychologically robust' (Beliappa, 1991; MacCarthy & Craissati, 1989; Nadirshaw, 1992; Webb-Johnson & Nadirshaw, 1993) and suggestions of cultural factors being implicated in the pathology of psychological distress (Nadirshaw, 1992; Smaje, 1995) have not helped. Neither have references to minority ethnic groups lacking 'psychological mindedness' and the associated belief that people who are insufficiently assimilated into Western cultures are incapable of analytical reflection (see for example Fatimilhelin, 1989; Littlewood, 1992; Slater, 1994). These references have led some concerned observers to assert that this merely provides support for the level of professional ignorance and inappropriate stereotypical assumptions that appear to be operating within the clinical psychology and other healthcare professions (Coleman & Salt, 1996; Fernando, 1991, 1995; MacCarthy & Craissati, 1989; Smaje, 1995).

Whilst these processes will undoubtedly discourage referrals of minority ethnic groups to clinical psychology services and may have contributed to their poor up-take, some critiques have also argued that they have seriously undermined a profession that has done little to actively promote and redress the inequitable access of clinical psychology service

provisions to an increasingly large and vulnerable section of the British community, who by their very presence and unique experiences, could undoubtedly benefit from their help (Bender & Richardson, 1990; Fatimilehin, 1989; Nadirshaw, 1992; Roach, 1992).

The influence of cultural factors on service up-take

While access to psychological provisions are not always forthcoming for members of minority ethnic communities, there is also research evidence to show that even if these services were offered to them more routinely, this may only have a minute effect on service up-take *unless* other culturally-relevant factors are also taken into consideration (Beliappa, 1991; Nadirshaw, 1992). Chief amongst these has been a general unease from the Black community about the profession's genuine ability to allay concerns about the lack of cultural sensitivity afforded to minority ethnic groups and expectations from services that they should conform to practices that may be in disagreement with these (Aitken, 1998; Harworth, 1998; Pfeffer, 1998).

Much of these difficulties are thought to emerge due to the following: misguided and misinformed knowledge about the religious and cultural values, norms, customs and practices of the different ethnic groups (Aitken, 1998; Lokare, 1992; Nadirshaw, 1992; Roach, 1992; Smaje, 1995); a general lack of awareness of the uniqueness of individual differences in relation to these; and the practice of making inappropriate comparisons with norms in the British culture, as a standard against which other cultures may be judged (Alladin, 1993, 1997; D'Ardenne, 1993; Lokare, 1992; Webb-Johnson & Nadirshaw, 1993).

Whilst unfavourable, it is also argued that the greater the level of ignorance, the greater the propensity for healthcare professionals to rely on stereotypes (positive and negative) and inexact generalisations about minority ethnic groups (Fernando, 1991; Webb-Johnson & Nadirshaw, 1993). This may in turn lead to unfair judgements in the assessment of these individuals, the clinical formulations that are derived and the process and outcome of the therapeutic encounter (Fatimilehin, 1989; Harworth, 1998; Katz, 1985; Laungani, 1992; Pedersen, 1988; Pope-Davis & Coleman, 1997).

Research studies have also shown ethnic minorities to be sceptical of clinical psychology services in their ability to adequately understand and work with issues of racism, discrimination, oppression and experiences of social isolation, that so often arise from being a member of a minority ethnic group (Coleman et al, 1998; Fatimilehin & Coleman, 1998). Much of this is related to the general unease about the visible lack of black clinical psychologists in the profession (Coleman et al, 1998; Fatimilehin & Coleman, 1998; Nadirshaw, 1993; Patel, 1998; Webb-Johnson & Nadirshaw, 1993) and fears by minority ethnic communities that they will not be welcomed by services, on the assumption that clinical psychology services are more suitable for people who are White and middle-class (Fatimilehin & Coleman, 1998; Coleman et al, 1998). This relates to similar concerns raised mainly by Black clinicians in the profession, who have asserted that the historical foundations, Eurocentric and ethnocentric practice of clinical psychology, and the profession's reluctance to seriously address issues of structural and institutional inequality, may leave it open to criticisms of acceptability, and charges and

perceptions of racism, however unintentionally (Fatimilehin, 1989; Husband, 1992; Morgan, 1998; Nadirshaw, 1992, 1994; Owusu-Bempah & Howitt, 1994).

Whilst not a familiar concept in the UK, there is also a rapidly increasing body of literature from the US pertaining to an important psychological notion of 'cultural mistrust' (for a review refer to Whaley, 2001), which may help to explain the fear, distrust and reluctance of minority ethnic groups in the UK to engage with psychological services. Although the term has been deferentially re-framed over the last 2 decades (e.g. with references to notions of 'cultural paranoia' and 'paranoid ideations'), its' meaning has remained consistent over time. Used as a legitimate method of coping with experiences of discrimination and racism, it refers to the lack of trust or 'distancing' that may be held by minority ethnic groups about certain cultures, institutions and professionals (including their practices, e.g. the use of psychological therapies), in their encounters with them. Translated into a British context, this may therefore help to explain the 'healthy cultural suspicions' (Boyd-Franklin, 2002) minority ethnic individuals may have about engagement with psychological services, due to a fear that their psychological distress may be misunderstood, misconstrued and/or pathologized, and their beliefs severely compromised or at worse, undermined (Boyd-Franklin, 2002; Whaley, 2001).

Other factors that have been found to affect minority ethnic access to sources of psychological help, have included: the lack of access to bilingual healthcare professionals, language and communication barriers, stigma related to service

involvement, fears that confidentiality may be compromised, negative past experiences of services and insufficient awareness of existing services and what they may have to offer (Beliappa, 1991; Coleman et al, 1998; Fatimilehin & Nadirshaw, 1994).

Towards alternative psychological models of mental health

Given the relatively poor utilisation of clinical psychology services by minority ethnic groups (particularly the psychological therapies), and the inequitable and culturally insensitive provisions that are offered, a growing body of literature has emerged expressing grave concerns about the relevance of using Westernised models of mental health, as a framework to address psychological difficulties in the Black community (e.g. Alladin, 1993; Lago & Thompson, 1996; Webb-Johnson & Nadirshaw, 1993). Much of this unease relates to the Eurocentrism of mainstream models, the biased interpretations they permit (due to their conceptual frameworks), and the consequential inadequacies they afford for use with minority ethnic service users (Lakore, 1992; Patel, 1992; Patel et al, 2000; Ridley, 1995).

In response to this, a number of alternative models and approaches to therapy have been proposed to incorporate frames of reference that are more appropriate for ethnic minority service users. Whilst there are differences in terminology in relation to these approaches (e.g. transcultural, intercultural, cross-cultural, multi-systems and multicultural models of therapy), they are generally based on the same premise that the style of the therapy offered, should at least be culturally sensitive and fair (rather than culture-denying or culture-superior), give valued consideration to the uniqueness of whole life experiences,

and are able to incorporate and understand the complex dynamics of sexism, racism, alienation and power within the wider socio-political context, the effects of this on the client and how this may impact on the therapeutic process (e.g. Alladin, 1993; d'Ardenne, 1993; d'Ardenne & Mahtani, 1999; Boyd-Franklin, 1989; Eleftheriadou, 1994; Kareem & Littlewood, 1992; Webb-Johnson & Nadirshaw, 1993). However, whilst these approaches are generally well received and provide some support for the inappropriateness of Eurocentric models, they tend only to be used and offered most explicitly in predominantly specialist organisations, often operating independently of statutory healthcare provisions (e.g. Roach, 1992). Furthermore, while they serve a genuinely useful purpose, it could be argued that they may also encourage professions like clinical psychology to buy into such provisions, rather than to seek to address these issues and implement appropriate strategies to integrate them into mainstream services.

In America, there has also been a drive to develop 'Africentric' perspectives, based on theories and concepts of psychological health that have origins in African and Asian knowledge-bases (e.g. Akbar, 1984). However, the success of these perspectives have yet to be evaluated and due to conceptual difficulties, may not be applicable to minority ethnic groups in the UK (Fatimilehin & Coleman, 1999).

Discussion

This review of the literature has indicated some of the ways in which minority ethnic groups have generally been marginalized and excluded from mainstream clinical psychology services. The research illustrated how this may be operationalized at a number of different levels: from the first point of service contact (usually incorporating the role of the GP), through to the process of differential diagnosis, conventions in referral criteria's and procedures, misguided stereotypical assumptions about the different minority ethnic groups, and the Eurocentric and ethnocentric foundations from which clinical psychology services are provided. However, researchers have also highlighted some of the cultural factors that have been shown to affect service-uptake by members of minority ethnic communities. These have included references to the general unease about the profession's ability to allay concerns that their cultural, religious and spiritual values will not be compromised. There are also fears that their psychological distress may be judged against incompatible frameworks or at worst, inappropriately pathologised. In addition to this, there is also genuine scepticisms about the ability of psychological services to understand and address issues related to experiences of racism and discrimination. Other pertinent factors associated with the fear of stigma and notions of cultural mistrust have also been implicated, as has the presence of inadequate service provisions for minority ethnic groups (e.g. lack of access to Black clinical psychology staff and bi-lingual healthcare professionals).

The literature has also revealed the important role some agencies may play in the provisions of more culturally appropriate therapeutic services, although by implication,

this may also negate the responsibility of the profession to take adequate steps to seriously challenge, address and manage these issues.

The clinical, professional and personnel implications

This review suggests that there are a number of implications for the diversity of clinical psychology service provisions to minority ethnic groups in the UK. As the evidence shows, mainstream clinical psychology services are failing to meet the needs of the Black community on a clinical as well as a professional level. This appears to reflect both a workforce and diversity issue, related to training concerns and the global under-representation and lack of ethnic diversity within the profession[5]. Given that current figures suggests that approximately 6% of the British population are from diverse non-White, minority ethnic communities (OPCS: Office of Population Censuses & Surveys, 1994), and it is estimated that by the year 2020 this population will have doubled (Runneymede Trust, 1994), it therefore becomes incumbent that the profession takes serious measures to address this issue.

Unfortunately, the low recruitment and retention of minority ethnic clinical psychologists has received extensive coverage in the British psychological literature for some time, but has yet to be significantly implemented in practice (DCP Briefing paper No. 16, 1998; Coleman et al, 1998; Fatimilehin, 1989; Fatimilehin & Coleman, 1998; Webb-Johnson & Nadirshaw, 1993). However, it may be wise for the profession to note that numerous documents have already emerged in the public domain, as part of the current

[5] Although the BPS does not have any official record to confirm the levels of qualified minority ethnic clinical psychologists in the UK, it is estimated that there are at least 25 who are of African or African Caribbean descent (McInnis, 2000).

government's national strategy on health, which may lead to greater scrutiny of professions like clinical psychology in relation to these issues. Indeed, the White Papers: *The New NHS: Modern Dependable* (1998), *Working Together: Securing a Quality Workforce for the new NHS* (2000); *Making a Difference: The New NHS*; (1999), *Excellence Not Excuses* (2000); and the conference paper, *Health Gains for Black and Minority Ethnic Communities* (1997), to name but a few, have all indicated that issues of diversity, race, the removal of discriminatory practices and a commitment to the recruitment and retention of minority ethnic health professional staff, have been identified as priority areas of concern to be placed at the forefront of the NHS agenda. As was exemplified by the then Secretary of State for Health, the Right Honourable Frank Dobson:

'Understanding and responding to local health needs and working with local communities will become an increasingly significant aspect of professional practice. Our new vision is of professions that better reflect the communities they serve, able to provide sensitive and responsive services, care and support'. (Making a Difference, 1999).

There is also a large body of research from the US relating to practical suggestions about the recruitment and retention of minority ethnic groups in the clinical psychology profession, which may also help to ameliorate the current situation in the UK (American Psychological Association, Office of Ethnic Minority Affairs, 1997; Hammond & Yung, 1993; Thomason, 1999; Yutrzenka, Todd-Bazemore & Caraway, 1999). These have included: the development of specific committees within the American Psychological

Association (APA) for the recruitment of minority ethnic staff (APA report, 1997), the establishment of various training programmes targeted at the recruitment, retention and training of different ethnic groups (e.g. Yutrzenka et al, 1999), pre-doctoral training courses (e.g. Myers, Wohlford, Guzman & Echemendia, 1991) and widespread multi-cultural training packages for perspective clinical psychology trainees (e.g. Bernal, Sirolli, Weisser, Ruiz, Chamberlain & Knight, 1999).

As earlier mentioned, a related concern that has also been highlighted by this review, has been the implications of these findings for the education and training of culturally competent staff, who given the lack of Black representation in the profession, are better able to serve and meet the needs of clients from minority ethnic groups. This issue has already received extensive coverage in the literature (both here and abroad) and is far too large for the scope of this review, suffice to say that tokenism should not be the name of the game and as the evidence shows, there is a real need for the profession to give serious consideration and attention to the preparation of clinical psychologists for work with a range of ethnically, racially and culturally diverse population groups (Bender & Richardson, 1990; Division of Clinical Psychology, Briefing Paper, No. 16, 1998; Davenhill, Hunt, Pillay, Harris & Klein, 1989; Patel, 1992, Williams, 2000).

Much of the responsibility for these concerns have (unfairly or fairly) been placed in the direction of clinical psychology training courses, given that they play a significant role in the selection, recruitment and training of postgraduate students (Bender & Richardson, Davenhill et al, 1989; Nadirshaw, 1992), but this position also implies that those

individuals and intuitions giving the training are equally informed about and adept at working with and teaching such issues (Patel, et al, 2000; Sayal-Bennett, 1991). The quality of clinical supervision also has an integral role to play in this important learning process and being a mandatory requirement for all trainees, should therefore be subject to the same level of scrutiny (Bhui & Bhugra, 1998).

Finally, this review has also shown that there is a need to establish clinical psychology service provisions that are attractive, accessible and culturally sensitive to the needs of minority ethnic communities. This has implications for the way services are operated and advertised; referral criteria's; the types, choice and range of psychological therapies that are offered; the composition of clinical psychology staff teams; and the ability of services to be appropriately innovative in their practice, so as not to marginalize or exclude a significantly large proportion of the British population.

Limitations and future research

Whilst this review has predominately focussed on clinical psychology as a profession and the diversity of service provisions it affords minority ethnic groups, there remain some important limitations about the conclusions raised if they are considered in isolation. Firstly, there is much known about the different cultural concepts of psychological ill-health and well-being (e.g. Laungani, 1992; Webb-Johnson, 1991), which has been beyond the scope of this review to include. However, since interpretations of these different concepts will have some influence on the expectations some minority ethnic

groups may have of services, it seems important that these factors are also taken into consideration in an evaluation of the conclusions drawn.

A further limitation of this review, relates to the limited focus on the perspectives and concerns of just the African, African Caribbean and South Asian minority ethnic groups to the exclusion of others, like those of East Asian origin, whose psychological needs are just as pertinent as those covered, but are more likely to be over-looked by services due to their comparatively smaller numbers. For instance, research has shown that the mental health needs of the Chinese community in the UK have been inadequately addressed by mainstream provisions and, as a diverse minority ethnic group, they tend to have limited access to other sources of support and often feel isolated in their contacts with services (see for example, Li, Logan, Yee & Ng, 1999). It would therefore be important if future research considered the psychological and service needs of these smaller minority ethnic communities as well, so as not to further exclude, alienate or marginalize them from services.

Other areas for future research might include consideration of the psychological needs of other diverse communities, such as asylum seekers and those with refugee status, of whom little is known, but given their diverse life experiences and perhaps a greater propensity to have experienced trauma and significant loss as a result, they may become an increasingly important focus for the provisions of psychological services.

In conclusion, therefore, it seems there is much scope for the clinical psychology profession to seek to redress the inadequate provisions of services it provides for minority ethnic groups in the UK. As this review showed, there are many concerns minority ethnic groups have of this profession and it seems pertinent that they are able to feel 'assured' that they will be 'welcomed and respected' by clinical psychology services (Bender & Richardson, 1990), should they wish to seek their help. However, given the critically low representation of minority ethnic clinical psychologist that there are at present, and the profession's lack of success in attracting and recruiting staff from minority ethnic groups, an exploration of the perceptions of clinical psychology as a profession and possible future career choice seems imperative, both for the future benefit of it's members and the increasingly diverse community it seeks to serve.

References

Aitken, G. (1998). Reflections on working with and across differences: Race and professional differences in clinical psychology therapy encounters. *Clinical Psychology Forum,* 118, 11-17.

Akbar, N. (1984). Africentric social sciences for human liberation. *Journal of Black Studies,* 14, 395-414.

Alladin, W. J. (1993). The ethnomedical model as a conceptual tool for counselling in health-care decision-making. *British Journal of Guidance and Counselling,* 21, 8-19.

American Psychological Association Commission on Ethnic Minority Recruitment, Retention and Training. (1997). *Visions and transformations: The final report.* Washington DC: American Psychological Association.

Balarajan, R., Yuen, P., & Raleigh, V. S. (1989). Ethnic differences in general practitioner consultations. *British Medical Journal,* 299, 958-960.

Beliappa, J. (1991). *Illness or distress? Alternative models of mental health.* London: Confederation of Indian Organizations.

Bender, M. P., & Richardson, A. (1990). The ethnic composition of clinical psychology in Britain. *The Psychologist: Bulletin of the British Psychological Society,* 250-252.

Bernal, M. E., Sirolli, A. A., Weisser, S. K., Ruiz, J. A., Chamberlain, V. J., & Knight, G. P. (1999). Relevance of multicultural training to students' applications to clinical psychology training programs. *Cultural Diversity and Ethnic Minority Psychology,* 5, 43-55.

Bhui, K. (1999). Common mental disorders among people with origins in or immigrant from India and Pakistan. *International Review of Psychiatry,* 11, 136-144.

Bhui, K., & Bhugra, D. (1998). Training and supervision in effective cross-cultural mental health services. *Hospital Medicine,* 59, 861-865.

Boardman, A. P. (1987). The general health questionnaire and the detection of emotional disorder by general practitioners. *British Journal of Psychiatry,* 151, 373-381.

Boyd-Franklin, N. (1989). *Black families in therapy: A multisytems approach.* London: Guildford Press.

Boyd-Franklin, N. (2002). *Working with Black clients and families in therapy.* Visibility/Invisibility Conference Presentation. University of Leeds.

Cochrane, R., & Bal, S. S. (1989). Mental hospital admission rates of immigrants to England: A comparison of 1971 and 1981. *Social Psychiatry and Psychiatric Epidemiology,* 24, 2-11.

Coleman, D., & Salt, J. (1996). Ethnicity in the 1991 census: Demographic characteristics of the ethnic minority populations (Vol. 1). London: Office of Population Censuses and Surveys.

Coleman, P. G., Brown, R., Acton, C., Harris, A., & Saltmore. S. (1998). Building links with a black community: experience in central Manchester. *Clinical Psychology Forum,* 118, 43-48.

Commander, M. J., Sashi Dharan, S. P., Odell, S .M., & Surtees, P. G. (1997). Access to mental health care in an inner-city health district.1: Pathways into and within specialist psychiatric services. *British Journal of Psychiatry,* 170, 312-316.

Commander, M. J., Sashi Dharan, S. P., Odell, S. M., & Surtess, P. G. (1997). Access to mental health care in an inner-city health district II: Association with demographic factors. *British Journal of psychiatry,* 170, 317-120.

D'Ardenne, P. (1993). Transcultural counselling and psychotherapy in the 1990s. *British Journal of Guidance and Counselling,* 21, 1-7.

D'Ardenne, P., & Mahtani, A. (1999). *Transcultural counselling in action.* London: Sage.

Davenhill, R., Hunt, H., Pillay, H. M., Harris, A., & Klein, Y. (1989). Training and selection issues in clinical psychology from an equal opportunities perspective. *Clinical Psychology Forum,* 21, 34-37.

Department of Health. (1997). *Health gains for black and minority ethnic communities.* London: Department of Health.

Department of Health. (1998). *The new NHS: Modern, dependable.* Leeds: Department of Health.

Department of Health. (1999). *Making a difference: The new NHS.* Leeds: Department of Health.

Department of Health. (2000). *Working together: Securing a quality workforce for the NHS* Leeds: Department of Health.

Department of Health. (2000). *Excellence not excuses.* London: Department of Health.

Department of Health and Home Office. (2000). *Reforming the Mental Health Act. White Paper.* London: The Stationery Office.

Eleftheriadou, Z. (1994). *Transcultural counselling.* London: Central Books.

Fatimilehin, I. A. (1989). Psychotherapy for Blacks. *Changes,* 7, 52-57.

Fatimilehin, I. A., & Coleman, P. G. (1998). Appropriate services for African Caribbean families: Views from one community. *Clinical Psychology Forum,* 111, 6-11.

Fatimilehin, I. A., & Coleman, P. G. (1999). 'You've got to have a Chinese chef to cook Chinese food!!' Issues of power and control in the provisions of mental health services. *Journal of Community and Applied Social Psychology,* 9, 101-117.

Fatimilehin, I. A., & Nadirshaw, Z. (1994). A cross-cultural study of parental attitude and beliefs about learning disability. *Mental Handicap Research,* 73, 202-227.

Fernando, S. (1991). *Mental health, race and culture.* London: Macmillan/MIND.

Fernando, S. (ed.). (1995). *Mental health in a multi-ethnic society: A multi-disciplinary handbook.* London: Routledge.

Fernando, S., Ndegwa. D., & Wilson, M. (1998). *Forensic psychiatry, race and culture.* London: Routledge.

Frankish, P. (2000). Thought and feeling: You can't have one without the other. *The Psychologist,* 13, 396-399.

Gater, R., & Goldberg, D. (1991). Pathways to psychiatric care in south Manchester. *British Journal of Psychiatry,* 159, 90-96.

Gillam, S. J., Jarman, B., White, P., & Law, R. (1989). Ethnic differences in consultation rates in urban general practice. *British Medical Journal,* 299, 953-957.

Goldberg, D., & Huxley, P. (1980). *Mental illness in the community: The pathway to psychiatric care.* London: Tavistock.

Goldberg, D., & Huxley, P. (1992). *Common mental disorders – a bio-social model.* London: Tavistock.

Hammond, W. R., & Yung, B. (1993). Minority student recruitment and retention practices among schools of professional psychology: A national survey and analysis. *Professional Psychology Research and Practice,* 1993, 3-12.

Harrison, G., Owens, D., Holton, A., Neilson, D., & Boot, D. (1988). A prospective study of severe mental disorder in Afro-Caribbean patients. *Psychological Medicine,* 18, 643-657.

Harworth, R. (1998). Mental health professionals' accounts of clients who are from ethnic minorities. *Clinical Psychology Forum,* 118, 6-10.

Husband, C. (1992). A policy against racism. *The Psychologist,* 5, 414-417.

Iiahi, N. (1980). *Psychotherapy services to ethnic minorities.* In: S. Fernando. (Ed), *Mental health in a multi-ethnic society: A multi-disciplinary handbook.* London: Routleldge.

Johnson, M., Cross, M., & Cardew, S. (1983). Inner-city residents, ethnic minorities and primary health care. *Postgraduate Medical Journal* , 59, 668-70.

Kareeem, J., & Littlewood, R. (eds). (1992). *Intercultural therapy: Themes, interpretations and practice.* Oxford: Blackwell.

Katz, J. H. (1985). The socio-political nature of counseling. *The Counselling Psychologist,* 13, 615-624.

Kinderman, P. (2001). The future of clinical psychology training. *Clinical Psychology,* 8, 6-10.

Knight, P., & Llewelyn, S. (2001). Recruitment and retention in clinical psychology. *Clinical Psychology,* 5, 32-34.

Lago, C., & Thompson, J. (1996). *Race, culture and counselling.* Buckingham: Open University Press.

Laungani, P. (1992). Cultural variations in the understanding and treatment of psychiatric disorders: India and England. *Counselling Psychology Quarterly,* 5, 231-244.

Li, P., Logan, S., Yee, L., & Ng, S. (1999). Barriers to meeting the mental health needs of the Chinese community. *Journal of Public Health Medicine,* 21, 74-80.

Littlewood, R. (1992). Psychiatric diagnosis and racial bias: Empirical and interpretive approaches. *Social Science and Medicine,* 34, 141-149.

Lloyd, K. (1992). Ethnicity, primary care and non-psychotic disorders. *International Review of Psychiatry,* 4, 257-266.

Lokare, V. G. (1992). Respect for cultures, beliefs and attitudes: A way to better relationships and understanding. *Counselling Psychology Quarterly,* 5, 227-229.

MacCarthy, B., & Craissati, J. (1989). Ethnic differences in response to adversity: A community sample of Bangladeshi and their indigenous neighbours. *Journal of Social Psychiatry and Psychiatric Epidemiology,* 24, 196-201.

McInnis, E. (2000). Black in fashion? *Clinical Psychology Forum,* 139, 44-46.

McKeigue, P. M., & Karmi, G. (1993). Alcohol consumption and alcohol related problems in Afro-Caribbeans and South Asians in the United Kingdom. *Alcohol and Alcoholism,* 28, 1-10.

