# PROFESSIONAL SOCIALISATION IN CLINICAL PSYCHOLOGY TRAINEES.

**Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy**

**by Katherine Elizabeth Cheshire**

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## DECLARATION

**The research described herein is entirely my own, and the thesis has been composed by myself.**

Karine Eclaire 16.8.00

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## ABSTRACT

This qualitative study explores the professional socialisation of British clinical psychology trainees. Three cohorts of trainees (N=39), representing successive intakes of one doctoral training programme, were interviewed about their experience of this process. The study design incorporated longitudinal and cross-sectional elements and examined five consecutive chronological stages of professional socialisation: preparation for clinical training in psychology assistants' posts; first, second and third years of the doctoral programme; and the first eighteen months of post-qualification work. Data were primarily collected through semi-structured interviews with the trainees. Interview transcripts were analysed for themes using a theory-driven approach to code development (Boyatis, 1998). These themes were derived from earlier studies of professional socialisation, together with constructs drawn from literature on the sociology of the professions and symbolic interactionism.

The study was largely naturalistic, but an intervention into the training programme is also reported. The intervention consisted of a series of workshops conducted with study participants by the researcher, based on the study's findings. These workshops were designed to facilitate reflection on the process of professional socialisation to assist individuals to negotiate this status passage (Glaser & Strauss, 1971).

The study's findings support the symbolic interactionist view of the trainee professional as an "active, choice-making factor in his own socialisation" (Olesen & Whittaker, 1968). Interviews with psychology assistants revealed that considerable anticipatory professional socialisation occurs before individuals commence formal training. While individuals become well-versed in the rhetoric of the profession, the majority retain some scepticism about aspects of this discourse, such as the scientist-practitioner model. This scepticism was still evident at later stages in the socialisation process.

The transition to trainee status was experienced by many individuals as a period of anxiety and confusion. During clinical training, adequate opportunities to role play allow trainees to develop mastery in their clinical work, but role conflict and role ambiguity impede the development of their professional identity. Role conflict and role ambiguity are considered as outcomes reflecting both structural and situational/interactional factors (Bucher & Stelling, 1977). The transition from trainee to qualified practitioner was difficult for most individuals. Increased workload and responsibility, more complex cases, isolation, and inadequate supervision/support contributed to individuals' stress.

The study's findings are discussed in relation to current debates in clinical psychology concerning the profession's role within the "psy complex" (Ingleby, 1983) and, more specifically, within the NHS. In the light of these findings, recommendations to improve clinical training are offered.

## ACKNOWLEDGEMENTS

The original inspiration for this study came from reading an incisive analysis of my profession: Clinical Psychology Observed (Pilgrim & Treacher, 1992). Several months later, after more reading and much more thinking, I sent a research proposal to that book's first author, Professor David Pilgrim, for his comments on an idea that evolved into this PhD project. Professor Pilgrim not only provided helpful comments on the proposal, but offered to supervise the study, and this supervision has been invaluable throughout. I am extremely grateful for his unfailing enthusiasm, support and constructive criticism that provided me with sufficient focus and encouragement to complete this work.

I was also supported and encouraged at the outset of this enterprise by my Head of Department, Professor Frank McPherson. Over many years Professor McPherson has demonstrated that it is possible to combine clinical work in the NHS with research activity, and he has assisted myself and other colleagues to do the same. The initial push to register for a PhD came from him, and for that I owe him many thanks.

Once this study was under way, many other people helped to bring it to fruition. First and foremost I would like to thank the study participants for their interest and time. I thoroughly enjoyed doing the interviews that provided the data for this thesis, and I formed a new network of relationships in the process. I would also like to thank the clinical psychology trainees who were not interviewed, but took part in the workshops I piloted during my stint as a lecturer on the DClinPsychol course. Their contributions helped me to refine my ideas and their receptivity prompted me to keep developing the workshops.

Family, friends and colleagues kept me afloat when I was drowning in data and had lost sight of the shore. My thanks, in particular, go to Dr Gellisse Bagnall, a dear friend and fine researcher who was generous enough to read this thesis in its entirety and helped me to clarify my thinking in some important respects. My partner, Chris, helped me to create my attic study space that gave me mental space to do this work and, more importantly, endured 5 years of my increasing chaos and distractibility with amazing good humour. Finally, my thanks go to Rob, computer wizard and fellow night owl; Peg, for help with endless proof-reading; and Ellie for stress management.

# CHAPTER 1

# INTRODUCTION

## 1.1 Rationale for Undertaking the Present Study.

The initial impetus for doing this study came from my own experience of clinical psychology training, which I completed in 1993. When I first began to think about this project, I had been clinically qualified for two years and I was working in primary care within the NHS. This job, as well as my previous post in a multidisciplinary community mental health team, caused me to reflect on issues that had first demanded my attention when I was training. I reflected, for example, on the boundaries and overlap between my work and that of other mental health professionals; on the scientist-practitioner model that informed my training; on the relationship between theory and practice in clinical work; and on the relationship between my private and professional self.

The latter preoccupation is, I believe, defensible as more than narcissistic self-absorption. Cherniss (1980) observes that the personal identities of those he designates "human service workers" (such as social workers, psychologists, teachers, doctors and the clergy) merge with their professional identities to a greater extent than in other occupations. He suggests that this occurs because these workers have a greater emotional investment in the outcome of their work. Other writers have commented on this merging of identities with specific reference to psychotherapists. Kottler (1986) contends that the role of the psychotherapist involves the total personality of the individual and his/her worldview therefore becomes inextricable from the therapeutic work. Guy (1987), writing about psychotherapy training, notes that as trainees immerse themselves in the "psychological world", they are likely to analyse most, if not all, interactions using this newly found awareness. This interpretative stance is increasingly likely to enter their personal lives as their training proceeds, rather than remaining confined to therapy sessions.

While the literature provided many accounts of this fusing of personal and professional identities, I recalled no discussion of these issues during my training. Indeed, it will become evident in the course of this thesis that one of the central questions confronting clinical psychologists is how they define their professional identity and the extent to which they view themselves as therapists. The scientist-practitioner model informed our teaching: we were being trained to work as applied scientists and the personal impact of our work therefore received little attention from lecturers and supervisors. During my first year post-qualification, my sense of professional identity remained tenuous, my role was

frequently ambiguous, and at times my clinical practice felt uncomfortably a-theoretical. Discussions with contemporaries confirmed that these dilemmas were not peculiar to me, and I started to re-examine my assumptions about my role and my profession and to consider afresh the basis for these beliefs.

In the course of my reflections, I began to try and make sense of my experience, first as a clinical psychology trainee, and latterly as a qualified practitioner, by exploring the literature in two discrete areas. Initially, I sought a clearer understanding of the context that had produced the clinical training course I completed. I began to research the origins and evolution of clinical psychology in Britain, and then proceeded to investigate current debates within the profession. The source that focussed my enquiry and provided much of the inspiration for the present study was Clinical Psychology Observed (Pilgrim & Treacher, 1992). This book was written by two clinical psychologists (one of whom, DP, has supervised this study) and provides an historical and sociological analysis of the profession. From here, I branched out into both the North American and British literature on professional issues in clinical psychology, since psychologists on both sides of the Atlantic have grappled with the dilemmas that are central to this study.

As I became better acquainted with the current issues under debate within clinical psychology, and began to make connections between these and my own experiences, I turned to the literature on professional socialisation to provide a focus for my enquiry. Jacox defines professional socialisation as the

> ...process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into the person's own behaviour and self-conception. (Jacox,1973, p.6)

In Chapter 2, I will consider competing perspectives on the process of professional socialisation and their differing emphases on particular aspects of that experience. In this introductory chapter, Jacox' summary serves as an adequate operational definition of the process that I wished to investigate in this study.

The literature on professional socialisation contains numerous studies within the fields of medicine and nursing. Indeed, medicine has traditionally been viewed as the prototypical profession and thus came under scrutiny in some of the seminal early studies of professional socialisation, such as The Student-Physician (Merton, Reader & Kendall, 1957) and Boys in White (Becker, Greer, Hughes & Strauss, 1961). Other health professions are less widely represented, and there are no published studies of this process within the field of clinical psychology.

There are, in fact, few published studies that have attempted to investigate any aspect of British clinical psychology training from the point of view of the trainees themselves. The small numbers of studies that do exist have tended to focus on clinical supervision (McCrea & Milsom, 1996; Pratt, 1999; Sharrock & Hunt, 1986) or trainee stress (Cushway, 1992; Kuyken 1997). There are no published accounts of how trainees acquire a professional identity, and yet such an enquiry promises to raise interesting questions given the lack of consensus within the profession about how it defines itself.

Clinical psychology is a very young profession: it began to develop in Britain in the aftermath of the Second World War and has undergone huge transformations over the past fifty years. Having begun as a profession of clinical researchers and psychometricians, clinical psychologists adopted the model of the scientist-practitioner as their gold standard. This model remained central to the profession's self-definition when its members expanded their role to include treatment of the disorders they were assessing. Other changes followed (see Chapter 2). Within the past decade, its leadership has taken two significant steps in pursuit of occupational closure. Firstly, it has phased out two-year Masters programmes and replaced them with three-year practitioner Doctorates as the route to professional membership; secondly, it has introduced (voluntary) chartering of members (see Chapter 9). While the profession has been engaging in these exclusionary strategies (Witz, 1992), it has arguably become increasingly segmented (Bucher & Strauss, 1961) as psychologists take on more specialised roles. At the same time, psychologists continue to re-define their roles in relation to other mental health professionals who are fighting their own territorial battles. As this study will demonstrate, the "sense of occupational identity" that British clinical psychologists in the 1990's acquire through professional socialisation reflects continuing uncertainty about their proper role within the "psy complex" (Ingleby, 1983).

In summary, the present study provides formerly unavailable data on the professional socialisation of British clinical psychology trainees. As noted above, the aims of the study evolved out of my experiences, and those of my peers, concerning the process of clinical training and the transition to qualified practitioner. A review of the literature revealed that the concept of professional socialisation provides an appropriate theoretical basis for the enquiry that would enable me to make links between respondents' experiences and debates/dilemmas of concern to the profession as a whole. In the following section, I will provide a brief overview of both the study design and the organisation of this thesis.

## 1.2 Overview of the Study and Organisation of the Following Chapters.

This largely naturalistic study derives most of its findings from semi-structured interviews with clinical psychology trainees recruited from a Scottish training course between 1995 and 1997. Professional socialisation is not, of course, synonymous with professional training: it continues throughout one's professional life. However, most of the studies in this field of enquiry have focussed on the experiences of trainees because this is generally the period when individuals experience the greatest attitude and behaviour change. It is at this stage that recruits begin to develop professional personae and start to internalise the profession's norms and values. I therefore planned to follow the lead of other researchers and investigate trainees' experiences during the three-year clinical doctorate programme. However, I decided to enlarge this snapshot of the bigger picture by examining individuals' attitudes towards their future profession before they begin the doctorate, for reasons that will become clear in the next chapter. In addition, I decided to investigate the experiences of newly qualified clinical psychologists, given that the dilemmas I experienced during this stage of professional socialisation had initially prompted me to undertake the study.

In Chapter 2, I introduce the theoretical framework of this research. I begin by considering the meaning of "profession" and proceed to examine contrasting definitions of "professional socialisation". Since previous studies of professional socialisation have generally adopted a functionalist or symbolic interactionist approach, I have limited my discussion of competing perspectives to these two schools of thought. More recent studies of professional socialisation have favoured the framework of symbolic interactionism, and my study falls within this tradition. After a brief analysis of relevant research in this field, I proceed to discuss a symbolic interactionist model of professional socialisation developed by Bucher & Stelling (1977) that provides the theoretical basis for this investigation.

Chapter 2 introduces the concept of "anticipatory socialisation" – the socialisation that occurs before formal training commences. As I demonstrate through the study's findings, the structure of clinical psychology training means that a considerable degree of anticipatory socialisation occurs, and this shapes trainees' responses to the doctoral programme. In this chapter I also introduce relevant concepts from role theory (role ambiguity and role conflict) that elucidate respondents' accounts of their experiences. I propose, following Cherniss (1980) and others, that the work of clinical psychologists makes them particularly vulnerable to these forms of role stress and strain.

In the penultimate section of Chapter 2, I establish the context for the study by relating the above concepts to clinical psychology in Britain in the 1990's. I describe how organisation of training for clinical psychologists facilitates anticipatory socialisation of trainees: most of them work as assistants

in clinical psychology departments to gain work experience before they apply to training courses. I then trace the evolution of the clinical psychologist's role in Britain and suggest that the scientist-practitioner model has generated role conflict and role ambiguity for practitioners. I conclude section 2.6 by considering the indeterminacy of professional knowledge and proposing that this makes a further contribution to role strain in clinical psychologists.

In the final section of Chapter 2, I state the initial research questions that shaped my investigation. Since this study was exploratory, and incorporated a longitudinal element in the design, I expected that these initial questions would be progressively refined by the responses of the research participants.

Chapter 3 provides the theoretical basis for the study's qualitative method. I contend that both technical and epistemological concerns make a qualitative approach the most appropriate choice for this investigation (Bryman, 1988). Most of the data reported here derive from semi-structured interviews: these findings are interpreted and evaluated with reference to papers and documents written by clinical psychologists about their own profession. In section 3.1, I consider the status of interview data from an interactionist perspective (Miller & Glassner, 1997).

Section 3.2 provides the rationale for the selection of the research site and choice of the study participants. Here, I also discuss the ethical issues that were considered in relation to these choices and describe how ethical approval was obtained for the project.

The rest of Chapter 3 presents the study's design and procedures. The initial research design is described, followed by a report of amendments made to the design when my job changed in the course of the data collection and altered my relationship to the study participants.

Chapters 4, 5, 6, 7 and 8 contain the research findings. Chapter 4 reports the characteristics of the study participants, including their reasons for choosing clinical psychology as a career and selecting a particular training course. The remainder of the chapter analyses the organisation of the training course and the relationships between the institutions that support it. This contextual analysis identifies the structural factors in Bucher & Stelling's (1977) model of professional socialisation that shape respondents' experience of training.

Chapter 5 is the first of four chapters reporting interview data obtained from individuals (1) about to commence clinical training; (2) undergoing clinical training; and (3) adjusting to work as recently qualified clinicians. Chapter 5 is concerned with the first group and explores their experience of anticipatory socialisation. In particular, it considers the role negotiation that has been required of

these individuals during their time as psychology assistants. The chapter also reports how respondents' viewed their future profession at that stage in their socialisation, and describes their expectations of clinical training.

Chapter 6 examines the transition from psychology assistant to clinical psychology trainee. It introduces the theory of "status passages" (Glaser & Strauss, 1971) to elucidate respondents' experiences during this transition and considers how individuals define their role as they begin the course. Chapter 6 also explores respondents' personal responses to the change of role and increased responsibility for the welfare of patients.

Chapter 7 covers the period of formal training as respondents pass through the three-year doctoral programme. It describes how trainees shape this passage and develop a sense of mastery concerning their professional skills. The chapter also examines the structural factors that shape trainees' experiences. It identifies role conflict arising from trainees' joint status as postgraduate students and NHS employees, and role ambiguity deriving from the system of feedback operating within the course. This chapter returns to the examination of individuals' personal responses to clinical training and describes a series of workshops for trainees that I devised and piloted as part of this research project to address some of the needs revealed in the research findings.

Chapter 8 reports the exit interviews conducted with third year trainees shortly before they completed the doctoral programme, and the follow-up interviews conducted with the same cohort 12-18 months later. The chapter contains trainees' reflections on the course and their views of the profession they are about to join. It then examines the transition to qualified status, which most respondents found difficult and disorientating, together with the factors that facilitated this transition. Finally, Chapter 8 explores the new graduates' views of their profession and their role within it.

Chapter 9 presents the conclusions I have drawn from these findings and discusses their implications. Here, I consider how the concepts contained within the initial research questions, together with the theory of status passages, elucidate clinical psychology trainees' experience of professional socialisation. This discussion leads to examination of wider issues and I will argue that many of the difficulties reported by study respondents reflect uncertainties and contradictions within the profession itself. In particular, I will contend that the scientist-practitioner model does not adequately represent the work of clinical psychologists, and while the role of reflective practitioner (Schon, 1983) has begun to receive support within the profession, it does not yet inform training or practice to a sufficient extent. The final chapter of this thesis concludes with recommendations on the basis of the study's findings that are designed to improve clinical training and ease trainees' transition to qualified practitioners.

In this introduction, I have provided the rationale for undertaking this research into the professional socialisation of British clinical psychologists. I have also given a brief overview of the study and the organisation of the following chapters. I will now proceed to a detailed account of this investigation and its findings, starting with the theoretical framework of the study presented in Chapter 2.

# CHAPTER 2

# THEORETICAL FRAMEWORK OF THE PRESENT STUDY

In the following two chapters I aim to provide a coherent theoretical context for this study. Chapter 3 will present and evaluate the theoretical constructs underpinning the methodology of the study. First, however, I wish to locate my study within the literature on professional socialisation and that is the purpose of this chapter.

This chapter has five specific aims:

i. to present those sociological frameworks which have been applied to both the professions and the process of professional socialisation, and have been most influential in shaping studies in this field
ii. to review relevant studies on professional socialisation and identify both constructs and findings that appear likely to assist an exploration of professional socialisation in clinical psychology trainees
iii. to summarise current tensions surrounding role definition within the profession of clinical psychology, and provide an account of their origins
iv. to integrate the theory presented in (ii) with the context described in (iii) in a manner which elucidates the salience for this study of particular constructs derived from the literature on professional socialisation
v. to provide a statement of the initial aims of the study.

## 2.1 Professional Socialisation: An Introduction.

Olesen & Whittaker (1970) observe that three fields of sociological enquiry overlap in the study of professional socialisation: the study of occupations; the investigation of individual change; and the examination of social institutions. They comment that:

> ... the study of occupations brings the student of professional socialization to questions of social change which shifts occupations and their incumbents vertically or horizontally in the society, splintering, eliminating, corroding or enhancing old occupations, whilst evolving new ones. (Olesen & Whittaker, 1970, p.183)

Within the study of occupations, one branch of enquiry has tried to identify those characteristics that differentiate the professions from other occupational groups. Pilgrim & Rogers (1999) observe that early sociological analyses of the professions were based on a relatively uncritical acceptance of the way the professions chose to portray themselves. These accounts emphasised the special skills and altruism of professionals. Later analysts have adopted a more critical stance towards the professions. Some writers have drawn attention to the self-serving manoeuvrings of professionals and have noted that these sometimes occur at the expense of the society that they are presumed to serve (Gould, 1981). Illich (1977) is one of the more out-spoken critics, describing medicine (generally considered the prototype of the professions) as a threat to health. Despite the continuing academic debate, Pilgrim & Rogers conclude that "professional" still holds meaning for the general public, who assume that it implies competency, efficiency, altruism and ethical propriety.

Enquiries into the nature and business of the professions spawned interest in the process of professional socialisation. The early ground-breaking studies in professional socialisation were undertaken in the United States in the 1950's and 1960's. These investigations were framed within one of two sociological paradigms: functionalism and symbolic interactionism (Atkinson, 1983). In the following section I will first summarise these two approaches in relation to the professions themselves, and then proceed to discuss the implications of these paradigms for studies of professional socialisation. I will illustrate the latter through discussion of the relevant research.

## 2.2 What is a Profession? Functionalist and Symbolic Interactionist Approaches.

### 2.2 i. Functionalist Analyses of the Professions.

Writers in the functionalist tradition, which has its origins in the work of Emile Durkheim, view the professions as a cohesive element within society. Durkheim's belief that the division of labour provided the moral foundation for society led him to value the professions as stabilising elements and upholders of tradition that would protect society from moral breakdown. From the functionalist perspective, a profession is conceptualised as:

> .... a relatively homogeneous community whose members share identity. values, definitions of role, and interests. There is room in this conception for some variation, some differentiation, some out-of-line members, even some conflict; but, by and large, there is a steadfast core which defines the profession, deviations from which are but temporary dislocations. (Bucher & Strauss, 1961, p.325)

Pilgrim & Rogers (1999) note that a "neo-Durkheimian" approach is rare in contemporary sociological analyses of the professions, but is detectable when professionals attempt to give a "public relations" view of their work. An example of such a view pertaining to clinical psychology is found in a recent account of the profession by two of its senior members (italics in the original):

> In summary, clinical psychologists are *psychologist-practitioners* applying *scientific knowledge and principles* in a *professional role* to the *alleviation of human suffering* and the *improvement of the quality of life.* (Marzillier & Hall, 1999, p.9)

This statement, with its emphasis on the amelioration of suffering and implicit suggestion of the practitioners' altruism, is very much in the spirit of functionalism.

Some of the theorists within this school attempted to identify the traits or criteria that defined the professions. The criterion approach was essentially inductive: the criteria did not derive from an ideal prototype, but were determined by examination of occupations generally recognised as professions, such as medicine, the law, and the church. This approach has failed to achieve consensus regarding which criteria to emphasise (Millerson, 1964) and, in some instances, produced results that were strongly influenced by aspirational rhetoric from the professions themselves.[1] For example, one attempt to list these criteria reads as follows:

(a) a unique, definite and essential social service;
(b) an emphasis on intellectual techniques in performing this service;
(c) a long period of specialized training;
(d) a broad range of autonomy for both the individual practitioner and for the occupational group as a whole;
(e) an acceptance by the practitioner of broad, personal responsibilities for judgements made and acts performed within the scope of professional autonomy;
(f) an emphasis upon the services rendered rather than the economic gain to practitioners;
(g) a comprehensive, self-governing organization of practitioners.