Marsella, A. J. & Kameoka, V. A. (1989). Ethnocultural issues in the assessment of psychopathology. In: S. Wetsler (Ed) *Measuring mental illness: Psychometric assessment for clinicians.* (pp. 231-256). Washington DC: American Psychiatric Press.

Meldrum, E. (1998). Pakistani teenage girls' constructions of help-seeking from mental health professionals. *Clinical Psychology Forum,* 118, 37-42.

Morgan, HY. (1998). Between fear and blindness: The White therapist and the Black client. *British Journal of Analytical Psychotherapy,* 34, 48-61.

Mumford, D. B., Nazier, M., Jilanic, F. et al. (1996). Stress and Psychiatric disorder in the Hindu Kush. A community survey of mountain villages in Chitral, Northern Pakistan. In K. Bhui, *International Journal of Psychiatry* (p. 137), 11, 145-152.

Mumford, D. B., Saeed, I., & Ahmad, S. et al (1997). Stress and psychiatric disorder in rural Punjab. A community survey. In K. Bhui, *International Journal of Psychiatry* (p. 137). 11, 145-152.

Myers, H. F., Wohlford, P., Guzman, L. P., & Echemendia, R. J. (eds). (1991). *Ethnic minority perspectives on clinical training and services in psychology.* Washington DC: American Psychological Association.

Nadirshaw, Z. (1992). Therapeutic practice in multi-racial Britain. *Counselling Psychology Quarterly,* 5, 257-276.

Nadirshaw, Z. (1993). The implications for equal opportunities training in clinical psychology: A realist's view. *Clinical Psychology Forum,* 53, 3-6.

Nadirshaw, Z. (1993). Therapeutic practice in multi-racial Britain. *Counselling Psychology Quarterly,* 5, 257-261.

Nazroo, J. Y. (1997). *Ethnicity and mental health: Findings from the National Community Survey.* London: Policy Studies Institute.

Ndegwa, D. (1998). Part 2: Clinical Practice. In S. Fernando., D. Ndegwa., & M. Wilson, *Forensic psychiatry, race and culture* (pp. 130-143). London: Routledge.

Odell, S. M., Surtees, P. G., Wainwright, N. W. J., Commander, M. J., & Sashidharan, S. P. (1997). Determinants of general practitioner recognition of psychological problems in a multi-ethnic inner-city health district. *British Journal of Psychiatry,* 171, 537-541.

Office for National Statistics. (1992). *Census 2001*. London: HMSO.

Office for National Statistics (1995). *The prevalence of psychiatric morbidity among adults aged 16-64 living in private households in Great Britain. ONS surveys of psychiatric morbidity in Great Britain, Report 1.* London: HMSO.

Office for Population Censuses and Surveys. (1994). *Undercoverage in Great Britain (census user guide no. 58).* London: HMSO.

Owusu-Bempah, K., & Howitt, D. (1994). Racism and the psychological textbook. *The Psychologist,* 4, 163-166.

Patel, N. (1992). Psychological disturbance, social support and stressors: A community survey of immigrant Asian women and the indigenous population. *Counselling Psychology Quarterly,* 5, 263-276.

Patel, N. (1998). Black therapists/White clients: An exploration of experiences in cross-cultural therapy. *Clinical Psychology Forum,* 118, 18-23.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., & Nadirshaw, Z. (2000). *Clinical Psychology, 'race' and culture: A training manual.* Leicester: The British Psychological Society.

Pedersen, P. B. (1988). *A handbook for developing multicultural awareness.* Alexandria, VA: American Counseling Association.

Pfeffer, N. (1998). Theories of race, ethnicity and culture. *British Medical Journal,* 317, 1381-1384.

Pope-Davis, D. B., & Coleman, H. L. K. (eds) (1997). *Multicultural counseling competencies.* London: Sage.

Roach, F. (1992). Community mental health services for black and ethnic minorities. *Counselling Psychology Quarterly,* 5, 277-290.

Ross, H., & Hardy, G. (1999). GP referrals to adult psychological services: A research agenda for promoting needs-led practice through the involvement of mental health clinicians. *British Journal of Medical Psychology,* 72, 75-91.

Runnymede Trust. (1994). *Multi-ethnic Britain: Facts and trends.* London: Runnymede Trust.

Sayal-Bennett, A. (1991). Equal opportunities: Empty rhetoric. *Feminism and Psychology,* 1, 74-77.

Sethi, B. B. (1986). Epidemiology of depression in India. *Psychopathology,* 19, 26-36.

Shaukat, N., DeBono, D., & Cruickshank, J. (1993). Clinical features, risk factors and referral delay in British patients of Indian and European origin with angina matched for age and extent of coronary atheroma. *British Medical Journal,* 307, 717-718.

Slater, D. (1994). Exploring other zones of the postmodern: Problems of ethnocentrism and difference across the north-south divide. In A. Rattansi., & Westwood, S. (eds). *Racism, modernity and identity on the western front* (pp. 87-126). Cambridge: Policy Press.

Smaje, C. (1995). *Health, 'race' and ethnicity: Making sense of the evidence.* London: King's Fund.

Smaje, C. (1995). Race and ethnicity: True colours. *Health Service Journal,* 26, 28-29.

The Division of Clinical Psychology. (1998). *Services to black and minority ethnic people: A guide for commissioners of clinical psychology services (briefing paper no. 16).* Leicester: The British Psychological Society.

Thomason, T. C. (1999). Improving the recruitment and retention of Native American students in psychology. *Cultural Diversity and Ethnic Minority Psychology,* 5, 308-316.

Webbe, A. (1998). Ethnicity and mental health. *Psychiatric Care,* 5, 12-16.

Webb-Johnson, A. (1991). *A cry for change: An Asian perspective on developing quality mental health.* London: Confederation of Indian Organizations.

Webb-Johnson, A., & Nadirshaw, Z. (1993). Good practice in transcultural counselling: An Asian perspective. *British Journal of Guidance and Counselling,* 21, 20-29.

Whaley, A. L. (2001). Cultural mistrust: An important psychological construct for diagnosis and treatment of African Americans. *Professional Psychology Research and Practice,* 32, 555-562.

Williams, P. E. (2000). *How does ethnicity effect the therapeutic alliance? Implications for clinical training and practice.* Unpublished paper, University of Sheffield, Clinical Psychology Unit.

Wilson, M., & Francis, J. (1997). *African Caribbean and African users' views and experiences.* London: MIND.

Wilson, M., & MacCarthy, B. (1994). GP consultation as a factor in the low rate of mental health service use by Asians. *Psychological Medicine,* 24, 113-119.

Yutrzenka, B. A., Todd-Bazemore, E., & Caraway, S. J. (1999). Four winds: The evolution of culturally inclusive clinical psychology training for Native Americans. *International Journal of Psychiatry,* 11, 129-135.

Clinical psychology, ethnic diversity and the theory of planned behaviour: Predicting intention to become a clinical psychologist in the future

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Abstract

Objectives: To explore the perceptions of a sample of ethnically diverse undergraduate psychology students towards clinical psychology as a profession and possible career choice, and to examine their intention or otherwise to pursue a career in clinical psychology, using the Theory of Planned Behaviour (TPB) as a model.

Method: A total of 364 White and 103 minority ethnic undergraduate psychology students, responded to a postal questionnaire designed to assess their: (a) intention to become a clinical psychologist in the future and (b) the factors that may facilitate or hinder their decision-making processes.

Results: The TPB was found to be predictive of intention in all cases. However, significant differences were found between the ethnic groups on the factors that may facilitate or hinder their intention to become a clinical psychologist in the future. Minority ethnic undergraduates had greater perceptions of disadvantage and identified significantly more factors that would deter them from entering the profession. However, all undergraduates were able to identify a number of other concerns in relation to their perceptions of clinical psychology and in regards to the possibility of work within the National Health Service (NHS).

Conclusions: The results suggests that the clinical psychology profession needs to attend to a vast array of concerns raised by all the ethnic groups, to avoid alienating a potentially large number of prospective recruits.

Introduction

During the last two decades, the under-representation of minority ethnic staff groups within the profession has been the subject of much debate. Parallel to these discussions, has been the questionable ability of clinical psychology to adequately address, provide for and meet, the psychological and clinical needs of an increasingly ethnically diverse, multi-racial and multicultural society (DCP: Briefing paper No. 16, 1998; Eleftheriadou, 1994; McInnis, 2000). However, whilst the profession has long-acknowledged that these concerns exist and tentative attempts have been made to countenance this issue (BPS report, 1988b & 1988c), it has been accused of complacency in meeting these ideals (Davenhill, Hunt, Pillay, Harris and Klein, 1989; Nadirshaw, 1994). This has been despite: extensive research evidence from the UK and abroad (e.g. APA Report, 1997; Yutrzenka, Todd-Bazemore and Caraway, 1999; Fatimilehin & Coleman, 1999), increasing practitioner concerns (e.g. Nadirshaw, 1999; Robinson, 2001; Sayal-Bennett, 1991) and consultations with minority ethnic communities, professional groups and government bodies (e.g. DoH, reports 1996 & 1999), which consistently support the need for a more ethnically diverse profession.

Ethnic diversity within clinical psychology

In a report prepared by the BPS: Working Party on the Future of the Psychological Sciences (1988b), an 'open and active commitment to equal opportunities' was proposed to redress the under-representation of minority ethnic groups in the profession. This occurred after it was acknowledged they faced 'exceptional' difficulties 'realising their potential' and was a 'sufficient problem for the society to consider further action' (p. 75).

In response to this the Board proposed a series of recommendations for consideration, including suggestions that the Society should examine the perceptions of psychology/psychologists held by minority ethnic groups (20.8.4), seek advice and strategies from other professions to increase their recruitment (20.8.1, 20.8.9) and consider developing a code of practice for professional psychologists, to enable them to work more effectively in a multi-ethnic society (20.8.5).

However, whilst welcomed, critics argued that the recommendations did not go far enough in seeking to address specific issues concerned with the selection, recruitment and training of minority ethnic groups into the profession. A further recommendation to the Professional Affairs Board to make explicit their commitment to the principles of equal opportunities was suggested by the Working Party on the Training of Psychologists (BPS report, 1988c), but this was similarly received. However, the subsequent publication of a paper by Davenhill et al (1989) significantly changed this position and as a consequence, signified the start of a much-needed debate in the profession.

In this paper, Davenhill et al (1989) challenged some of the basic assumptions outlined in the above reports, arguing that in order to effectively implement the principles underlying an equal opportunities policy, 'members will need to involve black and minority ethnic groups directly in the profession' (p. 34). Three key areas were identified as requiring 'urgent implementation' (i.e. the accessibility of clinical courses, selection procedures and the content of training) and together with a comprehensive list of recommendations, it was hoped this would make the 'prospect of applying for clinical training a possible

and positive one for black and minority ethnic' groups (p. 36). However, in concluding the paper, the authors also noted that there was an awareness amongst both:

'clinical and academic bodies, of the need to make the necessary adjustments that acknowledge the multicultural nature of British society as well as the possibility of racially discriminatory practices in the clinical psychology profession' and recommended 'that the issues raised are regarded as requiring immediate and specific action' (p. 37).

Since this paper was published, and in view of the considerable lack of success the profession has had in recruiting minority ethnic groups[1], there have been repeated (albeit relatively isolated) requests, mainly from concerned practitioners within the profession, to urgently address this issue (e.g. Bender & Richardson, 1990; Sayal-Bennett, 1991; Webb-Johnson & Nadirshaw, 1993).

Whilst numerous explanations have been offered to account for the lack of ethnic diversity within the profession, including: the visible absence of minority ethnic practitioners as role models (Fatimilehin & Coleman, 1999), the failure of undergraduate and postgraduate psychology courses to positively promote and attract minority ethnic students (Davenhill et al, 1989; Nadirshaw, 1993), the Eurocentric and ethnocentric practice of clinical psychology (Eleftheriadou, 1994; Lago & Thompson, 1996; Patel, Bennett, Dennis, Dosanjh, Mahtani, Miller & Nadirshaw, 2000) and the absence of practical measures to address anti-racist and discriminatory practices on clinical training

[1]Despite initial commitments by some clinical courses in 1990 to explicitly endorse an equal opportunity statement as part of their course entry preamble (now standard practice) and the formal implementation of an Equal Opportunities Policy Statement by the British Psychological Society in February 1994.

courses (Sayal-Bennett, 1991; Bender & Richardson, 1990; Robinson, 2001), some writers have now insisted that the profession needs to be proactive at a number of different levels (i.e. from undergraduate to professional/policy levels) to avert a recruitment crisis of minority ethnic groups into the profession. However, one area that has received scant attention in recent times, but may yet prove to be an area of considerable importance, has been the career choice aspirations of minority ethnic groups.

Minority ethnic groups and career choice aspirations

In a recent OFSTED (Office for Standards in Education) review of the educational achievements of minority ethnic groups (Gillborn & Gipps, 1996), it was found that although people from minority ethnic backgrounds (as defined by the 1991 Census) were generally more representative within post-16 compulsory education than their White peers, and accounted for proportionately more applications to institutes of higher education, they nevertheless received lower acceptance rates and were therefore less likely to obtain a place at university than their White peers. Whilst differences in course specialisms, educational qualifications, academic attainment levels, socio-economic factors and demographic/other variables (e.g. gender differences and attempts to remain in the home region), may account for some of this disparity, the report also identified major differences between minority ethnic groups (Gillborn & Gipps, 1996). Thus, Chinese and Asian-other applicants (excluding Indian, Pakistani and Bangladeshi students) were significantly more likely to obtain admissions to university, but Black

Caribbean and Pakistani applicants were significantly less likely to secure a university place.

It is difficult to ascertain how relevant these findings may be for the progression of minority ethnic students onto undergraduate psychology courses, but given that this is the most traditional route for graduates who may be seeking clinical psychology training (i.e. post relevant experience), an exploration of this process seems reasonable.

According to the most recent figures of total applications for single honours psychology degrees[2], minority ethnic students accounted for 15% (13.4% adjusted) of all applications to universities, and of this total 11.8% (11% adjusted) were successful in obtaining university places (UCAS; Universities and College Admissions Service Annual Report, 2000). However, whilst these figures do not account for successful minority ethnic applicants reading combined honours degrees where psychology is a major, and excludes data on the different ethnic groups, completion rates and the degree class obtained, there still appears to be a sizeable pool of available candidates from minority ethnic backgrounds (n = ~800), who may *potentially* be eligible for clinical psychology training (Turpin, 2001). Indeed, given the above limitations, a comparison of these figures with those available for applicants applying for post-graduate clinical training, shows that although minority ethnic representation at the application stage is relatively equivalent to the rates found at the university undergraduate level (mean = 10% for last 3 years), there is a notable reduction (mean = 6.7% for last 3 years) amongst minority ethnic applicants who are eventually accepted onto clinical psychology training courses. This discrepancy

[2] Covering the period 1998 and 1999 combined (adjusted for non-returns).

between applications and acceptance rates could be accounted for by differences in degree classes obtained, relevant prior experiences and the status of referees inter alia, but it may also reflect the presence of discriminatory course selection procedures that may be in operation (Turpin, 2001; Davenhill et al, 1989; Nadirshaw, 1993 & 1994).

However, given the relatively modest effect between minority ethnic representation at the undergraduate psychology level and the subsequent progression onto post-graduate clinical psychology training courses, it would therefore seem reasonable to also examine what the alternative or proposed career paths may be for minority ethnic undergraduates taking psychology degrees.

Unfortunately the literature in this area is extremely poor. There are some papers that have examined the proposed career paths of psychology undergraduates generically (e.g. Morris, Cheng & Smith, 1992; Frederickson & Collins, 1997) but without specific regards to ethnicity. However, a recent qualitative study of 80 Black African-American psychology undergraduates (Sparks, 2001) has shown that although their primary reasons for selecting psychology as a major[3], were unrelated to their decisions to pursue doctorates in clinical psychology[4], the results also indicated that psychology doctorates were a secondary or tertiary career choice to other related fields, such as medicine and social work. Although there are important cultural and institutional differences between minority ethnic academic experiences in the UK and America, these findings nevertheless

[3] They being: interest in psychology, human behaviour, a desire to help others and understanding people of colour.
[4] Associated with: their exposure to psychology, mentor availability, support for career choice, interest in psychology and severe financial aid constraints.

offer striking parallels with the comparatively high representation of minority ethnic groups in other professions (such as law, medicine and social work) in the UK (Turpin, 2001; Coker, 2001).

As shown above, there are many reasons why there may be a lack of ethnic diversity within clinical psychology as a profession, but one factor that seems increasingly important, are the decision-making processes involved in the career choice aspirations of psychology undergraduates from different ethnic groups. The Theory of Planned Behaviour (Ajzen 1985, 1988, 1991) offers a useful theoretical framework in which to explore this and, it is therefore to this subject-matter that the enclosed report will now turn.

The theory of planned behaviour

Dominant in the research of health and social-related behaviour, the Theory of Planned Behaviour (TPB) is one of the most successfully applied models used to predict a wide range of behaviours (Ajzen, 1991). It has received strong empirical support (e.g. Norman & Smith, 1995; Raats, Shepherd & Sparks, 1995) and through a well-established criterion, is able to identify the relevant factors that may have contributed to the decision-making processes involved in the outcome of a particular behaviour.

The Theory of Planned Behaviour is an extension of the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and was developed out of the original model's limitations to account for predictions of non-volitional behaviours.

According to this theory, the nearest determinant of any behaviour [B] is the individual's intention to engage in that behaviour. *Behavioural intention* [BI] is in turn influenced by three factors: (1) the individual's *attitude towards the behaviour* [A], which reflects the individual's positive or negative evaluation of the behaviour; (2) the *subjective norm* [SN], reflecting the individual's perceived social pressure from significant others to perform or not perform the behaviour; (3) and *perceived behavioural control* [PBC], which refers to the individual's perception of the ease or difficulty of performing the behaviour.

However, just as behavioural intentions are determined by attitudes, subjective norms and perceived behavioural control, these factors are in turn influenced by their own determinants. Thus attitude towards the behaviour is thought to be determined by perceived *behavioural beliefs* [BB] (i.e. beliefs about salient outcomes of a perceived behaviour) and their *evaluations* [Eval(s)] about the success or otherwise of this outcome. Subjective norms are determined by *normative beliefs* [NB] (i.e. perceptions the individual has about whether significant others/referents believe the individual should or should not perform the behaviour) and the individual's *motivation to comply* [MC] with that referent's expectation(s). Whilst perceived behaviour control is thought to be influenced by the presence of internal and external *control beliefs* [CB]. Internal control beliefs are regarded as facilitating factors, to the extent that they increase the perceived likelihood of a behaviour occurring (e.g. the personal skills and abilities of an individual), whilst external control beliefs are regarded as inhibiting factors, because they tend to be out of the direct control of the individual (e.g. available opportunities, the degree to

which an individual is dependent on the actions of others) and therefore have the potential to inhibit performance of the behaviour. The control beliefs are weighted by the *perceived power* [P] of each internal and external control factors.

The TPB therefore differs from the TRA, in that the former has extended the original model to incorporate an additional component, perceived behavioural control, to account for those behaviours which are subject to a degree of uncertainty (e.g. successful admission onto a clinical training course) and therefore not under complete volitional control. It is assumed therefore, that perceived behavioural control may also have a direct effect on behaviour (thus predicting behavioural achievements independent of intention), as well as on the behavioural intention. Ajzen (1985, 1988, 1991) postulates two ways in which this may occur: (a) where perceived behaviour control is used as a substitute measure of actual control; and (b) (controlling for intention), where individuals holding strong perceptions of control in the performance of a behaviour, persist regardless of any obstacles or other impediments, leading to an increased likelihood of performing that behaviour (see Figure 1 - Appendix 5, for an illustration of the model).

Although the model is presented as a complete theory of behaviour and posits the underling processes that may be involved in the performance of a given behaviour, one variable that has consistently been found to emerge as an additional predictor of intentions, is self-identity i.e. the extent to which performing the behaviour forms an integral part of an individual's self-concept (Eagly & Chaiken, 1993; Sparks & Shepherd, 1992). However, given that self-concept (i.e. one's personal identity) is an essential

component of Social Identity Theory (SIT; Tajfel & Turner, 1979, 1986), where a continuum exists between an individual's personal and social identity (i.e. one's sense of group belonging), the TPB may also provide a useful framework to determine the extent to which group or personal-related characteristics influences behaviour.

The present study

Given the lack of ethnic diversity within clinical psychology and the considerable lack of success the profession has had in attracting and recruiting people from minority ethnic groups, an evaluation of the 'perceptions' of clinical psychology held by minority and other ethnic group perspectives, seems timely. To date, no such study exists in psychology, although undergraduate perspectives of educational psychology as a profession (Frederickson, Morris & Osborne, 2000) and qualitative research on the perceptions of minority ethnic students with regards to nursing and other professions allied to medicine (Darr, 1998), have been undertaken.

A study was therefore convened to explore the different ethnic groups perceptions of clinical psychology as a profession and possible career choice. The study was designed to address four main aims:

- To identify the issues and areas that are relevant for different undergraduate ethnic groups in their perceptions of clinical psychology.

- Use this information to develop a questionnaire designed to assess the strength of these perceptions across cultural and ethnic groups.

- Relate this to their intention to enter clinical psychology as a profession, using the Theory of Planned Behaviour (Azjen, 1985, 1988, 1991) as a model.

- Establish the important predictors associated with intention and the relevance of Social Identity Theory (Tajfel & Turner, 1979, 1986) in this process.

Method

Introduction

The overall study design involved two main stages; this is consistent with the study aims. The main stage (henceforth referred to as Study 2) was designed to explore the views of undergraduate psychology students concerning their perceptions of clinical psychology as a profession and possible career choice, using postal questionnaires as a methodology. However, due to limited research in this area, a preliminary study (Study 1) was undertaken to generate relevant items for the questionnaire, in accordance with the Theory of Planned Behaviour (see Appendix 3 for letter of ethnical approval).

For the purpose of clarity, the two parts of this study will be described and reported separately, commencing with a summary of Study 1 below. The full report of Study 1 can be found in Appendix 8(a).

Study 1

Introduction and Method

This preliminary stage of the study was designed to establish the factors that may be relevant to a diverse range of undergraduate psychology students in their perceptions of clinical psychology and the information used to generate relevant items for construction of the questionnaire. A combination of focus group methodology, face-to-face contact and telephone interviews were utilised, to ensure that as far as possible, a broad range of different ethnic groups, age and gender perspectives were obtained. All participants were recruited from three universities in the North Trent region, after the researcher obtained prior consent from the relevant Psychology Department Heads. These universities were selected in appreciation of their relatively diverse ethnic intake.

An overhead was produced for year lecturers, to inform students of the study, the date, time and location of the proposed focus group meeting and how they may get involved. It was emphasised that confidentiality would be assured and students did not have to be interested in pursuing clinical psychology training to participate, but those who volunteered were invited to collect an information sheet about the research project from the course secretary and complete a brief socio-demographic form, for collection by the researcher (see Appendix 6a-c for details).

Participants

Five potential volunteers declared an interest in participating in the focus group discussion. They were all 20 year old, single White (British) females, in their final year

of study on a BSc (Hons) psychology degree program, with an expressed interest in pursing clinical training. Although not a representative sample, all volunteers were nevertheless eligible for inclusion in the study and were therefore contacted by telephone within seven days of expressing an interest, to confirm their availability for the focus group discussion. This telephone contact also provided volunteers with an opportunity to ask the researcher any questions they might have had in relation to their involvement, and to ensure consistency in the responses given, a Recruitment Script was prepared for this purpose (see Appendix 6d for details). Following telephone contact, a letter was despatched to each volunteer within 24 hours of making contact with them, to confirm details of the arrangements discussed (Appendix 6e).

Following this preliminary development, a specific request for minority ethnic psychology undergraduate volunteers from two further universities were made, after it became known to the researcher that a large majority of minority ethnic undergraduates at the original university would be classified as 'overseas' rather than 'home' students, and would therefore be ineligible for inclusion in the study. The research methodology was also revised slightly to maximise minority ethnic participation. This was achieved by forwarding multiple copies of an amended research information sheet in the form of a poster to both universities, specifically requesting minority ethnic volunteers. It was emphasised that confidentiality would be assured and either a brief telephone interview or face-to-face contact would suffice, provided specific exclusion criteria did not apply (Appendix 7). A socio-demographic form was completed in all cases (as shown in

Appendix 6c), with this being undertaken by the researcher, in the event of the interview being conducted over the telephone.

Nine potential volunteers were identified through this process. Eight of the volunteers were female, but the only male volunteer in the study had to be excluded, on account of being registered as an 'overseas' and not a 'home' student. The sample consisted of five Asian/Asian British (four Indian and one Pakistani), two mixed (Asian White and Mixed Other) and one African Caribbean volunteer. Five of the volunteers were single, two were married (with four dependents between them) and one was divorced. Four of the sample were enrolled on a BSc (Hons) psychology degree program, three were undertaking a BA combined degree (where psychology accounted for at least 50% of their degree component) and one was on a conversion course in psychology. Three of the undergraduates were in their first year of study, three in their second and one each in their third and forth year respectively. The mean age of volunteers was 24.75 years, with an age range of 19-35 years and a standard deviation of 6.80. All volunteers expressed a long-term interest in pursing clinical psychology as a profession.

Procedure

For the focus group discussion meeting, a semi-structured interview was used to facilitate an exploration of a number of pre-determined areas identified as being relevant for generating items for the 'beliefs' sub-section of the questionnaire, according to the Theory of Planned Behaviour (TPB; Conner & Sparks, 1996). Research has also shown this to be a useful method for exploring other subject-matters that may emerge (e.g. King,

1994) and was therefore considered an opportune strategy for locating other issues that may not have been identified by the researcher.

A 'questioning route' (based on the use of a series of pre-arranged questions, with probes as required) was utilised to explore: participants perceptions of clinical psychology as a profession, the possibility of pursuing clinical psychology as a potential career choice, factors that may help or hinder their decision-making process and the importance of significant others in their career decision-making choice. An overview of the format used for the focus group discussion, can be found in Appendix 6 (h).

For individual telephone and face-to-face interviews, the same format as above was followed, with the exception of the conversation being audio-taped (responses were instead recorded verbatim, as far as possible) and the requirement for written consent was waived for practical reasons. In the latter instance, the consent form was read aloud to volunteers, and their verbal consent to participate in the study was obtained. These interviews tended to last for between 15-20 minutes duration each.

Data analysis

Procedures outlined in accordance with the TPB to access the relevant 'beliefs' items for the questionnaire (Conner & Sparks, 1996) and qualitative analysis based on procedures recommended by Vaughn, Shay-Schumm and Sinagub (1996), were utilised to analyse the data. The former method involves a standard procedure of analysis, used to identify and generate specific items for measurements of: behavioural beliefs and their

evaluations, normative beliefs and motivations to comply, and the internal and external control beliefs sub-section of the questionnaire (Ajzen, 1991; Ajzen & Fishbein, 1980; Ajzen & Driver, 1991; Conner & Sparks, 1996).

Results and discussion

This preliminary stage of the study sought to explore and establish those factors that may be relevant for a diverse range of undergraduate psychology students in their perceptions of clinical psychology, to generate relevant items for construction of a questionnaire for distribution to a large number of undergraduate students. The results indicated that undergraduates had some awareness of the role of the clinical psychologist, but this was predominately limited to 1:1 therapeutic work within a hospital setting. The most identified skills undergraduates perceived as being necessary to become a clinical psychologist, were the need to be: open-minded, insightful, respectful, skilful and resourceful. For most volunteers, personal qualities (e.g. self-motivation) and intrinsic factors (related to the nature of the job), support from significant others and the reward of a recognised professional 'status', were some of the factors identified that would persuade them to become a clinical psychologist in the future. For many respondents, having greater financial support and opportunities to gain the relevant experience necessary for training, would help them to pursue this course of action, as would the support and advice of family members, close friends, people in the profession and/or university lecturers. Conversely, the lack of support from significant others and the possibility of not getting on a clinical course, were some of the inhibiting factors

identified. To overcome these potential barriers, undergraduates' thought having greater knowledge and information about the profession would be helpful, as would closer contact with clinical psychologists. Other factors were also identified (e.g. removing the 2:1 degree requirement for entry).

Those factors that were identified and used as the theory of planned behaviour items included the characteristics: insightfulness, skilful, resourceful, respectful and being open-minded; the views of significant others (i.e. family members, friends and people in the profession/university lecturers); and the following facilitating and inhibiting factors: opportunities to gain relevant experience, greater financial support, the possibility of not obtaining a university place and the lack of support from significant others (refer to Appendix 8a for further details).

Conclusion – Study 1.

The findings of this preliminary study are supported by the results of Frederickson et al (2000), in regards to the concerns raised by the undergraduate psychology students they studied and the findings relating to the career choice aspirations of psychology degree students, undertaken by Morris et al (1992). However, the results also show that although undergraduates in this study were able to successfully identify a number of facilitating and inhibiting factors concerned with the possibility of becoming a clinical psychologist in the future, they could nevertheless benefit from further overall knowledge about the profession to clarify some of the concerns they raised and to enable them to

make a more informed choice about the possibility of becoming a clinical psychologist in the future.

The limitations of this study with regards to the small sample size and the lack of diversity in age, gender and career choice aspirations, are acknowledged. Further research may wish to explore the views of a larger and more diverse sample, and possibly over two different time frames (e.g. during the first and final years of the degree program), to ascertain whether perceptions held by undergraduates remain consistent or change over time.

Study 2

Introduction

The main purpose of this stage of the study was the distribution of a postal questionnaire, designed to explore the views of a relatively large and representative sample of ethnically diverse undergraduate psychology students, concerning their perceptions of clinical psychology as a profession and possible career choice.

Participants

The process of recruiting potential participants for this stage of the study was initially informed by the results of a previous survey of all British universities, undertaken by one of the project supervisor's, on behalf of the British Psychological Society (Turpin, 2001). The survey was conducted in collaboration with the Association of Heads of Psychology Departments and involved contacting all Psychology Department Heads, requesting information concerning the minority ethnic composition of successful admissions of undergraduate psychology students for the years 1998 – 2000. Department Heads were also asked to provide an estimate of the minority ethnic composition of the local population where the university is based and amongst other things, invited to indicate whether they 'would', 'would not' or 'may be' prepared, to be contacted in connection with future research in relation to this topic area.

Of the 36 Psychology Department Heads that responded to this survey[5], 11 indicated that they would be happy to be included in future research and a further 10 specified that they

[5] A further two were excluded because they did not admit undergraduate students.

would consider the possibility if approached. However, given the nature and focus of this stage of the research project, a selection criterion was improvised in an attempt to increase the potential likelihood of the ethnic diversity of respondents. Therefore, only those 21 universities who responded favourably to the original survey (Turpin, 2001), which: (a) had an above average or high intake of minority ethnic students; (b) that were located in communities which roughly reflected this presence and; (c) had students enrolled on a British Psychological Society accredited psychology degree program, were selected for further contact in regards to this research project. At this stage in the research process, the discrepancy between 'old' and 'new' universities was acknowledged but not directly taken into consideration as a criteria for selection, as the fundamental project aim was to increase the potential diversity of likely respondents rather than to obtain an equal representation of the different university types. From this sample of 36 universities, a total of eight universities were identified through this process.

A letter was then sent to the Psychology Department Heads of each university, providing brief details about the nature of this research project (with a draft questionnaire attached) and asking them to complete a reply slip, indicating whether they would be willing to allow the researcher to survey the views of their current undergraduate psychology students towards clinical psychology as a profession and possible career choice. It was emphasised that ethical approval had been obtained and respondent confidentiality would be assured. If Department Heads were in agreement with this arrangement, they were also asked to indicate the number of questionnaires that would be required for those

undergraduate psychology students attending their institution. The letter also indicated that a follow-up contact (either by e-mail or telephone) would be made, if a response were not received from a university within two weeks of the despatch date (see Appendix 9a).

A further 20 universities who were not included in this list, were also identified from a British Psychological Society information website and selected for inclusion as above, on the basis that these universities were known to have either a reasonably high minority ethnic in-take and/or were situated in a community population that had a relatively high minority ethnic representation. The latter justification relates to research findings that indicate minority ethnic students undertaking first degrees, generally attend universities within or close to their home counties (for personal and socio-economic reasons) and those that do not, tend to select universities with a similar ethnic representation to the communities in which they previously lived (e.g. Darr, 1998; Gillborn & Gipps, 1996).

Overall, a total of thirteen replies were received within the original two weeks' deadline from all the universities who were selected for further approach. One university declined to participate, for reasons unknown, and the remaining 15 universities who did not respond were sent e-mails with a letter attached, requesting a response to the original letter sent (see Appendix 9b). Subsequent responses were received from a further eight universities to this follow-up request. As one refused (no reasons given) and seven did not reply, this left an overall total of 19 universities who had given their consent to survey the opinions of their undergraduate psychology students. However, as one of

these universities only permitted this to be done via e-mail, this university was also deleted from the list, because of the impracticalities that would be involved.

Of the final 18 universities in this sample, eight were located in the South of England, two in the Central/North Trent region (these did not include any of those universities formerly approached in Study 1), and the remaining eight were situated in the North of England. In terms of the old/new university classifications, a third of the universities would have been formerly defined, and in the overall sample, six of the universities selected, also offered accredited professional courses for post-graduate training in clinical psychology.

Each of the 18 universities were then sent a parcel containing a cover letter and the following enclosures in bulk: a set of questionnaires (see Appendix 4a), corresponding numbers of research information sheets and pre-paid self-addressed envelopes, three research overheads, three laminated publicity posters and three additional research information sheets that were also laminated for each of the student years (see Appendix 9c). The numbers of questionnaires despatched to each university varied according to the totals requested by each Psychology Department Head.

Approximately two months following the distribution of the parcels, a follow-up letter briefly up-dating Psychology Department Heads about the progress of the research study was despatched and a separate letter was forwarded as an e-mail attachment to each of the psychology department secretaries, requesting this be sent as a mail attachment to

their undergraduates. The purpose of the latter communication was to remind students of the research project and to inform them that there was still sufficient time to complete and return the questionnaires. Appendix 9(d) provides copies of the above correspondents.

Of the 18 universities surveyed, no responses were received from five of these universities and a total of just three questionnaires were returned from a further two. As neither of the students from the former universities actually received the questionnaires that were despatched and the questionnaires were not extensively distributed to undergraduates in the latter two universities, the figures were adjusted to take account of these eventualities. This left a total of 11 universities who were formerly surveyed at this stage in the study and a total sum of 3,070 questionnaires that could be reasonably considered as being available for distribution to undergraduate psychology students.

In total, 467 psychology undergraduates completed and returned their questionnaires; this represents an overall response rate of 15.21%, which is slightly below the usual 20% limit in most research studies of this kind. However, if we consider the figures relating to the diversity of respondent types, nearly a quarter of all undergraduates in this overall total (i.e. 22.05%; n=103) defined themselves as belonging to a specific minority ethnic group. This figure is important, given that current estimates suggests that minority ethnic groups account for just 6% of the overall non-White British population (OPCS: Office of Population Censuses and Surveys, 1994) and of the student population alone, 11.8% (11% adjusted) of successful applicants to read psychology are from minority ethnic

groups (UCAS; University and College Admissions service Annual Report, 2000); which would imply that the response rate achieved in this study could be seen as being at least 11.05% greater than current estimates show.

In the overall sample, the majority of respondents were aged 24 years or below (83.9%), single (83.3%) and female (85.4%). Most respondents were enrolled on a full-time basis (87.4%), in their first (41.8%) or third year (27.8%) of undergraduate study [one missing value], undertaking predominately BSc (Hons) psychology degree programs (78.6%).

Regarding the different ethnic groups (see Table 2.1 below), the White ethnic group had the largest number of undergraduate respondents (n=364), followed by the Asian/Asian British sample (n=41), the Black/Black British (n=30), Chinese/Other (n=20) and the Mixed ethnic (n=12) groups. Tables 2.2:1 and 2.2:2, also provides a summary of the socio-demographic characteristics of undergraduate respondents according to ethnic group.

Table 2.1. Summary table showing the ethnic composition of undergraduate respondents.

	Ethnic composition	
Ethnic group	N	*Percentages (%)
White	**364**	**78.0%**
British	315	67.5%
Irish	10	2.1%
Other White background	39	8.4%
Asian/Asian British	**41**	**8.8%**
Bangladeshi	6	1.3%
Indian	22	4.7%
Pakistani	5	1.1%
Other Asian background	8	1.7%
Black/Black British	**30**	**6.4%**
African	16	3.4%
Caribbean	11	2.4%
Other Black background	3	0.6%
Chinese/Other Ethnic Group	**20**	**4.3%**
Chinese	17	3.6%
Other Ethnic group	3	0.6%
Mixed	**12**	**2.6%**
Asian and White	1	0.2%
Black African and White	3	0.6%
Black Caribbean and White	3	0.6%
Other Mixed background	5	1.1%

* Figures calculated to the nearest decimal point.

Table 2.2:1. Table showing socio-demographic characteristics for each ethnic group.

Variable	Ethnic group	
	White ethnic group N (percentages)	**Asian/Asian British** N (percentages)
Gender:		
Male	62 (17%)	2 (5%)
Female	302 (83%)	39 (95%)
Age (years):		
Mean	22.16	*23.78
Range	18–53	18-47
Standard deviation	5.49	6.72
Marital status:		
Single	302 (83%)	34 (83%)
Married/cohabiting	55 (15%)	7 (17%)
Other/divorced/widowed	7 (2%)	-
Children:		
None	336 (92.3%)	37 (90%)
One or more	27 (7.4%)	4 (10%)
Missing value (s)	1 (0.3%)	-
Undergraduate status:		
Home	344 (94.5%)	38 (93%)
Overseas	19 (5.2%)	3 (7%)
Missing value(s)	1 (0.3%)	-
Year of degree:		
1st year	146 (40.1%)	14 (34%)
2nd year	89 (24.5%)	18 (44%)
3rd/4th year	113 (31%)/15 (4.1%)	7 (17%)/2 (5%)
Missing value(s)	1 (0.3%)	-
Degree type:		
BSc (Hons)	282 (77.5%)	29 (71%)
BA (Hons)	5 (1.4%)	-
Combined (Hons)/Other	77 (21.2%)	12 (29%)
Mode of study:		
Full-time	320 (87.9%)	34 (83%)
Part-time	10 (2.7%)	3 (7%)
Sandwich/other arrangement	34 (9.3%)	4 (10%)
Family attended university:		
None	152 (41.8%)	12 (29%)
1 – 3 other	189 (51.9%)	21 (51%)
4 – 6 other	19 (5.2%)	4 (10%)
Missing value(s)	4 (1.1%)	4 (10%)
Disability:		
None	350 (96%)	37 (90%)
Declared disability	14 (4%)	4 (10%)

* 1 missing value.

Table 2.2:2. Table showing socio-demographic characteristics for each ethnic group.

Variable	Ethnic group		
	Black/Black British N (percentages)	**Chinese/Other ethnic group** N (percentages)	**Mixed group** N (percentages)
Gender:			
Male	1 (3%)	4 (20%)	2 (17%)
Female	29 (97%)	16 (80%)	10 (83%)
Age (years):			
Mean	25.73	22.10	26
Range	18-45	18-44	18-40
Standard deviation	7.58	5.54	7.19
Marital status:			
Single	24 (80%)	19 (95%)	10 (83.3%)
Married/cohabiting	4 (13%)	1 (5%)	1 (8.3%)
Other/divorced/widowed	2 (7%)	-	1 (8.3%)
Children:			
None	20 (67%)	19 (95%)	12 (100%)
One or more	10 (33%)	1 (5%)	-
Undergraduate status:			
Home	24 (80%)	10 (50%)	10 (83%)
Overseas	4 (13%)	10 (50%)	2 (17%)
Missing value(s)	2 (7%)	-	-
Year of degree:			
1st year	22 (73.3%)	7 (35%)	6 (50%)
2nd year	7 (23.3%)	8 (40%)	2 (17%)
3rd/4th year	1(3.3%)/ -	5 (25%)	4 (33%)/ -
Degree type:			
BSc (Hons)	28 (93.3%)	19 (95%)	9 (75%)
BA (Hons)	1 (3.3%)	-	3 (25%)
Combined (Hons)/Other	1 (3.3%)	1 (5%)	-
Mode of study:			
Full-time	25 (83%)	20 (100%)	9 (75%)
Part-time	-	-	2 (17%)
Sandwich/other arrangement	5 (17%)	-	1 (8%)
Family attended university:			
None	9 (30%)	5 (25%)	2 (17%)
1 – 3 other	14 (47%)	14 (70%)	7 (58%)
4 – 6 other	3 (10%)	1 (5%)	2 (17%)
Missing value(s)	4 (13%)	-	1 (8%)
Disability:			
None	30 (100%)	19 (95%)	12 (100%)
Declared disability	-	1 (5%)	-

Questionnaire measures

The 'Perceptions of Clinical Psychology as a Career Choice' questionnaire comprised of a 61-item inventory, which was sub-divided into three sections (see Appendix 4a for details). Section 1 (questions 1-16) was concerned with basic socio-demographic information with the ethnic group categories synonymous to those used in the 2001 Census (ONS; Office for National Statistics, 2001), although information was also requested from respondents concerning the name of the university they attended and their degree type. Parental occupations were assessed against categories identified in the Labour Force Survey Quarterly Supplement (ONS, 2001), to provide an approximate measure of socio-economic class.

Section 2 (questions 17-56) explored respondents perceptions of clinical psychology, examined their intentions or otherwise towards becoming a clinical psychologist in the future and the relevance of Social Identity Theory (SIT) in this process. Items 17-50 related to the TPB components of the questionnaire and were constructed according to recommendations outlined by Ajzen (1991). The relevant belief items were derived from the findings that had emerged out of Study 1 of the research process. All items were measured on a 7-point response scale, commencing with a minimum value of +1. Measures of internal consistency (i.e. Cronbach alpha, α) were also calculated for the sample overall (regardless of ethnicity at this stage in the analysis process). Further details can be found in Appendix 4 (b).

The remaining questions in Section 2 of the questionnaire (i.e. questions 51-56) were designed to measure Social Identity and the influence of these factors in relation to intentions to become a clinical psychologist in the future. These items were derived from research findings pertaining to the importance of 'self-identification' or personal related characteristics (questions 51 and 52), 'group norms' (questions 53 and 54), and 'group identification' (questions 55 and 56) factors in relation to this theory (Tajfel & Turner, 1979, 1986). These items were also coded on a scale from +1 to +7, the values recoded (to ensure that the positive responses were given the highest value) and an overall measure for Social identity was created, by calculating the mean score across each of the items.

Section 3 (questions 57 to 61) was designed to assess the factors that may help improve the accessibility of clinical psychology training for the different ethnic groups and examined other relevant factors that may be pertinent to psychology undergraduates in evaluating their career decision-making choice. Some of the items for these questions were generated from findings derived from salient themes and issues raised by respondents in the focus-group discussion, individual and telephone interviews (e.g. the three years of training, competition for places and negative feedback sub-items listed in question 59). Others were included for research interests only. Space was provided at the end of five of these questions, for additional comments.

Method of analysis

Rationale for selection

Data were analysed using SPSS v.10 for Windows. The analysis was concerned with assessing ethnic group differences in: (a) socio-demographic and other characteristics; (b) predictors for behavioural intention; (c) and the factors that may help or hinder undergraduate psychology students in their intention to become a clinical psychologist in the future.

As much of the data involved a nominal or ordinal level of measurement, most of the statistical tests were non-parametric (two-tailed), although means, standard deviations and percentages were also presented where appropriate, to aid interpretation. Pearson product moment correlations were used to measure associations between the main theory component parts (including the SIT scale) and regression coefficients computed to assess the predictive utility of the constructs. Qualitative data for the 'other reason(s)' options in Section 3 of the questionnaire were analysed using content analysis methodology (Krippendorf, 1980).

Procedure for data analysis

The data obtained from Sections 1 and 3 of the questionnaire were subject to descriptive analyses and Pearson Chi-square tests (independent samples) were used to assess the differences in frequencies between the White and Non-White ethnic groups. The decision to collapse the minority ethnic groups together was undertaken to enable

sufficient analyses of the relevant test variables, given the relatively small sample (*n*) size in some of the frequencies obtained.

For the TPB and SIT constructs, additional independent analyses were completed for each of the different ethnic groups separately, in accordance with formal procedures and recommendations outlined by Azjen (1991), Conner and Sparks (1996; as shown in the Appendix 4b). Correlation matrices and hierarchical linear regressions were then computed to: (a) identify the relationship between intention and the main theory component parts (including SIT) and (b) to predict the different ethnic group intention to become a clinical psychologist in the future. Cronbach alpha scales and skewness statistics for the intention scale are shown in Tables 3.1 and 3.2 (Appendix 10).

Results

Ethnic group differences in sample characteristics

An examination of the demographic characteristics (Table 4.1 and 4.2) showed that there were no significant differences between the two ethnic groups with regard to marital status, type of degree undertaken, current year of study, mode of study and paternal occupational status. It was not possible to compute the disability characteristic, because the cell sizes were too small. However, Pearson Chi-square tests revealed significant differences between the groups on age and gender characteristics, the importance of ethnicity, country of birth, number of children, religious affiliation, immediate family members who have attended university and maternal occupational status. Significant

differences between the groups were also found for the year of degree, student type and the university attended.

The mean ages were 23.9 (SD = 6.93, range 18-47) for the minority ethnic group and 22.1 (SD = 5.49, range 18-53) for the White ethnic group ($\chi^2 = 12.593$, df = 3, p = .01). Regarding the significant gender differences, 9/103 (8.7%) of respondents who belonged to the minority ethnic group were male, compared with 62/364 (87.3%) of respondents in the White group ($\chi^2 = 4.285$, df = 1, $p < .05$). In respect of the relevance of ethnicity, 51/103 (49.5%) of those with minority ethnic status indicated that their ethnicity was important to them, compared to 39/103 (22.2%) and 13/103 (12.6%) other minority ethnic undergraduates whose ethnicity was sometimes or not at all important to them. This compares with 74/362 (20.4%), 126/362 (34.8%) and 162/362 (44.8%) of those in the White group, respectively ($\chi^2 = 47.418$, df = 2, $p < .01$). Regarding parental status, 15/103 (14.6%) of minority ethnic respondents had one or more children, compared with 27/363 (7.4%) of White respondents ($\chi^2 = 4.967$, df = 1, $p < .05$).

Significantly more respondents in the minority ethnic group (39/103; 37.9%) were born outside the UK, compared to 35/364 (9.6%) of the White group ($\chi^2 = 48.043$, df = 1, $p < .001$) and a greater proportion of respondents in the minority ethnic group 64/83 (77.1%) indicated having a religious affiliation, compared with 144/250 (57.6%) of those in the White group ($\chi^2 = 10.570$, df = 2, $p < .05$).

In respect of opportunities to attend university, 152/364 (42.8%) of those in the White ethnic group declared being the only member of their immediate family to have attended university, as opposed to 28/103 (27.2%) in the minority ethnic group ($\chi^2 = 9.749$, df = 2, $p < .01$). This was also relative to 150/364 (41.2%) and 62/364 (17%) in the White ethnic group who had up to two other and three or more immediate family members who had also attended university, compared to 46/103 (44.7%) and 29/103 (28.2%) of those in the minority ethnic group, respectively.

Regarding the significant difference found for maternal occupational status, the mother of 153/347 (44.1%) respondents in the White ethnic group was either self-employed or held a professional status, compared with 32/89 (36%) of mothers in the minority ethnic group ($\chi^2 = 11.362$, df = 3, $p < .05$). In addition, 21/347 (6.1%), 96/347 (27.7%) and 77/347 (22.2%) of mothers in the White group were employed in a semi-skilled/student, administrative/clerical/sales capacity or were either unemployed/retired or deceased. For the minority ethnic group, the proportions were 11/89 (12.4%), 16/89 (18%) and 30/89 (33.7%) respectively, for the same categories above.

Attending to differences in degree year, 49/103 (47.6%) of respondents in the minority ethnic group were currently in their first year of undergraduate study, as opposed to 35/103 (34%) and 19/103 (18.4%) in their second, third or fourth year respectively. This compares with 146/363 (40.2%), 89/363 (24.5%) and 128/363 (35.3%) of undergraduates currently in their first, second, third or fourth year of study respectively, in the White group ($\chi^2 = 10.928$, df = 2, $p < .01$). Significantly more students in the White group

(344/363; 94.8%) were registered as 'home' students, compared with 82/101 (81.2%) of students in the minority ethnic group ($\chi^2 = 19.373$, df = 1, $p < .01$). Finally, regarding university location, 210/364 (57.7%) of White respondents attended a university in the North of England, rather than in the South (90/364; 24.7%) or the Midlands (64/364; 17.6%), compared with 15/103 (14.6%), 64/103 (62.1%) and 24/103 (23.3%) of minority ethnic undergraduates attending university in the North, South and Midlands area, respectively ($\chi^2 = 66.462$, df = 2, $p < .01$).

Table 4.1. Summary table of sample characteristics for the Minority ethnic and White ethnic groups.