(Lieberman, 1956, pp.2-5, quoted in Hoyle & John, 1995, pp.4-5)

Other writers have argued that professions are more usefully understood as located along a

[1] Hoyle & John (1995) and Macdonald (1995) point out that not all writers who adopted the "trait" approach assumed a functionalist perspective, though most of them did.

continuum, rather than being included or excluded according to whether or not they meet established criteria. This view has produced distinctions such as Carr-Saunders' (1955) "professions", "new professions", "near professions" and "would-be professions", and Etzioni's (1969) "semi-professions". Etzioni argues that semi-professions can be distinguished from fully-fledged professions by their high proportion of female members. He also claims that members of semi-professions are typically employed in large bureaucracies; require shorter training time than those in fully-fledged professions; have a less legitimated status; possess less specialist knowledge and enjoy fewer established rights to privileged communication. Etzioni cites school teaching, social work and nursing as examples of semi-professions.

While the functionalist view of the professions was hugely influential in the middle years of this century, it did not go unchallenged. One of the major challenges came from another intellectual camp: the school of symbolic interactionism.

### 2.2 ii. Symbolic Interactionism and the Professions.

Followers of Everett Hughes and the Chicago school of symbolic interactionists reject the functionalist view of the professions. While the functionalists approached the professions as a special category of occupations, the interactionists do not accord them special status. The interactionists interpret "profession" as a symbolic title used by some occupational groups in the absence of distinctive features of work, training or values to warrant differentiation from other groups. Indeed, they argue that individuals may attempt to create a self-fulfilling prophecy by labelling themselves as professionals, since this designation is associated with high status.

The symbolic interactionists also criticise the functionalist emphasis on the cohesiveness of the professions, arguing that heterogeneity and conflict are normal features of occupational groups. Bucher & Strauss maintain that professions are composed of groupings representing different interests, values and identities. They label these groupings "segments" and propose that professions are "...loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular period in history" (Bucher & Strauss, 1961, p.326). Segment members establish their presence through their "sense of mission" as they try to establish their own legitimate area of expertise. Divisions between segments may cut across professional groupings, creating specialities (Bucher, 1970).

Macdonald (1995) notes that the symbolic interactionist tradition challenged the functionalist view of professionals as altruistic public servants. In one of the classic interactionist studies of professional socialisation (Boys in White, Becker *et al.*1961), trainee doctors were depicted developing cynicism about their profession instead of altruism. Macdonald also points out that the "power approach" to the professions, as exemplified by writers such as Freidson in The Profession of Medicine (1970a) developed from the interactionist tradition. Thus, Freidson. who typically employs the terms "organized autonomy" or "dominance", rather than "power", has written about how doctors exercise power as individuals within the health care system, and how the medical profession has both attained and maintained its autonomy (Freidson, 1970a,1970b,1993).

As noted above, the competing paradigms of functionalism and symbolic interactionism produced the classic early studies of professional socialisation. Selected examples of these studies provide the starting point for the review of existing research in Section 2.4 onwards. Before proceeding to a discussion of these studies, however, I will first expand on the concept of professional socialisation introduced in Chapter 1.

## 2.3 Professional Socialisation: A Definition.

Brim defines *socialisation* as "the process by which persons acquire the knowledge, skills and dispositions that make them more or less able members of their society" (Brim, 1968, p.227). He identifies the purpose and function of *childhood socialisation* as the development of the personality and a sense of identity. Olmsted & Paget (1969) suggest that childhood socialisation focuses on what individuals "should" do or think. They note that the child typically occupies the role of learner, and the socialising agents enjoy varying degrees of power and authority in relation to the child. In contrast, *adult socialisation* generally targets behaviours rather than values, does not require the individual to assume a learner role, and does not rely on a power differential. Role acquisition is the most important aspect of adult socialisation (Brim, 1968).

As noted in the previous chapter, Jacox (1973) defines *professional socialisation* as the

> ...process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into the person's own behavior and self-conception. (Jacox, 1973, p.6)

Olmsted & Paget (1969) argue that professional socialisation combines elements of both child and adult socialisation. They argue that medical school conforms to the model of childhood socialisation: students are provided with a list of "shoulds" by figures in authority. The attitudes, values and norms learned at this stage are therefore "role general", relating to the abstract role of doctor, rather than "role specific". Kramer (1974) draws the same conclusion regarding nursing students. Olmsted & Paget suggest that role specific behaviours, characteristic of adult socialisation, are then learned by new graduates once they enter internships and residency programs. At that stage, the main socialising agents are the patients and the role transformation occurs under pressure as trainees struggle to cope with new responsibilities. In the 1960's, Rue Bucher and colleagues explored the difficulties experienced by psychiatric and internal medicine trainees during this transition. I will return to their work in 2.4 i. below. Although these writers describe experiences of professional training that occurred nearly thirty years ago, their observations remain relevant to the experience of clinical psychology trainees in the 1990's, as the present study will demonstrate.

In the following sections I will expand on the concept of professional socialisation by contrasting the way it has been interpreted by the functionalists and the symbolic interactionists. My account of the former will be brief since it is included merely to demonstrate what the interactionists were reacting against; it is their approach that informs the present study.[2]

### 2.3 i. The Functionalist View of Professional Socialisation.

From the functionalist perspective, the socialisation of trainee professionals maintains the requisite harmony between individual agency and the requirements of an adequately functioning society. Socialisation, it is argued, inducts the neophyte into the norms and codes that regulate the professional's behaviour. Once these core values are internalised, "a homology is assured between the system's norms and values and the subjective meanings of social actors" (Atkinson, 1983).

[2] In both the following sections I will provide examples of studies of professional socialisation within the health professions only. This selectivity is intended to assist a focussed and concise discussion of the relevant issues but is not intended to imply that similar studies of other professions are less important.

In The Student-Physician, Robert Merton and his colleagues presented their seminal study of the socialisation of medical students at Columbia University. They articulated their expectations of medical schools as follows:

> It is their function to transmit the culture of medicine and to advance that culture. It is their task to shape the novice into the effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act and feel like a physician. It is their problem to enable the medical man to live up to the expectations of the professional role long after he has left the sustaining value-environment provided by the medical school. (Merton, Reader & Kendall, 1957, p.7)

This view encapsulates the functionalist position on professional socialisation. The Student Physician describes the trainee doctors enjoying the status of junior colleagues while senior staff nurture their emerging professional identities. Merton's team acknowledges the existence of a student culture but interprets its function as enforcing the norms shared by trainers and trainees.

### 2.3 ii. The Symbolic Interactionist View of Professional Socialisation.

The fundamental tenets of symbolic interactionism are summarised by Blumer as follows:

> ...human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Their "response" is not made directly to the actions of one another, but instead is based on the meaning which they attach to such actions. Thus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions. (Blumer, 1962, p.145)

Blumer proceeds to assert that the symbolic interactionist perspective requires its students to "catch the process of interpretation through which [acting units] construct their actions"; in order to do this, "the process has to be seen from the standpoint of the acting unit" (Blumer, 1962, p.151). Thus, the symbolic interactionists' studies of professional socialisation privilege the trainees' point of view and attempt to show how these individuals are interpreting their milieu.

Writers in this tradition particularly object to the functionalists' portrayals of trainee professionals as passive recipients of knowledge imparted to them by their mentors. Olesen & Whittaker caricature the functionalist perspective in the following excerpt:

> Once the educational system has formally started work on the student, his empty head is filled with values, behavior and viewpoints of the profession, the knowledge being perfect and complete by the time of graduation...The result: "the true professional", "the finished product", "the outcome of the system". (Olesen & Whittaker,1968, p.5)

Consistent with their emphasis on the tensions and shifting allegiances that characterise professions, the symbolic interactionists focus on the survival strategies of members and pay less attention than the functionalists to the objectives of training identified in the official documentation of training institutions. Boys in White (Becker *et al.* 1961), another North American study of medical students, exemplifies the symbolic interactionist approach. In this study, the medical students occupy a clearly subordinate position in relation to staff and their student identity, rather than their identity as embryonic doctors, is primary. The students' collective response to the demands of training is interpreted as a student culture, described by Atkinson (1983) as "a sort of underground resistance movement." This perspective contrasts with the view of Merton's group, who describe a comradely rather than adversarial relationship between staff and students.

A number of other investigators (for example: Atkinson, 1977; Bloom, 1973; Bucher *et al.* 1969a and 1969b; Miller, 1970; Preiss, 1968; Shuval, 1975) have taken an interactionist approach in their studies of medical students and junior doctors. Professional socialisation among other health care workers has received similar treatment. For example, Kramer (1974), Melia (1981, 1987) and Olesen & Whittaker (1968) have investigated this process in nursing students, while Dingwall (1977) has examined the training of health visitors.

Olesen & Whittaker (1968) describe the art of "studentmanship", the students' strategies to ensure survival and success, in a manner reminiscent of the description of student culture in Boys in White. This approach to professional socialisation portrays it as an experience distinguished by conflict and personal dilemmas. Its emphasis on the differences in individual responses to the system provides a rationale for differentiation within the professions (Wrong, 1961). Olesen & Whittaker combine symbolic interactionism with a phenomenological approach and concentrate on the student nurses' experience of "becoming". Rejecting the image of students as empty vessels waiting to be filled with knowledge sanctioned by the profession, they set out to develop a "model of the student as an active, choice-making factor in his own socialization" (Olesen & Whittaker, 1968, p.300). They also identify a tension between the parallel roles of the trainee professional working with patients, and that of the nursing student within the classroom. They observe that the student role and student culture supports the "old self" which existed prior to the onset of professional socialisation and also forms the basis of both intra-group solidarity and competitiveness. In a subsequent commentary, Olesen & Whittaker (1970) argue that it is more helpful to approach professional socialisation as a form of *acculturation,* rather than adopting the model of *enculturation* implicit in the functionalist

approach. The authors note that the concept of acculturation assumes contact and exchange between groups, while enculturation emphasises the unidirectional transmission of norms and values from the parent/teacher to the child/student.

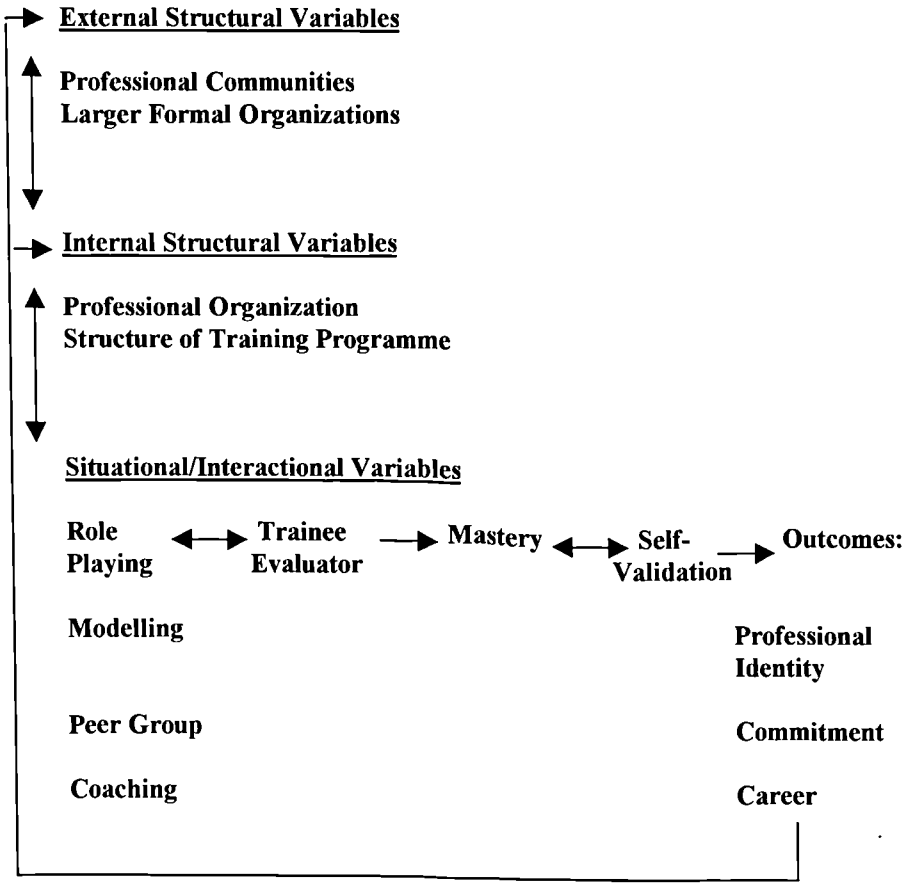
Atkinson (1983) notes that the interactionist approach has its own pitfalls, and comments on the tendency of writers in this school to ignore extra-institutional influences on students. He exempts Olesen & Whittaker (1968) from this criticism, since they explicitly examine the nexus of student experience and other roles. Atkinson also comments on the widespread failure of researchers to acknowledge the effect of professional segmentation on trainees. This widespread failure has, he argues, contributed to a misleading representation of professions as socialising agencies that are internally homogeneous and analogous to Goffman's (1968) "total institutions". In his doctoral study, Atkinson examined the implications of segmentation for medical students attempting to negotiate their passage through training. As a consequence of elaborating his view of the training institution, Atkinson found it necessary to elaborate his view of "studentmanship', which becomes "a 'shadow structure' of the medical school as institution, congruent with the lines of cleavage and segmentation within it" (Atkinson, 1976, p.215).

In the following section, I will proceed from a general discussion of the interactionist approach to professional socialisation to consider a theoretical model of this process developed by one of the research teams mentioned above.

### 2.3 iii. A Symbolic Interactionist Model of Professional Socialisation.

In a study with considerable relevance to the present investigation, Bucher and colleagues (Bucher *et al.* 1969a, 1969b; Bucher & Stelling, 1977) followed four groups of postgraduates through professional training programmes in the United States: PhD students in biochemistry; residents in internal medicine; and two groups of psychiatric residents. Bucher's team developed the following model of professional socialisation, which incorporates the concept of segmentation, to represent their findings. The model provides a means of conceptualising the interactive relationship between trainee professionals and the many factors involved in the socialisation process that is congruent with the symbolic interactionist perspective. Bucher & Stelling (1977) argue that these factors can usefully be separated into two categories: those that are situational and those that are structural. They represent the relationship between these factors or variables in the following way:

**Figure 2.1: A Symbolic Interactionist Model of Professional Socialisation.**
(from Bucher & Stelling, 1977, p.276)




The model identifies one set of external structural variables as the professional communities outwith the formal organisation in which the training programme is located. Some members of these communities will also play a role within the training organisation, so there will be a transactional relationship between the two. The second external variable consists of the network of formal organisations in which the training programme is embedded. Bucher & Stelling observe that both the host institution and the larger network exercise some control on the professional autonomy of the trainers.

The internal structural variables identified in the model are professional organisation and the structure of the training programme. The former refers to the number, type, roles and

interrelationships of the professionals in the training organisation, and whether or not more than one segment of the profession is represented. The model postulates that the structure of a training programme will be a function of the professional organisation, since staff members will select trainees for compatibility with their programme and the programme's goals will reflect staff ideology.

Bucher & Stelling further hypothesise that the internal structural variables will influence the situational or interactional variables within the training programme. Both the professional organisation and the structure of the training programme will influence the activities and roles of the trainees, the models they encounter, the characteristics of their peer group and the coaching they receive. Furthermore, trainees' experiences in these domains will influence outcome in terms of professional identity, commitment and career choices.

So far, I have discussed the model as a "top-down", unidirectional account of professional socialisation. However, the bi-directional arrows signal the reciprocal relationship between trainees and trainers that is characteristic of the symbolic interactionist perspective. Thus, the trainee as evaluator is represented exercising influence over the situational variables – choosing, for example, how to respond to role models and coaching. The autonomy of the trainee is also suggested by the inclusion of "self-validation" within the process and this, in turn, is proposed to influence the development of mastery during professional training. As trainees progress through their training, they acquire varying degrees of mastery, and this encourages an increasingly selective approach to training experiences, as well as trainees' growing reliance on their own professional judgement. Finally, the feedback loop from the outcomes of "professional identity, commitment and career" to both levels of structural variables represents the influence that individuals (first as trainees and later as full professionals) exert on the course structure and the institutions that contribute to it. Thus, the model proposes a reciprocal relationship between the micro and macro levels of explanation. The authors conclude that their model describes the experience of novices who actively construct their own professional identities, but are shaped in the process by both structural and situational variables.

This model usefully summarises the interrelationship between the many factors that determine an individual's trajectory through professional training. In the chapters ahead I will return to discuss the model in greater depth in relation to my own study.

2.3 iv. Status Passages in Professional Socialisation.

Glaser & Strauss (1971) made a significant contribution to the literature on professional socialisation with their formal theory of status passages. In the preface to their book, Glaser & Strauss express the hope that social scientists researching issues such as socialisation might find their theory useful. Bucher & Stelling (readers of their original manuscript) soon demonstrated that it was. Anselm Strauss became a consultant for these researchers while they conducted the study of trainee biochemists, psychiatrists and medical residents referred to above.

At the beginning of their exegesis, Glaser & Strauss explain that they have chosen not to define status passages, preferring to let the elaborated meaning of the concept emerge from the analyses and research examples in the text. They argue that an understanding of status passages is essential to our understanding of social structures because:

> Insofar as every social structure requires manpower, men are recruited by agents to move along through social positions or statuses. Status is a resting place for individuals. But while the status itself may persist for many years, no matter how long an individual remains in, say, an office, there is an implicit or even explicit date when he must leave it. (Glaser & Strauss, 1971, pp.2-3)

Addressing the theory's implications for the individual, the authors note that status passages within occupations may entail a change in the individual's degree of influence or privilege, a change in his/her behaviour, and an altered sense of self. They proceed to list the characteristics (or properties, to use their term) that distinguish status passages (occupational and otherwise) from each other, before selecting a sample of these for more detailed discussion.

Bucher & Stelling (1977) employed the concept of the status passage to understand the experiences of their trainees, using an operational definition of status passages as transitional points in trainees' passage through the system.[3] The investigators set out to determine whether these transitional points were clearly marked for trainees, and whether or not they provided feedback for trainees about the stage they had reached in their development. As I shall show in the analysis of my own results, this concept can fruitfully be applied in the present study, and comparison of my findings with those of Bucher & Stelling is also illuminating.

[3] Glaser & Strauss (1971) remind us that status passages are composed of a succession of these transitional points, which may or may not be clearly delineated.

## 2.4 Anticipatory Socialisation.

The preceding discussion implicitly equates professional socialisation with the period of formal training which individuals undertake prior to qualification as full members of their professional body. However, from the earliest studies of professional socialisation onwards, researchers have acknowledged that this process generally begins before formal training commences. Merton calls this preparatory phase "anticipatory socialisation" and envisages it occurring in fantasy as students anticipate their training. Bucher *et al.* (1969b) distinguish Merton's notion of imaginal experience from students' actual experience of acquiring values, attitudes and expectations relating to their future profession before they commence formal training. They label this phenomenon "prior socialisation". Other writers (for example, Kramer, 1974; Olesen & Whittaker, 1968; Wheeler, 1966) use "anticipatory socialisation" in a manner analogous to Bucher's "prior socialisation". Since this is the more common usage, the term "anticipatory socialisation" will be used throughout the remainder of the text, with the understanding that it refers to both actual and imaginal experience and, in the present study, will generally be referring to the former.

The degree of anticipatory socialisation that occurs is influenced by a number of factors, including the age of trainees when they enter their professional programs, and the structure of those programs. Neophyte health care professionals entering training straight from school may have little or no prior experience of hospitals, clinical tasks or other caring roles. Mature entrants may be more likely to have worked as unqualified staff gaining relevant experience before commencing their formal training. Trainees in post-graduate programs (such as GP or psychiatry trainees; post-qualification nurses completing specialist courses; and solicitors studying for the Bar) possess considerable knowledge in their field, yet simultaneously occupy novice roles as they pursue these specialist skills.

Olesen & Whittaker (1968) comment on the differing degrees of anticipatory socialisation evident in trainee professionals. At one end of the spectrum they locate the "over-socialized" students or "premature prima donnas", while at the other end they identify the dependent students who provoked one divinity school lecturer to exclaim: "I get so sick and tired of these first year seminarians showing up, umbilical cord in hand, looking for some place to plug it in" (Novak, 1966, quoted by Olesen & Whittaker, 1968, p.94).

A number of writers have considered how initial naivete influences trainees' responses to their training programmes. Olesen & Whittaker describe the "initial bravado" of a new intake of nurses "...the majority of...[whom]...had already cloaked themselves in the role of nurse without regard to

some of the difficulties of presenting the self to the patient in the role of nurse". They were surprised to find, for example, that only a quarter of the sample considered that "attending to intimate physical needs" or "feeling so much sympathy for patients that it interferes with your own life" might cause them difficulty (Olesen & Whittaker, 1968, p.107). Davis (1975) likens the professional socialisation of nurses to doctrinal conversion, and suggests that the students start in a state of "initial innocence". During this stage they are primarily influenced by lay imagery of nursing consisting of "a strong instrumental emphasis on *doing* alongside a secularised Christian-humanitarian ethic of care, kindness and love for those who suffer" (Davis, 1975, p.122). Davis proceeds to demonstrate how this lay imagery is replaced by "institutionally approved" imagery in the course of the nurses' training.

Olesen & Whittaker (1968) found that relatives in the nursing profession were a significant source of anticipatory socialisation for the students they studied. In their sample, 45% of respondents had a relative in the profession, and half of that group said that this had influenced their choice of career. Individuals with relatives in nursing began training with a more negative view of the profession than the rest: these relatives had challenged the students' idealised visions of nursing with stories about its less attractive aspects.