	Minority ethnic group		**White ethnic group**		
Variable	N	Percentages (%)	N	Percentages (%)	Chi-square (χ^2)
Age (years)					
18 – 20	43	42.2%	181	49.7%	
21 – 24	31	30.4%	136	37.4%	12.59**
25 – 29	11	10.8%	17	4.7%	
30+	17	16.7%	30	8.2%	
Gender:					
Male	9	8.7%	62	17%	4.28*
Female	94	91.3%	302	83%	
Marital status:					
Living alone/divorced	87	84.5%	302	83.2%	0.09 ns
Other (married/co-habiting, other)	16	15.5%	61	16.8%	
Children:					
None	88	85.4%	336	92.6%	4.96*
One or more	15	14.6%	27	7.4%	
Ethnicity important:					
Yes	51	49.5%	74	20.4%	
Sometimes	39	37.9%	126	34.8%	47.41***
No	13	12.6%	162	44.8%	
Country of birth:					
UK	64	62.1%	329	90.4%	48.04***
Outside UK	39	37.9%	35	9.6%	
Religious affiliation:					
Yes	64	77.1%	144	57.6%	
None	6	7.2%	44	17.6%	10.57 **
Non-believer	13	15.7%	62	24.8%	
Year of degree:					
1st year	49	47.6%	146	40.2%	
2nd year	35	34.0%	89	24.5%	10.92**
3rd or 4th year	19	18.4%	128	35.3%	
Degree type:					
BSc (Hons)	85	82.5%	282	77.5%	1.21 ns
BA (Hons)/combined	18	17.5%	82	22.5%	

* $p < .05$, ** $p < .01$, *** $p < .001$, ns = not significant.

Table 4.2. Summary table of sample characteristics for the Minority ethnic and White ethnic groups.

	Minority ethnic group		**White ethnic group**		
Variable	N	Percentages (%)	N	Percentages (%)	Chi-Square (χ^2)
Mode of study:					
Full-time	88	85.4%	320	87.9%	0.44 ns
Part-time/other	15	14.6%	44	12.1%	
Student type:					
Home	82	81.2%	344	94.8%	19.37***
Overseas	19	18.8%	19	5.2%	
Registered university:					
North	15	14.6%	210	57.5%	
Midlands	24	23.3%	64	17.6%	66.46***
South	64	62.1%	90	24.7%	
University members:					
None other	28	27.2%	152	41.8%	
One or two other	46	44.7%	150	41.2%	9.74**
Three or more other	29	28.2%	62	17.0%	
Occupational status (mother):					
Professional/skilled	32	36.0%	153	44.1%	
Semi-skilled/student	11	12.4%	21	6.1%	11.36*
Admin/clerical/sales	16	18.0%	96	27.7%	
No work/retired/deceased	30	33.7%	77	22.2%	
Occupational status (father):					
Professional/skilled	54	63.5%	228	66.5%	
Semi-skilled/student	11	12.9%	46	13.4%	4.90 ns
Admin/clerical/sales	3	3.5%	27	7.9%	
No work/retired/deceased	17	20.0%	42	12.2%	
Disability status:					
Declared disability	5	5%	14	3.9%	-
No disability	95	95%	342	96.1%	

* $p < .05$, ** $p < .01$, *** $p < .001$, ns = not significant, - = cell size too small to compute.

Assessing the main TPB component parts, SIT and the factors that predict intention for the different ethnic groups

The Asian/Asian British sample:

A Pearson product moment correlation matrix was computed to assess the relationship between the main Theory of Planned Behaviour (TPB) component parts and the further impact of Social Identity Theory (SIT) in this process. The results of these correlation, which are presented in Table 5 below, show that intention was significantly related to all the theory of planned behaviour component parts, with attitude emerging as the strongest correlate of intention ($r = 0.66$, $p < .01$).

Table 5. Pearson product-moment correlations of the main TPB component parts and SIT for the Asian/Asian British sample.

Components	INT	ATT	SN	PBC	SIT
INT	-	.66**	.49**	.49**	.53**
ATT		-	.55**	.46**	.54**
SN			-	.44**	.46**
PBC				-	.63**
SIT					-

**$P < 0.01$ level (2-tailed), INT = intention, ATT = attitude, PBC = perceived behavioural control, SIT = Social Identity Theory scale.

Predicting behavioural intention

A hierarchical linear regression analysis was performed to assess the predictive utility of each of these significant behavioural component parts (see Table 6). This was completed in two stages, using intention as the dependent variable. The independent variables: attitude, subjective norm and perceived behavioural control, were entered in the first stage (block 1); and the SIT scale was entered in the second stage (block 2).

Table 6 shows that a significant proportion of the variability to predict intention was accounted for by the TPB predictors ($R^2 = 0.47$; $F(3,36) = 10.80$, $p < .001$). Furthermore, the addition of the SIT component in the second block, did not lead to any significant improvement in the prediction of this group's future intention to become a clinical psychologist (R^2change = 0.004, Fchange = 0.25, $p < .05$).

Summary

As far as the individual theory of planned behaviour predictors are concerned, attitude is therefore the significant predictor of intention for this sample and not subjective norm or perceived behavioural control.

Table 6. Multiple linear regression analyses of intentions to become a clinical psychologist in the future, for the Asian/Asian British sample

Model Predictor	Beta	t-value	Significance
Block 1			
Attitude	.523	3.456	.001***
Subjective norm	.149	.994	.327
Perceived behavioural control	.125	.888	.380
Block 2			
Attitude	.499	3.119	.004**
Subjective Norm	.135	.874	.388
Perceived behavioural control	.098	.643	.524
Social Identity Theory scale	.082	.507	.616

** $p = 0.01$, *** $p < 0.001$.

Model summary

Model	R	R Square (R^2)	F change	Sig. F change
1	.688	.474	10.804	.000
2	.691	.478	.257	.616

The Black/Black British sample:

Table 7 shows the Pearson product moment correlation matrix of the main TPB items (and the SIT scale) for the Black/Black British sample. Like the Asian sample, the results of the correlation analysis show that intention was significantly related to all the theory of planned behaviour component parts, with the strongest association occurring between intention and social identity theory ($r = 0.78$, $p < .01$).

Table 7. Pearson product-moment correlations of the main TPB component parts and SIT for the Black/Black British sample.

Components	INT	ATT	SN	PBC	SIT
INT	-	.77**	.62**	.61**	.78**
ATT		-	.71**	.52**	.68**
SN			-	.30	.61**
PBC				-	.61**
SIT					-

** $p < 0.01$ level (2-tailed), INT = intention, ATT = attitude, PBC = perceived behavioural control, SIT = Social Identity Theory scale.

Predictions of intention

A hierarchical linear regression analysis was computed to ascertain the main predictor of intention for this ethnic group, following the same procedures as before. Table 8 shows that a significant proportion of the variability to predict intention in the first block, was accounted for by the TPB predictors ($R^2 = 0.649$; $F(3,23) = 14.19$, $p < .001$). However, as expected from the correlations shown in Table 7, the addition of the SIT scale led to a significant enhancement in intention to become a clinical psychologist in the future ($R^2change = 0.07$; $Fchange = 5.17$, $p = .04$).

Summary

These results therefore indicate that both attitude and SIT were the main predictors for this ethnic group.

Table 8. Multiple linear regression analyses of intentions to become a clinical psychologist in the future, for the Black/Black British sample

Model Predictor	Beta	t-value	Significance
Block 1			
Attitude	.525	2.611	.016*
Subjective norm	.158	.889	.383
Perceived behavioural control	.263	1.791	.086
Block 2			
Attitude	.422	2.216	.037*
Subjective Norm	.026	.148	.884
Perceived behavioural control	.106	.697	.493
Social Identity Theory scale	.407	2.273	.033*

* $p = 0.05$.

Model summary

Model	R	R Square (R^2)	F change	Sig. F change
1	.806	.649	14.187	.000
2	.846	.716	5.168	.033

The Chinese or Other ethnic group:

Table 9 shows the intercorrelations for the main TPB component parts and the SIT component for the Chinese/Other ethnic group. It can be seen that only attitude, subjective norm and SIT were significantly correlated with intention, with attitude emerging as the strongest correlate at this stage ($r = 0.662$, $p < .01$).

Table 9. Pearson product-moment correlations of the main TPB component parts and SIT for the Chinese/Other ethnic group.

Components	INT	ATT	SN	PBC	SIT
INT	-	.84**	.78**	.04	.79**
ATT		-	.71**	-.21	.65**
SN			-	.16	.75**
PBC				-	.32**
SIT					-

** $p < 0.01$ level (2-tailed), INT = intention, ATT = attitude, PBC = perceived behavioural control, SIT = Social Identity Theory scale.

Predicting intention

A hierarchical linear regression was performed in two stages (as above), to assess the predictive utility of the significant constructs (Table 10). In this case, the perceived behavioural control component was omitted from the analysis altogether, because it was not significantly related to intention.

As shown, a significant proportion of the variability to predict intention in the first block, was accounted for by the TPB predictors ($R^2 = 0.77$; $F(2,17) = 23.248$, $p < .001$). Furthermore, the addition of the SIT component in the second block led to an enhancement in the predictive utility of intention (over an above the subjective norm component), close to a point approaching significance (R^2change = 0.47, Fchange = 4.08, $p = .06$).

Summary

Therefore, as far as the individual predictors are concerned, it can be concluded that attitude is the significant predictor of intention in this sample, but subjective norm and SIT are not.

Table 10. Multiple linear regression analyses of intentions to become a clinical psychologist in the future, for the Chinese/Other ethnic group.

Model Predictor	Beta	t-value	Significance
Block 1			
Attitude	.572	3.468	.003**
Subjective norm	.373	2.260	.037*
Block 2			
Attitude	.487	3.092	.007**
Subjective Norm	.181	1.013	.326
Social Identity Theory scale	.338	2.019	.061

* $p < .05$, ** $p <$ 0.001.

Model summary

Model	R	R Square (R^2)	F change	Sig. F change
1	.877	.769	28.248	.000
2	.903	.816	4.075	.061

The Mixed ethnic group:

A Pearson product moment correlation matrix was also computed for the mixed ethnic group to assess the relationship between the main TPB component parts and the additional impact of SIT. The results of these correlations are shown in Table 11. Unlike all the other intercorrelations, the only significant component to correlate with intention, was attitude. No further analysis was therefore computed in this case.

Table 11. Pearson product-moment correlations of the main TPB component parts and SIT for the Mixed ethnic group.

Components	INT	ATT	SN	PBC	SIT
INT	-	.80**	.47	.51	.57
ATT		-	.32	.28	.65*
SN			-	-.18	.23
PBC				-	.13
SIT					-

* $p < 0.05$ (2-tailed), ** $p < 0.01$ level (2-tailed), INT = intention, ATT = attitude, PBC = perceived behavioural control, SIT = Social Identity Theory scale.

The White sample:

Table 12 shows the results of the intercorrelations between the main TPB component parts and the SIT scale, for the White sample. Like the Asian/Asian British and Black/Black British groups, intention was significantly related to the SIT scale and all of the main TPB component parts, with attitude again emerging as the strongest correlate (r = 0.66, $p < .001$).

Table 12. Pearson product-moment correlations of the main TPB component parts and SIT for the White sample.

Components	INT	ATT	SN	PBC	SIT
INT	-	.75**	.62**	.21**	.69**
ATT		-	.59**	-.01	.55**
SN			-	.02	.56**
PBC				-	.10**
SIT					-

** $p < 0.01$ level (2-tailed), INT = intention, ATT = attitude, PBC = perceived behavioural control, SIT = Social Identity Theory scale.

Predicting intention

The procedure of completing a two-stage hierarchical linear regression analysis was repeated as above, to assess the predictive utility of each of these significant constructs, using intention as the dependent variable. The results, which are presented in Table 13, show that the TPB predictors accounted for significant proportions of the variability to predict intention in block 1 ($R^2 = 0.66$; $F(3,354)$, $p < .001$). The addition of the SIT scale in block 2 was also found to significantly enhance the prediction of this group's future intention to become a clinical psychologist (R^2change = 0.57, F change = 71.81, $p < .001$).

Summary

As far as the individual predictors are concerned, the results show that all of the theory components were therefore significant predictors for this ethnic group, with attitude and SIT, emerging as the strongest two main predictors of intention (based on degrees of variability).

Table 13. Multiple linear regression analyses of intentions to become a clinical psychologist in the future, for the White ethnic group.

Model Predictor	Beta	t-value	Significance
Block 1			
Attitude	.608	15.837	.000***
Subjective norm	.255	6.634	.000***
Perceived behavioural control	.213	6.872	.000***
Block 2			
Attitude	.502	13.509	.000***
Subjective Norm	.146	3.918	.000***
Perceived behavioural control	.181	6.341	.000***
Social Identity Theory scale	.308	8.474	.000***

*** $p < 0.001$.

Model summary

Model	R	R Square (R^2)	F change	Sig. F change
1	.813	.661	230.386	.000
2	.848	.719	71.814	.000

Ethnic group factors that help/hinder future intention to become a clinical psychologist

For calculations of Pearson Chi-square non-parametric tests in this section, all respondents of minority ethnic status were collapsed into one group and compared with respondents in the White ethnic group, to enable sufficient difference analyses of the tests variables.

Factors that make clinical training more desirable

There were generally few differences between the two ethnic groups with respect to this question. However, Chi-square tests revealed significant differences on two of the factors, with respect to the number of years' experience required prior to training and the option to train part-time. Regarding the former factor, 55/102 (53.9%) respondents in the minority ethnic group considered a place on a training course after 2 years experience, a desirable characteristic, as opposed to 143/364 (39.3%) of respondents in the White group ($\chi^2 = 6.98$, df = 1, $p < .01$). Furthermore, 35/102 (34.4%) minority ethnic undergraduates thought the option to train part-time would also make clinical psychology more desirable, compared to 85/364 (23.4%) of undergraduates in the White ethnic group ($\chi^2 = 5.01$, df = 1, $p < .05$).

Perceptions of disadvantages in pursing clinical psychology as a profession

There were significantly more ethnic group differences on questionnaire items related to these factors, with respect to: degree class, gender and relationship status, childcare responsibilities, religious affiliation and racial/ethnic identification. Regarding degree

classifications, 38/103 (36.9%) minority ethnic undergraduates thought their likely degree class might put them at a disadvantage in pursing a career in clinical psychology, compared to 6/363 (1.7%) of undergraduates in the White group ($\chi^2 = 5.60$, df = 1, $p < .05$). In terms of gender, 14/103 (13.6%) minority ethnic respondents considered this detrimental to their chances of pursing clinical training, as opposed to 6/363 (1.7%) of White respondents ($\chi^2 = 27.84$, df = 1, $p < .01$). Furthermore, 8/103 (4.9%) of minority ethnic respondents, thought their relationship status might also be a disadvantage, compared to 4/363 (1.1%) in the White group ($\chi^2 = 5.97$, df = 1, $p < .05$). Regarding childcare responsibilities, 8/103 (7.8%) minority ethnic respondents considered this factor would place them in an unsuitable position, as opposed to 9/363 (2.5%) of White respondents ($\chi^2 = 6.38$, df = 1, $p < .05$). A greater proportion of minority ethnic undergraduates (7/103; 6.8%), relative to White undergraduates (3/363; 0.8%) also thought being religious would not be helpful ($\chi^2 = 13.62$, df = 1, $p < .001$). However, with regards to ethnicity factors per se, 39/103 (37.9%) of the minority ethnic group thought their racial/ethnic status might be a disadvantage for them in pursing clinical psychology as a career, as opposed to 7/363 (1.9%) of respondents in the White group ($\chi^2 = 116.46$, df = 1, $p < .001$).

Factors that might deter the different ethnic groups from entering the profession

There were four questionnaire items that revealed significant differences between the two ethnic groups: the possibility of not obtaining a place on a clinical psychology course, the lack of status/understanding alluded to the profession from a cultural perspective,

negative feedback in respect of pursing clinical training and the lack of minority ethnic representation in the profession.

Regarding the former factor, 67/103 (65%) of minority ethnic undergraduates considered the possibility of not getting onto a clinical psychology course a likely deterrent, as opposed to 191/363 (52.6%) of White undergraduates ($\chi^2 = 5.02$, df = 1, $p < .05$). For 7/103 (6.8%) minority ethnic respondents, becoming a clinical psychologist is not valued or understood in their culture. This compares to 7/363 (1.9%) of respondents in the White group ($\chi^2 = 6.52$, df = 1, $p < .05$). In respect to negative feedback from courses, articles and other mediums, 28/103 (27.2%) minority ethnic undergraduates declared this would discourage them from pursing clinical training, compared to 38/363 (10.5%) of the White group ($\chi^2 = 18.44$, df = 1, $p < .001$). The lack of minority ethnic representation in the profession was also considered a deterrent by 30/103 (29.1%) minority ethnic respondents, compared to 3/363 (8%) of respondents in the White group ($\chi^2 = 97.66$, df = 1, $p < .001$).

Other professions to pursue if unsuccessful in obtaining a clinical place

Responses related to this question were coded according to six derived categories based on: (a) indecisions about other career options; (b) psychology related professions (e.g. educational psychology, forensic psychology and occupational psychology); (c) research/teaching/lecturing; (d) other health or mental health careers (e.g. nursing, midwifery, medicine, psychiatry); (e) careers in business (e.g. personnel, management, marketing) and; (f) other careers (e.g. police, armed forces/military). A total of 435

undergraduates completed this category, 95/435 (22%) were from the minority ethnic group and 340/435 (78%) were from the White group. A Pearson Chi-square test was computed according to the two ethnic group categories and the results revealed no significant differences.

The National Health Service as an employer

Pearson Chi-square tests revealed significant differences between the ethnic groups on five factors: Pay and conditions, female friendly employer, job security, working for a large employer, the ethnic diversity of the workforce, and entitlement to trust-wide initiatives (e.g. in-service training). Regarding pay and conditions, 25/103 (24.3%) minority ethnic undergraduates considered this factor appealing in becoming a clinical psychologist, as opposed to 53/363 (14.6%) of White undergraduates ($\chi^2 = 5.39$, df = 1, $p < .05$). In respect of the employer type, 25/103 (24.3%) of respondents from the minority ethnic group regarded the predominately female make-up of the NHS attractive, compared to 47/363 (12.9%) from the White group ($\chi^2 = 7.88$, df = 1, $p < .01$). For 55/103 (53.4%) of the minority ethnic group, the job security afforded by the National Health Service (NHS) was considered appealing, compared to 132/363 (36.4%) of the White group ($\chi^2 = 9.69$, df = 1, $p < .01$). A total of 22/103 (21.4%) of minority ethnic undergraduates also found being associated with a large employer an attractive factor, compared with 46/363 (12.7%) of White undergraduates ($\chi^2 = 4.89$, df = 1, $p < .05$). Regarding the ethnic diversity of the NHS workforce, 38/103 (36.9%) of minority ethnic respondents found this factor appealing in becoming a clinical psychologist, as opposed to 40/363 (11%) of White respondents ($\chi^2 = 38.54$, df = 1, $p < .001$). For 27/103

(26.2%) minority ethnic undergraduates, entitlement to NHS trust-wide initiatives was also considered a significantly appealing factor in becoming a clinical psychologist in the future, compared to 45/363 (12.4%) of respondents in the White ethnic group (χ^2 = 11.73, df = 1, $p < .01$).

Qualitative results

Although there were some open questions which respondents were invited to respond to, these are not provided in the body of the report. The details of the results can be found in Appendix 11 (a).

Discussion and conclusions – Study 2

This discussion will be divided into three parts. The first will outline the study limitations and offer a word of caution for the interpretation of the results. This will then be preceded by a discussion of the main research findings with recourse to relevant literature, and will conclude with practical implications and directions for future research.

The present study explored different ethnic groups perceptions of clinical psychology as a profession and possible career choice, and examined their intention or otherwise to pursue a career in clinical psychology. However, prior to discussing the results, several limitations should be acknowledged. First, the relatively low response rate prevents reasonable generalisation of the research findings and implies that the study results should be interpreted with caution. This is especially pertinent, given the lack of

information about those who did not respond and the selectivity of those who did. Furthermore, the small sample size limited the possibility of obtaining a greater diversity of respondents in terms of the different ethnic groups, thus preventing a more extensive and rigorous exploration of the data. Reliance on mainly non-parametric statistical analyses may have also increased the likelihood of obtaining Type I and Type II errors, thereby limiting the confidence of the research findings. A further concern, relates to the significant socio-demographic differences that were found between the two main ethnic groups. Although it could be argued that differences with regards to age, gender and maternal occupational status, were the most pertinent characteristics that emerged, it is difficult to assess whether these differences would have been retained had there been access to a larger sample.

Finally, other potential factors may have influenced the outcome of these results. The cross-sectional design meant undergraduates were only sampled at a particular point in time, without regard to academic pressures, family commitments, cultural and other issues that may have impacted on them during this time. Moreover, focussing on their behavioural intention to become a clinical psychologist in the future, does not offer an evaluation of the accuracy of these judgements, nor the extent to which intention predicts implementation of the behaviour.

However, given these limitations, a number of findings have emerged. Although the overall response rate was relatively poor, the proportionate number of respondents who did participate from a minority ethnic group, was at least 11% greater than current

estimates suggests of successful minority ethnic applications reading psychology at university (UCAS Report, 2000). This indicates that the study was able to attract a fair proportion of the available pool of minority ethnic undergraduates, although it is acknowledged the numbers were insufficient to permit separate group analyses.

Regarding the main socio-demographic findings (where the minority ethnic samples were collapsed together to form an overall group), the observations that minority ethnics were marginally older and in their first year of undergraduate study relative to their White peers, is not surprising and is consistent with previous research on poorer university acceptance rates and admissions at an older age (Gillborn & Gipps, 1996; Reid, 1989; Shiner & Modood, 2002). It should also be borne in mind that a significant proportion of the minority ethnic sample were parents, male, born outside the UK (thus increasing the likelihood of being first, as opposed to second or third generation migrants) and were more likely to be registered as an 'overseas' and not a 'home' student, which may also place them at a potential disadvantage in obtaining a university place at an earlier age (Gillborn & Gipps, 1996). The finding that significantly more minority ethnics attend universities in the South and Midlands regions, also corroborates evidence of strong regional variations in degree choice locations (Darr, 1998; Turpin, 2001)

The findings relating to a higher proportion of White undergraduates being the only family member to have attended university, is also supported by data on university admissions rates (Gillborn & Gipps, 1996), although it could also be argued that their relatively superior parental occupational status (especially maternal), would have

nevertheless enhanced their chances of pursing further education (Gillborn & Gipps, 1996).

It is interesting to find a significantly greater number of minority ethnic undergraduates in the sample with a declared religious belief and an admission that their ethnic identity is important to them, given research on the supportive role religious institutions play in combating experiences of cultural isolation, and evidence relating to the value of positive ethnic identity formation, for promoting psychological well-being (Fernando, 1991; Cross, 1991; Boyd-Franklin, 1989; Franklin & Jackson, 1990; Henley & Schott, 1999).

Turning now to findings in relation to the Theory of Planned Behaviour (TPB), the results of the multiple regression analyses (and correlations for the Mixed group) showed that in all cases for the Asian/Asian British, Chinese/Other ethnic group and the Mixed ethnic sample, attitude emerged as the single most significant predictor of intention to become a clinical psychologist in the future. According to Ajzen (1991), attitude is predictive of intention only to the extent that an individual is able to make a favourable (or unfavourable) judgement about their *own* performance of the behaviour. It may be therefore that undergraduates in these samples have greater self-confidence in their abilities of becoming a clinical psychologist, perhaps based on current academic performance, predicted grades/degree classifications and opportunities to gain relevant experience necessary for clinical training.

For the Black/Black British ethnic sample, both attitude and the influence of social Identity Theory (SIT) emerged as the only significant predictors of intention. This provides support for the moderating effect self-identity, group membership and norms may have on intention to perform a given behaviour, as shown in previous research by Terry, Hogg and White (1999). They were able to demonstrate the mediating role of attitude and social identity in predicting behavioural intention and the importance of group norms among individuals who have a strong sense of affiliation with their social group. However, because the individual SIT constructs in this study were not independently explored in the analyses computed (given there were two questionnaire items for each construct), it is difficult to assess the individual influence of each of these factors. Incidentally, the White group were the only sample to show significant predictive utilities of intention for all the main TPB component parts and the influence of SIT in this process. This supports the supposition of theorist such as Ajzen (1991), Ajzen and Fishbein (1980), in stressing the importance of the multifarious nature of the theory component parts in predicting behavioural intention. Therefore, for this ethnic group, it may be that a collection of factors will influence their intention to become a clinical psychologist in the future and this may also be mediated to a certain extent, by the strength of affiliation or identification with their social group, as in the Black/Black British sample.

Turning now to the findings relating to ethnic group differences of the factors that might help or hinder intention to become a clinical psychologist in the future, the results showed that for the minority ethnic group, the option to train part-time and the guarantee

of a place after 2 years relevant experience, were identified as desirable options in pursing clinical psychology, relative to their White peers. They also regarded NHS pay and conditions, entitlements to trust-wide initiatives and the ethnic diversity of the workforce, appealing and considered a large, female friendly employer an advantage. These findings suggest that if clinical courses wish to attract more minority ethnics into the profession, they may have to consider the possibility of offering more flexible training routes, including part-time (perhaps similar to the framework offered for post-graduate qualification) and find alternative ways of valuing relevant experience (e.g. in-house training or by promoting assistant posts to a probationary graduate level after 2 years relevant experience). Courses may also wish to draw on and promote the factors minority ethnics identified as appealing, in working for the NHS.

Regarding perceptions of disadvantage, significantly more minority ethnics considered they would be disadvantaged relative to their White peers, regarding degree classification, religious affiliation, racial/ethnic identification, gender, relationship status and childcare responsibilities. The latter two concerns may be related to the desire for flexibility in training options as discussed above, but there is a relatively large body of psychological literature on the exclusivity of the profession and the under-representation of minority ethnic groups, that would support some of these other concerns (e.g. Bender & Richardson, 1990; BPS Report, 1988b; BPS Briefing Paper, 1998: Davenhill et al, 1989; Patel et al, 2000). However, in this study the results suggest that the clinical profession needs to be more proactive in reassuring minority ethnic groups that they will be valued and welcomed in the profession. For perceptions of disadvantage in degree

class, it may be helpful if courses were to be more specific about alternative ways of pursing clinical training, in the event that a lower than expected degree class is obtained (e.g. through taking a higher qualification to support applications).

Finally, the findings that minority ethnics also regarded the possibility of not obtaining a place on a clinical course, the lack of ethnic representation in the profession and the low cultural status afforded to becoming a clinical psychologist as deterrents, also collaborates well with what has already been discussed above. However, concerns regarding negative feedback in relation to pursing clinical training, may indicate a need for the profession to focus more on the positive advantages of becoming a clinical psychologist in the future and less on the difficulties that may be faced in the process.

A discussion of the findings in relation to the qualitative results can be found in Appendix 11 (b).

General conclusions

In summary, this study has identified specific factors that may predict the different ethnic groups intention to become a clinical psychologist in the future and has explored those factors that may help or hinder undergraduates in this process. However, the generality of the research findings will require more extensive research, involving larger population samples, with a greater diversity of respondents over a longer period of time. Future work may also wish to examine the influence social identity, group affiliations and

norms, may have on career choice aspirations for the different ethnic groups, consider ways of measuring the implementation of behavioural intention, and the role played by the clinical psychology profession, careers advisors and university tutors, in promoting clinical psychology as a viable and possible profession, to minority ethnic groups.

References

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckmann (eds.), *Action and control: From cognitions to behavior* (pp. 11-39). Heidelberg: Springer-Verlag.

Ajzen, I. (1988). *Attitudes, personality and behavior.* Milton Keynes: Open University Press.

Ajzen, I. (1991). The theory of planned behavior. *Organizational behavior and human decision processes,* 50, 179-211).

Ajzen, I., & Driver, B. L. (1991). Prediction of leisure participation from behavioral, normative and control beliefs: An application of the theory of planned behavior. *Leisure Sciences,* 13, 185-204.

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior.* New Jersey: Prentice-Hall Inc.

American Psychological Association Commission on Ethnic Minority Recruitment, Retention and Training. (1997). *Visions and transformations: The final report.* Washington DC: American Psychological Association.

Bender, M. P., & Richardson, A. (1990). The ethnic composition of clinical psychology in Britain. *The Psychologist: Bulletin of the British Psychological Society,* 6, 250-252.

Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach.* London: Guildford Press.

Coker, N. (2001). *Racism in Medicine: An agenda for change.* London: King's Fund.

Conner, M., & Sparks, P. (1996). The theory of planned behaviour and health behaviours. In M. Conner & P. Norman (eds.), *Predicting health behaviour* (pp. 121-162). Buckingham: Open University Press.

Cross, W. E. (1991). *Shades of black: Diversity in African-American identity.* Philadelphia: Temple University Press.

Darr, A. (1998). *Improving the recruitment and retention of Asian students on nursing, midwifery, radiography and physiotherapy courses: A qualitative research study.* Report published by the University of Bradford.

Davenhill, R., Hunt, H., Pillay, H. M., Harris, A., & Klein, Y. (1989). Training and selection issues in clinical psychology from an equal opportunities perspective. *Clinical Psychology Forum,* 21, 34-37.

Department of Health. (1996). *Ethnic minority staff in the NHS: A programme of action.* Leeds: Department of Health.

Department of Health. (1999). *Making a difference.* Leeds: Department of Health.

Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes.* Texas: Harcourt Brace Jovanovich.

Eleftheriadou, Z. (1994). *Transcultural counselling.* London: Central Books.

Espin, O. M. (1995). 'Race', racism and sexuality in the life of narratives of immigrant women. *Feminism and Psychology,* 5, 223-238.

Fatimilehin, I. A., & Coleman, P. G. (1998). Appropriate services for African-Caribbean families: Views from one community. *Clinical Psychology Forum,* 111, 6-11.

Fatimilehin, I. A., & Coleman, P. G. (1999). 'You've got to have a Chinese chef to cook Chinese food!!' Issues of power and control in the provision of mental health services. *Journal of Community and Applied Social Psychology,* 9, 101-117.

Fernando, S. (1991). *Mental health, race and culture*. London: Macmillan/MIND.

Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention and behavior: An introduction to theory and research.* New York: Wiley.

Franklin, A. J., & Jackson, J. S. (1990). Factors contributing to positive mental health among black Americans. In D. S. Ruiz (ed.), *Handbook of mental health and mental disorder among black Americans.* (pp. 291-305). New York: Greenwood Press.

Frederickson, N., & Collins, R. (1997). The future of professional training: Views of aspiring entrants. *Educational Psychology in Practice,* 13, 147-155.

Frederickson, N., Morris. S., Osborne. L. A., & Reed, P. (2000). Averting a recruitment crisis in educational psychology services: An investigation of psychology undergraduate perspectives on the profession. *Educational Psychology in Practice,* 16, 405-429.

Gillborn, D., & Gipps, C. (1996). *Office for standards in education (OFSTED): Recent research on the achievements of ethnic minority pupils.* London: HMSO.

Henley, A., & Schott, J. (1999). *Culture, religion and patient care in a multi-ethnic society: A handbook for professionals.* London: Age Concern England.

Jarrett, R. L. (1994). Living poor: Family life among single parent, African-American women. *Social Problems,* 41, 30-49.

King, N. (1994). The qualitative research interview. In C. Cassell, G. Symon. (eds), *Qualitative methods in organizational research.* London: Sage.

Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research and participants. *Sociology of Health and Illness,* 16, 103-121.

Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal,* 311, 299-302.

Krippendorf, K. (1980). *Content analysis: An introduction to its methodology.* London: Sage.

Krueger, R. A. (1998). *Developing questions for focus groups: Focus group kit 3.* London: Sage.

Lago, C., & Thompson, J. (1996). *Race, culture and counselling.* Buckingham: Open University Press.

McInnis, E. (2000). Black in fashion? *Clinical Psychology Forum,* 139, 44-46.

Morgan, D. L., & Scannell, A. U. (1998). *Planning focus groups: Focus group kit 2.* London: Sage.

Morris, P. E., Cheng, D., & Smith, H. (1992). How and why applicants choose to study psychology at university. *The Psychologist: Bulletin of the British Psychological Society,* 5, 247-251.

Nadirshaw, Z. (1993). The implications of equal opportunities in training in clinical psychology: A realist's view. *Clinical Psychology Forum,* 54, 3-6.

Nadirshaw, Z. (1994). Clinical psychology and ethnic communities. *Clinical Psychology Forum,* 69, 38-39.

Nadirshaw, Z. (1999). Clinical psychology. In K. Bhui & D. Objide (eds.), *Mental health service provision for a multi-ethnic society* (p156-168). London: W. B. Saunders.

Norman, P., & Smith, L. (1995). The theory of planned behaviour and exercise: An investigation into the role of prior behaviour, behavioural intentions and attitude variability. *European Journal of Social Psychology,* 25, 403-415.

Office for National Statistics. (2001). *Labour force survey quarterly supplement no. 16.* London: HMSO.

Office for National Statistics 2000. *Census 2001.* London: HMSO.

Office of Population Censuses and Surveys. (1994). *Undercoverage in Great Britain (census user guide no.58).* London: HMSO.

Office of Population Censuses and Surveys. (1997). *1991 National Census.* London: HMSO.

Patel, N., Bennett. E., Dennis. M., Dosanjh. N., Mahtani, A., Miller, A., & Nadirshaw. Z. (2000). *Clinical psychology 'race' and culture: A training manual.* Leicester: British Psychological Society.

Raats, M. M., Shepherd, R., & Sparks, P. (1995). Including moral dimensions of choice within the structure of the theory of planned behaviour. *Journal of Applied Social Psychology,* 25, 484-494.

Reid, I. (1989). *Social class differences in Britain: Life chances and life styles.* London: Fontana.

Robinson, L. (2001). Intercultural communication in a therapeutic setting. In N. Coker (Ed), *Racism in medicine: An agenda for change* (pp. 191-210). London: King's Fund.

Sayal-Bennett, A. (1991). Equal opportunities – empty rhetoric? *Feminism and Psychology,* 1, 74-77.

Shiner, M., & Modood. T. (2002). Help or hindrance? Higher education and the route to ethnic equality. *British Journal of Sociology of Education,* 23, 209-232.

Sparks, P., & Shepherd, R. (1992). Self-identity and the theory of planned behaviour: Assessing the role of identification with 'green consumerism'. *Social Psychology Quarterly,* 55, 388-399.

Sparks, R. J. (2001). *A qualitative study of the proposed career paths of Black/African American undergraduate junior and senior psychology majors.* US Thesis: Fordham University.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (eds.), *The social psychology of intergroup relations* (pp. 33-47). California: Brooks-Cole.

Tajfel, H., & Turner, J. C. (1986). The social identity of intergroup relations. In S. Worchel & W. G. Austin (eds.), *Psychology of intergroup relations* (pp. 7-24). Chicago: Nelson-Hall.

Terry, D. J., Hogg. M. A., & White, K. M. (1999). The theory of planned behaviour: Self-identity, social identity and group norms. *British Journal of Social Psychology,* 38, 225-244.

The British Psychological Society (Working Party on the Future of the Psychological Sciences). (1988b). *The future of the psychological sciences: Horizons and opportunities for British psychology.* Leicester: British Psychological Society.

The British Psychological Society. (1988c). *Key equal opportunities issues that should be covered in BPS criteria for evaluating training courses in applied psychology.* Leicester: British Psychological Society.

The British Psychological Society. (1994). *The British Psychological Society: Equal opportunities statement and policy.* Brochure produced by the Society. Leicester: British Psychological Society.

The Division of Clinical Psychology. (1998). *Services to black and minority ethnic people: A guide for commissioners of clinical psychology services (briefing paper no. 16).* Leicester: The British Psychological Society.

Turpin, G. (2001). *BPS training strategy group briefing paper: Provisional statistics on clinical psychology training and cultural diversity.* Unpublished paper. University of Sheffield.

Universities and College Admissions Service. (2000). *UCAS annual report (1998/1999).* UCAS.

Vaughn, S., Schumm, J. S., & Sinagub, J. (1996). *Focus group interviews in education and psychology.* London: Sage.

Webb-Johnson, A., & Nadirshaw, Z. (1993). Good practice in transcultural counselling: An Asian perspective. *British Journal of Guidance and Counselling,* 21, 20-29.

Wilkinson, S. (1998). Focus groups in health research: Exploring the meanings of health and illness. *Journal of Health Psychology,* 3, 329-348.

Yutrzenka, B. A., Todd-Bazemore, E., & Caraway, S. J. (1999). Four winds. The evolution of culturally inclusive clinical psychology training for Native Americans. *International Review of Psychiatry,* 11, 129-135.

Critical Appraisal

Critical Appraisal

Introduction

The purpose of this critical appraisal is to provide an overview of the research process from the perspective of the trainee. This will incorporate an appraisal of each stage of the research project, including: the research origins, the planning process, literature review, interviewing and data collection, data analysis and writing up. Throughout the appraisal, the trainee will reflect on the factors that facilitated and hindered the research process, discuss motivating factors and conclude with salient learning points for the future.

Origins of the research

Throughout my training experience, my ethnic identity has posed many challenges. For clients it has been a persistent area of intrigue and curiosity, often playing an interesting part in the formation of the alliance. Surprisingly, I have found this to be equally present in my work with ethnically different clients, as with those who share the same ethnicity as my own. I have discovered that much of the latter is related to an element of surprise at the knowledge that there are 'Black' clinicians within the profession, given that there are so few, and reassurance at having the opportunity to share their concerns in a way that they are able to feel heard (Fatimilehin & Coleman, 1999; Lokare, 1992)

However, outside of my clinical role, my presence within the Black community is either viewed with encouragement or with a degree of suspicion. Encouragement, for the

reasons already noted and suspicion, seemingly due to my motivations for wanting to enter a profession that is not always perceived positively by some members of the minority ethnic community (Boyd-Franklin, 2002; Whaley, 2001; Fatimilehin & Coleman, 1999). With these issues in mind, I had intended to focus on exploring one of these many concerns but for the prior reasons mentioned, I was also anxious to ensure that I would be included within this context. Therefore, when one of my supervisors, Professor Turpin, had made it known to me of an area of interest that would incorporate some of these ideals, the opportunity was not dismissed.

After securing Dr Hardy, as a further supervisor with an interest in this area, preliminary computerised searches of the literature ensued. I soon became aware of the dearth of psychological research that was available in relation to minority ethnic groups and in their perceptions of the clinical psychology profession. Contacts with specialist research units, also confirmed this to be the case, as was my sense of the need to establish a more diligent search of the literature in order to consolidate my understanding of the key concerns. Following discussions with my supervisors, it was agreed that research focussing on the perceptions of clinical psychology as a profession would be useful, if explored from the perspectives of the different ethnic groups. This then became the focus of the research.

Planning the research

After establishing a viable area for research together with the formation of a specific question, the next stage in the research process involved exploring the practicalities of the project implementation, in preparation for submission of the research proposal.

Although time-consuming, this became an important area of discourse. Consideration had to be given to the study design, participant numbers and types, data analysis, the time frame, finance and resource limitations. Careful consultations with my supervisors ensued and together we were able to reach agreement on how best they could be implemented. However, despite much deliberation, one area of persistent concern remained: how could we maximise obtaining a diversity of responses from the different minority ethnic groups, given the small pool of minority ethnic undergraduates taking psychology degrees? (UCCA, 2000). We were hoping that part of this problem would be addressed by the university selection criteria we had established, however, it was also clear that it would be difficult to work within the constraints of the available research budget, if a sufficient number of universities were to be surveyed. The possibility of applying for further funds was tentatively considered, but at this stage in the research process it seemed more important to find a way of working within the given budget, rather than to raise hopes of monies that may not necessarily be obtained.

The research proposal was subsequently completed and submitted to the internal research sub-committee at the university, in March 2001. Feedback from the committee in May 2001, suggested that further changes were necessary before approval could be obtained.

This left me feeling quite anxious, given the amount of time, thought and effort that had already been invested into the research project. However, with the knowledge that time was crucial, due to having to complete the preliminary stage of the study before I could then go on to design the questionnaire, a period of time was set aside to complete the amendments. Once changes had been made and the proposal approved, it was then submitted to the Departmental Ethnics Sub-committee (DESC) at the University of Sheffield. This was implemented in late September 2001 and by early October 2001, ethnical approval had been obtained.

Interviewing and data collection

Recruitment of participants

The next stage in the research process involved recruiting participants for the focus group discussion. Gaining access to potential psychology undergraduates had not been difficult, due to my prior links with the psychology department of the first university approached. However, I was slightly disappointed with the low number of volunteers and left troubled by the homogeneity of the sample. Therefore, following the focus group discussion, I arranged a meeting with the Psychology Head to establish possible reasons for the latter outcomes. From this meeting I learnt that competition for participant involvement in research studies at the university was extremely high (with most recruiting at the beginning of the term), and so may have exhausted the interests of the undergraduates by the time that I had become involved. I also learnt that students were usually offered payment or an alternative (e.g. record tokens) for their participation, which was not provided in this case. Regarding the homogeneity of the sample, I

discovered that a large number of minority ethnic undergraduates at the university were registered as 'overseas' students and would have therefore been subjected to specific exclusion criteria.

Admittedly I felt naïve about some of the points the Psychology Head had raised. Had I given this more thought, all of these problems could have been avoided. It seemed I had taken my prior contacts with the university for granted and should have been as stringent in my contacts with them, as I had been during the initial stages of the research planning process. However, determined not to become complacent again, in approaching the other two universities, I took it upon myself to ask the relevant questions before deciding on the viability of obtaining a greater number of diverse volunteers, in terms of the different minority ethnic groups. Consequently, the collaborative nature of the consultation processes proved immensely helpful and resulted in the successful recruitment of a reasonable sample of minority ethnic undergraduates.

During this period, the possibility of obtaining extra monies from the Diversity Committee of the North Trent Workforce Confederation, became known. An application for £1,650 was submitted and successfully obtained. This therefore enabled the possibility of surveying a greater number of universities, with a view to increasing the potential response rates of the different minority ethnic groups.

Development of the questionnaire

Once the preliminary stage of the recruitment process was completed, the next step involved selecting relevant items for construction of the questionnaire. Most of the socio-demographic material had already been established during the planning process, but the items related to the Theory of Planned Behaviour (TPB), which data from the focus group and individual interviews provided, required more careful thought. I was therefore grateful for the guidance and support provided by a local expert, Dr Norman, in completing this process, and grew to value his somewhat effortless expertise. For the remaining items in section three of the questionnaire, the process was largely facilitated by the results of the preliminary stage, prior reading of relevant literature and preparation of items during the research planning process.

Distribution of the questionnaires

The next stage involved the dissemination of the questionnaires to the various universities. Collaborative dialogue with the universities helped to facilitate this process, as did providing an approximate date for the due delivery of the questionnaire parcels. This also enabled an arbitrary time-frame to be established for data-dissemination and collection.

Unfortunately, I had vastly under-estimated the length of time it would take to compile the items for the parcels and found it a most tedious and frustrating process. More so, because I had selected a particularly busy day at the university to complete this work, when the other two trainee years were also present. As a consequence, most of the

parcels were completed after they had left the department and having already arranged for a parcel delivery service to collect the items the next day, I had no choice but to remain in the clinical psychology unit until all the parcels were secured and appropriately labelled. Unfortunately, this necessitated working until the early hours of the morning. This was a most painful learning point and on reflection, careful planning with regards to a more appropriate date, period of time and room booking, would have helped to avoid the above eventualities.

After the parcels had been distributed, I felt a degree of relief knowing that the questionnaires were now in the public domain, although I was little anxious about how the undergraduates would respond. Acknowledging this was out of my control did not help, but retaining contacts with the various universities ensured that interest in my research remained.

Literature review

Due to limited research in this area, a more extensive search for relevant material was required. Contacts with different research units with specialisms in minority ethnic affairs were established and helpful advice and references were obtained. I also attended conferences related to minority ethnic concerns and through this process managed to extend my networks with minority ethnic clinicians, significant writers and researchers in the area.

Access to particular databases were obtained through a process of consultation and negotiation with a local university department, although an open invitation to attend a London university was also obtained, in the event that the latter was unsuccessful. These contacts were immensely helpful and made this process less stressful. However, with a number of pertinent papers being published in specialist journals or enclosed within relevant books, the inter-library loan facility had to used beyond the given budget available for this facility within the clinical psychology department. Part of this problem was overcome by e-mailing requests for journals from the first author and whilst doing so, I was also able to obtain further references that might be of interest.

Data-analysis and writing up

Commencing the writing process was difficult, due to competing demands on my two clinical placements, having to attend a job interview, the two-week mini-block period, and course work deadlines. Therefore, the writing up did not commence until relatively late after I felt in a better position to re-focus on this stage of the research process. Once commenced and work submitted for checking, the feedback from my supervisors was encouraging and helped to facilitate progress.

Like the writing up, there was also some time before the data-analysis had commenced, due to my anxieties about wanting to wait longer for the return of the questionnaires. Initially, I spend a period of time 'eye-balling' the data, before descriptive and then more detailed analyses were completed. Having being familiar with SPSS, this did not prove too difficult, although consultations with Dr Norman and the statistician, Dr Simpson,

proved immensely helpful. I also quickly learnt that the easiest way to complete this process was to totally immerse myself in the data and not to be frightened to ask questions of others, regardless of how naïve they may appear.

Maintaining motivation

My supervisors proved immensely valuable in maintaining motivation. Their persistent words of encouragement helped to contain my anxieties and gave me a sense of self-belief that I could get through this process. I was also able to feel confident in the judgements and suggestions they had made, secure in the knowledge that they had successfully guided numerous other trainees through this somewhat anxious process.

I also gained much encouragement from the contacts I had established at conferences and in relation to my literature review. Furthermore, what I had read resonated quite closely to my own experiences of clinical training and at times, I felt driven to produce something that would do this justice. In addition to the support I gained from clinical (placement) supervisors, family and friends, I was also encouraged by the immense desire for change that were evident in my contacts with clients and the undergraduate psychology students I had met during Study 1. This helped me to stay motivated and focussed on the tasks in hand.

Learning points

Through undertaking this research project, I have learnt to be more realistic in my expectations of conducting research when there is a limited time frame, research budget

and other competing demands. I have come to value the importance of the planning process and the need to ensure sufficient time-management of these plans, if pertinent deadlines are to be adhered to. Finding ways in which to contain my anxieties of the research process was also helpful, as was the necessity to work collaboratively with my supervisors and all those who were pertinent to the research process.

I have also learnt a great deal about research in this area and through the responses obtained, I have become more aware of the different perceptions of the clinical psychology profession and possible reasons for why this may be the case. I feel more informed about the views of psychology undergraduates, particularly in regards to the different minority ethnic groups, given that so little was known about their perceptions beforehand. My only regret was having to collapse the minority ethnic groups together. It had always been my wish that they be compared as unique groups in their own right, given the whole objective of this thesis. We (i.e. my supervisors and I) had hoped that by sampling a large enough population, we would be able to obtain sufficient numbers. The actual proportions were really good, given the available pool of minority ethnic undergraduates, however the *n* was smaller than hoped.

In returning to the origins of this report, I feel that the literature review has helped me to further understand the concerns of minority ethnic communities and I remain optimistic that changes will be implemented in the profession, to make it more accessible for them to gain the appropriate support and help.

Finally, through completing this research project, it has given me the confidence to consider completing other areas of future research on minority ethnic groups, primarily to inform practice, but also to extend current knowledge within the clinical psychology profession, given that there is so little research in this area. This process has undoubtedly been facilitated through undertaking this research project, knowing that it is possible to do so with limited resources and competing demands.

References

Boyd-Franklin, N. (2002). *Working with black clients and families in therapy.* Visibility/Invisibility Conference Presentation. University of Leeds.

Fatimilehin, I. A., & Coleman, P. G. (1999). 'You've got to have a Chinese chef to cook Chinese food!!' Issues of power and control in the provision of mental health services. *Journal of Community and Applied Social Psychology,* 9, 101-117.

Lokare, V. G. (1992). Respect for cultures, beliefs and attitudes: A way to better relationships and understanding. *Counselling Psychology Quarterly,* 5, 227-229.

Universities and College Admissions Service. (2000). *UCAS annual report (1998/1999).* UCAS.

Whaley, A. L. (2001). Cultural mistrust: An important psychological construct for diagnosis and treatment of African Americans. *Professional Psychology Research and Practice,* 32, 555-562.

Appendix 1

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The following types of paper are invited :

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- Theoretical papers, provided that these are sufficiently related to the empirical data;
- Review articles which need not be exhaustive, but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments (see below).

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   (e) For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: *Objectives, Design, Methods, Results, Conclusion*. Review articles should use these headings: *Purpose, Methods, Results, Conclusions* (more details on Structured Abstracts can be obtained by contacting the Journals Department).
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   These allow rapid publication of research studies, and theoretical, critical or review comments with an essential contribution to make. Case studies are normally published only as Brief Reports. They should be limited to two printed pages with the text, including references and a 100 word abstract set at 150 lines. Abstracts should also be structured under these headings: *Purpose, Methods, Results, Conclusions* (more detailed guidelines on structured abstracts are available from the Journals Department). Figures and tables should be avoided. Title, author and name and address for reprints and data of receipt are not included in the allowance. However, deduct three lines from the text each and every time any of the following occur:
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   c) each address after the first address
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11. **Checklist of requirements:**
    - A signed submission letter
    - Correspondent's title/name/address
    - A cover page with title/author(s)/affiliation
    - Double spacing with wide margins
    - Tables/figures at the end
    - Complete reference list in APA format
    - Four good copies of the manuscript (or an e-mail attachment)

Appendix 2

Research Sub-Committee approval of journal choice

THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

Department of Psychology.University of Sheffield.Western Bank.Sheffield S10 2TP

Tel: 0114 2226570 Fax 0114 2226610 e-mail:

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Unit Director: Prof G Turpin (26569) PQ Director : Dr P Slade (26568) Clinical Practice Director: Ms J Scaife (26574)
Senior Lecturers: Dr G Hardy (26571) Dr S Walsh (26567) Dr. G Kent (26527)
Lecturers: Dr N Beail (26575) Ms L Buchan (26609)
Clinical Tutors: Ms L Monaghan (26577) Ms A Rowlands (26572)
Course Administrator: Mrs C Gillespie (26570) Course Secretaries: Mrs M Dickens (26573) Ms M Maltby (26576)

Pat Williams,
3rd Year Trainee,
Clinical Unit
Department of Psychology,
University of Sheffield.