Glaser & Strauss (1971) note that anticipatory socialisation may be encouraged and facilitated by "control agents" who anticipate that trainees will return to their organisation after further training. They also observe that in other situations, anticipatory socialisation may not be encouraged or even recognised by agents in charge of professional training. Describing an aspect of what Olesen & Whittaker call "studentmanship". Glaser & Strauss comment:

> In all training passages it behooves passagees not to act as if they know too much at the beginning. Agents, when they are training people, usually do not wish to de-indoctrinate simultaneously, unless in fact they are set up specifically to convert their trainees, as in religious sects. (Glaser & Strauss, 1971, p.85)

Wheeler (1966) suggests that anticipatory socialisation may be so effective in some cases that recruits will show no change in opinions or attitudes after they enter the "socialising organisation". He predicts that anticipatory socialisation will best prepare individuals to enter an organisation when the socialising agents are from the recruit's peer group, rather than officials presenting an idealised picture of the organisation.

## 2.4 i. "Becoming Professional": the Work of Rue Bucher and Colleagues.

In their longitudinal study of four post-graduate programmes in the United States (see 2.3.iii. above), Bucher and colleagues (Bucher *et al.* 1969a and 1969b; Bucher & Stelling, 1977) examined differences in anticipatory socialisation between the cohorts. Trainees entering these programs were first interviewed soon after they commenced their courses. The investigators found that the cohorts differed in terms of the richness of the imagery they used to describe their field; the specificity and naivete of their expectations; the amount of overlap between the expectations and imagery of individuals in the same cohort; and the ease with which they could imagine themselves fulfilling future professional roles.

These indices of anticipatory socialisation distinguished the internal medicine residents from the other three cohorts. The medical residents used clearer and more elaborate imagery when describing their field; they demonstrated greater convergence of priorities and expectations regarding their program; and they were most decided about future career plans. The psychiatric residents converged on only one theme (the importance of supervision) while their imagery was less elaborate and their career plans were more speculative. The biochemists converged on several idealistic themes (for example, that they would carry out their research relying largely on their own initiative; that their work would be exciting; and that it would enable them to help people), but there was no agreement on their experience of training. Of all the cohorts they were the vaguest about career goals and had expectations that the researchers characterised as naïve.

The authors interpreted these results in terms of the relationship between the trainees and their training systems. They note that the medical residents were not entering a new system but merely changing their positions within it: all but one of them had been a student previously at the university where they were now doing postgraduate work. Bucher and colleagues concluded that these trainees had probably developed a shared set of expectations regarding their residency. They also concluded that the medical trainees had prior experience of patient care, and had observed other residents and senior staff at work. All these factors shaped their expectations of both their role and the clinical work itself.

In contrast, both the psychiatry trainees and the biochemists were entering their training systems for the first time. Most of them had completed their undergraduate studies elsewhere and joined their current institution for the first time when they began their postgraduate programme. There was also greater discontinuity of subject matter between undergraduate theoretical work and the application of theory at postgraduate level for these students than for the medical trainees. The biochemists had

had very little opportunity to observe senior colleagues at work. While some of the psychiatry trainees may have had limited experience treating psychiatric patients as undergraduates, they would have had less opportunity than the medical residents to observe senior staff working clinically. The researchers suggest that this explains the psychiatrists' collective emphasis on supervision. One of them described his dilemma as follows:

> There is no textbook that ...gives you many answers for specific sets of problems, so you have to learn to...withstand the anxiety; you have to be able to do nothing, which is hard; and I think that...would set [the] psychiatrist off from the rest of medical personnel, and also irritate other medical personnel...I spent an internship [learning] how to handle medical emergencies, and when I got out...I was quite good at it...I could handle most things thrown at me, because I knew the rules; there aren't any here and I think that's the difference...You have to spend yourself, and that's a difficult thing to do. (Bucher *et al.* 1969b, p.220)

Other psychiatry residents dealt with their disorientation by emphasising the links between psychiatry and other fields of medicine. One trainee remarked, for example: "...eventually we will discover the links between neurology and psychiatry" (Bucher *et al.* 1969b, p.221).

Bucher and colleagues conclude that anticipatory socialisation has implications for both the trainees and the systems they enter. They observe that anticipatory socialisation influences the type of peer culture that develops among trainees, the amount of "trouble" they experience, the degree of disruption they introduce into the system, and the number of failures and defections among them. The researchers emphasise that a "trouble-free" system is not necessarily desirable and may not deliver effective training. However, they suggest that undergraduate programmes can be modified to facilitate an optimal degree of anticipatory socialisation that will assist the transition to postgraduate training. For example, they recommend that medical undergraduates receive greater exposure to clinical situations (Bucher *et al.* 1969b).

### 2.4 ii. Anticipatory Socialisation During Formal Training as Preparation for Post-Qualification Work.

Other writers have extended the concept of anticipatory socialisation to include what occurs during professional training to prepare trainees for the transition to qualified practitioners. Melia (1987) found that the student nurses she interviewed were so preoccupied with the demands of being successful students that they gave little thought to the very different demands that would confront

them after they qualified. She argues that adequate anticipatory socialisation in this context would depend on student nurses spending longer in clinical placements and assuming more clinical responsibility so that their work better resembles that of staff nurses.

Kramer (1974) investigated the prophylactic effect of an anticipatory socialisation programme incorporated within nursing training that was designed to minimise the "reality shock" experienced by newly qualified nurses. One of the major sources of reality shock is role deprivation: the disparity between an idealised role and that found operating and sanctioned in the work place (Corwin, 1960). According to one explanatory model, this disparity derives from the conflict between the professional values that individuals acquire during training and the demands of the bureaucracy that subsequently employs them. Kramer therefore developed a programme to introduce students to the problems arising from this professional-bureaucratic conflict that were likely to confront them post-qualification. Within the programme, she incorporated opportunities for the students to work out some coping strategies for dealing with these conflicts. Kramer found support for her theory that anticipatory socialisation facilitated by instructors can minimise reality shock. Nurses who received this input were better able to maintain behaviour consistent with professional values after graduation, and made a more satisfactory transition from college to their first jobs.

## 2.5 Role Acquisition and Negotiation in Human Service Workers.

The preceding sections have discussed general issues in professional socialisation and factors that facilitate or impede this process, with particular reference to studies of medical and nursing students. In this section, I will focus specifically on factors that facilitate or impede acquisition and maintenance of the *professional role* by human service workers. Cherniss uses this generic term to embrace a range of occupations, such as social workers, psychologists, teachers, doctors, nurses and the clergy, in which individuals "have direct responsibility for the well-being of other people" (Cherniss, 1980, p.49). This section draws on the occupational stress literature for elaboration of constructs relating to role acquisition and role strain among these workers.

Several studies have examined the effect on trainees of discrepancies between idealised role conceptions and those that operate in the workplace (Corwin, 1960; Kramer, 1974; Myers, 1982). As noted above, adequate integration of clinical and academic work prior to qualification may minimise this "reality shock" (Kramer 1974) through anticipatory socialisation. However, while

strategies such as these may assist individuals with role acquisition, a number of writers have commented on the potential for role strain among human service workers in general, and health care workers in particular.

Goldie observes:

> Health work ...involving doing something to others, can raise the most acute personal dilemmas for the doer in terms of the pain and suffering involved, the possession of 'guilty' knowledge, the consequence of getting it wrong and the ethical dilemmas of interfering in someone else's life. (Goldie, 1995, p.28)

Cherniss (1980) suggests that the personal identities of "human service workers" merge with their professional identities to a greater extent than in other occupations because there is greater emotional investment in the outcome of the work. This increases the potential for individuals to be adversely affected when they experience role strain. A number of writers have made this point with specific reference to psychotherapists (for example, Farber, 1985; Henry, 1966; Raskin, 1978). Kottler (1986) argues that the role of the psychotherapist involves the total personality of the individual and therefore his/her worldview becomes inextricably bound up with the therapeutic work.

Cherniss (1980), citing the work of Kahn, Wolfe, Quinn, Snoek & Rosenthal (1964), identifies *role conflict* and *role ambiguity* as two sources of role stress (when demands exceed resources) and role strain (the individual's emotional/behavioural reactions to this stress: for example, anxiety and fatigue). Cherniss describes three types of role conflict: (1) role overload, when excessive demands are made on the roleplayer; (2) role conflict arising from incompatible demands being made on the roleplayer; and (3) person-role conflict that occurs when a "role requires behaviour that is inconsistent with the role player's motives, abilities or moral values" (1980, p.83). Person-role conflict includes the professional-bureaucratic conflict addressed by Kramer (1974) in her anticipatory socialisation programme (see 2.4 ii. above). Cherniss provides an example of person-role conflict at the level of tasks, citing the psychotherapist who wished to work as a specialist and viewed the organisation's expectation that she perform as a generic worker as unacceptable. Vasco, Garcia-Marques & Dryden (1993) found evidence of person-role conflict occurring at a more fundamental level. In a study of Portuguese psychotherapists, they investigated the experience of therapists who train in a therapeutic orientation that is incompatible with their world-view. They found that dissonance between therapists' personal philosophies and values, and the theoretical foundation of their selected orientations was related to their dissatisfaction with that orientation, particularly for cognitive-behaviour therapists. The authors suggest that there are four possible

responses to this dissonance: re-entrenchment within the existing paradigm; enlargement/revision of the paradigm; abandonment of one's career; and entering a state of crisis.

Cherniss suggests that human service workers are also subject to role strain engendered by role ambiguity, which "occurs when the role player lacks the information necessary for adequate performance of the role" (Cherniss, 1980, p.89). Kahn *et al.* (1964) note that the roleplayer may lack information regarding: (1) the scope and responsibilities of the job; (2) co-workers expectations; (3) what is required for satisfactory job performance; (4) opportunities for advancement; (5) supervisors' evaluations and (6) what is happening in the organisation. Cherniss concludes that human service workers are particularly vulnerable to role ambiguity because the nature of their work limits opportunities for external validation of their skills. In the field of mental health, positive feedback from patients has, as all therapists learn, a weak association with therapist-rated improvement. There is also the problem of "authorship": whatever the direction of change, other sources of influence and the patients' degree of motivation will mediate the therapist's efficacy. Finally, the therapist has to evaluate efficacy over a long or uncertain time-scale, enduring periods without obvious progress before there is a satisfactory resolution, assuming this occurs. Role ambiguity may also arise because therapy has inherently ambiguous goals (psychological growth v. symptom reduction), and controversy continues about the relative efficacy of different therapies.

In summary, the literature suggests that the concepts of role ambiguity and role conflict are likely to be useful in understanding the experiences of trainee clinical psychologists as they become socialised into their professional role, since these concepts have previously illuminated accounts of role playing by human service workers. Since the present study was not designed to measure occupational stress, these concepts will be employed in a descriptive sense only. In the following section I will introduce the professional context for the socialisation of clinical psychology trainees, and its historical origins. In the process, I will identify some potential sources of both role ambiguity and role conflict for these trainees.

## 2.6 Professional Socialisation in Clinical Psychology.

In the preceding sections of this chapter I have introduced the concepts of professional socialisation and anticipatory socialisation, and discussed these with reference to key studies in nursing and medicine. As noted earlier, there are no comparable published studies describing the experience of clinical psychology trainees. In the following sections of this chapter I will consider the applicability

of these concepts to clinical psychology training in Britain. I will begin by relating anticipatory socialisation to the structure of training in the profession.

## 2.6 i. Anticipatory Socialisation in Clinical Psychology Training.

In Britain, the professional qualification for clinical psychologists is a doctoral degree acquired through a three-year course that incorporates clinical placements within the NHS, academic assessments and a research dissertation. In order to be eligible for postgraduate training, potential clinical psychology trainees must have an undergraduate honours degree in psychology. In addition, they are usually expected to have demonstrated their commitment to the profession by working for 1-2 years (minimum) to gain "relevant" experience. This experience is most commonly acquired by working as a psychology assistant in a clinical setting, under the supervision of a qualified clinical psychologist. Experience can also be acquired in many other ways: for example, doing clinical research, working in residential settings with ill or disabled people, working in the voluntary sector, or working as a nursing auxiliary. This preparatory period is justified by the British Psychological Society (BPS) as a prerequisite for formal training to facilitate assessment of candidates' suitability for clinical work. However, the hiatus between undergraduate and postgraduate training in Britain is also an artefact of the bottleneck caused by a limited number of training places for a large number of applicants. In 1999, for example, 1,556 people applied for 377 places: 24% of applicants were therefore accepted for clinical training (University of Leeds, 2000, p.147).

Given the requirement of relevant experience prior to clinical psychology training, one might predict that these individuals would experience considerable anticipatory socialisation before commencing the doctoral programmes. It is therefore doubtful that they will begin their courses in a state of "initial innocence", with a lay view of the profession, like the nursing students studied by Davis (1975). Similarly, clinical psychology trainees are unlikely to share the naivete of the biochemists studied by Bucher and colleagues regarding their future profession (Bucher *et al.* 1969a).

The psychology trainees may, however, be expected to display characteristics of both the medical and psychiatry residents in that study. The majority of successful applicants to the University of Edinburgh/ East of Scotland clinical psychology training course studied here had prior links with its academic or clinical institutions. Indeed, some individuals progressed from assistant psychologists

to clinical psychology trainees within the same NHS department (and some of them remained in those departments after qualification).[4] Like Bucher's medical residents, these trainees are likely to have quite clear expectations of their postgraduate course, since they have prior knowledge of the institutions and staff involved and have often had contact with previous intakes of trainees. The minority of trainees who enter the course from further afield would be expected to experience anticipatory socialisation in a more general sense. Those individuals are likely to have acquired attitudes and knowledge about the profession, but will not have acquired specific expectations of the system that they enter at the commencement of the course.

The clinical psychology trainees resemble Bucher's psychiatry trainees and medical residents in another respect. The psychiatry trainees struggled with the discontinuity between the knowledge base they acquired as undergraduates and the specialist knowledge they required as postgraduates. The clinical psychology trainees make a similar leap from a broad theoretical base of undergraduate work to an applied specialist field. The psychiatry trainees also found that they initially lacked the necessary clinical skills to work psychotherapeutically and establish a different quality of relationship with patients than the relationships they had formed earlier in their careers when treating physical complaints. Postgraduate work more closely resembled undergraduate clinical work for the medical residents, and they had observed senior role models more frequently than their psychiatric colleagues. Some clinical psychology trainees will begin doctoral programmes with considerable clinical experience and will thus resemble the medical residents. Others (for example, those coming from research backgrounds) will be clinically naïve in comparison and will therefore better resemble the psychiatry trainees in this respect.

[4] The preponderance of local applicants relates to the course's selection policy. For a number of years there has been a belief among applicants that the selectors favour candidates who are likely to take jobs in the region where they trained once they qualify, given that local health authorities fund the course (for details of the funding arrangements, see 4.2.i. below). The folklore that surrounded application to clinical psychology courses therefore leads people to believe that working "within the system" beforehand will lend credibility to claims that one intends to work in the Scottish NHS post-qualification. Furthermore, the strong competition for places encourages applicants to believe that selectors are particularly reliant on references to distinguish between individuals, and referees known to the selectors are perceived to be more influential advocates. This widespread belief (aired at gatherings of psychology assistants and trainees) about the advantages of being a "local" candidate has recently received some support from the Clearing House Handbook that provides information on all the clinical psychology courses in Britain. Both the Scottish courses (the University of Edinburgh/East of Scotland course and the University of Glasgow/ West of Scotland course) now state in their selection criteria that preference will be given to candidates who intend to work in Scotland after they qualify.

2.6 ii. The Role of the Clinical Psychologist: Current Issues and Historical Legacies.

Role acquisition is fundamental to the notion of professional socialisation. I began this study by postulating that current tensions in the profession were likely to have a negative impact on role acquisition during training. In order to understand these tensions and their implications for this aspect of professional socialisation, it is necessary to comprehend how clinical psychology has evolved into its current form in Britain. The following section provides that historical context.

In the fifty years since clinical psychology emerged in Britain as a new profession, there have been radical changes in the organisation of the NHS and in clinical psychologists' views of their role within the Health Service. A number of writers, including Pilgrim & Treacher (1992), have suggested that clinical psychology training has not adequately reflected these changes. In particular, there has been a debate about the appropriateness of the scientist practitioner model (Claridge & Brooks, 1973; Cooke & Watts, 1987; Crockatt, 1976; Martin, 1987; Milne, Britton & Wilkinson, 1990; Spellman & Ross, 1987) which has traditionally underpinned clinical psychology training in Britain. This controversy is part of a wider debate about the defining characteristics of clinical psychology taking place within a climate of increasing competition between the mental health professions.

Clinical psychology emerged in Britain after the Second World War, although it was not formally recognised until 1966 when the British Psychological Society (the main academic and professional body for all psychologists in this country) established a Division of Clinical Psychology. Prior to the formation of the National Health Service in 1948, there were a very small number of clinical psychologists who worked in hospitals, often on a part-time or voluntary basis. The numbers began to increase once the NHS was established, and the profession of clinical psychology has evolved in Britain almost entirely within the Health Service (Liddell, 1983). The new profession emerged in a milieu dominated by the medical model, and its theoretical foundation was positivist and empirical. Marzillier & Hall (1999) describe its origins and evolution:

> In Britain fifty years ago, there were only a handful of clinical psychologists, working as technician scientists in psychiatric hospitals. Like physicists and biochemists they were 'backroom boys', whose contribution to health care consisted of highly specialized scientific investigations, mainly in the form of psychometric tests and investigations. In many other countries in Western Europe, clinical psychologists did not exist. Only in the United States, had clinical psychology any appreciable history and a developing professional identity. In the late 1990s, the picture is very different. Clinical psychology has become an established profession in most European countries, in the English-speaking areas of Australia, New Zealand, and South Africa, and in South America. Some countries such as Britain have seen a rapid increase in the number of clinical psychologists, particularly over the last decade. (Marzillier & Hall, 1999, p.343)

The first formal postgraduate clinical psychology training course in Britain began in 1947 and was based at the Maudsley Hospital in London. The leading figure at the Maudsley was Hans Eysenck, who was originally appointed as a research psychologist. Eysenck's view of the appropriate role for clinical psychologists strongly influenced the development of the profession in Britain. In 1949, Eysenck outlined his position in a paper responding to the American Psychological Association's statement on clinical psychology training that defined the core tasks of psychologists as diagnosis, therapy and research. In his reply, Eysenck advocated that clinical psychologists should only be trained in research and diagnostic testing, or psychometrics.[5] He did not consider therapeutic skills to be necessary or desirable, believing that therapy should be left to psychiatrists (Eysenck, 1949). "Talking treatments" undertaken by psychiatrists were, at that time, primarily psychoanalytic and Eysenck viewed psychoanalysis as theoretically unsound and ineffective (Eysenck, 1952). However, as Pilgrim & Treacher have pointed out, Eysenck and many leading psychologists who shared his views, combined an ideological campaign with a political agenda: "If psychoanalysis could be refuted successfully, and cast aside as pre-scientific, then a new style of psychologising could be ushered in" (Pilgrim & Treacher, 1992, p.15).

During the 1940s and 1950s, Eysenck and his colleague, Monte Shapiro at the Maudsley, attempted to legitimate the emerging profession of clinical psychology by emphasising the scientific underpinnings of their practice. Thus, the scientist-practitioner model played a defining role in shaping the emergent identity of clinical psychologists in Britain. The Maudsley position dominated clinical psychology training in Britain until the mid 1970s because most of the courses were headed by Maudsley graduates. The dominance of the scientist-practitioner model in Britain was paralleled by similar developments in the United States. A major conference on training convened by the American Psychological Association in 1949 in Boulder, Colorado also accepted this model (henceforth known in both the USA and Britain as the "Boulder model") as the basis for training clinical psychologists in the United States. As a result, the scientist-practitioner ideal was singularly influential in shaping both British and North American clinical psychology training during the profession's early years. Behaviour therapy subsequently emerged in the 1960s, and enabled clinical psychologists in both countries to embrace the therapeutic role without compromising their positivistic stance as applied scientists (Pilgrim & Treacher, 1992).

The training courses that were founded during the 1960s and 1970s were generally university based, and awarded Masters degrees as the clinical qualification. NHS in-service courses that awarded BPS

[5] The Second World War contributed to this early emphasis on psychometric assessment because of the Armed Forces' demand for assistance with personnel selection.

Diplomas were also established in the late 1960s as a stop-gap until more university courses came on stream. In-service courses have now been largely superseded by university based/administered courses that organise clinical placements in NHS facilities. As I will argue in Chapter 9, this trend, together with the evolution from the Masters degree to the Doctorate as the clinical qualification, is symptomatic of the increasing professionalisation of clinical psychology.

By the 1970s, the profession had become increasingly eclectic (Richards, 1983). Pilgrim & Treacher (1992) identify several factors that contributed to the reaction against the Maudsley agenda of psychometrics and behaviour therapy that developed during the 1970s. They note the shift in the zeitgeist away from positivism and empiricism; the emergence of a psychiatric libertarianism that implicitly challenged the conservative, scientific Maudsley tradition; the trend towards eclecticism in other mental health professions; and a growing resistance within clinical psychology itself to the Maudsley agenda. An expression of this resistance was the formation of the Psychology and Psychotherapy Association in 1973, founded by a group of psychologists with a broadly humanistic approach. The increasingly humanistic and eclectic ethos within the profession did not coexist easily with the Maudsley interpretation of the scientist-practitioner model. This theoretical tension had political ramifications. Clinical psychology had previously protected its occupational niche by claiming specialist science-based skills. Therefore, in order for the profession to maintain its scientific credibility, a compromise position of scientific humanism developed (Pilgrim & Treacher, 1992).

Smail (1982) characterises applicants for clinical psychology training during the eclectic period as uncommitted, confused or agnostic regarding psychological theory. He suggests that they had nothing to fight for or react against. Within the profession there was no consensus about the theoretical stance or form of practice that should be identified with clinical psychology. However, despite growing interest in psychotherapy, the model of scientist-practitioner still dominated training.

Claridge & Brooks (1973) surveyed applicants to the Glasgow clinical psychology course. They found that only 12% of the trainees identified strongly with the applied scientist role and were entering the profession with the intention of pursuing research. Eighty-seven percent of the trainees identified helping and problem solving as the most important aspects of their future role and were primarily motivated by a desire to become therapists. Claridge & Brooks argued that university courses had two aims that were not readily compatible: vocational training to equip clinical psychologists for a role within the NHS, and academic training to maintain the scientific credibility of abnormal psychology. They recommended increased flexibility in training to meet different needs,

and suggested that some courses might emphasise academic training, leaving others to emphasise practical skills.

Pilgrim & Treacher (1992) argue that some increased flexibility has been evident in training since the study by Claridge & Brooks, but assert that the role of clinical psychologist as researcher has not developed adequately in line with the scientist-practitioner model. As they point out, this is partly due to the evolution of the profession within the NHS: there are very few clinical psychologists who work outwith this system. Recently there has been more interest in and funding for research evaluating services within the NHS, but traditionally clinicians in all professions have prioritised waiting lists over research.

Pilgrim & Treacher conclude that the model of scientist-practitioner is no longer tenable in Britain or the USA. O'Sullivan & Dryden (1990) surveyed clinical psychologists in the South-East Thames region and found that research was the least frequent activity, filling only 6% of their time. Several studies in the USA have published similar results and on both sides of the Atlantic a very small proportion of the profession produces the research. Most of these individuals are relatively senior, and many are affiliated with academic centres. Frosh & Levinson (1990) surveyed supervisors from in-service courses in North-West Thames and found that only 11% considered that combining research and practitioner roles was central to clinical psychology training. None of the supervisors identified research as a skill to be learned on placement or one that should have been learned earlier. It may, however, be significant that this study surveyed in-service rather than university-based courses, given the traditional tension between the work place and the academy.

Other writers have suggested reconsidering the type of research that clinicians might usefully and feasibly complete in order to bridge the gap between scientist and practitioner. Thus, small N designs, "quick and dirty" research, and projects based on routine clinical work are advocated instead of more theoretical studies which require large Ns and well-controlled variables (Milne, 1987; Paxton, 1987; Spellman & Ross, 1987). Head & Harmon (1991) have argued the opposing view, asserting that these proposals amount to a double standard within the profession, with rigour demanded during training and dispensed with after qualification.

Despite indications that its influence may be limited, the scientist-practitioner model has persisted in the self-presentation of the profession. It has done so because the model is an essential feature of the identity projected by clinical psychology in order to differentiate itself from medicine, nursing, social work, and therapists of different backgrounds. Indeed, it is arguably the increasing

professionalism of clinical psychology that has exacerbated the tensions between its vocational and academic/research roles.

Schon (1983) proposes that the model of Technical Rationality underlies the professions, if we assume that law and medicine are the prototypical professions. According to this model, professional activity consists of instrumental problem solving, following rigorous scientifically determined procedures. He presents a hierarchy of professional knowledge, with general principles occupying the highest level and concrete problem solving occupying the lowest level. Within the model of Technical Rationality, research is institutionally separate from practice. Researchers provide basic and applied science as the foundation for the techniques required in diagnosing and solving the problems of professional practice. Practitioners, in turn, supply the researchers with problems to be investigated and test the usefulness of research findings. In this model, the researcher is generally accorded higher status than the practitioner. Pilgrim & Treacher (1992) argue that this disparity exists within clinical psychology.

Since the applied scientist rather than the therapist remains the predominant model, the clinical psychology trainee as a person has traditionally received little attention from trainers. Pilgrim & Treacher suggest that this is not surprising given the way the profession has evolved:

> The original psychometrician-diagnostician role was essentially a peripheral, paramedical role....It is highly likely that the type of psychologist that was attracted to this peculiar role themselves preferred to be distant from people. Needless to say, such psychologists created training courses that tended to institutionalise this distancing from clients albeit in the name of scientific objectivity. (Pilgrim & Treacher, 1992, p.96)

Promotion of the scientific role by trainers has been accompanied, implicitly and explicitly, by expectations of objectivity and detachment. By adopting this stance, trainers have contributed to the perceptions of many trainees that it is not appropriate to express doubts or distress arising from their work with patients. Mollon (1989) suggests that reliance on the scientific role may also serve an important function for the profession in protecting individuals against distress or feelings of inadequacy.

Recently, a few courses have begun to offer personal therapy to trainees, either as an option or a requirement, in recognition of the gap in training. However, this remains a contentious issue that, in part, reflects the disagreement within the profession about whether clinical psychologists are first and foremost applied scientists or therapists. Mollon (1989), who trained first as a clinical psychologist and later as an analytic psychotherapist, observes that his identity as a psychotherapist

is clearer than his identity as a clinical psychologist. He suggests that clinical psychology lacks a central task, which contributes to this confusion.

In the preceding section I have argued that conflict within the profession over the scientist-practitioner model may interfere with role acquisition by trainees, by generating both role conflict and role ambiguity. Another factor that may impede this process is the complexity and indeterminacy of the profession's knowledge base. I will introduce this argument below.

### 2.6 iii. The Knowledge Base of Clinical Psychology.

During the past thirty years, much has been written about the nature and acquisition of professional knowledge and skills. In an influential paper, Jamous & Peloille (1970) argued that occupations can be distinguished by their ratio of *indeterminate* and *technical knowledge* (I/T). Technical knowledge can be codified according to explicit, unambiguous rules and its transmission does not necessarily require modelling by an expert. Thus, clinical psychology trainees can read an instruction manual to learn how to instruct patients in relaxation techniques. Indeterminate knowledge, however, is implicit and defies codification or precise specification. In the words of Atkinson (1981, p.110): "The language of indetermination is a language of personal knowledge". Jamous & Peloille propose that professions are distinguishable from other occupational groups by a high degree of indeterminacy. Describing the ideology of clinical medicine, they conclude that good treatment results are more readily attributed to the "potentialities and talents" of practitioners than "techniques and transmissable rules" (Jamous & Peloille, 1970, p.140). The authors suggest that this emphasis on the indeterminacy of knowledge allows professionals considerable autonomy and powers of self-regulation.

Some more recent commentators have drawn attention to limitations of the I/T ratio as a model for understanding professional work. Applying Jamous & Peloille's framework to his analysis of medical training, Atkinson (1981) argues that the I/T ratio implies a false dichotomy. Rather, he suggests, the two are inextricably interrelated, since the appropriate application of technical knowledge depends on interpretative ability: the indeterminate knowledge concerning when to apply rules that we usually refer to as "experience". Macdonald (1995) reminds his readers that Jamous & Peloille developed their concept in the 1960s by studying the French hospital system of the 1950s. He points out that both the practice of medicine and the public's expectations of professionals have changed considerably since then:

> ...it is difficult to see how a body of professionals could maintain their knowledge base at a high level of indeterminacy indefinitely, because they would have to acknowledge the primacy of scientific knowledge if they were to maintain their legitimacy in the modern world. (Macdonald, 1995, p.165)

In his recent review of the literature on professional knowledge, Macdonald accepts that the concept of indeterminacy still has limited usefulness, but suggests that the framework proposed by Abbott (1988) provides greater explanatory power. Abbott's analysis of the professions gives primacy to professional work, while acknowledging that abstract knowledge is the essential foundation for this activity. Macdonald summarises the relationship thus:

> At either extreme, the profession tends to lose credibility; too great abstraction appears to be mere formalism, too great concreteness is judged to be no more than a craft. At some nicely chosen spot in the middle, the possessor of knowledge and technique can successfully exercise professional judgement" (Macdonald, 1995, p.165).

Cox (1995), writing in the Australia and New Zealand Journal of Surgery, challenges the view that abstract, and in particular scientific knowledge, is the basis for professional practice. He identifies "clinical working knowledge" as the basis of clinical practice and proposes that the multiple sources of this knowledge are the clinician's awareness of basic scientific processes; empirical descriptions of disease; clinical experience; consultation with colleagues and common sense. Cox argues that

> Clinical practice is not, and can not, be conducted as the application of bioscience theory to clinical problems. First, clinical practice is too complex, ill-defined, multifaceted and situational to be handled by applying scientific method to its activities of diagnosis and management. Second, value judgements pervade the balancing of trade-offs in every clinical decision; but science has no calculus for handling meaning, purpose and choice of actions. (Cox, 1995, p.553)

Having identified the application of scientific theory as an inappropriate goal for clinical practice, Cox suggests that clinical practice is worthy of study in its own right. Studying clinical practice would, he concludes, involve trying to understand how the clinician manages situations to achieve optimal results, given that clinical judgements must often be made in the absence of reliable empirical predictive data.

The development of professional judgement is a process that a number of investigators have scrutinised. Dreyfus & Dreyfus (1986), writing about the knowledge processes involved in clinical practice, identify a sequential model of knowledge acquisition in trainee practitioners. In the first (or novice) stage, the source of knowledge is primarily external to the practitioner and practice involves the application of rules and procedures learned in academic training. By the final (or expert) stage, the source of knowledge is primarily the practitioner's own experience and this allows him/her to

apply theory to practice in a manner that is appropriate to the clinical context. Commenting on this analysis, Hoshmand & Polkinghorne conclude:

> In other words, experts work with knowledge differently than do novices. It suggests that an epistemology of practicing knowledge should be based on the processes of expert practitioners, not on the deliberative procedures and theoretically derived rules that constitute the practicing knowledge of novices. (Hoshmand & Polkinghorne, 1992, p.60)

The premium that this developmental model places on clinical experience reflects a similar emphasis in Freidson's earlier analysis of "the clinical mind". The Profession of Medicine (1970a) contains a persuasive and insightful account of the psychological and pragmatic factors that sustain clinicians' faith in the primacy of experience. Freidson argues that clinicians are fundamentally people of action:

> Given a commitment to action and practical solution, in the face of ambiguity the practitioner is more likely to manifest a certain will to believe in the value of his actions than to manifest a sceptical detachment. (How could a present-day psychiatrist work if he really believed the careful studies which emphasize the unreliability of diagnosis and the undemonstrability of success of psychotherapy? And how could physicians work one, two or five centuries ago?)...One whose work requires practical application to concrete cases simply cannot maintain the same frame of mind as the scholar or scientist: he cannot suspend action in the absence of incontrovertible evidence or be sceptical of himself, his experience, his work and its fruit. In emergencies he cannot wait for the discoveries of the future. Dealing with individual cases, he cannot rely solely on probabilities or on general concepts or principles: he must also rely on his own senses. By the nature of his work the clinician must assume responsibility for practical action, and in doing so he must rely on his concrete, clinical experience. (Freidson, 1970a, pp.168-170)

Freidson's conclusion, that the clinician must develop "[belief] in the value of his actions...in the absence of incontrovertible evidence", leads him to assert that clinicians must not only learn to accept the uncertainty of the knowledge base they draw on, but may strategically emphasise this uncertainty (italics in the original):

> ...the practitioner is very prone to emphasize the idea of *indeterminacy or uncertainty*, not the idea of regularity or of lawful, scientific behaviour. Whether or not that idea faithfully represents actual deficiencies in available knowledge or technique it does provide the practitioner with a psychological ground from which to justify his pragmatic emphasis on first hand experience. (Freidson, 1970a, p.169)

Atkinson (1981) challenges this interpretation. He argues that the concept of "training for uncertainty" has been over-emphasised in the literature on clinical training. In response, he observes that the clinician's reliance on personal knowledge is not reliance on his own, or colleagues', uncertainties, but reliance on the *certainty* of first hand experience. For clinical supervisors, whether in medicine, psychology or any other field, the challenge is to be sufficiently transparent about the

nature of this personal knowledge and the experiential justification for this certainty, so that trainees can be guided by this expertise.

Within the clinical psychology literature, the debate about the profession's knowledge base is frequently couched in terms of the "theory-practice dilemma" (Gibbons, 1994): the challenge of grounding clinical practice in empirically sound theory. I have previously noted, with reference to Bucher's study, the leap taken by both psychiatry trainees and clinical psychology trainees as they move into the increasingly ambiguous world of clinical practice. In clinical psychology this world has arguably become ever more indeterminate as the profession has given up its singular attachment to the positivistic stance of behaviourism. Pilgrim & Treacher suggest that the trend towards eclecticism in clinical psychology may reflect diminishing confidence in the conceptual underpinnings of psychology, as well as increasing faith in clinical experience as the appropriate source of knowledge. They caution that "an eclectic approach which does not help the trainee to create an overarching integrated model of therapy can be hopelessly confusing" (Pilgrim & Treacher, 1992, p.134).

Choice of theoretical orientation is central to the trainee's development of professional identity. Psychotherapists surveyed by Norcross & Prochaska (1983) reported that their personal theoretical orientation was the most important single influence on their clinical practice. Several American studies have investigated acquisition of theoretical orientation in psychotherapists, although the nature of the process remains unclear. Halgin (1985) found that some trainees choose an orientation before they begin post-graduate training, based on personal therapy, life experience or the influence of undergraduate lecturers. Halgin also notes that trainees who begin post-graduate training without a chosen orientation, experience growing pressure from supervisors and colleagues to make a choice and develop expertise in a particular approach. Norcross, Brust & Dryden (1992) surveyed members of the BPS Clinical Division and found that only 27% considered themselves to be eclectic/integrative therapists, suggesting that choice of a particular orientation remains the norm.

The shortage of clinical psychology training places in Britain means that most trainees have little or no choice about where they train and may therefore be trained in an orientation that is not compatible with their values/world view. The findings of Vasco, Garcia-Marques & Dryden (1993), reported in 2.5 above, lend credence to the hypothesis that clinical psychology trainees may therefore be particularly likely to experience the person-role conflict described by Cherniss (1980) in relation to the theoretical orientation of their training course.

In summary, the overview of the training structure in clinical psychology in Britain presented in 2.6 i., and the account of the evolution of the profession and its knowledge base presented in 2.6 ii-iii., demonstrate the applicability of particular concepts in the professional socialisation literature to a study of this process in clinical psychology trainees. These concepts are anticipatory socialisation, role ambiguity and person-role conflict and, together with the explanatory model of professional socialisation proposed by Bucher & Stelling (1977), they generated the initial research questions that framed this enquiry. These questions are articulated below.

## 2.7 The Initial Focus of This Enquiry.

Since this study was exploratory and incorporated a longitudinal element in the data collection, I anticipated that my initial research questions would be progressively refined by the responses of the research participants. However, the initial questions that emerged from the literature review provided a focus and theoretical basis for an enquiry that had originated in personal experience and anecdote. These questions were as follows:

1. Does anticipatory socialisation influence professional socialisation during clinical psychology training?

2. Do clinical psychology trainees experience person-role conflict? If so, how does this arise?

3. Do clinical psychology trainees experience role ambiguity? If so, how does this arise?

4. With reference to Bucher & Stelling's (1977) model, what are the structural and situational variables that influence clinical psychologists' professional socialisation?

In the following chapter, I will discuss the method, and its theoretical foundation, that I employed to investigate these questions within a symbolic interactionist framework.

# CHAPTER 3

# RESEARCH METHOD: THEORETICAL FOUNDATION AND PROCEDURES

This chapter has two objectives:

i. to establish the theoretical rationale for the qualitative method selected for this study
ii. to describe the design and procedures employed in this investigation.

I will begin by tackling the first of these objectives, beginning with a consideration of the qualitative approach in general, and proceeding to a discussion of more specific methodological issues.

## 3.1 Rationale for Conducting a Qualitative Study.

This study adopts a qualitative approach in its investigation of professional socialization. It therefore represents a departure from my earlier research, which followed a quantitative paradigm. My starting point in devising the method for this study is close to that of Stiles, who observes:

> In my own opinion, accepting qualitative research as viable need not deny the value of traditional experimental design, quantitative measurement, and statistical analysis. However, recognizing the scope, the goals, and the epistemological implications of qualitative approaches may make us more humble about traditional methods' ability to come to grips with the psychological topics of greatest interest to many people, which, I think, involve accounting for the range and depth of human experience. (Stiles, 1993, p.594)

Bryman (1988) observes that the researcher's decision to adopt a quantitative or qualitative approach should be informed by his/her response to both technical and epistemological questions. Bryman defines the technical question as: "Which approach is best suited to the research question?" The epistemological question asks the researcher to ally himself/herself with one of two contrasting positions. The quantitative paradigm seeks to establish objective knowledge of universal laws of cause and effect by testing hypotheses against phenomena in the empirical world. The qualitative

paradigm, however, privileges the search for understanding or intersubjective meaning (*verstehen*[6]), rather than abstract universal laws. It assumes that knowledge is generated in networks of social activities and systems of socially constituted meanings. Consonant with the postmodern approach to science, theories and interpretations are understood to have a "local and historical character" and do not purport to be "universal frameworks of truth" (Geertz, 1983).

In terms of the present study, both technical and epistemological concerns determined its qualitative approach. In response to the technical question, the study was originally envisaged as exploratory and naturalistic (although the design was later amended to incorporate an intervention: see Section 3.4). The aims of the investigation were theory-driven (Boyatis, 1998), but I anticipated that they would be modified by the responses of the study participants. This exploratory approach in search of a detailed, in-depth understanding of trainees' experience (Geertz' [1973] "thick" description) requires a qualitative methodology. The present study can therefore be located within the mainstream of research into professional socialization, which has traditionally been predominantly qualitative. This is entirely appropriate, given the complexity of the experience under scrutiny and the impossibility of attempting to test hypotheses and control variables in such circumstances without destroying all ecological validity.

In response to the epistemological question, I have observed that qualitative approaches generate less dissonance than quantitative methods between my role as a clinician and my role as a researcher, and I therefore now find the stance of the qualitative researcher more comfortable. The positivist paradigm requires researchers to remain objective and detached, to view subjects as sources of data. This requirement, which I have tried to meet in previous research projects, increasingly jars with the values I espouse as a therapist. In my clinical role, I seek empathic engagement with patients; I work to create collaborative relationships with them rather than objectifying them as sources of pathology. The method chosen for this study has allowed me to engage fully with the participants and the stories they have told me. In this investigation, as in my clinical work, I collaborated with the storytellers to generate a shared meaning. I did not, therefore, set out to be objective. Instead, I aim to be transparent about my preconceptions and assumptions in this account. This disclosure of orientation will allow my readers to assess the *permeability* of my account: the degree to which my experiences have permeated my understanding of socialisation in clinical psychology trainees (Stiles, 1993). This point is developed further below (see Section 3.2).

[6] Schwandt (1998) provides an account of the historical origins of the *Verstehen* tradition in sociology that aims to apprehend the actor's view of a situation. This tradition developed out of the

3.1 i. The Status of Interview Data.

Since this study relies primarily on semi-structured interviews with qualified and trainee clinical psychologists, I will next describe my approach to interview data. My perspective on my own data is closely allied to the position of Miller & Glassner (1997). Presenting their argument for "in-depth interviewing", Miller & Glassner encourage other researchers to move beyond the objectivist vs. constructivist debate that has dominated much of the writing about interview-based research. They question the feasibility and desirability of the "pure" interview located in a "sterilized" context that the positivists hoped would "mirror reality" (Miller & Glassner, 1997, p.99). At the same time, they also reject the position of radical social constructionists who claim that interviews cannot illuminate a reality beyond the individual, since each interview is co-created by the interviewer and interviewee, is delimited by the demands of the situation, and represents nothing beyond it.

Miller & Glassner note that interactionist research assumes that individuals create and maintain meaningful worlds that exist beyond the interview context. They assert that it is possible to learn about those worlds by analysing interviews as situated elements within social worlds. Furthermore, they argue that the tension implicit in the interactionist perspective can clarify rather than obscure the focus of enquiry. Although interactionists do not posit "a singular objective or absolute world out-there", they accept the existence of "objectified worlds" as an "accomplished aspect of human lived experience" (Dawson & Prus, 1995, p.113). Miller & Glassner maintain that qualitative interviews can provide insights into these objectified worlds by "exploring the points of view of our research subjects, while granting these points of view the culturally honoured status of reality" (Miller & Glassner, 1997, p.100).

Working within an interactionist paradigm, Miller & Glassner identify strategies that interviewers can employ to produce authentic accounts of social worlds. They begin by acknowledging that the interview "fractures" the respondent's story, which is inevitably partial, shaped by culturally determined beliefs, and subject to the limitation and filtering of language. This story will also be mediated by the relationship between the interviewer and the respondent, and the expectations each has of the other. The data analysis and subsequent representation of the data in the researcher's accounts produce further fractures, and researchers must be cognisant that they have reinterpreted the "ideal text": the subjective experience of the respondent. The authors respond to these caveats by arguing that language does shape meaning, but also allows intersubjectivity and the creation of meaningful worlds. They assert that it is possible to create a truthful representation of a segment of

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work of Dilthey and Weber; later theorists, notably Schultz (1967), have distinguished between different senses of the term: see (May, 1991) for a full discussion of these technical issues.

another person's experience, and suggest that by accepting the limitations of the representation, we can achieve greater authenticity than by deluding ourselves that we have captured the totality of someone's experience. Miller & Glassner contend (like Stiles [1993] and others) that this authenticity will be further protected if researchers are sufficiently transparent about their own concerns and experience to allow for scrutiny of the research process. They note that either too much or too little overt identification by interviewers with interviewees is likely to inhibit their story telling. However, if respondents trust the interviewer both to protect confidentiality and to represent them accurately, they are likely to provide the interviewer with valuable insights into their worlds. Miller & Glassner propose that these insights can then be compared with pre-existing narratives or "cultural stories' about the social group to which the respondents belong.