Dear Pat,

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature review: British Journal of Clinical Psychology

Research report: Option A

Please remember to bind in a copy of the relevant Instructions to Authors with your thesis.

Yours sincerely,

Gerry Kent
Chair, Research Sub-Committee.

Appendix 3

Ethical Approval

THE UNIVERSITY OF SHEFFIELD

Department of Psychology

Prof R I Nicolson (Head of Department)

Prof K J Connolly
Prof P Dean
Prof C Eiser
Prof J R Eiser
Prof J P Frisby
Prof J E W Mayhew
Prof M Siegal
Prof G Turpin
Prof T Wall
Prof P Warr

Psychology Building
Western Bank Sheffield
S10 2TP UK

Phone +44 (0)114 222 2000
Fax +44 (0)114 276 6515

Patricia Williams
Clinical Psychology Unit
Department of Psychology
University of Sheffield

8th October, 2001

Re: The perceptions of clinical psychology as a career among psychology undergraduates from different ethnic groups

Dear Ms Williams,

Thank you for your submission to the Departmental Ethics Sub-committee (DESC). I am pleased to inform you that the ethics of your proposal are approved.

Sincerely,

Paschal Sheeran

Paschal Sheeran, PhD
Chair, DESC

THE UNIVERSITY OF SHEFFIELD

Department of Psychology

Prof R I Nicolson (Head of Department)

Prof K J Connolly
Prof P Dean
Prof C Eiser
Prof J R Eiser
Prof J P Frisby
Prof J E W Mayhew
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Sincerely,

Paschal Sheeran

Paschal Sheeran, PhD
Chair, DESC

PERCEPTIONS OF CLINICAL PSYCHOLOGY AS A CAREER CHOICE

Questionnaire Overview and Completion

This questionnaire is concerned with clinical psychology as a profession and possible career choice. It will seek to explore your views, beliefs and perceptions of the profession and examine areas that may be pertinent to the concerns of psychology undergraduates like yourself. **Your views are important, irrespective of whether or not you wish to become a clinical psychologist in the future.**

The questionnaire is divided into three sections. Section 1 concerns basic socio-demographic details, which will be required to enable sufficient analysis of respondent variables. Section 2 relates to your perceptions of clinical psychology and examines your intentions or otherwise to pursue clinical training. The final section assesses factors that may make clinical training more accessible for you as well as for others and examines the influence of other relevant factors that may be pertinent to the decision making process. Instructions on completing each section are detailed in bold print at the start of each section. Please complete by writing firmly on the paper.

It should be noted that there are no right or wrong answers and your responses are anonymous (i.e. it will not be possible to identify who you are). Any publications that may arise from this research study will be reported collectively to maintain respondent anonymity and appropriately acknowledged.

Thank you for taking the time to complete this questionnaire.

Section 1: Socio-demographic Details

Please place a tick (✔) in the appropriate box.

1. Gender ( ) Male ( ) Female

2. Age ( ) Please state your age

3. Marital status ( ) Cohabiting ( ) Divorced ( ) Single

( ) Married ( ) Widowed ( ) Any other

marital arrangement – Please describe .....

PLEASE TURN OVER

4. Children ( ) None ( ) One ( ) Two

( ) Three or more

5. Ethnicity Please indicate your ethnic group using one of the options below:

Asian or Asian British

( ) Bangladeshi ( ) Indian ( ) Pakistani

( ) Any other Asian background - Please describe.....

.....

Black or Black British

( ) African ( ) Caribbean

( ) Any other Black background – Please describe .....

.....

Chinese or Other Ethnic Group

( ) Chinese ( ) Other ethnic group – Please describe

.....

.....

Mixed

( ) Asian and White ( ) Black African and White

( ) Black Caribbean and White

( ) Any other mixed background – Please describe .....

.....

White

( ) British ( ) Irish

( ) Any other White background – Please describe .....

.....

6. Is your ethnicity important to you? ( ) Yes

( ) No

( ) Sometimes/Not always

7. Country of birth Please indicate.....

If you were born outside the UK, how old were you when you migrated to the UK? ( )

8. Religion Please indicate your religion (if any) .....

9. Year of degree ( ) 1st ( ) 2nd ( ) 3rd

( ) 4th

10. Degree type ( ) BSc Hons in psychology

( ) BA Hons in psychology

( ) Combined Hons degree/or other – please state.....

.....

11. Mode of study ( ) Full time study ( ) Part-time study

( ) Sandwich course ( ) Other arrangement – please state....

.....

PLEASE TURN OVER

12. Student type ( ) Home student ( ) Overseas student

13. University Please state the name of your university.....

14. Family Please state number of <u>immediate</u> family members (i.e. parents, siblings) who have also attended university .....

15. Occupation Please state main occupation of mother .....

Please state main occupation of father.....

16. Disability Do you have a disability? Yes/No (please delete)

Section 2: Perceptions of Clinical Psychology & Intentions to Pursue Clinical Training

Please place a circle around the appropriate number (e.g. if you wish to select option 4 for a question, then place a circle around this number i.e. (4)).

17. I would like to become a clinical psychologist in the future

Definitely would 1 2 3 4 5 6 7 Definitely would not

18. I want to be a clinical psychologist at some time in the future

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

19. I expect to become a clinical psychologist in the future

Extremely likely 1 2 3 4 5 6 7 Extremely unlikely

20. How likely is that you will become a clinical psychologist in the future?

Extremely likely 1 2 3 4 5 6 7 Extremely unlikely

21. My becoming a clinical psychologist in the future would be:

(a). Good	1	2	3	4	5	6	7	Bad
(b). Wise	1	2	3	4	5	6	7	Foolish
(c). Beneficial	1	2	3	4	5	6	7	Harmful
(d). Pleasant	1	2	3	4	5	6	7	Unpleasant
(e). Enjoyable	1	2	3	4	5	6	7	Unenjoyable
(f). Rewarding	1	2	3	4	5	6	7	Punishing

22. Most people who are important to me think that I

Should 1 2 3 4 5 6 7 Should not
become a clinical psychologist in the future

23. Most people who are important to me would

Approve 1 2 3 4 5 6 7 Disapprove
of me becoming a clinical psychologist in the future

24. Most people who are important to me would

Want me 1 2 3 4 5 6 7 Not want me
to become a clinical psychologist in the future

25. How much control do you think you have over becoming a clinical psychologist in the future?

Complete control 1 2 3 4 5 6 7 Absolutely no control

26. For me, becoming a clinical psychologist in the future would be

Easy 1 2 3 4 5 6 7 Difficult

27. How confident are you of becoming a clinical psychologist in the future?

Very confident 1 2 3 4 5 6 7 Not at all confident

PLEASE TURN OVER

28. Whether I do or do not become a clinical psychologist in the future is entirely up to me

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

29. I intend to become a clinical psychologist in the future

Definitely do 1 2 3 4 5 6 7 Definitely don't

30. Becoming a clinical psychologist in the future would make me...

(a). Open-minded:

Likely 1 2 3 4 5 6 7 Unlikely

(b). Self-confident:

Likely 1 2 3 4 5 6 7 Unlikely

(c). Insightful:

Likely 1 2 3 4 5 6 7 Unlikely

(d). Respectful:

Likely 1 2 3 4 5 6 7 Unlikely

(e). Resourceful:

Likely 1 2 3 4 5 6 7 Unlikely

(f). Skilful:

Likely 1 2 3 4 5 6 7 Unlikely

31. Being open-minded would be...

Good 1 2 3 4 5 6 7 Bad

32. Having self-confidence would be...

Good 1 2 3 4 5 6 7 Bad

33. Being insightful would be...

Good 1 2 3 4 5 6 7 Bad

34. Being respectful would be...

Good 1 2 3 4 5 6 7 Bad

35. Being resourceful would be...

Good 1 2 3 4 5 6 7 Bad

36. Being skilful would be...

Good 1 2 3 4 5 6 7 Bad

37. My family think that I

Should 1 2 3 4 5 6 7 Should not
become a clinical psychologist in the future

38. Close friends think that I

Should 1 2 3 4 5 6 7 Should not
become a clinical psychologist in the future

39. People in the profession and/or university lecturers think that I

Should 1 2 3 4 5 6 7 Should not
become a clinical psychologist in the future

PLEASE TURN OVER

40. With regards to becoming a clinical psychologist in the future, how much do you want to do what your parents think you should?

Very much 1 2 3 4 5 6 7 Not at all

41. With regards to becoming a clinical psychologist in the future, how much do you want to do what your closest friends think you should do?

Very much 1 2 3 4 5 6 7 Not at all

42. With regards to becoming a clinical psychologist in the future, how much are you willing to follow the advice of people in the profession and/or university lecturers?

Very much 1 2 3 4 5 6 7 Not at all

43. Limited places on clinical training courses makes pursuing a career as a clinical psychologist in the future

More likely 1 2 3 4 5 6 7 Less likely

44. Being able to gain relevant experience makes pursuing a career as a clinical psychologist in the future

More likely 1 2 3 4 5 6 7 Less likely

45. Having financial support whilst training makes becoming a clinical psychologist in the future

More likely 1 2 3 4 5 6 7 Less likely

46. There are limited places on clinical psychology courses

Likely 1 2 3 4 5 6 7 Unlikely

47. I would be able to gain relevant experience that would enable me to become a clinical psychologist in the future

Likely 1 2 3 4 5 6 7 Unlikely

48. Having financial support whilst training is...

Likely 1 2 3 4 5 6 7 Unlikely

49. I would have the approval of my close friends and family members in pursing a career to become a clinical psychologist in the future

Likely 1 2 3 4 5 6 7 Unlikely

50. Approval from close friends and family members to pursue a career as a clinical psychologist would make my becoming a clinical psychologist in the future

More likely 1 2 3 4 5 6 7 Less likely

51. Becoming a clinical psychologist in the future is an important part of who I am

Definitely 1 2 3 4 5 6 7 Definitely not

52. I would feel at a loss if I were to give up the opportunity to pursue a career in clinical psychology

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

53. Most of my close friends and confidantes think becoming a clinical psychologist in the future would be

Good 1 2 3 4 5 6 7 Bad

54. Most of my friends and confidantes would be interested in becoming a clinical psychologist in the future

Agree 1 2 3 4 5 6 7 Disagree

55. How well do you feel you fit into your group of friends?

Very much so 1 2 3 4 5 6 7 Not very much

PLEASE TURN OVER

56. How much do you identify with your group of friends?

Very much so 1 2 3 4 5 6 7 Not very much

Section 3: Other Factors

Please tick (✔) the required box(es) that apply to you.

57. What would make entering clinical psychology a more desirable career option for you?

( ) More information about the profession

( ) Closer contact with clinical psychology courses

( ) An assessment of suitability for training prior to pursing this career option

( ) Greater financial support during training

( ) Courses incorporating a foundation year for those with less clinical experience

( ) Having a vocation and and profession with a clear career path

( ) A higher starting salary on qualification

( ) Knowledge of the job

( ) Clarity concerning relevant experiences required for training

( ) A place on a training course after 2 years experience

( ) Flexibility in working hours once qualified

( ) Sufficient job choice on completion of training

( ) Not having to obtain a 2:1 in my undergraduate psychology degree as a basic requirement for entry to training

( ) Having the opportunity to give something back to society

( ) Status/prestige

( ) The option to train part-time

( ) Other reason(s) – please state .....

.....

.....

58. Do you think there is anything about you that may place you at a disadvantage in pursuing a career in clinical psychology?

( ) My age

( ) Likely degree class

( ) My gender

( ) Relationship status

( ) Childcare responsibilities

( ) My disability

( ) My racial/ethnic status

( ) Being religious

( ) Other reason(s) – please state .....

.....

59. What factors would deter you from entering the profession?

( ) The 3 years of training

( ) Starting salary on qualification

( ) The possibility of not getting onto a clinical course

( ) Lack of status/prestige

( ) Poor financial status during training

( ) Becoming a clinical psychologist is not valued or understood in my culture

( ) Working in the NHS

( ) Having to gain relevant experience for training

( ) Competition for places

( ) Lack of support from family/close friends

( ) Negative feedback from clinical courses, articles, etc

( ) Lack of ethnic representation in the profession

( ) Working in a helping profession is not valued or understood in my culture

( ) Other – please state below:

.....

. . ..

.....

PLEASE TURN OVER

60. If you were unsuccessful in obtaining a place on a clinical psychology course, which other profession would appeal to you (psychology or otherwise)?

Please state.....

61. If you were successful in becoming a clinical psychologist, what would you find most appealing in the NHS as an employer?

( ) The delivery of care for all

( ) Opportunities to work with other healthcare professionals

( ) Pay and conditions

( ) The opportunity to give something back to society

( ) Female friendly employer

( ) Job security

( ) Career development

( ) Belonging to a large employer

( ) The choice of working either part-time or full-time

( ) Pension package

( ) Diversity in career choice (e.g. general management)

( ) Ethnically diverse workforce

( ) Entitlement to trust-wide initiatives (e.g. in-service training, IntraNet)

( ) Other reason(s) – please state .....

.....

.....

.....

.....

Please ensure that you have completed <u>every</u> question before returning the questionnaire in the pre-paid envelope provided. Your time and effort is very much appreciated. Thank you for completing this form.

Pat Williams, The University of Sheffield (Clinical Psychology Unit)

Appendix 4b

Questionnaire measures for the Theory of Planned Behaviour (TPB) items

Theory of Planned Behaviour Items

Introduction:

The following exemplars have been taken from Section 2 (items 17-50) of the 'Perceptions of Clinical Psychology as a Career Choice' questionnaire.

Theory of Planned Behaviour (TPB) Items:

Behavioural intentions (INT) to become a clinical psychologist in the future, were measured by five items: 'I *would like* to become a clinical psychologist in the future', 'I *want* to be a clinical psychologist in the future', 'I *expect* to become a clinical psychologist in the future', 'How *likely* is it that you will become a clinical psychologist in the future', and 'I *intend* to become a clinical psychologist in the future'. Responses for each of the questions were measured on four differential scales (i.e. definitely would – definitely would not, strongly agree – strongly disagree, extremely likely – extremely unlikely (twice) and definitely do – definitely do not'). Cronbach alpha's (α) for the five items in the overall sample, equated to .97. An overall measure of behavioural intention was obtained by calculating the mean score for each of the five items.

Attitudes (ATT) towards becoming a clinical psychologist in the future were measured against five semantic differential scales in response to the statement, 'my becoming a clinical psychologist in the future would be...': good - bad, wise - foolish, beneficial - harmful, pleasant - unpleasant, enjoyable - unenjoyable and rewarding - punishing (α = .95 for the overall sample). An overall measure of attitudes was obtained by calculating

the mean score for each of the five items. *Subjective norm* (SN) or social pressure to perform this behaviour was measured by three questions. The first item began: 'most people who are important to me think that I ...' (should/should not become a clinical psychologist in the future) and the remaining two stated: 'Most people who are important to me would...' (approve/disapprove of me becoming a clinical psychologist in the future; want me/not want me to become a clinical psychologist in the future). Cronbach alpha for the three items was found to be .81. An overall measure for the subjective norm was obtained by calculating the mean score across each of the items.

Perceived behavioural control (PBC) or the amount of *perceived control* the respondent believes they have over performing this behaviour, was measured by four different items: 'How much control do you think you have over becoming a clinical psychologist in the future?' (complete control - absolutely no control); 'For me, becoming a clinical psychologist in the future would be...' (easy - difficult); 'How confident are you of becoming a clinical psychologist in the future?' (very confident - not at all confident); 'Whether I do or do not become a clinical psychologist in the future is entirely up to me' (strongly agree - strongly disagree). Internal reliabilities for each of the four scales were found to be .73. An overall measure of behavioural intention was obtained by calculating the mean score for each of the four items.

Behavioural beliefs (BBs) items were derived from responses obtained in Study 1 (question 2), relating to the personal attributes, skills and characteristics that respondents thought were necessary to become a clinical psychologist. From an analysis of the responses given, six belief items were selected for inclusion in the final questionnaire, in

answer to the question, 'becoming a clinical psychologist in the future would make me...': open-minded, self-confident, insightful, respectful, resourceful and skilful. A single response measure (i.e. likely - unlikely) was provided. The *evaluations* (Evals) of these belief items were examined by the questions: 'being open-minded would be ...': good-bad; 'having self-confidence would be...': good - bad; 'being [insightful, respectful, resourceful, skilful] would be...': good - bad. Corresponding scores for the behavioural beliefs and evaluation items were recoded (from –3 to +3) and then multiplicatively combined, from which 6-paired BB x evals (BB.evals) scores were achieved (scores ranged from –9 to +9). A single mean BB x evals (MBB.evals) score was then computed.

Normative beliefs (NBs) were measured against three items derived from the results of question 5 in Study 1. The questions focussed on three identified significant others: 'my [family, close friends, people in the profession and/or university lecturers] think that I...' should/should not, become a clinical psychologist in the future. Respondents *motivations to comply* (MC) to the views of significant others were assessed by three corresponding set of questions: 'with regards to becoming a clinical psychologist in the future, how much do you want to do what your [parents, closest friends] think you should do?' (very much - not at all) and 'with regards to becoming a clinical psychologist in the future, how much are you willing to follow the advice of people in the profession and/or university lecturers?' (very much - not at all). The same procedures as for the behavioural beliefs and evaluations were undertaken, in order to compute a single NBs.MC scale.

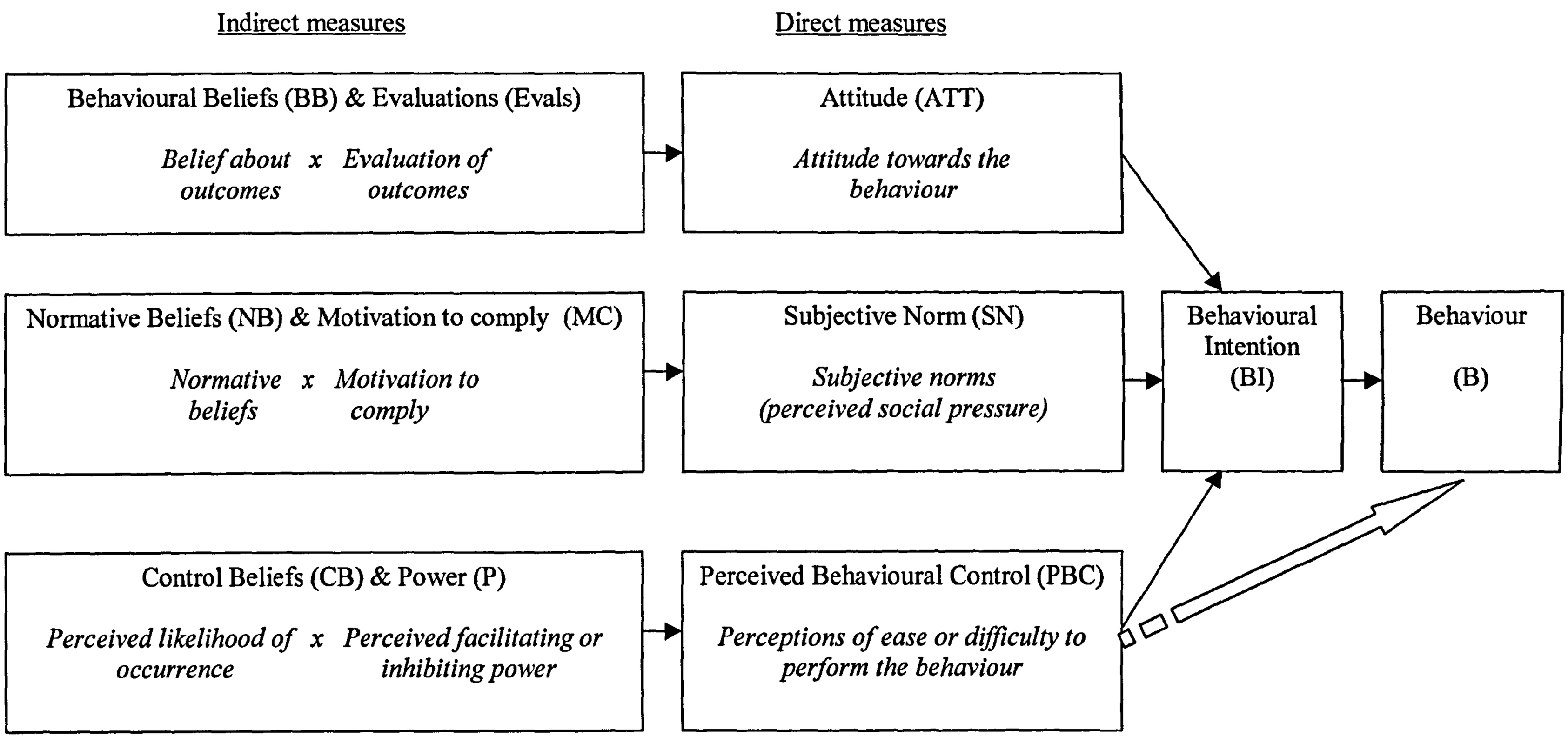
Control beliefs (CBs) items were obtained from questions 4 and 6 of Study 1, relating to the identification of facilitating and inhibiting factors that may enable or prevent an individual from becoming a clinical psychologist in the future. Internal factors (e.g. 'approval from close friends and family members to pursue a career as a clinical psychologist ...') and external control factors (e.g. 'limited places on clinical training courses...') were identified and included in the final questionnaire. These four items were then measured on scales ranging from 'more likely – less likely'. Corresponding questions relating to the *power* (P) of the individual to respond to these control beliefs (e.g. 'I would have the approval of my close friends and family members in pursuing a career to become a clinical psychologist in the future') were measured on scales ranging from 'likely – unlikely'. Computations as for the BB.evals items were calculated and a single CB.P scale obtained.

Appendix 5

The Theory of Planned Behaviour Model

The Theory of Planned Behaviour (TPB) Model

Figure 1. *Model of the TPB



*Adapted from Conner & Norman, 1996.

Study 1

Appendix 6a

Copy of overhead produced for Year Lecturers

(The name of the university & contact person have been deleted)

Clinical Psychology as a Career Choice

- I'm a third year trainee on the University of Sheffield training course.
- I'm looking for volunteers for a focus group discussion on clinical psychology as a possible career choice.
- You do not have to be interested in pursuing clinical training to take part.
- The session will be held on **Wednesday 28th November at 3.00p.m., Department of Psychology, University of [redacted].**
- It will comprise of 8-12 people and last for between 60-90 minutes. The session will be audiotaped, but all steps will be taken to maintain your confidentiality.
- If you are interested, please obtain an information sheet and complete a brief form, obtainable from [redacted].
- Thank you for your interest.

Pat Williams, Trainee.

Appendix 6b

Focus group discussion information sheet

Clinical Psychology as a Career Choice

Volunteers Required for a Focus Group Discussion

I'm a third year clinical psychology trainee based in Nottingham, on the University of Sheffield training course. As part of my research project I am looking for volunteers who would be interested in participating in a focus group discussion about clinical psychology as a profession and possible career choice. I am particularly interested in a wide range of views, including those for whom clinical training may not be an interest.

Purpose of Focus Group

The purpose of the group will be to explore your perceptions, views and beliefs about clinical psychology. **The session will be held on Wednesday 28th November at 3.00p.m., at the Department of Psychology, University of [redacted].** The session will last between 60-90 minutes maximum and will be audiotaped. All steps will be taken to maintain your confidentiality.

How to Volunteer

If you are an undergraduate psychology student and interested in taking part in this focus group discussion, please complete a brief form obtainable from [redacted]. The forms should be returned to the psychology reception office in the envelope provided, where they will be collected by myself. The group will comprise of between 8-12 students. It may be, therefore, that even though you volunteer I do not ask you to attend the discussion. However, those who are selected will be contacted by telephone in the first instance, so please remember to include all your relevant contact details.

If you have any questions about this, please contact me on the telephone number or e-mail address shown below. Many thanks for your interest.

Pat Williams, Trainee.
Tel: 0114 222 6570
E-mail: PCP99PEW@SHEFFIELD.CO.UK

Appendix 6c

Copy of socio-demographic form

CLINICAL PSYCHOLOGY AS A CAREER CHOICE

FOCUS GROUP DISCUSSION TO EXPLORE YOUR VIEWS

1. Name _____

2. Gender ( ) Male ( ) Female

3. Age ( ) please state.

4. Marital status ( ) Married ( ) Single ( ) Divorced

( ) Cohabiting ( ) Any other arrangement –

Please describe .....

.....

5. Do you have any dependants? ( ) No ( ) Yes – please describe .....

.....

6. Your ethnic group

Asian or Asian British

( ) Bangladeshi ( ) Indian ( ) Pakistani

( ) Any other Asian background – Please describe

.....

Black or Black British

( ) African ( ) Caribbean ( ) Any other

Black background – Please describe .....

.....