Holstein & Gubrium (1997) also discuss the status of interview data. They note that various intellectual schools, including the poststructuralists, postmodernists, constructionists, and ethnomethodologists, have challenged the conventional view that interviews are conduits for knowledge that will be most reliable if the interaction between interviewer and interviewee is strictly controlled. These challenges arise from the assumption, shared by these schools, that meaning is socially constituted. The interview is, therefore, "...not merely a neutral conduit or source of distortion, but is instead a site of, and occasion for, producing reportable knowledge itself" (Holstein & Gubrium, 1997, p.114). Adopting this perspective, Holstein & Gubrium recommend that researchers should acknowledge and use interviewers' and respondents' constitutive contributions to the interview, thereby attending not only to <u>what</u> is said, but <u>how</u> it is conveyed. They contrast the traditional approach of the social scientist as prospector, seeking to uncover the "reality" that lies beyond the respondent's interview performance, with an image of the *active interviewer*. The active interviewer approaches the subject behind the respondent not as a vessel of answers, but as a collaborator in the production of meaning. This approach allows the interviewer to encourage the respondent to make links between aspects of his/her experience and facilitates interpretation of events. Holstein & Gubrium describe this form of interview:

> As a drama of sorts, its narrative is scripted in that it has a topic or topics, distinguishable roles, and a format for conversation. But it also has a *developing* plot, in which topics, roles and format are fashioned in the give-and-take of the interview. This active interview is a kind of limited 'improvisational' performance. The production is spontaneous, yet structured – focused within loose parameters provided by the interviewer, who is also an active participant. (Holstein & Gubrium, 1997, p.123)

The authors note that this approach allows the interviewer to respond to the rich and contradictory nature of personal narratives, and enables both interviewer and respondent to consider alternative

perspectives as they emerge during the interaction. However, this flexibility must be balanced by directive techniques, so that the interviewer focuses the storytelling on the research task.

Active interviewing has implications for the researcher's approach to data analysis. While traditional analyses subordinate the how to the what of the conversation. Holstein & Gubrium advocate illumination of both aspects of the interaction. Thus, the analytic objective is to report the meanings produced by the interaction between interviewer and interviewee, while documenting the circumstances of the meaning-making process.

The preceding discussion provides a theoretical starting point for the choice of method in this study: that is, a qualitative approach relying on active interviewing within an interactionist paradigm. In the next section I will describe the procedural starting point: the choice of a research site and identification of potential study participants.

## 3.2 Selection of the Research Site and Study Participants.

In line with many qualitative studies, I decided to aim for depth rather than breadth in my data collection and analysis. That is, I wished to explore the training experiences of a relatively small sample of individuals, with the intention of trying to understand the explanatory concepts presented in the previous chapter. The model of professional socialisation developed by Bucher & Stelling (1977) that provides some of these concepts requires a detailed understanding of the system providing the training. It therefore seemed prudent to seek participants from only one system, or training course. Although this is not a quantitative study attempting to establish causal relationships between variables, the narrow focus also has the advantage of limiting the number of factors to be considered within a model of professional socialisation. This makes it easier to understand the influences on individuals' career trajectories.

Having chosen to study only one clinical psychology training course, I had to decide which one. There were no theoretical reasons associated with the study's aims for choosing any particular course. Indeed, most of the clinical psychology training courses in Britain follow a similar model, since they must all meet BPS criteria for accreditation (see Chapter 4 for a detailed description of the course studied here). Furthermore, the "representativeness" of the trainees I aimed to recruit would depend on their "generalizability... to theoretical propositions rather than to populations or

universes" (Bryman, 1988, p. 90). Bryman explains this proposition with reference to Glaser & Strauss' study of the care of terminally ill patients:

> The issue of whether the particular hospital studied is 'typical' is not the critical issue; what is important is whether the experiences of dying patients are typical of the broad class of phenomena...to which the theory refers. Subsequent research would then focus on the validity of the proposition in other milieux (e.g. doctors' surgeries). (Bryman, 1988, p.91)

In the absence of any theoretical justification for selecting a particular research site, there were three courses that were most suitable in practical terms since their bases were within commuting distance. The University of Edinburgh/East of Scotland course where I trained myself (between 1991-1993) was one of these. There were arguably both advantages and disadvantages associated with choosing that course.

One potential disadvantage is that studying a known environment may increase investigator bias. In response to this possible objection, Stiles observes that guidelines for good practice in qualitative research rest on scepticism, if not rejection, of the concept of objectivity: "...the notion that a scientist can stand outside his or her personal frame of reference to view objects or events in a neutral way" (Stiles, 1993, p.602). Instead, the concept of *permeability* emerges in qualitative research: "...the capacity of theories or interpretations or understandings to be changed by encounters with observations" (Stiles, 1993, p.602). Stiles suggests that good practice in qualitative research maximises permeability and requires disclosure by the researcher of his/her bias to the reader. The reader is then able to decide how to interpret the findings, with an understanding of that layer of the study's context. Following this argument, choosing to study the course I knew best did not need to be a disadvantage, providing that I scrutinised and discussed my preconceptions about the field I was investigating.

A further disadvantage is that when the investigator has a role within the field being investigated, that role is likely to influence the extent and nature of participants' disclosures. I therefore considered my role within the field. When I began this study I was working full-time for the NHS within the geographical area that contains the clinical placements for the course. My only involvement in the course was a once-a-year lecture to the first year trainees. I was not and had never been a clinical supervisor for the course, or held any other position on its staff. I knew many of the "key players" on the course (both university and NHS staff), as well as more peripheral members of the system (such as clinical supervisors), both from the days when I was a trainee and, more recently, after I had qualified. I was, therefore, not formally part of the training structure but I had past and present links with people who were. It was possible that this degree of association with

the course would inhibit trainees from speaking openly to me about their experiences. Alternatively, if I could convince them that confidentiality would be maintained, it was arguable that my insider status would encourage disclosure for two reasons. First, trainees might perceive me as more empathic and understanding because of our shared experience and second. I might be better equipped to ask searching questions because of insider knowledge.

Thus, balanced against the possible disadvantages of selecting trainees on the course I had completed some years previously were significant advantages. The main advantage was detailed knowledge of the system, which might facilitate deeper exploration of the socialisation process by helping me to frame the most useful questions, encouraging participants' disclosures, and assisting my interpretation of the findings. [7]A further probable advantage was that I was likely to find it relatively easy to obtain permission from the course staff to approach trainees and request participation. Finally, my informal links with the system were likely to make my presence "as a researcher" less obtrusive, on both university and NHS sites used by the course.

After weighing up the pros and cons of choosing the course that I had attended as my research site, I decided that the advantages did outweigh potential problems. I therefore approached the Course Director with my research proposal, and it was discussed and approved, in principle, by the course staff. Permission to proceed was, of course, contingent on approval from the appropriate ethics committee (see below).

Once a research site had been chosen, I identified a potential sample of subjects. Initially, I intended to try and recruit two consecutive intakes of clinical psychology trainees, beginning the course in October 1995 and October 1996, and follow their progress through the three years of training. This design was subsequently modified (see 3.3 and 3.4 below).

[7] My familiarity with the system should not be over-stated. There had been changes of personnel among course staff since I trained, including a change of Course Director. Most significantly, the two year Masters course I completed in 1993 became a three-year Practitioner Doctorate in 1997, which entailed a number of changes in the clinical and academic requirements of the training programme.

### 3.2.i. Ethical Considerations.

Since trainees are both university postgraduates and NHS employees, it was initially unclear where ethical approval should be sought. On the advice of the chairman of the ethics committee for the local health authority, I contacted the Advisory Committee on the Use of Student Volunteers for Experimental Work at Edinburgh University. Its chairman confirmed that vetting the study would be within its remit. A proposal was therefore submitted to the Advisory Committee, requesting permission to recruit trainees from the university's DClinPsychol course. Ethical approval for the study was subsequently obtained in October 1995.

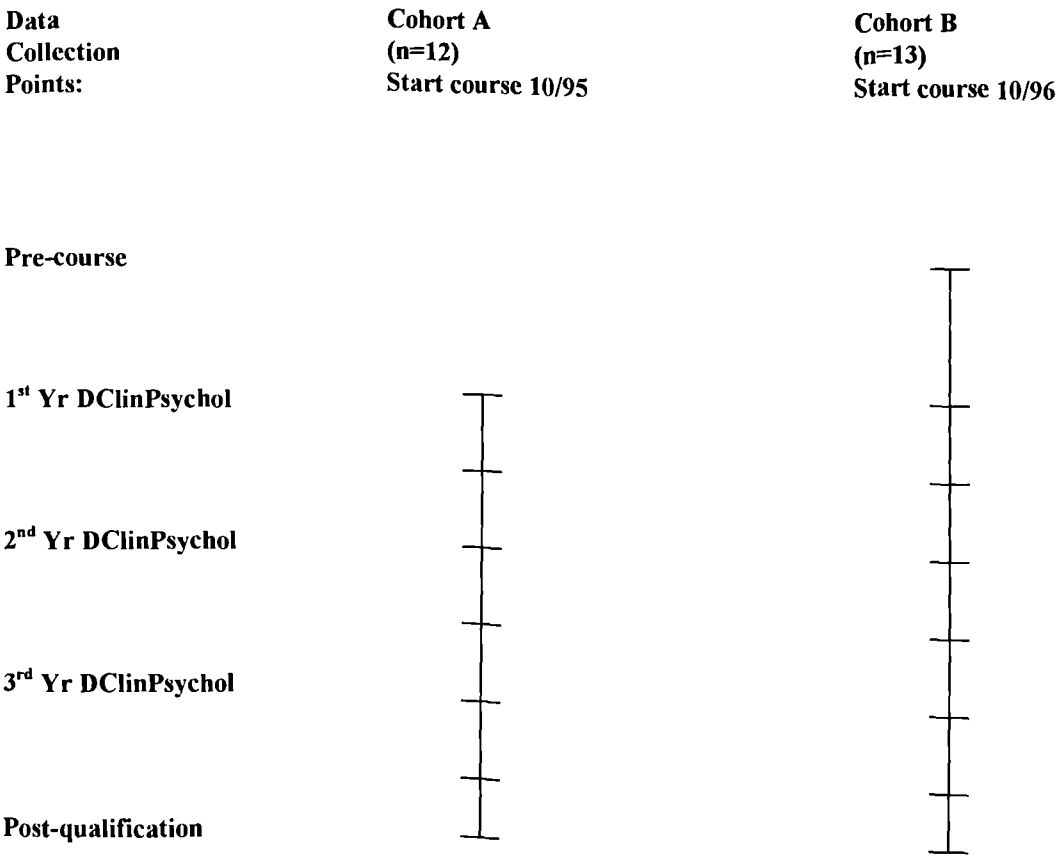
Obtaining ethical approval for the study was not the only ethical issue that required consideration at the outset of the project. In order to satisfy the ethics committee and allay anxieties of participants, as well as my own, it was imperative that I could guarantee confidentiality for my respondents. Clinical psychology is a small profession, and anonymity of respondents was therefore particularly important. For this reason, it would not have been appropriate to select a research supervisor from within the system I was studying. My eventual choice of research supervisors was based primarily on the expertise they offered, but it was also determined by the fact that they were clinical psychologists who had trained and currently practiced outwith the system being studied. I was therefore able to reassure potential participants that their responses would be heard/read in unedited form by me alone, while only my supervisors, who are not part of the local professional milieu, would have access to the data in the form of anonymous transcripts. Finally, I reassured participants that the data would be presented in this thesis or subsequent publications in a manner that would not permit the identification of individuals.

The preceding sections describe both the theoretical and procedural starting points for this investigation of professional socialisation in clinical psychology trainees. In the following section I will describe the initial study design, including the creation of the semi-structured interview guides, and the method I used to conduct those interviews.

### 3.3 Initial Study Design.

The initial study design was naturalistic and longitudinal. As noted above, I intended to recruit two consecutive intakes of clinical psychology trainees to the DClinPsychol course as study participants. Ideally, both cohorts would have been recruited after they had been accepted for clinical training, but before they began the course, so that I could begin by interviewing them about their experience of anticipatory socialisation while it was still occurring. However, a delay in receiving ethical approval for the study meant that the 1995 cohort was first interviewed three-four months after they began the course, shortly after they began their first clinical placement. The data obtained from these interviews supported the importance of interviewing the second cohort before they commenced formal training, to investigate whether they confirmed the 1995 cohort's retrospective account of anticipatory socialisation. A flow chart of the initial study design is provided in Figure 3.1:

**Figure 3.1: Initial Study Design**



This protocol allowed for one in-depth, face-to-face interview (45-90 minutes), and one briefer, follow-up interview (30-45 minutes, by telephone or face-to-face) during each year of training, plus one in-depth interview pre-course and one in-depth interview 12-18 months post-qualification. Clearly, professional socialisation is an ongoing process throughout one's career, and a cut-off point at 18 months post-qualification is therefore arbitrary. It is justifiable here primarily on pragmatic grounds: this protocol required data collection extending over a four-year period, which was the maximum that was feasible for a PhD project. However, this design was also sufficient to fulfill the study's aims and it allowed me to study two transitional points that I expected to yield rich data: the commencement of formal training and the transition to qualified status.

### 3.3 i. Recruiting Study Participants: Empowerment as a Research Goal.

Recruitment proved easy, and I obtained agreement from 100% of the psychologists whom I attempted to recruit. I think the study's face validity is the main factor that accounts for this unusually high rate of response: respondents perceived it as an important piece of research that would allow them to express their views about training and might lead to improvement in clinical training. Given that individuals struggling to get on to clinical psychology training courses, and trainees themselves, frequently feel disempowered by the system (see 6.1 i., 6.2 and 6.3 below), the empowerment that the study represented was its greatest inducement. Many qualitative researchers advocate empowerment or emancipation as a legitimate research goal. As Stiles observes:

> The imposition of an interpretation on participants' experiences can be seen as a political as well as a scientific act, and it inevitably has implications for the power relationships among the research's producers, consumers and participants. Taking this perspective directs attention to (a) constructing interpretations that further participants' interests rather than maintaining vested interests, and (b) involving participants in the construction of their interpretation. (Stiles, 1993, p.598)

Recruitment procedures were straightforward. Members of each cohort were initially sent letters at their university base, in which I introduced myself and the aims of the study, and requested their participation (see Appendix A). Individuals were invited to contact me for further information if required, and asked to sign and return the consent form if they wished to take part in the study (see Appendix B). In the case of Cohort B, who were initially contacted before they began the course, the

course administrator sent out the letters for me, since their home addresses were confidential. I followed up initial non-responders with a further letter, requesting a reply.

Once I had interviewed participants for the first time, other factors combined to prevent them dropping-out of the study. After each interview, I sent a transcript of our conversation to the interviewee. This not only allowed respondents to correct any errors I had made while transcribing, and gave them an opportunity to expand on points they had made in the interview, but it also added to their sense of empowerment. Furthermore, many interviewees commented that they had found their first interview session "therapeutic", because someone was listening to them for a change. This experience provided an additional inducement for them to speak to me again later.

### 3.3 ii. Creation of the Interview Schedule: Learning the Pitfalls of the Focus Group.

I decided to adopt a semi-structured approach to interviewing. Miller & Crabtree characterise this form of interview as "guided, concentrated, focused, and open-ended communication events that are co-created by the investigator and interviewee(s) and occur outside the stream of everyday life" (Miller & Crabtree, 1992, p.16). This approach is consonant with the "spontaneous, yet structured" active interviewing technique advocated by Holstein & Gubrium (1997, p.123).

Semi-structured interviews rely on flexible interview guides, composed of questions and prompts, which allow the interviewer to respond sensitively and empathically to respondents'concerns and priorities. To create my interview guide, I first identified a list of potential topics. This list was derived from the four research aims, presented in the previous chapter:

1. Does anticipatory socialisation influence professional socialisation during clinical psychology training?
2. Do clinical psychology trainees experience person-role conflict? If so, how does this arise?
3. Do clinical psychology trainees experience role ambiguity? If so, how does this arise?
4. With reference to Bucher & Stelling's (1977) model, what are the structural and situational variables that influence clinical psychologists' professional socialisation?

The list was then revised following discussion with members of my professional peer group. The revised list became the basis for a focus group that I conducted with third year trainees in the summer of 1995, while I was designing the project. These trainees did not participate in the main study.

The focus group itself, with a class of eleven trainees, had unexpected benefits and limitations. As an attempt to uncover how trainees had negotiated their clinical training, it failed. In this my first focus group, I received what Wiersma (1988) calls the "press release": when respondents provide the gloss on their experience that they think you want to hear, or is socially acceptable. I had naively assumed that this class of third year trainees would know each other well enough (and be sufficiently uninhibited with me) to feel comfortable in disclosing difficulties and dilemmas they had faced as trainees. Instead, my questions about issues such as ambiguity of role as a trainee, or the challenge of linking theory and practice, produced responses that downplayed the difficulties of clinical training and presented respondents as competent and confident professionals. A possible interpretation of this behaviour is that the trainees were "demob-happy" and exhibiting understandable euphoria, with the end of the course in sight while the realities of work post-qualification remained obscure. This interpretation was not supported by the different, less confident response I later received during individual interviews with another cohort of third year trainees (see Chapter 8). It is therefore more likely that the response from the focus group was, at least partly, an artifact of the situation.

Despite the failure of the focus group to meet my original objectives, it proved extremely useful in two respects. First, it taught me about the pitfalls to avoid in future focus groups, thereby improving the quality of the ones I ran during the main study. It also provided a vivid sense of the impression management that trainees (*en masse*, at least) considered necessary as they entered the profession. They reminded me of first year medical students whom I interviewed some years ago for another study. When those students were asked whether they had found their first contact with cadavers disquieting, most of them denied that the experience had had any emotional impact on them at all. To my surprise, these final year clinical psychology trainees adopted a similarly detached and dispassionate demeanor as they fielded my questions.

I was able to obtain more revealing feedback on my list of possible interview topics from questionnaires, which I circulated to the class at the end of the focus group for them to complete anonymously (see Appendix C). These responses did help me to focus the semi-structured interview guide. Most significantly, the questionnaires succeeded in uncovering trainees' doubts: about their choice of profession, competency, and their responses to the emotional impact of the work. Having

thus glimpsed the territory behind the press releases, I produced the guide that I used in the initial interviews (see Appendix D). As the study progressed, I allowed respondents' concerns to shape the interviews within the parameters of the study's objectives.

### 3.3 iii. Conducting the Interviews.

Most of the interviews took place wherever trainees were based for their clinical placements (or where respondents were working prior to starting the course), so I travelled to hospitals and clinics throughout the east of Scotland. On a small number of occasions, I interviewed respondents in their homes or in my office at the university, if this was more convenient for them. I generally opted for their place of work so that the interviews took place in their territory, not mine, and this also minimised the study's demands on participants.

Early on in the study, during the second round of interviews with Cohort A (while I was simultaneously conducting interviews with Cohort B), I decided to try out telephone interviews with trainees in Cohort A who were most geographically distant. I made this decision purely on pragmatic grounds. However, after conducting about six interviews by telephone, I abandoned this method because they yielded poorer quality data. Perhaps the rapport between the interviewees and myself was weaker on the telephone because the responses I obtained were less well elaborated. All the rest of the interviews in the study (a further eighty-four) were conducted face-to-face.

In all cases except the six above, I asked for permission to record the interviews, and all the participants agreed. On a few occasions, individuals volunteered more information after the tape was switched off, and I had to rely on retrospective notes to record these disclosures. In general, I found participants open and comfortable with the interview format.

3.3 iv. Triangulation.

Stiles defines triangulation as

> ...seeking information from multiple data sources, multiple methods, and multiple prior theories or interpretations, and assessing convergence. Convergence across several perspectives ...represents a stronger validity claim than does any one alone. (Stiles, 1993, p.608)

While the present study relies primarily on interview data, other sources of data were also utilised to facilitate triangulation. The major source outwith interview data was the literature generated by British clinical psychologists about their own profession. The majority of these references came from the principle professional journals that serve the profession: The Psychologist , Clinical Psychology Forum, and Bulletin of the BPS. Other key texts were theses, books and articles in other journals written by British clinical psychologists (for example, Cushway, 1992; Marzillier & Hall, 1999; Pilgrim & Treacher, 1992; Richards, 1983). This literature included examples of "impression management" by clinical psychologists attempting to improve the standing of their profession, as well as critical pieces by colleagues resisting professional closure. It therefore documents the historical and current debates within clinical psychology which have influenced the attitudes and practices of its members and provides the basis for understanding the system I intended to study.

The design also incorporated an element of participant observation as an additional source of data. Given my familiarity with the milieu I was studying, I did not consider it necessary to immerse myself in it for a period before beginning to interview trainees in order to understand their responses. I was also more interested in the stories trainees told about their experiences, than my own interpretations of their experience based on my observations. Here, as in therapy, I intended to immerse myself in the reality of the people I interviewed through hearing their stories, and then attempt to understand them within a particular social and historical context. As I argued above, I expected the writings of the profession to illuminate the context in a way that would enable me to understand how the training course I studied could be located within the bigger picture of clinical psychology training in Britain. However, I carried out a small number of exercises in participant observation during the first year of the study. These exercises had three objectives. First, I experienced the milieu as an observer and tried to view it through the eyes of my respondents; second, I sought disconfirmation of my hypotheses as a validity check; and third, I allowed myself the opportunity to discover unexpected issues that I could follow-up in interviews (Bryman, 1988).

Guba and Lincoln (1989) describe triangulation as fairness: a fair interpretation respects alternative constructions, including those of the study's participants. Throughout the study I sought out these alternative constructions in a number of ways. I returned transcripts of each interview to interviewees for their retention and asked for comments. As themes emerged, I presented them to interviewees for discussion in relation to experiences they were recounting.

I also sought views from other clinical psychology trainees about those expressed by the study's respondents. During the study period, I led a series of workshops with clinical psychology trainees at the University of Liverpool as part of their Professional Issues module. The workshops were based on my interviews for the study. Emerging themes (for example, anticipatory socialisation and status passages) were introduced for discussion. These sessions were invaluable as they provided an additional perspective from members of another course and helped me to separate the local issues concerning my respondents from those with wider relevance. I was explicit with the Liverpool trainees about the origin of the sessions I ran with them, and asked for permission to take notes (and later, to tape) these half-day workshops.

As discussed in Chapter 7, I introduced some similar workshops into the Professional Issues module of the University of Edinburgh/East of Scotland DClinPsychol course from September 1997 onwards (see 3.4 i. below). While the workshops for the Liverpool trainees took place only once with each class, those on the Edinburgh course were designed as part of a series extending through the three years of training and covered a wider range of issues explored in this research. Most of the participants in these workshops were not study respondents, and so this opportunity allowed me to sample the views of a further 45 trainees over a two year period.

Finally, in June 1998 I was asked to present my study findings to a meeting of psychology assistants working in Scotland. My presentation focussed on the experiences of the assistants whom I had interviewed, and the transition to trainee status. The ensuing discussion again provided an opportunity for triangulation as audience members commented on my findings.

### 3.3 v. Reflexivity

Describing the art of participant observation, Bogdewic comments: "...who you are and what you see cannot be separated, only understood" (Bogdewic, 1992, p.69). The same remark is equally

applicable to other qualitative approaches that assume the researcher and the researched are interdependent. This assumption requires the researcher to be reflexive: to try and understand and reveal his/her role in the study. Stiles, among others, notes that reflexivity involves the researcher's disclosure

> ...of his or her expectations for the study, preconceptions, values and orientation, including any theoretical commitments (collectively, *forestructure*). Despite inevitable limitations (e.g., investigators' limited insight or inability to articulate relevant preconceptions), these disclosures can help readers infer the observations' meaning to the investigator....Like the initial expectations, the investigator's internal processes while conducting the investigation and developing the interpretation...are part of the investigation's context. (Stiles, 1993, pp. 602-603)

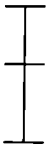
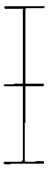
Lincoln & Guba (1985) recommend keeping a "reflexive journal" as one aspect of fieldwork documentation, to record one's changing values and assumptions in relation to the study. I incorporated this record-keeping into my fieldwork, and its usefulness became increasingly evident as the study progressed. Relevant insights taken from these notes will be disclosed in the chapters devoted to the study's findings.

### 3.4 Amended Study Design.

Eighteen months after I began data collection, following the above design, I was invited to apply for a post as lecturer in clinical psychology on the training course that I was studying. This raised ethical and theoretical dilemmas. If I applied for, and got the post, I would become part of the system I was studying. My perspective would inevitably change: I would be less detached about the phenomena I was investigating and would need to reconsider my attitudes towards the data. The ethical dilemma concerned my relationship with the study participants. I had by then interviewed trainees in first and second year. Even if I gave assurances that I would continue to maintain confidentiality if I joined the course, some of my respondents might feel compromised and regret disclosures made to me earlier. The question of confidentiality raised the third dilemma: once I changed jobs it would not be ethical to ask trainees to be interviewed further, and this meant revising the study's design.

I took advice from my research supervisor and other colleagues on all of these points. At the time that the possibility of changing jobs arose, the following interviews had been completed:

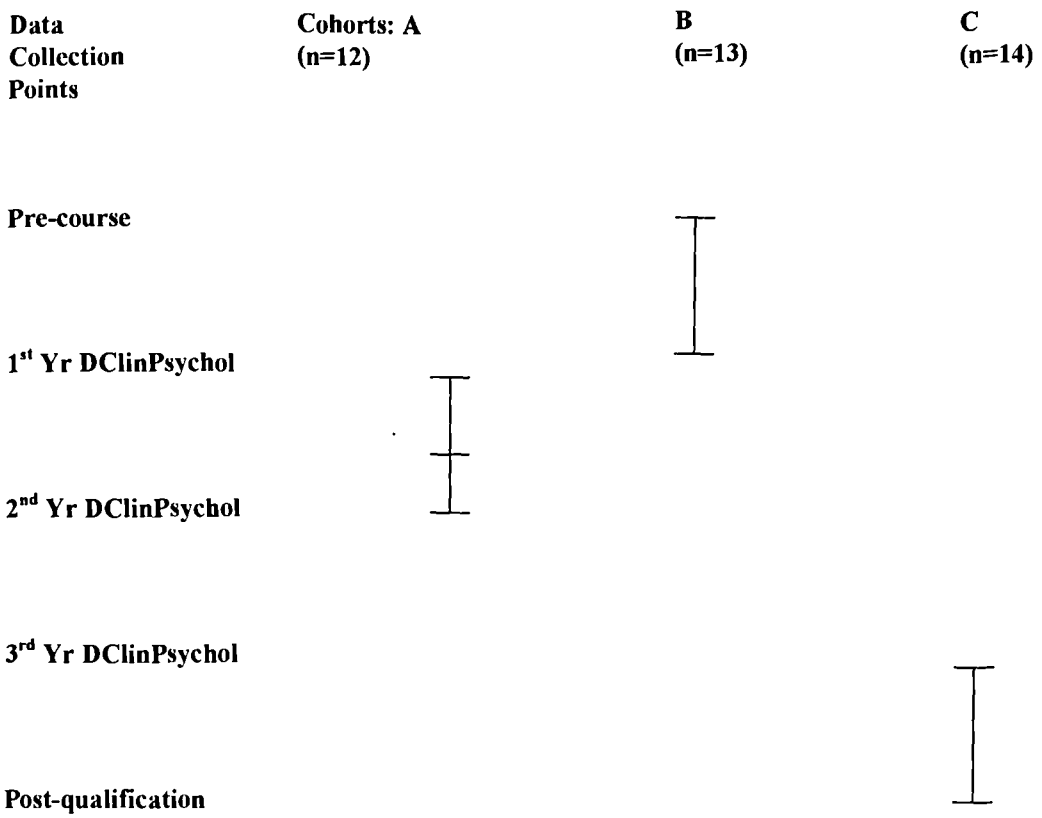
Figure 3.2: Data Collection Completed Before Study Design Was Amended.

| Data Collection Points: | Cohort A (n=12) | Cohort B (n=13) |
|---|---|---|
| **Pre-course** | |  |
| **1st Yr DClinPsychol** |  | |
| **2nd Yr DClinPsychol** | | |

I decided it would be possible to amend the original design, combining cross-sectional and longitudinal elements, so that I would not need to obtain further interviews from trainees on the course if and when I joined it as a lecturer. The amended design is presented in Figure 3.3. It includes three cohorts of trainees, representing five consecutive chronological stages of professional socialisation:

- individuals who have been offered a place on the DClinPsychol, but have not yet started professional training
- first year DClinPsychol trainees
- second year DClinPsychol trainees
- third year DClinPsychol trainees
- clinical psychologists 12-18 months post-qualification.

Figure 3.3: Amended Study Design.




The main disadvantage of the amended design was that it meant losing the purely longitudinal approach to the investigation. However, the objective of the study was not to examine the data for evidence of cause and effect, and a cross-sectional approach was adequate to sample trainees' experience at different stages in the socialisation process.

The main advantage of the revised design was that my change of role would enable me to incorporate an intervention into the study. Preliminary discussions about the prospective job with the Course Director indicated that, if successful, I would be asked to co-ordinate a Professional Issues module within the teaching curriculum. This would provide an opportunity to pilot a series of sessions with trainees, based on the interview data. These sessions would be designed to encourage reflection on and discussion of aspects of the training and socialisation process that respondents had

highlighted as particularly instructive or problematic. (For further discussion of the programme, see Section 3.4.i). An additional advantage of the revised design was that it would allow me to expand the number of study participants from 25 to 39, thus providing more diversity in the accounts I received.

Having generated a possible solution to the design problem, I considered the remaining theoretical and ethical issues. As I returned to the question of bias, I began to wonder if I was making false distinctions. In many respects, I was already part of the system I was studying: I was a graduate of the course I was studying and I knew many of the people in the system before I began this research. Denzin (1994) argues that all researchers take sides, either knowingly or unknowingly, because they approach the problem they are investigating with preconceptions and interpretations. He refers to the *hermeneutical circle* identified by Heidegger (1927): the circle of interpretation that all scholars enter. Denzin urges us to accept that preconceptions are inevitable and suggests that we expend our effort identifying them and disclosing them to our audience.

Qualitative research methods not only acknowledge the subjectivity of the investigator, but also frequently accommodate his/her shifting point of view. Adler & Adler (1987) note that membership roles in field research are typically fluid. They describe a continuum of roles adopted by researchers, ranging from that of the empathic but relatively detached participant, to that of the "convert" who has full "insider" status in the group. Within the tradition of field research represented by the Chicago School, investigators often move through different roles in the course of their data collection. In some studies, researchers may begin as passive participants, attempting to orientate themselves in the milieu while interacting very little with group members. They may then progress through a stage of moderate engagement with the group, to active engagement and "complete participation". In other studies, the pattern may be different. Investigators may begin from a position of active participation in the milieu they are studying, and increase, maintain, or decrease that involvement as their research progresses. Adler & Adler observe that the roles assumed by researchers are influenced by four factors: conditions in the field prior to their arrival; fieldworkers' personal characteristics; changes in the setting during the study; and changes in the fieldworkers during the study. Examples of the latter include changes in oneself as an individual, or as a social scientist wishing to assume new roles in pursuit of further data. This, then, describes the transformation I was contemplating.

For fieldworkers within the tradition of the Chicago School, the objective is to balance the benefits of insights acquired through actively participating in the group against the loss of perspective likely to ensue if they "go native":

> There can be no question of total commitment, "surrender," or "becoming." There must always remain some part held back, some social and intellectual "distance." For it is in the "space" created by this distance that the analytic work of the ethnographer gets done. Without that distance, without such analytic space, the ethnography can be little more than the autobiographical account of a personal conversion. (Hammersley & Atkinson, 1983, p.102)

This, then, would be the challenge if I changed roles: to maintain simultaneously an insider-outsider position (Lofland 1971) in relation to the course I was studying. That position has obvious parallels with the stance we adopt in therapeutic work, where sufficient identification with our patients' worlds is a prerequisite for effective therapy, but loss of analytic perspective reduces our effectiveness. I decided to take on the challenge of attempting this balancing act in a research setting, and came to the conclusion that changing my job need not compromise the integrity of my research if I was sufficiently reflective and self-disclosing about the change of role and shift in perspective.

On the question of my relationship with the study participants, I felt it would be unethical for me to pursue the post if trainees were unhappy about this. I discussed the issue with the Course Director, and decided to write to each of the study participants, advising them that I was considering the job application and asking them if they had any objections. With the agreement of the Course Director, I advised them that if I did apply and got the job, I would not take on any evaluative or supervisory role in relation to them, but would have only peripheral involvement with them as one of several lecturers running the course. In order to encourage a frank response, I invited the trainees to contact me by letter or phone, or to pass on their views to the Course Director, if they wished to remain anonymous. In the event, there were no negative responses from study participants. On the contrary, several of them contacted me to wish me luck with the job application, saying that they thought my research would enable me to make a useful contribution to the training course because I understood the difficulties they had had on the course.

After resolving the issues described here, I did apply for the lectureship and was successful in getting the post. The implications of my change in role will be explored further in Section 3.5 and again during the presentation of the study's findings.

### 3.4.i. The Intervention.

As noted above, empowerment of the research participants was an objective of this study from the outset. However, my change of job allowed me to incorporate an intervention that I hoped would further empower the participants, and empower their successors on the training course. In planning this extension to the original design, I was responding to a question asked of me by one of my first interviewees. She inquired what direct benefit my study would have for trainees on the course I was studying, or trainees in general. At the time, I was only able to answer her with the researcher's stock response: that publication of my findings in professional journals might influence trainers in clinical psychology to review their courses in the light of the issues I raised. This sounded unsatisfactory to me then, and her question provoked growing dissatisfaction with my own objectives as the study progressed. I therefore welcomed the opportunity to develop workshops for trainees based on this research. I anticipated that further opportunity to triangulate between different data sources would be an added benefit from the intervention.

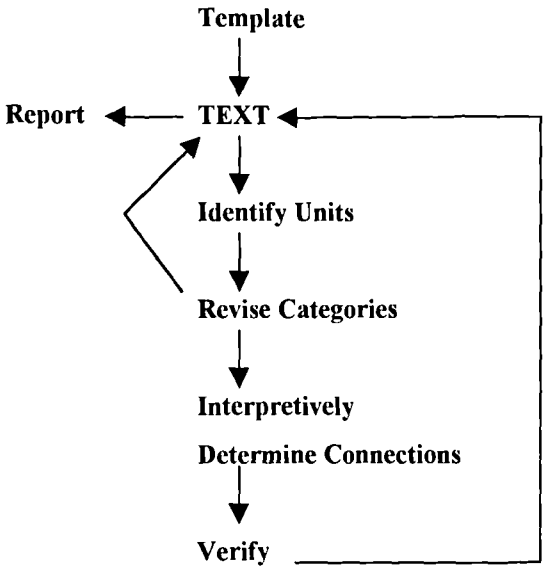
The intervention piloted during this study was a series of workshops led by me and incorporated within the Professional Issues module of the academic curriculum. They took place between October 1997, when I had been in post as a lecturer on the course for one month, and October 1999. The workshops were piloted with trainees in first, second and third year, beginning during trainees' induction week at the start of the course. The aim of the workshops was to encourage trainees to reflect on their experience of training and, more specifically, to encourage discussion of the issues raised by the study's respondents. The first workshop, for example, facilitated discussion of anticipatory socialization, couched in terms of trainees' expectations of the course, views about clinical psychology, and experiences of role ambiguity or conflict in the jobs they had done previously to gain clinically-relevant experience. Later workshops introduced themes such as the theory-practice split, returned to the subjects of role ambiguity and role conflict, and explored trainees' experience of "becoming professional". Sessions with final year trainees focussed on their preparation for the transition to qualified practitioners.

Each workshop was explicitly introduced to trainees as a product of my research, based on material drawn from interviews with their predecessors. I also used some verbatim quotations from the transcripts to stimulate debate, while taking care that these would not be attributable to any individuals. Using a combination of focus groups and questionnaires, I obtained feedback on the workshops from trainees and used this to shape subsequent sessions. For further detail about the content of these workshops and trainees' reaction to them, see Chapter 7.

## 3.5 Data Analysis

The approach to data interpretation taken in this study is characterised by Miller & Crabtree as the template analysis style. This process is summarised below in Figure 3.4.

**Figure 3.4: Data Analysis Using The Template Analysis Style (From Miller & Crabtree, 1992, p.18)**




The template, or analysis guide, can be derived from theory, research tradition, prior knowledge and/or an initial examination of the text. Boyatis (1998) notes that theory-driven code development is probably the most frequently used approach in social science research. The investigator starts with a theory concerning the focus of the research and then estimates how evidence relating to the theory will manifest itself in the data. The code reflects these hypotheses and therefore typically contains technical terms relating to the researcher's field. This study was a response to questions I formulated while reading the literature summarised in the previous chapter, and concepts such as anticipatory socialization, role ambiguity and role conflict informed the initial semi-structured interview schedule. The codes were therefore theory-driven. However, Miller & Crabtree point out that it is

entirely legitimate to begin with basic sets of codes derived from a priori theoretical understandings, and modify them after examining the text. Indeed, they advise that several iterations between template and text may be necessary, together with the collection of more data, until the template appears adequate. As the interviews proceeded, I applied my codes to each transcript as it was completed. In the process, the list of codes grew and the semi-structured interview schedule evolved to reflect participants' concerns.

Once the template, or codebook, is complete it can be used in one of two ways. The researcher can code the text and count the frequency of individual items to identify themes for further exploration. Alternatively, codes can be used as a "data management tool" and used to sort text segments to facilitate further analysis, generating clusters of themes. The latter path was followed in this study. The analysis then passes into the interpretive phase, when the units of meaning are assembled into an explanatory framework that is compatible with the text.

In terms of the practicalities of the data analysis, my field notes and interview transcripts were initially annotated with codes in the margins. The notes and transcripts were sorted first by individual code and secondly into clusters of codes. I then mapped the thematic clusters to achieve a diagrammatic representation of their interrelationships. The writing-up of the study paralleled the data collection and analysis: early descriptive pieces of writing identifying emergent themes became increasingly analytical as the account became more coherent and comprehensive. In the following chapters I will present the outcome of the data analysis: the findings of the study.

# CHAPTER 4

## RESULTS: SETTING THE SCENE

This chapter presents the characteristics of the study participants, the training course, and the wider professional/organisational context in which the course is located. This contextual analysis necessarily precedes an account of trainees' experiences, since meaning is context-dependent and contexts incorporate meanings (Mishler, 1979).

The specific objectives of this chapter are as follows:

i. to provide an account of why respondents chose to train in clinical psychology and why they selected this particular training course.

ii. to describe the occupational backgrounds of the study participants.

iii. to provide a detailed analysis of the training system in order to clarify the impact of structural variables on trainees' experience, with reference to Bucher & Stelling's (1977) model of professional socialisation.[8]

As discussed in Section 2.3 iii., these structural variables are both *external* (professional communities and larger formal organisations) and *internal* (the professional organisation itself and the structure of the training programme). In the following chapters, I will proceed to examine the influence of situational/interactional variables (such as role playing and modelling) on the socialisation process, and examine their transactional relationship with these structural variables. This exploration of professional socialisation will, therefore, integrate a micro and macro level of explanation. First, however, let us pursue the immediate objectives listed above.

[8] Throughout Chapters 4-8, which present the results of this study, the data will be contextualised, clarified and interpreted with reference to relevant research literature and theory. This breaks with the tradition in quantitative research where convention separates reporting of results from their interpretation. However, the approach I will employ is consistent with the conventions of qualitative method where "reporting is not separate from thinking, from analysis. Rather, it *is* analysis" (Miles & Huberman, 1994, p.299).

## 4.1 Characteristics of the Study Participants.

Cohort A (the 1995 intake to the DClinPsychol); Cohort B (the 1996 intake) and Cohort C (the 1994 intake) together yielded a pool of respondents totalling 39. The number of trainees in each cohort (A=12; B=13; C=14) is the total number of trainees in each class. This varies slightly from year to year, depending on how many training places are funded by the contributing health boards. The cohorts are designated A to C to signify the order of their recruitment to the study. Chapter 3 provides a summary of the stages in the socialisation process during which each cohort was interviewed (see Figure 3.3).

In terms of demographics, the three cohorts differed significantly only in gender distribution (M:F for A=1:11; B=5:8; C=2:12). Clinical psychology is predominantly a female profession[9] and this gender imbalance reflects the fact that more females than males complete undergraduate psychology degrees. The variance in male: female ratio of the three cohorts reflects apparently random variation in the gender ratio of applicants to the course: the course does not pursue a policy of positive or negative discrimination on grounds of gender. Since the male respondents constitute only one-fifth of the study participants, all the participants' observations reported in the following chapters will be attributed to females to prevent identification of individuals. There were no issues that arose in the course of the investigation that were identifiably gender-based.

The mean age of the trainees in the three cohorts was 27: range 22-36 years. The trainees had demonstrated commitment to the profession, in terms of work experience and academic choices, over periods varying from 1-11 years prior to commencing formal training (see 4.1 i. below). Thirty-one of the 39 respondents received their undergraduate psychology degrees from Scottish universities; 7 from English universities; and 1 from a university in the Netherlands. Eight of the trainees had also gained higher degrees before commencing the clinical psychology course: 4 had PhDs; 2 had MScs in Health Psychology; 1 had an MSc in Research Method; and 1 had an MA in Occupational Psychology. Finally, 1 trainee had previously completed training as a psychiatric nurse after finishing an undergraduate psychology degree. In every case bar one, individuals had pursued these higher degrees to maximise their chances of being accepted for clinical training, or as insurance in case they were unsuccessful in gaining a place on the course.

[9] Various commentators have noted that the higher echelons in the profession are nevertheless male-dominated in line with other "knowledge-based" professions such as medicine and law: see Murray & McKenzie (1998) and Pilgrim & Treacher (1992) for a discussion of the situation in clinical psychology, and Atkinson & Delamonte (1990), Goldie (1995) and Hearn (1982) for an account of male dominance in other professions.

### 4.1 i. Reasons for Choosing Clinical Psychology as a Career.

Respondents' experience of anticipatory socialisation prior to entering the DClinPsychol programme will be discussed in Chapter 5. However, it is appropriate to consider here how trainees made the decision to enter the profession. The majority (26 of the 39 respondents) first considered clinical psychology as a career during their undergraduate psychology degrees. This interest most commonly arose during their penultimate or final year, and was generally aroused through inclusion of clinical options in the undergraduate syllabi. Many of these individuals then chose clinical subjects for their undergraduate dissertations. Most of this group proceeded along a direct path to clinical training, acquiring the prerequisite "clinically relevant experience" after graduation (in addition to any previous experience) before applying for the DClinPsychol (see Figure 4.1). It was notable that the majority of trainees who first expressed an interest in clinical training as undergraduates were initially dissuaded by their lecturers on the grounds that it was so difficult to gain a training place that they would be better to choose another career. This advice prompted some trainees to "hedge their bets" by completing higher degrees or gaining experience in an allied field, such as social work or nursing.

**Figure 4.1: Study Participants' Routes to Clinical Training.**


Entry to clinical psychology training: N=39

A further eight trainees first considered clinical psychology as a career while they were at secondary school, and three-quarters of this group were influenced by direct/indirect experience of psychosocial difficulties. The least common route to clinical training followed a relatively late career choice, made after completion of an undergraduate psychology degree.

It was striking how few trainees initially considered clinical psychology because of first-hand knowledge of the profession, although this is perhaps predictable given its relatively small size. Nearly one-quarter of the total group had received some form of psychological therapy/pharmacotherapy prior to training, or had been involved in/witnessed intervention on behalf of a relative/close friend. However, in only one instance was the therapist a clinical psychologist: more commonly the help came from GPs, psychiatrists or other mental health professionals. No one was following another member of the family/close friend into the profession. One-fifth of the respondents considered other health care professions (most commonly medicine, psychiatry, or nursing) before settling on clinical psychology.