Chinese or Other Ethnic Group

( ) Chinese ( ) Other ethnic group – Please

describe .....

Mixed

( ) Asian and White ( ) Black African and

White ( ) Black Caribbean and White

( ) Any other mixed background – Please describe

.....

White

( ) British ( ) Irish ( ) Any other White

background – Please describe .....

.....

7. Current year of degree course ( ) 1st ( ) 2nd ( )3rd ( ) 4th

8. Type of degree

( ) BSc Hons in psychology

( ) Combined Hons degree – please state .....

.....

( ) Conversion course in psychology – please

state what degree course was completed before .....

.....

( ) Other - please describe .....

.....

9. Type of student

( ) Home student ( ) Overseas student – if

so, please state country of birth .....

10. Interest in Clinical training

( ) Yes ( ) No ( ) Unsure

11. Contact details

E-mail address (capitals) _____

Best time of contact _____

Mobile/telephone _____

Address (university or home) _____

_____

Thank-you for taking the time to complete this form. Please enclose in the envelope provided and **return to the Psychology Reception Office, University of [redacted],** where I will collect them and be in touch with you within the next week.

Pat Williams, Trainee (Tel: 0114 222 6570 E-mail: PCP99PEW@SHEFFIELD.AC.UK).

Appendix 6d

Researcher recruitment script for volunteers

Recruitment Script Guideline

Background Information

Study details: The purpose of the focus group discussion is to explore your perceptions, views and beliefs about clinical psychology as a profession and possible career choice. There are NO right or wrong answers and I am NOT seeking to find 'ideal' answers, because there are none. That's why I'm interested in hearing a wide range of views, including from those for whom pursuing clinical training may not be an interest.

Why their views and participation is important: As far as I am aware, there hasn't yet been any formal study undertaken where students have been asked to share their perceptions, views and beliefs about clinical psychology as a profession and career choice. This focus group discussion is a starting point and your responses important because the key points of the discussion will be used to help formulate questions for use in a wider study.

Inclusion criteria: The following conditions will have to be satisfied:

1. You are a psychology undergraduate student at the University of [redacted], Department of Psychology;
2. Engaged in full or part-time study on a pure or combined course of study of which psychology forms at least 50% of the degree component;
3. Volunteers can be of any age, gender, racial and ethnic group and at any stage in their undergraduate psychology degree, however, they MUST be registered as home and not overseas students;
4. As mentioned earlier, students DO NOT have to be interested in pursuing clinical training to participate;
5. Must be available to attend the discussion group on Wednesday 28th November, at 3.00p.m. at the Department of Psychology, University of [redacted].

Further contacts with them prior to the focus group discussion: Your contribution to this focus group discussion is important so I will also be sending you a letter just to remind you of the date, time and room where the focus group will be held. I may also follow this up with a telephone call to ensure that you have received this and that you are still available to attend on 28th November.

Before I leave you, could I just check that I have your correct contact details?

1. Address (university/home);
2. Landline & mobile telephone number;
3. Best time of contact (and day) for each;
4. E-mail address.

- Any other questions?

- If you wish to contact me – give e-mail address and university telephone number.

- Thank them for agreeing to take part. Reiterate that letter will be sent out to them to confirm the above arrangement and that I may also contact them again by telephone, nearer the day. In the meantime, I look forward to seeing them on Wednesday 28th November, at 3.00p.m.

Other Possible Concerns

What is a focus group discussion? It is a group discussion amongst a small number of people, used to explore your views about an area of interest. There are no right or wrong answers; I am just interested in hearing what the various opinions may be.

What are the questions that you are going to ask us? The questions will be concerned with your views, beliefs and perceptions of clinical psychology as a profession and possible career choice. As mentioned earlier, there are no right or wrong answers; I'm just interested in hearing what your views and opinions may be.

What is this study for? This discussion will form part of my final year research project, as part of my clinical training.

Will I have the opportunity to add any other/additional comments besides the questions that you will be asking the group? There will be opportunities during the focus group discussion and before the end of the session to add any additional comments that are important to you.

Confidentiality: Everything discussed during the session will remain confidential to my supervisors (names) and myself. I can assure you that there will be no feedback to your course team and/or university department. Every precaution will be taken to ensure that no identifiable factor will be included when my research is written up.

Will I hear about the results of this study? The research will be written up and available for perusal post September 2002. It is also possible that some parts of the study may be published.

Who can I contact to request more information about pursuing clinical training or clinical psychology as a career? If you would like more information about clinical psychology, as well as the skills and experiences required to pursue clinical training, you can obtain further information from the BPS website address: www.bps.org.uk or if you wish you can contact the BPS directly on: 0116 254 9568.

Appendix 6e

Letter sent to volunteers for the focus group discussion

THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

Department of Psychology.University of Sheffield.Western Bank.Sheffield S10 2TP

Tel: 0114 2226570 Fax 0114 2226610 e-mail: dclinpsy@sheffield.ac.uk

Direct dialling 0114 22 + ext no

Unit Director: Prof G Turpin (26569) PQ Director : Dr P Slade (26568) Clinical Practice Director: Ms J Scaife (26572)
Senior Lecturers: Dr G Hardy (26571) Dr G Kent (25627) Dr S Walsh (26567)
Lecturers: Dr N Beail (26575) Ms L Buchan (26609)
Clinical Tutors: Ms L Monaghan (26574) Ms A Rowlands (26572) Ms A Tosh (26577) Mr S Eltringham (26577)
Course Administrator: Mrs C Gillespie (26570) Course Secretaries: Mrs M Dickens (26573) Ms M Maltby (26576)

23 November 2001

Full name
Address
Address
City & postcode

Dear (name),

Re: Focus Group Discussion on Clinical Psychology as a Career Choice

Thank-you for agreeing to take part in the forthcoming focus group discussion. As mentioned over the telephone the session will take place on Wednesday 28th November at 3.00p.m. in room 327, at the Department of Psychology, University of [redacted].

As explained in the information sheet that accompanied your questionnaire, the purpose of the group will be to explore your perceptions, views and beliefs about clinical psychology as a profession and possible career choice. There are no right or wrong answers, I am just interested to hear what your views might be. The session will commence at 3.00p.m. prompt and will last for between 60-90 minutes maximum. Refreshments will also be provided.

Once again thank-you for agreeing to participate in this group discussion. As with any group, the success is dependent upon each of its members. I will therefore be counting on your assurance to attend. If you cannot attend for any reason, please let me know as soon as possible, by calling 0114 222 6570.

I look forward to meeting you on Wednesday 28th November.

Yours sincerely,

Pat Williams,
Trainee.

Appendix 6f

Consent Form

RESEARCH CONSENT FORM

I understand that this study is concerned with the perceptions of clinical psychology as a profession and future career choice. My participation will involve an informal discussion about my views, attitudes and perceptions of clinical psychology in relation to this and will seek to ascertain what the opinions of my peers/referent groups and significant others would be towards this. I have had an opportunity to ask questions and have received satisfactory answers. I also understand that I am free to withdraw from this discussion group at any time without having to give a reason. I give my consent to take part in this study and for the session to be audio-taped.

Date	Name	Signature

Appendix 6g

Focus group guide using the 'questioning route'

Focus Group Guide - Using the Questioning Route

Introduction:

Hello and welcome.

Thank you for coming today and agreeing to take part in this focus group discussion.

As you are aware, my name is Pat Williams and I'm a trainee clinical psychologist, in my third year, on the University of Sheffield training course.

As part of my final year thesis I'm working on a research project which is concerned with looking at the perceptions of clinical psychology from a wide range of perspectives. As an important part of this process, each of you have been asked to come along today so that I can find out what some of these views may be.

It's important for you all to know that there are no right or wrong answers and although some of your opinions may differ, everyone here is seen as a valued member of this group. So even though I'll be leading this discussion, all I ask, is that everyone respects the opinions of others, even if you are not in agreement with them.

I'm not expecting you to speak in an orderly fashion – so if you've got something to say, then please just say it, but again out of respect, can you ensure that only one person speaks at a time and please do not have side conversations. Also I'm interested in hearing everyone's points of views and not just a few.

Last but not least, just to remind everyone that everything you tell me will be kept completely confidential, and will not be shared with anyone not directly involved in the study. Has everyone read and signed the consent form? Does anyone have any questions?

Okay, once I start the tape-recorder we'll begin. Are you ready? [START THE TAPES].

Focus Group Discussion:

1. To begin with, I wonder if you could tell me what comes to mind when you hear the words 'clinical psychologist'? **5 mins**
2. What sort of person do you think you would need to be to become a clinical psychologist?
   [Probe for: (a). personal attributes/qualities (b). skills and (c). characteristics needed].
   10 - 15 mins
3. What would persuade you to become a clinical psychologist? **10 mins**
4. What factors would help you to pursue this course of action? **10 mins**

5. On deciding on becoming a clinical psychologist, whose views would be important to you? **5 mins**
6. What factors might get in the way of you becoming a clinical psychologist? **10 - 15mins**
7. What would be needed to help you overcome these barriers? **10 mins**
8. FACILITATOR GIVES AN ORAL SUMMARY OF MAIN POINTS RAISED DURING THE DISCUSSION, ACKNOWLEDGING DIFFERING POINTS OF VIEWS, THEN ASKS: (a). Is this correct? (b). Have I missed anything? **5 mins**
9. Does anyone have anything else they would like to add? **5 mins**

60-90 minutes <u>maximum</u> (to include 5 mins of closing comments).

Closing comments:

Thank you for taking part in this discussion group today. I hope you enjoyed it. I really enjoyed listening to you all – you were a great group – and I really valued hearing your views today. I found them very helpful and they will undoubtedly help to inform the rest of my research.

I'd just like to add that if anyone here is interested in pursing clinical psychology as a career or would like to know more about the skills and experiences required to pursue clinical training, you can obtain further information from the BPS website at <u>www.bps.org.uk</u> or if you wish, you can contact the BPS directly on 0116 254 9568.

Once again thank you for helping me today and I wish you every success with your studies and future careers.

Appendix 6h

Schedule for focus group discussion

Schedule for Focus Group Discussion

- **Introductions and overview of focus group discussion** – Participants were provided with an overview of the research study, based on the information contained in the information leaflet (as in Appendix 6b). The purpose of the discussion group was then outlined (i.e. to explore their 'views, attitudes and perceptions of clinical psychology' and '..to ascertain what the opinions of [their] peers/referent groups and significant others would be towards this') and issues of confidentiality discussed. It was emphasised that the researcher (who also acted as the facilitator) was interested in hearing everyone's points of views and not just the opinions of a few, that there are no right or wrong answers and although sentiments may differ, this was welcomed and should be respected. Participants were invited to ask the researcher any questions, following which written consent was obtained regarding their participation (including the right of respondents to withdraw from the discussion at any time) and for the session to be audio-taped (see Appendix 6f). Tape recording then commenced.
- **Question 1** – Immediate thoughts that come to mind on hearing the words 'clinical psychologist'. **[5 minutes]**
- **Question 2** – The personal attributes, skills and characteristics necessary to become a clinical psychologist (i.e. 'behavioural beliefs'). **[10-15 minutes]**
- **Question 3** – Factors that would influence their decision to become a clinical psychologist. **[10 minutes]**

- **Question 4** – Factors that would help to facilitate their decision to become a clinical psychologist (i.e. 'control beliefs'). **[10 minutes]**
- **Question 5** – Identification of significant others in relation to their decision to pursue clinical training (i.e. 'normative beliefs'). **[5 minutes]**
- **Question 6** – Factors that might get in the way of their decision to pursue clinical training (i.e. 'control beliefs'). **[15 minutes]**
- **Question 7** – The identification of factors that may help them to overcome these barriers. **[10 minutes]**
- **Oral summary** – This included an overview of the main points raised, acknowledging the diversity of opinions. Respondents were then asked (a) to confirm the accuracy or otherwise of the facilitator's summary and (b) invited to identify any points that may have been missed. This procedure was undertaken as a preliminary validity check, to ensure that all accounts were reported correctly and to safeguard against the possibility of facilitator bias (Krueger, 1998; Morgan & Scannell, 1998). Respondents were then asked if they had anything further to add, before the facilitator concluded with closing remarks. **[15 minutes]**[1]

References

Krueger, R. A. (1998). *Analyzing and reporting focus group results: Focus group kit 6* (p. 68). London: Sage Publications Ltd.

Morgan, D. L. & Scannell, A. U. (1998). *Planning focus groups: Focus group kit 2.* London: Sage Publications Ltd.

[1] Following the focus group meeting, the audiotape was transcribed by the researcher and checked for accuracy.

Appendix 7

Amended research information sheet for individual interviews

Clinical Psychology as a Career Choice

Volunteers Required for a Brief Discussion

I'm a third year clinical psychology trainee based in Nottingham, on the University of Sheffield training course. As part of my research project I am looking for volunteers from **minority ethnic groups** who would be interested in participating in a telephone discussion about clinical psychology as a profession and possible career choice. **I am particularly interested in a wide range of views, from students in all three years, including those for whom clinical training may not be an interest.**

Purpose of the Discussion

The purpose of the discussion will be to explore your perceptions, views and beliefs about clinical psychology. **The discussion can be arranged at a date and time convenient with yourself and will last for between 10-15 minutes maximum.** All steps will be taken to maintain your confidentiality.

How to Volunteer

If you are an undergraduate psychology student, from a minority ethnic group and would be interested in taking part, please contact me on the telephone number and/or e-mail address shown below, leaving your name and telephone/mobile (or e-mail) contact details. **I will be able to attend your university and meet you face-to-face if this would be more appropriate for you, in which case just 5-10 minutes maximum would be required.**

If you have any questions about this telephone discussion or would like to know more about what this may involve, please feel free to contact me. Many thanks for your interest.

Pat Williams, Trainee.
Tel: 0114 222 6570
E-mail: PCP99PEW@SHEFFIELD.CO.UK

Appendix 8

Method of analysis for the 'beliefs' section of the TPB

Method of Analysis for the 'Beliefs' Items of the Questionnaire:

An Example

Table 1. Organisation of Items for Normative Beliefs

Question: Whose views would be important to you (in becoming a clinical psychologist)?

Belief groupings	The views of significant others	Frequency	Belief number
• Family members	Parents	6	
	Mum/Dad	2	
	Family	4	
	Children/siblings/husband	4 **{16}**	1
• Close friends	Best friend	7	
confidante	Someone close (not directly family related) e.g. confidante, boyfriend.	5 4 **{16}**	2
• People in the profession	A clinical psychologist	4	
	Someone from the BPS	1	
	Course tutor/member	8 **{13}**	3
• University staff	Tutors/Lecturers	4 **{4}**	4
• Others	A high status (e.g. G.P or other health professional)	4	
	Teachers, mentor, careers advisors.	1	
	Someone similar to me (e.g. a mother)	1 **{6}**	5

Appendix 8a

Results, discussion & conclusions – Study 1

The Full Report of Study 1

Participants

The focus group meeting was held at one of the universities to elicit the views, attitudes and perceptions of psychology undergraduates, towards clinical psychology. Kitzinger (1994, 1995) and Wilkinson (1998) have shown this method to be particularly effective for exploring group norms, attitudes and perceptions, across a broad range of subject-matter and population groups. Researchers have also shown it to be sensitive to cultural variables, with favourable outcomes in cross-cultural research and work with minority ethnic groups (e.g. Espin, 1995; Jarrett, 1994).

A purposive sampling strategy was employed (Morgan & Scannell, 1998), whereby all undergraduate psychology students and those enrolled on the psychology conversion course were invited to participate, provided specific exclusion criteria did not apply. For the purpose of this stage of the research project, volunteers were excluded if they were registered as an overseas student and/or were completing a combined course of study where psychology did not comprise of at least 50% of their degree program. This criterion was established on recognition that these volunteers would not be representative of potential student cohorts who would be eligible for clinical training.

Procedure

The focus group meeting was of 90 minutes duration and held in the psychology building at the University. Before commencing the discussion, each of the volunteers were

presented with name labels and asked to formally introduce themselves to each other. A specified procedure then followed using a focus group technique commonly referred to as the 'questioning route' (Krueger, 1998). This involves the formulation of a series of pre-arranged questions in the form of complete sentences, that are read aloud to participants, with probes as appropriate (Appendix 6g). The semi-structured questions for the questioning route were primarily designed in accordance with the procedures outlined for the relevant 'beliefs' sub-section of the TPB (Conner & Sparks, 1996) and discussed with an adviser experienced in using this theory as a methodology. The questions were then finalised in consultation with the project research supervisors.

Method of analysis

Rationale for selection

The TPB items were analysed in accordance with standard procedures (Conner & Sparks, 1996) to be discussed below, whilst the remaining data were analysed using qualitative procedures advocated by Vaughn, Shay-Schumm and Singaub (1996).

The latter method of analysis was also selected to take account of other aspects of the focus group questioning route (including other areas of interest raised by respondents) that were not specifically related to the TPB. The technique suggested by Vaughn et al (1996) was used because it has particular relevance to focus group research, as well as other interviewing techniques that give rise to qualitative analysis. With this technique being based on the location of salient themes, it also seemed the most appropriate method to use in this instance given the specific purpose of this aspect of the research study.

Other more detailed methods of qualitative analysis were considered (e.g. Content Analysis: Krippendorf, 1980) but the extent and level of analysis required by these methods would have been less appropriate to the methodology selected and would have almost certainly exceeded requirements for this stage of the project aims.

Data analysis

Responses from the focus group discussion were analysed separately to those obtained from the individual telephone interviews and face-to-face contacts. This measure was undertaken to ensure that the views of the different ethnic groups were equally represented and a wide set of diverse beliefs were obtained.

The procedures for data analysis outlined by Vaughn et al (1996) were utilised as follows. First, the transcript for the focus group discussion was carefully read several times and on each occasion, salient responses to each question were noted when identified. Particular attention to frequently occurring responses, dissenting opinions and those that generated more extensive detailed discussion by members of the group was emphasised. The next stage involved 'unitizing' the data (i.e. identifying units of information or themes). This process involved re-reading the transcript again, with the emphasis being placed on locating emerging themes for each specific question. Verbatim exemplars to emphasise a particular theme were also identified in the transcipt, with coding at this stage in the analysis purposely comprehensive, to incorporate a wide range of perspectives. The information units/themes were then recorded on separate cards, in preparation for the next stage of the analysis. Categorisation of the units followed this

stage, where the themes for each question were listed and related and/or converging themes organised together into smaller groups with headings. This process continued until all the information units/themes were exhausted. The categories were reviewed for 'overlap and completeness' and those with similar properties, were collapsed to form a broader category.

This procedure was then repeated for each individual telephone/face-to-face contact interview, and concluded with shared and dissenting themes identified for each question across the majority and minority ethnic groups. In this way diversity in responses were maintained, given that some of these themes would also have to be used to generate relevant items for the questionnaire, in preparation for distribution to a diverse range of potential respondents. Analysing the groups separately (i.e. focus group respondents and those obtained through telephone interviews/face-to-face contact) also enabled the 'rule of triangulation' to be incorporated into the analysis, to validate data procured from at least two different and independent sources (Morgan & Scannell, 1998).

For the questions related to the relevant 'beliefs' items of the TPB (i.e. Questions 2, 4, 5 and 6), an adaptation of the procedures advocated by Conner and Sparks (1996), Ajzen and Fishbein (1980) and Ajzen and Driver (1991) were implemented. For each of the behavioural, normative and control belief items, a list was acquired of all the main points raised by respondents. These were then organised to ensure that all items that referred to similar outcomes were grouped together into outcome categories and coded in the left hand margin, under the heading 'belief groupings'. A frequency count of each item

elicited on the list was then recorded in the right hand margin (under the heading 'frequency') and a decision was made concerning which items were incorporated into the final questionnaire. Normally, the most frequently mentioned (i.e. modal) beliefs/referents, would be selected for inclusion, but given the focus and nature of this research project, and the requirement to generate a wide selection of questions that may be of potential interest to a diverse range of respondents, both the modal beliefs/referents and items that generated intense beliefs (i.e. depth of feelings) were identified (Krueger, 1998), and where appropriate, considered for inclusion in the final questionnaire. Appendix 8 provides an overview of the method of analysis used for this stage of the research process.

Results

Participants' responses to the category items are discussed and reported below, together with exemplars where necessary in italics. Those items highlighted in bold, forms the basis of the theory of planned behaviour scales that will be discussed in the methods section of Study 2.

Participants' thoughts on hearing the words 'clinical psychologist'

Fairly consistent responses were received for this item. For some respondents, clinical psychologists were seen as synonymous to psychiatrists but without prescription privileges. However, for the majority of respondents they were either defined in terms of their diverse working roles or in relation to their various work settings. Regarding the

former, long-term therapeutic work on a 1:1 basis was regarded as the norm, but the context of the relationship was perceived as being quite intimate, as would be the case in a doctor-patient relationship. Other working roles included: research, case studies and inter-professional work with other healthcare professionals. There was a strong perception of clinical psychologists being based in hospitals or specialised settings (e.g. drug rehabilitation clinics), schools and other less informal work environments, without being specific (e.g. *"somewhere nice, like a lounge"*). For most minority ethnic respondents, 'clinical psychologists' were seen as being predominately White and middle-class.

Personal skills and characteristics required to become a clinical psychologist

For this item, respondents identified six main characteristics they believed would be required to become a clinical psychologist. These involved the need to be: open-minded/objective, insightful, respectful, skilful, resourceful and self-confident. Being **open-minded** was highly regarded among respondents and in most cases perceived as a necessity. A typical response was: *"it's like not being judgemental...you can't be very opinionated...you have to be able to take on other people's perspectives"*. **Insightfulness** was often conceptualised in relation to learning gained from life experiences and from interactions with others, often dissimilar to themselves. This is exemplified by the comment: *"it's like insight into a group and cultures, like you wouldn't necessarily get. Like I've worked with children and autism and it's like looking at how they don't like interact with each other..."*. The need to be **respectful** was taken as the norm for work in this area, whilst having a variety of **skills** (e.g. in assessments, therapeutic approaches

and in relation to listening, empathy and communications), was seen as desirable. It was felt you needed to be **resourceful** in order to work within the constraints of the NHS and required self-confidence to undertake the various roles and for others to perceive you as 'professional'. Other personal qualities were also mentioned (e.g. the need to be trustworthy, honest and resilient).

Factors that would persuade them to become a clinical psychologist

Several motivating factors were identified, including: personal qualities (e.g. self-determination and personal interest in the profession), the professional status (e.g. *"that title...you feel that you've achieved something."*), intrinsic factors (i.e. ability to 'make a difference' to the quality of someone's life) and encouragement from significant others (e.g. lecturers, family and friends). However, for other respondents, greater financial incentives, a guaranteed job at the end of training, flexibility in training options (including the possibility of working part-time), diversity of working roles, closer contact with clinical psychologists and less restrictions on the 2:1 degree classification requirement, would also be influential.

Factors that would help them to pursue this course of action

For a large number of respondents, having more **opportunities to gain relevant experience** for training was considered helpful, but for others greater guidance from clinical courses was required: *"It would be really helpful if there was some sort of guidelines for experience published...maybe go through each clinical group...just saying relevant things and what they see as being sort of commendable...amounts of*

responsibilities you should have had and amounts of time you should have had with a clinical psychologist and if you can't, what's the next best thing". The introduction of a foundation year, possible assessment of suitability, contact with clinical psychologists, good referees, several job opportunities on completion of training, **financial support** and not having to obtain a 2:1 for entry, were also seen as persuasive. A few respondents also thought a good course structure and more detailed feedback from clinical courses would be helpful (e.g. *"anything to do with the degree that you've done or type or class or whatever...the type of experience, whether it's too much in the same field...or perhaps just your personality, something personal that's not likely to change"*).

Whose views would be important?

Family members, **close friends**/confidantes, **people in the profession and/or university lecturers,** were the most frequently cited persons. Others included: a general practitioner or other health professional, mentors, careers advisors, anyone with a high status and teachers (i.e. on the basis that they knew the individual well).

Factors that might get in the way

For most respondents, the time taken to get onto a training course, gaining relevant experience and the **possibility of not getting on,** were seen as problematic. Others were concerned about financial constraints and poor starting salaries. A number of respondents also thought there was too much negative feedback (e.g. from lecturers, clinical courses, articles and psychological journals) about the competitive nature of training and the difficulties of getting onto a course, which they found off-putting. Other factors that

might get in the way were: not obtaining a 2:1, lack of childcare provisions, the stresses of training, **lack of support from significant others**, poor job prospects, the inflexibility of training (e.g. no option to take a year out) and the length of the training period.

Factors that would help to overcome these barriers

For some respondents, more information and knowledge about the profession, and closer contact with clinical psychologists, would be helpful. Increasing course training numbers and the diversity of trainees admitted, was also considered helpful, as exemplified by the comment: *"If they could ease the bottle-neck at the top. There's only an elite number of people that get in and I'm not probably one of these people. It has to be a select person".* Other factors identified included: greater numbers of training courses, the ability to train part-time (for those with family commitments), childcare provisions, increasing the training salary, taking away the 2:1 requirement, having a good professional future and personal factors (e.g. self motivation and a positive attitude).