In summary, the main factors acknowledged by trainees to have influenced career choice were intellectual interest (combined with a desire to find a career within psychology), followed by personal experience (direct or indirect) of difficulty. In half of the cases where personal experience was a factor, individuals reported that the help they/relatives/friends had received was inadequate. Clinical psychology training was their response to that experience of unmet needs.

While intellectual interest was readily acknowledged as a motivating factor (forming part of respondents' initial "press release" to me in the early stages of our first conversation), trainees generally (and quite understandably) required prompting before they revealed the impact of life events on their decision. They were even more guarded about acknowledging the desire to help others, or understand themselves, as motivating factors. In fact, the majority identified "helping" or "caring" as central to their professional role, but they were uniformly cautious about expressing this.[10] The identification of these respondents with the caring role replicates the findings of Claridge & Brooks (1973) who interviewed Glasgow clinical psychology trainees nearly thirty years ago: see 2.6.ii. above.

In response to my question about why she had chosen clinical psychology, one respondent revealed her underlying motivation, while suggesting that her response was not politically correct:

[10] In the following paragraphs I am attempting to make sense of how interviewees decided what information was suitable for the press release (Wiersma, 1988), and what should remain private, by comparing them with existing "cultural stories" (Miller and Glassner, 1997: see 3.1.i. above) within the profession. It could be argued that interviewees will always begin with an account that reveals least about themselves. However, that view still assumes distinctions between public and private knowledge, which are culturally based. My argument here is that the culture within clinical psychology, which promotes the scientist-practitioner model, discourages its members from publicising personal values that conflict with the values implicit in this model.

> ...I was genuinely interested to hear people talking about their lives and what's happening, and I enjoyed with them trying to work out what had been happening and I felt that I generally got on quite well with people, and some wish to help people...in terms of you seeing somebody and at the end of the day they're feeling better and you get something from that. So, I always thought those types of things, but it's hard to put exactly into words. They're all the sort of things you shouldn't say, you don't say, oh, I want to help people, which seems to me slightly silly because I'm sure that's the underlying rule for people going into professions like psychology. (C10:4)

Her statement that "you shouldn't say...I want to help people" was echoed by several other trainees. This reaction fits with my own experience, both in terms of how members of the profession advised me and my peers to prepare for our selection interviews, and the advice colleagues continue to offer applicants.

As noted in 2.6.ii. above, clinical psychology in Britain has evolved in a milieu dominated by the medical model, and key figures in the profession, following in the steps of Eysenck, have promoted the model of the scientist-practitioner to enhance its respectability, and hence its status. The dilemma of acknowledging their work as carers, while defending their professionalism and avoiding exploitation, is not, of course, unique to clinical psychologists. Recent public debates in nursing have highlighted the dissatisfaction of some of its members with Florence Nightingale as a role model for the profession. Her detractors argue that the white, middle-class, Lady Bountiful image of nursing associated with her is unrepresentative and detrimental to the advancement of the profession. Abbott & Wallace (1990), Witz (1992), and Macdonald (1995) discuss the gender politics associated with the development of the caring professions and argue that the institutionalised subordination of women in these occupations involved distinctions between "masculine" skills, such as scientific objectivity and "feminine" abilities, such as caring and compassion.

I will return to this issue in Chapter 9, when I discuss the findings on the present study. For now, it is sufficient to note that the respondents in the present study displayed their awareness that it was not politically correct to declare their interest in "caring" or "helping" people. This awareness was present among those whom I first interviewed before they began the course, as well as those who were already trainees when we first met. Within the former group this understanding must have arisen through anticipatory socialisation.

4.1 ii. Reasons for Choosing This Particular Training Course.

In comparison with the question of how trainees selected their future career, their decisions about where to apply for training were straightforward. The two main factors which trainees considered when applying for courses were location and likelihood of acceptance. Most of the respondents were Scottish, were settled in Scotland, or wished to return to Scotland after leaving for education/work. Individuals were also pragmatic when making their choice: those working in regions served by the course believed that this would enhance their chance of being accepted for training because of recruitment issues (see 4.2 ii. and 2.6.i. above).

Most of the trainees had made little effort to select a course on the basis of content or organisation. The majority considered that there was very little difference between the clinical psychology courses in Britain and judged that any one of them would probably be satisfactory. (This may be post hoc rationalisation, given the difficulty of securing a training place). Only three of the 39 trainees began the DClinPsychol with any dissatisfaction about their choice of course. One person favoured the University of Liverpool course because she preferred its description and the fact that it was located in a department of clinical psychology rather than a department of psychiatry; another favoured the course at the Institute of Psychiatry because she thought it was more prestigious; and one English trainee expressed concerns about experiencing racial discrimination in Scotland.

4.1 iii. Relevant Experience Prior to Formal Training.

Having considered the reasons why these trainees chose this profession and this course, it will bring the group more clearly into focus if we next consider the variety of "clinically relevant experience" acquired by these individuals before they joined the course. This course, in line with the majority of British clinical psychology courses, selects trainees on the basis of experience and academic merit. In practice, after completing their undergraduate degrees in psychology, successful applicants have generally worked for at least one year, full-time, to gain this experience. This period of employment is more typically 18 months to two years, and it is not uncommon for it to last longer if individuals make several unsuccessful applications or decide to delay their applications. In addition to this period of full-time work, most applicants have previously worked in part-time or voluntary posts, often as a route towards full-time paid work.

Table 4.1 summarises the distribution of work experience acquired by trainees before they commenced formal professional training. Since most people fill a number of posts over several years, the numbers total considerably more than the number of trainees (39). The matrix shows that the bulk of this early work experience was acquired through psychology assistant posts and voluntary work within learning disabilities and adult mental health, followed by clinical research posts within adult mental health. This weighting among the psychology assistant posts reflects the availability of these jobs. Until recently, the majority of these have been in Learning Disabilities because of chronic difficulties recruiting qualified staff in this field. Within the last few years, psychology assistant posts have become more common within adult mental health; however, the degree of clinical contact experienced by these assistants is often less than that of their colleagues in learning disabilities who are frequently making up for a shortfall in qualified staff.

**Table 4.1: Work Experience Acquired by Individuals Prior to Commencement of DClinPsychol.**

| ROLE | CLIENT GROUP | | | | | |
|---|---|---|---|---|---|---|
| | Learning Disabilities | Adult Mental Health | Child /Adolescent | Elderly | Neuropsych -ology | Forensic |
| Psychology Assistant | 14 | 13 | 5 | 0 | 4 | 1 |
| Research | 1 | 9 | 1 | 1 | 1 | 2 |
| Residential | 0 | 3 | 0 | 0 | 1 | 0 |
| Voluntary | 10 | 12 | 5 | 0 | 0 | 1 |
| Nursing /Care Asst. | 2 | 3 | 3 | 4 | 0 | 0 |

I will return to the question of trainees' pre-course work experience in the next chapter, when I will discuss the impact of these early experiences in terms of anticipatory socialisation. However, having provided an initial profile of my respondents, I will now provide a similar gloss on the characteristics of the course they joined in order to finish setting the scene. The contextual analysis presented below differs from the analyses presented in the rest of the Results Chapters in its reliance on official documentation (from the BPS and the training course itself) and my own observations while a

lecturer on the course. The remainder of this chapter only refers briefly to trainees' first-hand accounts of their experiences.

## 4.2 Organisation of the Training Course.

Bucher & Stelling's (1977) model of professional socialisation proposes an interaction between the structural and situational variables implicated in this process. Their view of the structural constraints that shape trainees' experience emphasises *process* and *segments* (Bucher & Strauss, 1961; Atkinson 1977; and see 2.3 ii. above). From this perspective, professions are continually in flux: their relationships with external bodies are always changing while relationships between segments, or subgroups, are subject to constant readjustment. With these assumptions, Bucher & Stelling began their exploration of professional socialisation in biochemists, physicians and psychiatrists with several questions relating to the identity and function of the structural variables. These questions addressed the following issues: (1) the nature of the organisation housing the training program and its affiliations with other institutions; (2) the relationship between the course staff and both the training institution and the larger professional community; (3) the relationship between professional segments and their impact on the training programme; (4) the structure and content of the training programme itself: and (5) the nature of the selection processes operating in the training organisation (Bucher & Stelling, 1977, pp.21-24)

In the following sections I shall address these questions with respect to the University of Edinburgh/East of Scotland course, in order to illuminate the factors that shaped the experiences described in successive chapters. Specifically, I will describe the structural components of the institutions in which the course is embedded, and show how these have shaped the training course. I will conclude by commenting on the selection process, and what this reveals about the ideology of the course.

### 4.2 i. The Location and Administration of the Training Course.

The organisation of the training course is complex. Like the majority of other clinical psychology training courses in Britain it is university-based, but depends on the NHS to fund the training and to provide placements for trainees' clinical experience.

The course is based in a university department of psychiatry, within the faculty of medicine. Its physical base is a university building in the grounds of a large psychiatric hospital. The location of a clinical psychology course within a department of psychiatry has a certain irony, given the history of territorial warfare between the two disciplines.[11] The small number of clinical psychology staff (5) in a department of 16, particularly where psychiatrists hold most of the senior posts, has the potential to leave the psychology staff feeling marginalised.[12] The main consequence for trainees of this organisational feature is that most of the case conferences and visiting speakers at their academic base have a psychiatric, rather than a psychological orientation. In practice, this has limited implications for trainees who are infrequently available to attend these, even if they wished to do so. With the exception of occasional teaching contributions from psychiatrists (considerably less than when I trained), the trainees have little contact with members of the department other than the course staff. It is possible to argue that this limited integration is attributable to the psychologists' alienation from the dominant ethos in the milieu. However, it is equally likely that it results from the limited time trainees spend at the university, and their stronger allegiance to the clinical psychology department(s) where they do their placements.

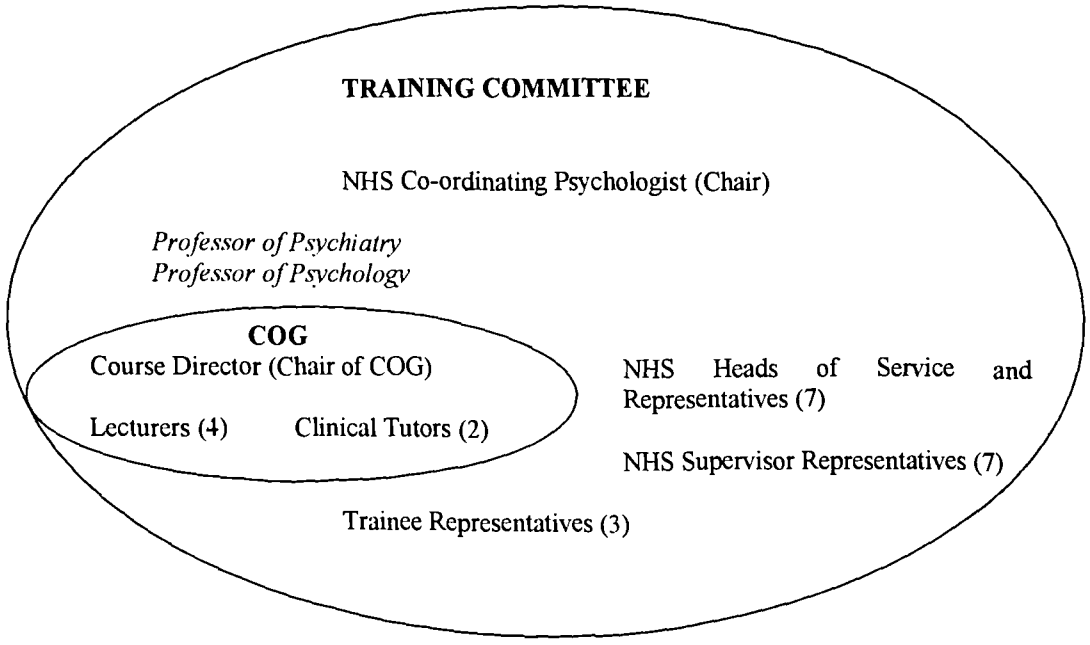
The day-to-day running of the course is the responsibility of two full-time and three part-time clinical psychology lecturers, two part-time clinical tutors and an administrator. This core group (the Course Organisation Group, or COG) meets fortnightly to discuss internal organisational matters; the academic curriculum; evaluation of trainees through examinations, written work, and clinical performance; and the welfare and progress of trainees. The course director, who is a full-time member of the university staff, chairs COG. All of the lecturers and tutors do clinical work within the NHS on one or more days per week and therefore have varying degrees of affiliation with both the university and the NHS. Lecturers and tutors also share clinical and academic roles in relation to trainees, although the lecturers have a larger commitment to the academic component of the course while the main business of the tutors is organising and monitoring the clinical placements. All lecturers and tutors are Directors of Studies for trainees (monitoring and evaluating their progress); mark written work and examinations; and teach on the course. In addition, lecturers and tutors are frequently acting as clinical supervisors for trainees on placement. This core group of course staff therefore represents the nexus between the university and the NHS.

[11] Only two other clinical psychology courses (of the 26 training courses in England, Scotland and Wales) are based in university departments of psychiatry: the Leeds and Newcastle courses. Most of the other courses are based in departments/schools of psychology/clinical psychology.

[12] The 11 psychiatrists consist of 2 Professors, 2 Readers, 4 Senior Lecturers, and 3 Lecturers; in clinical psychology, there is 1 Professor and 4 Lecturers.

While COG administers the course, the Training Committee (which meets two-three times a year) determines policy issues and takes larger organisational decisions, (see Figure 4.2). All the stakeholders are represented on the Committee: the members of COG; NHS supervisor representatives; Heads of Service for the different regions that provide training places; trainee representatives; and representatives from the university departments of psychiatry and psychology (who do not attend). The Committee is chaired by the NHS Co-ordinating Psychologist, who is the trainees' line manager, and represents the lead Trust for the East of Scotland consortium of Health Boards.[13] Through this committee, the university and the health service share responsibility for running the course.

**Figure 4.2: The Composition of the Training Committee.**




[13] Currently, this consortium of seven Health Boards contributes funding for these training places on a *pro rata* basis, and this is administered by the lead Trust. At the time of writing, the Scottish clinical psychology courses are in the process of joining the Scottish Council for Postgraduate Medical and Dental Education. This will alter funding arrangements and also has implications for the administration of the course. It is likely that the Training Committee will be reconfigured, but it is not yet clear what shape it will take.

4.2. ii. The Relationship Between the Training Course and Associated Institutions.

COG and the Training Committee are, in turn, part of a larger institutional context. Both are constrained by the demands and expectations of the British Psychological Society (which provides course accreditation every five years); the university (which awards the doctoral degree and must approve, for example, rescheduling of examinations or suspension of a trainee's degree registration on medical grounds); and the NHS Trusts that fund the trainees and provide clinical placements. Figure 4.3 illustrates the organisation of the course and the links between its internal structure, and the professional communities and larger formal organisations external to it:

**Figure 4.3: The Relationship Between the Training Committee and Associated Institutions.**

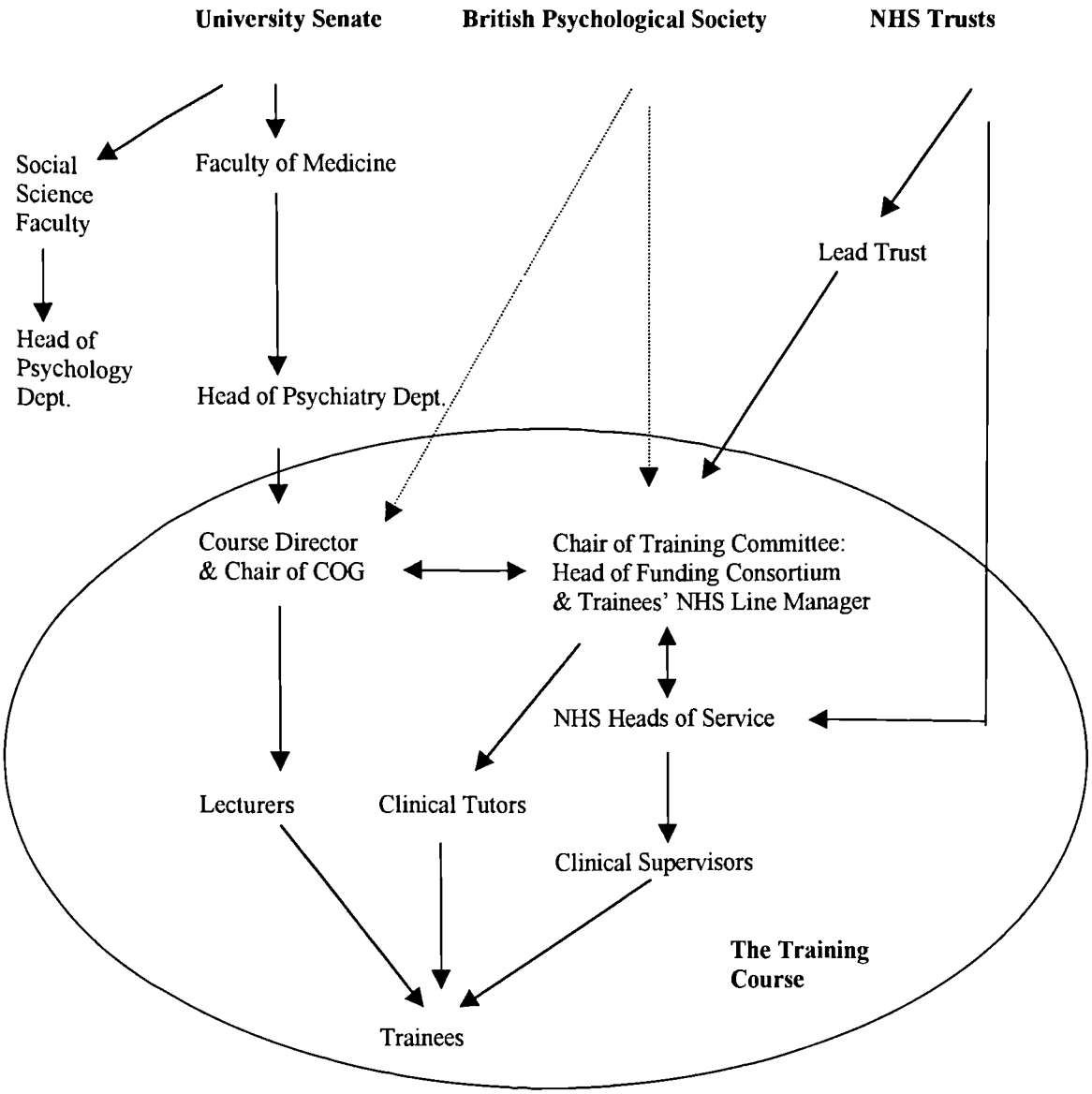



Figure 4.3 shows the relationship between the training course and the three major institutions that support it. It also delineates the lines of accountability for those involved in running the course. For example, the course director is accountable to the university, while the trainees' NHS line manager is accountable to the lead NHS Trust representing the consortium of NHS Trusts that finance the training posts. The downward arrows from the British Psychological Society (BPS) to both the

Course Director and the trainees' line manager are drawn with broken lines to indicate professional accountability (since the BPS accredits the course), rather than direct accountability to a line manager within the same organisation. The bi-directional arrow between the Chair of COG and the Chair of the Training Committee indicates a high degree of mutual influence. Within the course structure, these two individuals hold the most powerful positions, as chairs of the two main policy-making committees. They also share the right of veto in the selection of course applicants and would play key roles in any decision to fail a trainee (through the university) or dismiss a trainee for professional misconduct (through the Trust Personnel Department). Within the power hierarchy, the NHS Heads of Service occupy the next rung of the ladder in the formal course structure, although there is again a high degree of bi-directional influence between them and the Chair of the Training Committee. When trainees are doing their clinical placements, they are also accountable to these individuals through honorary clinical contracts that cover them in their place of work. The Heads of Service therefore assume more power in relation to trainees within the "real world" of work, particularly given their status as potential employers. However, the Heads of Service are also subject to constraints, principally those imposed on them by managers in their own Trusts/Health Boards who will determine staffing levels and facilities (such as office space for trainees) within these departments.

The relationship between the university and NHS staff in relation to the course has changed considerably over the past ten years. A decade ago, a vigorous power struggle between members of the two institutions was significantly undermining the course. Informal discussions (before and after I became a lecturer myself) with both camps confirmed the impressions I gained of this struggle during my training days (1991-3). The view generally expressed by each group is that relationships between the university and NHS reached their nadir between the late 1980's and early 1990's. During this period, both sides became increasingly suspicious and dismissive of the training objectives of the other. Coupled with the enduring dissatisfaction within the profession as a whole about the insufficiency of training places, the rift between the university and NHS led to discussions among NHS stakeholders about terminating their relationship with the university and returning to in-service training. This model was common in the 1970s and 1980s but has now largely disappeared in Britain (see 2.6 ii.). Local disagreements became entangled with wider issues that were polarising the profession. The national trend towards replacing the two-year clinical psychology Masters courses with three-year Doctorates, driven by the British Psychological Society, increased the dissatisfaction of some of the NHS stakeholders. Against the background of recruitment difficulties in the NHS, moves to prolong clinical training were seen by some members of the profession as counter-productive and ill timed. Critics dismissed it as an attempt to further professional closure in response to the increasing competition faced by clinical psychology from other occupational groups, such as counsellors and nurse-therapists. The Edinburgh course was, in fact, one of the last courses to adopt the three-year doctoral model. It first awarded the DClinPsychol in 1997.