Discussion and conclusions – Study 1

Overall, the results of this study showed that psychology undergraduates had some (albeit limited) awareness of the role of a clinical psychologist, were able to identify a number of characteristics relevant to undertake that role and factors that would be helpful if they were to pursue this course of action. Moreover, although they were able to identify a number of key concerns which may either deter or hinder them from pursing this aim (with suggestions for improvements), the results of this study also indicate that

undergraduates could benefit from further overall knowledge and information about the profession to clarify some of the concerns raised, and to allow them to make a more informed choice about the possibility of pursing clinical psychology as a profession. That besides, many of the findings are supported by the results of a similar study undertaken by Frederickson et al (2000) and the findings in relation to the career aspirations of undergraduate psychologists, undertaken by Morris et al (1992). The concerns raised by some minority ethnic undergraduate students about the image of clinical psychology being predominately White and middle-class, also find support in the relevant literature (e.g. Bender & Richardson, 1990; Fatimilehin & Coleman, 1998; Fernando, 1991).

However, whilst this preliminary study produced some useful findings, it should be acknowledged that the views of only a small sample of undergraduates were surveyed, all of whom were female, residing in the North Trent region and with little diversity in age. It is therefore quite possible that a different range of responses may have been received, had there been access to a larger and more diverse sample. Future research may wish to take these study limitations into consideration and perhaps explore undergraduates' perceptions of clinical psychology over two different time frames (e.g. in the first and final degree years), to ascertain whether their perceptions remain consistent or change over time.

References

Ajzen, I., & Driver, B. L. (1991). Prediction of leisure participation form behavioral, normative and control beliefs: An application of the theory of planned behavior. *Leisure Sciences,* 13, 185-204.

Ajzen, I., & Fisbein, M. (1980). *Understanding attitudes and predicting social behavior.* New Jersey: Prentice-Hall Inc.

Conner, M., & Sparks, P. (1996). The theory of planned behaviour and health behaviours. In M. Conner & P. Norman (eds.), *Predicting health behaviour* (pp. 121-162). Buckingham: Open University Press.

Espin, M. (1995). 'Race', racism and sexuality in the life of narratives of immigrant women. *Feminism and Psychology,* 5, 223-238.

Frederickson, N., Morris, S., Osborne, L. A., & Reed, P. (2000). Averting a recruitment crisis in educational psychology services: An investigation of psychology undergraduate perspectives on the profession. *Educational Psychology in Practice,* 16, 405-429.

Jarrett, R. L. (1994). Living poor: Family life among single parent, African-American women. *Social Problems,* 41, 30-49.

Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research and participants. *Sociology of Health and Illness,* 16, 103-121.

Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal,* 311, 299-302.

Krippendorf, K. (1980). *Content analysis: An introduction to its methodology.* London: Sage.

Krueger, R. A. (1998). *Developing questions for focus groups: Focus group kit 3.* London: Sage.

Morgan, D. L., & Scannell, A. U. (1998). *Planning focus groups: Focus group kit 2.* London: Sage.

Morris, P. E., Cheng, D., & Smith, H. (1992). How and why applicants choose to study psychology at university. *The Psychologist: Bulletin of the British Psychological Society,* 5, 247-251.

Vaughn, S., Schumm, J. S. & Sinagub, J. (1996). *Focus group interviews in education and psychology.* London: Sage.

Wilkins, S. (1998). Focus groups in health research: Exploring the meanings of health and illness. *Journal of Health Psychology,* 3, 329-348.

Study 2

Appendix 9a

Letter to Psychology Heads of Departments

THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

Department of Psychology.University of Sheffield.Western Bank.Sheffield S10 2TP

Tel: 0114 2226570 Fax 0114 2226610 e-mail: dclinpsy@sheffield.ac.uk

Direct dialling 0114 22 + ext no

Unit Director: Prof G Turpin (26569) PQ Director : Dr P Slade (26568) Clinical Practice Director: Ms J Scaife (26572)
Senior Lecturers: Dr G Hardy (26571) Dr G Kent (25627) Dr S Walsh (26567)
Lecturers: Dr N Beail (26575) Ms L Buchan (26609)
Clinical Tutors: Ms L Monaghan (26574) Ms A Rowlands (26572) Ms A Tosh (26577) Mr S Eltringham (26577)
Course Administrator: Mrs C Gillespie (26570) Course Secretaries: Mrs M Dickens (26573) Ms M Maltby (26576)

5th February 2002

Dear Head of Department,

Research on Psychology Undergraduates Perceptions of Clinical Psychology

As you will be aware the British Psychological Society has recently conducted a survey assessing the ethnicity of undergraduates reading Psychology at British universities. Under the auspices of the Association of Heads of Psychology Departments, we received helpful replies from Departments of Psychology throughout the UK concerning their ethnic make-up of undergraduate courses. We are now entering the second phase of this research where we would like to survey in greater detail the views and attitudes of undergraduates towards their perceptions of clinical psychology as a career.

We are writing to request that your Department might assist in this project by distributing a brief questionnaire to your undergraduate students. The questionnaire should take only about 10 minutes to complete and consists of three sections concerned with basic socio-demographic details, followed by a section on their perceptions, views and beliefs about clinical psychology as a possible career choice, and a final section which deals with their attitude to the NHS. If you were willing to agree, we would send you copies of the questionnaire in bulk, together with some publicity posters and information sheets. We only request that you make your students aware of

the research and ask them to participate by returning completed questionnaires via a prepaid post envelope.

All information supplied on the questionnaire by respondents will remain completely confidential. The study has received ethical approval from the Ethics Committee of the Department of Psychology at the University of Sheffield. The project is also being completed in partial fulfilment of D Clin Psy degree within the Clinical Psychology Unit.

We are hoping to distribute the questionnaires to participating Departments in about a months time, so that students have the opportunity to return them to us by Easter. We would therefore really appreciate an early reply and it would be most useful if you could return the attached reply slip to Pat Williams using the prepaid envelope supplied. If we haven't heard from you in a fortnights time, we will contact you either by e-mail or telephone to enquire whether your Department wishes to assist us in this research. We would be very happy to discuss this further with you and any of us may be contacted at the above address.

We look forward to hearing from you.

Yours sincerely,

Pat Williams,	Graham Turpin,	Gillian Hardy,
Trainee Clinical Psychologist	Professor in Clinical Psychology	Reader in Clinical Psychology

Undergraduate Psychologists' Perceptions of Clinical Psychology as a Career

Reply slip - *Please return ASAP to:*

Pat Williams

☐ **I am willing to allow your Department to approach our undergraduate students and request their participation in this project.**

I require .....individual questionnaires to distribute to all year/courses.

Please send to: **Pat Williams,**
University of Sheffield,
Clinical Psychology Unit,
Western Bank,
Sheffield,
S10 2TP.

☐ **I require further information.**

☐ **I am not willing for my Department to be approached for participation in this project.**

Appendix 9b

Reminder letter to Psychology Heads of Departments

THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

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Course Administrator: Mrs C Gillespie (26570) Course Secretaries: Mrs M Dickens (26573) Ms M Maltby (26576)

Please contact: Pat Williams at pcp99pew@sheffield.ac.uk

20th February 2002

Dear Head of Department,

Research on Psychology Undergraduates Perceptions of Clinical Psychology

We recently wrote to you to enquire about the possibility of surveying in greater detail the views and attitudes of your undergraduate psychology students towards their perceptions of clinical psychology as a career choice. As we have not received a reply from you about this request, we are writing to you again to ask whether you would be willing to assist us in this research.

We appreciate that university Departments have been under a lot of pressure with the QAA etc and consequently we have designed the project with the aim of minimising the effort required by the Department to do this research. It might be a task that could be delegated to an administrative or clerical officer in your Department.

As mentioned in our previous letter, we would send you copies of the questionnaire in bulk, together with some publicity posters and information sheets. We would only require that you make students aware of the research, perhaps at the beginning of a lecture and ask them to participate by returning the completed questionnaires via a prepaid envelope i.e. you will not have to collect them.

We believe that this project might facilitate the widening of access to post-graduate clinical psychology training and various NHS Workforce Confederations have shown a keen interest in its results. Accordingly, we hope that you might be able co-operate and enable us to recruit as representative a sample as is feasible.

We would be grateful if you could assist us in this research and inform us of your decision at the earliest possible convenience. In the meantime we would be happy to discuss this further with you.

We look forward to hearing from you.

Yours sincerely,

Pat Williams,	Graham Turpin,	Gillian Hardy,
Trainee Clinical Psychologist.	Professor in Clinical Psychology.	Reader in Clinical Psychology.

Appendix 9c

Cover letter notifying parcel contents for the research

(Poster	- enclosed)
(Information sheet	- enclosed)
(Overhead	- as poster but last paragraph omitted)
(Questionnaire	- refer to Appendix 4a)

THE UNIVERSITY OF SHEFFIELD
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Clinical Tutors: Ms L Monaghan (26574) Ms A Rowlands (26572) Ms A Tosh (26577) Mr S Eltringham (26577)
Course Administrator: Mrs C Gillespie (26570) Course Secretaries: Mrs M Dickens (26573) Ms M Maltby (26576)

E-mail address: pcp99pew@sheffield.ac.uk

20th March 2002

Dear Head of Department,

Research on Psychology Undergraduates Perceptions of Clinical Psychology

Thank you for agreeing to help us with the above research. As you agreed in the letter we sent to you last month (see attachment), we would be grateful if you could please make the enclosures available to your undergraduate psychology students and ask them to participate by returning the completed questionnaires using the prepaid envelopes provided.

The following have been enclosed:

- Laminated publicity posters and information sheets;
- 3 overheads;
- Questionnaires in bulk;
- Corresponding numbers of prepaid envelopes.

Please feel free to photocopy the questionnaires should your psychology undergraduates require any additional copies and do not mind enclosing their completed questionnaires in a pre-paid envelope with another student's.

Thank you for your assistance with the above.

Yours sincerely,

Pat Williams, Trainee Clinical Psychologist.

Graham Turpin, Professor in Clinical Psychology.

Gillian Hardy, Reader in Clinical Psychology.

Could you please return this to me when the questionnaires have been distributed.

Pat Williams,
Trainee Clinical Psychologist.

Name and address of institution: .....

.....

.....

Contact person: .....

E-mail/telephone number: .....

I have/have not received the questionnaires (please delete).

They were distributed to students: 1st years ..... (date)

2nd years..... (date)

3rd years..... (date)

Thank you for your assistance.

Volunteers Required

Could This Be For You?

I'm currently conducting a study about Clinical Psychology and career choice. The study is specifically concerned with the perceptions of clinical psychology from the perspective of minority and all other ethnic groups. If you are an **undergraduate psychology student** and would be interested in taking part in this study, all you have to do is obtain an information sheet and questionnaire from the Departmental Secretary (psychology) and return your completed form in the pre-paid envelope supplied.

Perceptions of

The questionnaire will only take a few minutes to complete and is totally confidential. No personal details are required and your anonymity is assured throughout (i.e. you cannot be identified).

If you know of any other persons who would also be appropriate for the study but are not located in your building, please feel free to take an information sheet and questionnaire for their completion. Please help if you can. This study is important because it is the first ever of its kind in the UK.

I would like all psychology undergraduates to participate in this research.

Thank-you for your help. It is very much appreciated.

Clinical Psychology

PERCEPTIONS OF CLINICAL PSYCHOLOGY AS A CAREER

RESEARCH INFORMATION SHEET

Researcher: Pat Williams, Trainee Clinical Psychologist at the University of Sheffield.

Supervisors: Professor Graham Turpin (Course Director) and Dr Gillian Hardy (Reader in Clinical Psychology).

What is the study about? The study will be looking at psychology undergraduates' views of clinical psychology as a profession and their future career choice intentions. I am particularly interested in identifying and exploring the factors that may persuade or discourage minority and other ethnic groups from pursing clinical psychology as a career, and the viable options which seem more attractive to you. Obtaining your opinions about these issues are important because it would help to redress the current barriers contributing to the shortfall of minority and other ethnic groups within the profession and appropriately inform policy decision-making practices.

What will be involved if I agree to take part? If you agree to take part in the study, all you will be asked to do is to complete a questionnaire (obtainable from the departmental secretary) and return it in the prepaid envelope provided. I can assure you that there will be no feedback to your University Department.

It is important to note that there are no right or wrong answers; I am only interested in your views alone. Throughout the questionnaire there will be opportunities for you to make additional comments of importance to you.

What about confidentiality and will participation have any bearing on my coursework/exam grades? Completion of the questionnaire is unrelated to your University activities and will not affect any gradings you receive. As mentioned above, there will be no feedback to your University Department and you cannot be identified. I will also take every precaution to ensure that no identifiable factor will be included when the research report is written up.

Do I have to take part in this study? You are not obliged to complete the questionnaire if you do not wish to do so. However, your views are important and I would very much value your input.

What can I do if I would like more information about pursuing clinical psychology as a career and/or about this study? If you would like further information about clinical psychology, as well as the skills and experiences required to pursue clinical training, you can obtain further information from the British Psychological Society (BPS) website address: www.bps.org.uk or if you wish, you can contact the BPS directly on: 0116 254 9568.

If you would like any further information about the study, you can contact me on: 0114 222 6570 or e-mail me on: pcp99pew@sheffield.ac.uk.

Appendix 9d

Update letter to Psychology Department Heads

&

Letter (sent as e-mail attachment) to undergraduate students

THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
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Course Administrator: Mrs C Gillespie (26570) Course Secretaries: Mrs M Dickens (26573) Ms M Maltby (26576)

10th May 2002

Dear Head of Department,

Update Related to Research on Psychology Undergraduates Perceptions of Clinical Psychology

I am writing to let you know that we are now beginning to receive completed questionnaires from undergraduates and it is not too late to return any forms that have yet to be completed. We realise that many departments would have received their packages of questionnaires shortly before or after Easter, and although some universities have returned their letter to confirm receipt of these parcels, we also thought we should write to let you know that it would be really helpful for the questionnaires to be distributed and the posters displayed as soon as is convenient, if this has not already been done yet.

Thank you for your participation and continued support.

Yours sincerely,

Pat Williams,
Trainee Clinical Psychologist

Graham Turpin,
Professor in Clinical Psychology

Gillian Hardy,
Reader in Clinical Psychology

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Course Administrator: Mrs C Gillespie (26570) Course Secretaries: Mrs M Dickens (26573) Ms M Maltby (26576)

E-mail address: pcp99pew@sheffield.ac.uk

10th May 2002

Dear Student,

Update Related to Research on Psychology Undergraduates Perceptions of Clinical Psychology

I recently distributed some questionnaires, information sheets and posters related to the above and although I have now begun to receive some completed questionnaires, I thought I should write to let you know that it is not too late to return any forms that have been completed using the prepaid envelopes provided, if you have not done so already.

Thank you for participation. I look forward to hearing from you.

Yours sincerely,

Pat Williams,	Graham Turpin,	Gillian Hardy,
Trainee Clinical Psychologist	Professor in Clinical Psychology	Reader in Clinical Psychology

Appendix 10

Cronbach alpha scales and skewness statistics

Measures of internal consistency for the intention scale by ethnic group

Table 3.1. Cronbach alpha reliabilities

Ethnic group	Alpha
Asian/Asian British sample	.95
Black/Black British sample	.97
Chinese/Other ethnic sample	.97
Mixed ethnic sample	.97
White ethnic sample	.96

Skewness statistics for the different ethnic group on the intention scale

Table 3.2. Skewness statistics

Ethnic group	N	Mean (SD)	Minimum - maximum	Skewness statistics	Std Error of Skew
Asian/Asian British sample	41	3.69 (1.55)	1 - 7	.198	.369
Black/Black British sample	30	4.09 (1.93)	1 - 7	-.014	.427
Chinese/Other ethnic sample	20	4.0 (1.80)	1 - 7	.120	.512
Mixed ethnic sample	12	3.48 (2.02)	1 – 6.60	.165	.637
White ethnic sample	363	3.77 (1.67)	1 - 7	.044	.128

NB: A skewness statistics value more than twice the standard error, is a departure from symmetry. The results show that all the intention scales are symmetrical and can therefore safely be used as a dependant variable.

Appendix 11a

Qualitative results - Study 2

The Findings of the Qualitative Results – Study 2

Introduction

Responses recorded in the 'other reason(s)' sections of questions 57 – 59 and 61, were combined together irrespective of ethnicity, due to the similarity of responses given and the comparatively low numbers of respondents who completed these optional sections. For multiple responses given by a single undergraduate, a decision was taken to accept the first response only and assume this to be the most pertinent reason supplied.

Results

A total of 63 respondents provided additional reasons that would make entering clinical psychology a more desirable career option for them. Four main themes emerged from the pattern of responses given. These included: (a) a requirement for further information about the profession and/or training needs; (b) personal and intrinsic factors; (c) changes to course policy related to the training of minority ethnic students and those from overseas; (d) and other reasons. Of the 73% (46/63) of responses given for the first theme, issues relating to more extensive knowledge of the profession, the possibility of a shorter training experience, the extension of available clinical places and greater numbers of training courses to make competition less severe, support factors and greater financial remunerations emerged. Typical responses were exemplified by the following comments: *"It would be more desirable if there were generally more information on what the job involves and how you train for it..."; "Greater guidance on the courses/work required following a degree before becoming a clinical psychologist";*

"shorter training, enabling you to enter the career sooner"; "More places required. Always adverts calling for clinical psychology but few training places..."; "Understanding the network of support available during training"; "When most graduates start in business on salaries of £17,000 and the average debt of graduates is getting larger, this is making clinical psychology less tempting".

A total of just 6/63 respondents (9.5%) indicated that personal/intrinsic reasons made pursing clinical psychology a more desirable career option for them. Examples of this theme included: "*My interest around the clinical area, being able to feel that I've helped individuals or made a difference helping people, would make it a worthwhile career"* and *"The possibility of helping those in need, especially children. Working with people that makes a difference in the world".*

For concerns related to ethnicity/cultural factors (3/63; 4.8%), exemplars of themes from this category included: "*clinical field jobs very limited for black students – we are all aware that there are only a few black psychologists. The same judgements and assessments should be equal"; "To include overseas students like myself without having to pay seven times the amount home students pay".* In the 'other' reason category, the responses from 8/63 (12.7%) of undergraduates ranged from no interest in the profession at all (e.g. "*It isn't a desirable career for me – most of all because I think we should better change society and not people who don't fit in"*), to other career choice options (e.g. *"I want to go into HRM"*).

Rather more responses (n = 100) were received for any other factors that may place undergraduates at a disadvantage in pursing a career in clinical training. Concerns with regards to financial/social class status emerged as the biggest theme (23%). Typical comments included: *"the fact that I am poor and working class"* and *"lacking of financial backing, too much in dept with student loan"*. Other respondents (19%) were concerned about their personal suitability for the profession (e.g. *"I may get too emotionally involved with the people and their situation"; "not detached enough as is necessary in the profession"* and *"commitment required. Not suitable for women who also want to focus on marriage and children"*), whilst 18% of respondents thought the lack of prior/relevant experience, might put them at a disadvantage (e.g. *"Lack of experience prevents me getting a place"* and "*Lack of opportunity to obtain relevant experience. All posts seem to want experienced staff, hard to get first break after university"*).

For 10% of respondents, they felt their degree classification or university status might place them at a disadvantage (e.g. *"what happens if you don't get a 2:1?"*and *"my university status i.e. it's position on league table"*). Similar concerns were expressed by 5% of respondents, with respect to the competitive nature of applicant places for training (e.g. *"competition from better candidates*"). A further 5% of respondents felt their student status or lack of proficiency in the English language, were a definite disadvantage: "*Being an overseas student"* and *"...that English is not my first language"*. Four respondents thought their mental health status was a barrier to clinical training (e.g. *"Being stuck with a manic depressive label. Something that happened in the past, may*

never happen again, but the label sticks"). For two undergraduates, being bound by prior commitments prevented them from pursing clinical training (e.g. *"bound to a Singapore scholarship for six years"*). A further six respondents gave other personal reasons that might place them at a disadvantage (e.g. *"being religious with certain ethnical aspects" and "possibly my sexuality"*). A final eight respondents expressed no or very little interest in pursing clinical psychology as a profession (e.g. *"I am not interested in this field of work"* and *"my interests in psychology do not lie in clinical, I prefer social psychology..."*).

For additional responses given in relation to other factors that would deter undergraduates' from entering the profession, just 43 replies were received. Numerous themes emerged, of which a fair proportion (i.e. 9) involved personal beliefs about the type of characteristics clinical courses appear to be looking for in respondents and the possibility that their own personal belief systems may be compromised. Examples of these included: *"I think the training/career would not fit in with my religious beliefs. I believe there would be a lack of understanding in the profession about Islam"; "snobbery towards people who have already experienced mental health problems"* and *"I don't think they want mature people or value life experience...I don't think they want people who have critical or controversial views"*). Seven respondents expressed concerns about the critical base of clinical psychology and viewed this as a deterrent (e.g. *"It's not pure research"* and *"X (university) require AAB at A-level for psychology BSc. Medicine requires ABB and leads to a superior position in the mental health field. Why take a softer option when you could do psychiatry, where the prescription advantage*

gives you an advantage if you decide to go private... "). For five respondents, financial concerns were a deterrent (e.g. "*having student loans. Worried about paying them off as soon as possible*" and "*mainly further financial hardship (I'm barely getting through my degree, despite working 24/7)*"). A further deterrent expressed by 4 respondents, was uncertainty regarding the different pathways into clinical training and competition for clinical places. Exemplars included: "*No prescribed path to get on course: people do 4 years assistant, others one year!! It's a lottery*" and "*mostly only first class students are approached by universities to think about doing PhD/Clinical training. If I had been asked to consider I probably would have done, but assumed 2:1 was not good enough*".

Two respondents each regarded the NHS as an employer a deterrent (e.g. "*the politics of the NHS*") and thought their student status/cultural origin was not conducive to this profession (e.g. "*Overseas student being exempted from selection for places ...*"). Fourteen other respondents expressed no interest in the profession and in some cases, specified reasons, e.g.: "*I don't want to spend my whole day listening to other people's problems. I think it gets to you after a while...*" and "*I would never consider the career as it is rather meaningless for me personally*".

Just 31 respondents provided additional comments regarding what they would find most appealing in the NHS as an employer, if they were to be successful in becoming a clinical psychologist. Twelve respondents declared having personal/intrinsic reasons. Exemplars included the following: "*Have done my sandwich year with the NHS and it gives me a sense of belonging*"; "*being a part of an organisation that has a fundamental*

role in ensuring the potential stability of society and its functioning" and *"being able to make a real difference to people's lives at a very direct and personal level"*. A further six respondents believed the NHS afforded them greater work experience/opportunities (e.g. *"opportunities to work in the community"; "good experience"* and *"to help implement changes to make a better more efficient NHS"*. Three respondents presented reasons related to financial/status issues (similar to those already mentioned), although seven respondents expressed a wish for changes to be implemented in the NHS to increase it's appeal (e.g. *"a more integrated profession. The segregation between the NHS and private organisation seem to be under the gap in respect. Working together to improve conditions would make career more appealing"* and *"I don't believe the NHS is a particularly competitive or progressive company to work for – not due to any lack of satisfaction but rather that pay and conditions are not competitive when compared to the benefits available to myself in non-government run companies. Given the duration of years that are necessary to become a clinical psychologist, the resultant 'package' is unappealing").*

Appendix 11b

Discussion and conclusions of qualitative results - Study 2

Discussion and conclusions of qualitative results – Study 2

The results of this study in relation to the qualitative findings (where the concerns of all the ethnic groups were analysed together), also suggests that there are a number of possible measures the profession could take to make clinical psychology a more attractive career choice for the different ethnic groups. First, there is a definite need for clinical psychology courses to improve the general accuracy and overall level of information that is disseminated to undergraduate psychology students about the profession and course training needs.

The findings from this study showed that students are often confused about the nature of the discipline, the career structure, what the practical implications of the work involved, support structures and lacked clarity about opportunities for and/or the type and extent of relevant experience required to pursue clinical training. There were also some misunderstandings about course entry requirements being a 'lottery' and the perception that the profession was seeking potential applicants with certain 'characteristics' (e.g. they being young, not working-class, uncritical of the profession/clinical base, and without a previous history of psychological problems). Given undergraduate concerns regarding the competitive nature of training, the profession may also need to give consideration to ways of increasing trainee numbers and the range of institutions offering courses in clinical training. The study results also indicate that financial concerns and the relatively low pay structure of assistants and trainees, were both a disadvantage and

deterrent in pursing clinical training. It may be therefore, that the profession may need to consider ways of improving the financial status and remuneration packages available to students, to make the possibility of pursing clinical psychology a more attractive and realistic career choice.

Finally, the finding that undergraduates placed a great deal of emphasis on intrinsic factors, status and the degree of variability offered for work within the NHS, provides training courses with a wealth of opportunity to appeal to the valued role potential applicants could make to society in becoming a clinical psychologist in the future.