It is arguable that this rift between the university and the NHS was possible because the Scottish NHS was a less powerful stakeholder in the course at that time. Prior to the 1990s, the Scottish NHS funded very few trainees (many were self-funded); over the past decade self-funded places have not been offered and the Scottish NHS has funded them all. The university has therefore been obliged to recognise its dependency on the NHS for funding, and this increased interdependency (with the university providing the BPS-approved professional qualification) has prompted both sides to develop an effective partnership.

The image of the phoenix rising from the ashes is unnecessarily dramatic here, but the course has certainly emerged from this period of conflict with renewed vigour. Some tensions remain: negative stereotyping is still detectable on both sides, with some NHS representatives caricaturing the university staff as residents of an ivory tower who are out of touch with the pressures of NHS work (despite the fact that all the university staff do 2-6 NHS sessions per week). In response, university staff privately criticise NHS colleagues whom they consider insufficiently rigorous as scientist-practitioners as members of the "muddle-through" class of clinical psychology. Despite this intermittent jibing, relationships have improved substantially over the past five years. This is largely attributable to changes in course organisation (represented by the Training Committee) designed to improve communication between the university and the NHS, and increase ownership of the course by stakeholders in the NHS. One indication of this new ethos is that its previous title – the University of Edinburgh Clinical Psychology Training Course – was changed in 1994 to the University of Edinburgh/East of Scotland Clinical Psychology Training Course.

4.2 iii. The Impact of Professional Segmentation on the Course and its Trainees.

Figure 4.3 is misleading in one respect: it presents the BPS as though it were a monolithic structure, rather than an umbrella organisation for a collection of interest groups, or segments (Atkinson, 1977). These segments form a complex stratified network of Divisions (e.g. Division of Clinical Psychology; Division of Educational and Child Psychology); Sections (e.g. Cognitive Psychology Section; Psychotherapy Section) and Special Groups (e.g. Special Group in Clinical Neuropsychology).[14] Within the hierarchy, segments periodically jockey for position within the

[14] The BPS provide the following criteria: Divisions are "clear professional groupings"; full membership requires an approved postgraduate training. Special Groups represent members working in a particular field; members have "some defining characteristic...that is less rigorous than that

hierarchy. For example, the Special Group in Clinical Neuropsychology has recently asked BPS members to vote on a proposal that it become The Division of Neuropsychology. In its proposal, the following rationale for the change is given: "There is a general tendency for most successful Special Groups to evolve into Divisions, which have a more substantial position within the Society's organisation". (BPS, 1999). In terms of this study, professional segmentation primarily impacts on trainees in two ways: through the Division of Clinical Psychology's sub-division into Special Groups representing specialised areas of work with particular client groups, and Groups representing different therapeutic schools. Typically, trainees first experience professional segmentation before they begin the course and the course structure later confirms this experience.

If we confine the discussion initially to trainees' experience of segmentation prior to the course, we can understand the impact of segmentation based on area of clinical work from the following example:

> So the first psychology job I did was working for the University of -----. And I was looking at the psychosocial consequences of chronic illness...And when I left there I worked for, um, -------- in the brain injury unit there, as a residential care worker...and [then] I applied for about 12 jobs, only 3 of which were assistant psychologist posts. The others were sort of project workers, or things like that, but I was mostly interested in doing assistant jobs...and then...I had an interview to be an assistant psychologist over at ------ in the neuropsychology department. I've never really made a strict decision that I was particularly interested in neuro...I just thought, well, I've got kind of hospital based experience in a neuro setting, so if I apply for assistant posts in neuro I've got a better chance...I didn't know enough about different areas of clinical psychology to make a decision...I thought I had very limited experience of just one area.... (A10:1)

This respondent entered the course directly from the last post described above: at that stage all her experience in clinical psychology was in neuropsychology. For some respondents, this early identification of clinical psychology with one area of clinical work may be strengthened through their involvement, as psychology assistants or research assistants, in one of the Special Groups. By attending Group meetings and/or helping to organise events, they may develop a greater degree of affiliation with a clinical speciality, which may continue or dwindle during their formal training. In the case of the trainee quoted above, she began the course "very sort of pro-neuro", and then discovered that she had "kind of drifted away" during her first placement in adult mental health and was no longer sure that she wanted to work, post-qualification, in neuropsychology.

The second form of segmentation that impacts on trainees before they enter formal training is the division between different therapeutic traditions and their adherents. This form of segmentation cuts

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required for a Division". Section members "pool and exchange scientific interest and knowledge". (BPS, 1995)

across the segmentation based on client group. (It also cuts across divisions based on professional discipline, but that takes us beyond the parameters of the present analysis). For example, my own clinical area is adult mental health. I recently trained in Dialectical Behaviour Therapy, to work with parasuicidal adults with borderline personality disorder. Most of the British clinical psychologists who have trained in DBT also work with adults, but a small number work with adolescents and are adapting the DBT model for young people who self-harm. Locally, there is a team working with adolescents, and our team working with adults. Periodically we meet to share supervision and training: the DBT model provides us with common ground despite our different client groups.

Psychology assistants and trainees detect the segmentation based on therapeutic traditions, even before they have a clear understanding of what the traditions represent. One assistant, who moved from a department with a psychodynamic emphasis into one with a strongly cognitive behavioural orientation, rapidly became aware of conflict between the two. She described her new head of department as "all scientist practitioner, and if you weren't cognitive-behavioural, you weren't worth knowing", and she reacted by allying herself privately with her previous head of department:

> I knew that the department at ----- didn't really fit in with what was going on up here, and I knew what I was letting myself in for. I didn't expect it to be as fulfilling but I thought it might be useful, and in a way I'm glad because its given me a different perspective, if only to say 'what you're doing is rubbish.' (B8:1)

The segmentation within the profession, to some degree institutionalised through the Divisions, Sections and Groups of the BPS, is reflected in the organisation of the training course. The DClinPsychol offers a generic training covering core areas (adult mental health; learning disabilities; child and adolescence; and older adults) as required by the BPS, plus electives in areas such as forensic and neuropsychology. During the first two years of the three-year course, trainees complete blocks of teaching in each of the core areas (plus neuropsychology), followed by a clinical placement with the same client group. The teaching is organised and delivered by clinicians working in these areas, so the different segments are represented in turn. While individual trainees each receive varying degrees of experience in the different fields, their obligation to complete clinical placements in the core areas at least introduces them to several client groups and allows them to form a view of the profession based on more than one segment. Similarly, although the course has a strongly cognitive-behavioural orientation (in common with most clinical psychology training courses in Britain) it introduces trainees to other therapeutic models through lectures, workshops, and clinical placements, where available.

The following chapters will return to this question of professional segmentation and consider in more detail how trainees experience it. However, I will now turn to the issue of trainee selection, and conclude this chapter with a discussion of that process, and its implications.

### 4.2 iv. The Selection of Trainees.

Given that these trainees are future entrants to the profession, the selection processes that the courses operate tell us quite a lot about the selectors' view of the profession and what they require of prospective members. For the University of Edinburgh/East of Scotland course, selection of trainees is a joint NHS-university enterprise, both at the initial stage of screening applicants and at the interview stage. The vetting of applicants occurs in three stages. Applications are initially screened by the university staff and NHS Supervisor Representatives, and rank-ordered on the basis of academic merit, relevant experience and general suitability (including commitment to Scotland). The resulting short-list goes to NHS Clinical Psychology Heads of Service/Representatives for each of the Health Boards in the East of Scotland, to select a briefer list of candidates for interview. At interview, candidates are assessed by a panel composed of the Course Director, the NHS Co-ordinating Psychologist (Chair of the Training Committee), an NHS Head of Service, and an NHS Supervisor Representative.

In 4.1ii above, I discussed trainees' reasons for selecting this course. If we now consider the other half of the equation, we find that the selectors' rationale matches that of the applicants quite closely. Trainees generally assumed that most courses were roughly equivalent in terms of what they offered, and based their applications on location and likelihood of acceptance. As footnoted in 2.6.i. above, their belief that it would strengthen their application if they indicated a willingness to work in Scotland post-qualification is supported by the course's information on entry requirements (University of Leeds Clearing House Handbook, 2000). The selectors' ability to prioritise applicants' commitment to Scotland is possible because of the number of high calibre applicants. In 2.6.i. I reported that 24% of applicants gained training places nationally in 1999; this compares with a success rate of 9% for applicants to the Edinburgh course in the same year who were competing for 16 places. In other words, selectors can prioritise the likelihood that trainees will accept jobs post-qualification because there are so many applicants who are roughly equivalent in terms of what they offer the selectors.

Given the choice of suitable candidates available to selectors, what other factors do they consider in making their choices? The following observations are based on my own involvement in the selection process as a lecturer on the course. Trainers do not want "empty vessels" entering the course (Olesen and Whittaker, 1968), preferring applicants who know what the job entails and whether or not they are suited to it. Both university and NHS selectors attach considerable importance to applicants' previous experience in the health service and, ideally, within the profession itself. A degree of professional socialisation is, therefore, considered desirable. The attributes that selectors typically associate with adequate, rather than over-socialisation ("the premature prima-donna" Olesen and Whittaker, 1968), include: experience of "getting one's hands dirty" with clinical work; understanding something about the stresses of working in the NHS, with its waiting lists and strained resources; and a recognition of the limits of one's competency and knowledge at this stage of training. Applicants are rewarded for indicating allegiance to the scientist-practitioner model and penalised for indicating that they want to "help people", since the latter is interpreted as naïve and unprofessional.

Selectors judge whether sufficient socialisation is likely to have occurred on the basis of the application form, referees' reports and the selection interviews. In many cases (17 of the 39 respondents in this study), one or more of the selectors know the applicants, since most of them have worked as assistants in NHS departments linked with the course. Candidates' prior experience provides a foundation for formal training. However, its main value lies in the opportunities it gives for individuals to assess their suitability for the job, and for future employers to do the same, since this increases the likelihood that trainees will successfully complete clinical training. Given that clinical psychology training costs approximately £250,000 per trainee over a three-year doctoral programme (McPherson, 1998), there is significant cost to the NHS when an individual fails to complete the course.

Once selected, trainees assume a tripartite identity. Firstly, they are post-graduate students, matriculated through the university's social science faculty (although the course is located in the faculty of medicine). The DClinPsychol, which they receive following the successful completion of the course, is their professional qualification.[15] Secondly, they are salaried employees of Edinburgh Healthcare Trust: the Trust administers salaries and contracts on behalf of a consortium of seven

[15] In this respect they differ from the psychiatry trainees, who obtain their professional qualification from the Royal College of Psychiatrists and register for, but do not always complete, their M Phil through the university. Their identity as trainees is arguably, therefore, less fragmented.

Health Boards that provide clinical placements and contribute to a funding pool for this purpose. Thirdly, trainees are members of individual clinical psychology departments distributed within these Health Boards. Trainees are appointed to work within a particular Health Board, and they then complete all/most of their clinical placements within that region. There is the expectation (which is not formalised contractually) that trainees will work in the same region after qualification, thus easing recruitment difficulties. The different hats worn by trainees, and resulting affiliations, have significant implications for the process of professional socialisation, which I will discuss further in Chapter 6 and 7.

### 4.2. v. A Summary of the Impact of Structural Variables on Trainees' Experience.

In conclusion, the balance of power between the university and the NHS within the course structure has shifted significantly over the past decade in favour of the NHS. The course now has, in effect, an informal contract for training with the NHS. This reduction in the university's autonomy has resulted in both university and NHS course staff prioritising selection and training for employment in the Scottish NHS within the broader remit of professional training. These objectives encourage selectors to value evidence that course applicants have acquired some professional socialisation before they enter training. In the following chapter, I will examine how individuals do acquire and experience this anticipatory socialisation.

# CHAPTER 5

## RESULTS: PREPARATION FOR CLINICAL TRAINING

Most of the data reported in this chapter derives from interviews I conducted with twelve successful applicants to the DClinPsychol course after they learned of their acceptance, but before they began the course.[16] These respondents (Cohort B) described their impressions of the profession they hoped to join and the experiences they had had as psychology assistants that had shaped these impressions. They also presented their expectations of clinical training and articulated their concerns about the path ahead.

Findings from these transcripts were triangulated with the retrospective accounts I obtained from the previous intake of trainees (Cohort A) whom I had initially interviewed during their first clinical placement 3-4 months into the course. The accounts of the two cohorts regarding their experiences *prior* to commencing formal training did not differ in substance/tone, but in degree of elaboration. Predictably, those interviewed before beginning the course provided richer, more detailed accounts of experiences that were still current. I will therefore present the views of both cohorts together, but weight the accounts in favour of Cohort B since these were better elaborated.

The aims of this chapter are as follows:

i. to describe the extent of anticipatory professional socialisation experienced by respondents before they commenced the DClinPsychol
ii. to describe the concerns and expectations of respondents in relation to clinical training.

This chapter and the three that follow contain the substantive findings of this study, drawn from interview data. Quotations from the interview transcripts are used to illustrate the themes that emerged during these conversations. Where appropriate, these transcript segments contain several turns in the conversation so that the reader can follow the emergence of the theme(s) and make an independent assessment of my interpretation.

[16] In one additional case, the interview was conducted after the course began because this respondent was accepted onto the course just a short time before it commenced through a seconding arrangement with one of the health boards. This interview took place 4 weeks into the course while the trainees were still completing their first teaching block, before beginning their first clinical placement.

## 5.1 Disclosure of the Researcher's Expectations and Responses to the Initial Interviews.

Before I proceed to report these findings, I will attempt to describe, fully and honestly, my own expectations as I embarked on these interviews. I undertake this exercise in the interests of transparency and permeability (see 3.1 and 3.2 above). In addition to the investigator's disclosure of expectations, Stiles (1993) identifies explication of his/her "internal processes" while collecting data and interpreting the material as an essential feature of good practice in qualitative research. He observes that these processes should be considered part of the investigation's context and made available to readers for their consideration as they construct their own interpretation of the researcher's findings. Stiles suggests that qualitative researchers should consider the following questions: "How did the investigation affect you? Were particular parts difficult? Were you surprised? Did the data make you change your mind?" (Stiles, 1993, p.603).

I will return to these questions, and my changing expectations (my "progressive subjectivity": Guba and Lincoln, 1989) in the following chapters, but begin the process of disclosure here. As noted in 3.3, the first round of interviews I completed for the study were those with Cohort A, when these trainees were 3-4 months into the course; the second round (with Cohort B before they started the course) were taped soon after. The interviews reported in this chapter, therefore, represent my earliest findings and shaped the focus of subsequent investigations.

It is now three years since I completed the interviews that form the basis for this chapter and, were it not for field notes, I would find it difficult to recollect what I did expect to hear when I went to talk to these individuals early in my data collection. Fortunately, my notes remind me how naïve I was at that stage in my research. My readings in professional socialisation (see 2.4 above) and a focus group that I conducted with third year trainees before I began the main study, led me to expect a degree of anticipatory socialisation, but not the depth and breadth that was reported by my respondents. A research proposal, written in August 1995 before data collection began, summarises my expectations at that time:

> Clinical psychology trainees typically demonstrate commitment to the profession by working for 1-2 years as psychology assistants before applying for a training place. It is therefore predictable that some socialisation in the professional role will occur before formal training begins. (Cheshire, 1995)

I proceeded to predict how this anticipatory socialisation would manifest itself. Based on the responses obtained in the focus group, I expected that the main indicator would be how individuals defined their own identity. Later in the same document, I wrote:

> At one end of the spectrum, a trainee began the course with enthusiasm but no clear idea of the professional identity she would assume, while at the other end of the spectrum a colleague stated that she felt she had assumed the identity of a clinical psychologist before the course started. (Cheshire, 1995)

This uni-dimensional interpretation of how anticipatory socialisation might impact on respondents is reflected in the semi-structured interview schedule I first employed with Cohort A (see Appendix D). Initial responses from members of this cohort, followed by the responses of Cohort B, persuaded me that I needed to interpret anticipatory socialisation much more broadly. I realised that I needed to investigate not only respondents' views about their own identity, but also their view of the clinical psychologist's role, and of the profession's role and identity within the mental health professions, or "psy complex" (Ingleby, 1983).

Why did I begin this study with such modest expectations of the influence of anticipatory socialisation within my profession? Largely because I did not, at that stage, recognise how unrepresentative my own experiences prior to the course had been. That experience had been acquired over a relatively lengthy period (six years) but incorporated virtually no contact with clinical psychology itself. During those years I worked on short-term research contracts in the University of Edinburgh department of psychiatry. Some of my research took me onto wards in various psychiatric hospitals; on other occasions I was in day hospitals, visiting research subjects in their homes, or working in a sleep laboratory. My colleagues were mainly psychiatrists, as well as some nurses, respiratory physicians and non-clinical psychologists; my links with clinical psychology were indirect (largely social) and informal. The fact that I never worked as a psychology assistant places me in the minority compared with both my own classmates and the respondents in this study.

In retrospect, I began my clinical training with a singularly vague idea of what the profession did, or professed to do. On the advice of a friend I did read the Manpower Advisory Service Report (MAS, 1989) in preparation for selection interviews (see 5.3.ii. below). From the Report I learned that clinical psychologists were, according to the psychologist who wrote it, the sole possessors of level 3 skills: the ability to theorise about new problems and solve them, using their "broadly based psychological knowledge". I was unable to situate this knowledge in an historical context because I knew nothing of the profession's history. I also had no first-hand knowledge of what clinical psychologists did, but I assumed that it was much the same as the work of psychiatrists without the emphasis on physical treatments. So, my own anticipatory socialisation was into the psy complex, and most particularly into the culture of psychiatry, rather than clinical psychology. For me, the process of professional socialisation began when I commenced clinical training.

Once I began conducting interviews for this study, I was not only surprised by the extent of anticipatory socialisation that respondents revealed, but I was also taken aback by how many of my

interviewees expressed critical or sceptical views about the profession they were intending to join. As I shall explain below, the idealism with which I commenced clinical training, as well as my ignorance, placed me within a minority of "converts" at this stage in training, compared with the majority of "sceptics" or "agnostics" whom I interviewed.

In addition to my conservative predictions about the role of anticipatory socialisation, 2.5-2.6 above present the theoretical justification for my prediction that clinical psychology trainees would experience person-role conflict (Cherniss, 1980). As I will demonstrate below, I did uncover evidence of this type of role strain. However, following Vasco *et al.* (1993), I expected it to stem from lack of synchrony between the trainees' personal values and the theoretical orientation of the training course. For example, I expected that trainees with strongly humanistic attitudes might find themselves in conflict with the directive, man-as-scientist, cognitive-behavioural model that the course emphasises. As we shall see, the person-role conflict I discovered did not neatly replicate the findings of Vasco and colleagues. Neither psychology assistants (as reported in this chapter), nor trainees, nor even newly qualified clinicians, typically identify the therapy model they have learned as a significant source of internal conflict. During these early stages in their careers, they are still too uncertain of their grasp of therapy models to react against them. Instead, the dissonance they describe is typically experienced more globally as a mismatch between their personal values and the perceived values of clinical psychology, or as a conflict between their aspirations and the constraints of the professional role itself.

Here again, my own experience had produced expectations that proved unfounded. When I began this study I was about to embark on post-qualification training in Interpersonal Psychotherapy. *I* was experiencing conflict because my training in cognitive-behaviour therapy seemed inadequate for the range of clinical problems I was seeing, and its intrapersonal focus allowed insufficient opportunity to work with either the therapeutic relationship or the interpersonal domain. What I failed to recognise when I predicted that my interviewees would share similar concerns was that these therapy-related issues probably arise a little later in one's career, after one has first negotiated the acquisition of the professional role. That preliminary stage provides ample opportunity for other variants of person-role conflict (see 5.2 ii below).

While the preceding paragraphs describe what I expected to learn from these early interviews, they say nothing about my expectations regarding the *process*. Here, again, I was naïve. As I declared in 3.1 above, I was keen to embark on a qualitative study because the method legitimises, indeed requires, the researcher to abandon attempts at objectivity and instead engage empathetically with his/her respondents. I expected this stance to reduce the cognitive dissonance I experienced previously as I alternated between the roles of quantitative researcher and therapist. This prediction

did prove accurate, and the outcome was a much more satisfying research experience. What I did not foresee was that while I was asking respondents about role ambiguity (see below), I would be experiencing some myself! Particularly during the early interviews, when I was getting used to my research role, I found myself periodically lapsing into therapist mode and having to re-focus by reminding myself of the different objectives and boundaries of the two roles. The potential for blurring these roles was enhanced by the responses of interviewees. First and second year trainees, in particular, frequently alluded, in a joking manner, to our meetings as "therapy sessions". Many of them commented that it was a relief to have someone listening to them for a change, and asking them about their experiences. Sometimes the interviews felt a little like debriefing sessions, when respondents disclosed that they had been going through tough times. The question of boundaries raised ethical issues. I realised very early in the study that I must restrict my interview questions to those that were relevant to the study's aims. This meant that I did not pursue many remarks or suggestions that would have seemed important in a therapeutic encounter. In this way I tried to maintain coherence in the research enterprise and honour my contract with respondents: they had consented to participate in a research study, not therapy, and I had to keep that distinction clear.

In summary, then, both the process and outcome of these early interviews brought the surprises Stiles mentions; these caused me to revise my expectations more than once. I will turn now to a discussion of those early findings.

### 5.2 The Status Passage of the Assistant Psychologist.

Before I discuss respondents' views of the profession or expectations of clinical training, I will first expand on the description of their pre-course experience that I summarised briefly in 4.1 iii above. In 2.3 iv. above, I introduced the concept of the status passage, developed by Glaser & Strauss (1971) and fruitfully applied to their own study of professional socialisation by Bucher & Stelling (1977). Using the analytical framework of Glaser & Strauss (1971) it is possible to identify the defining properties of the status passage that culminates with acceptance onto the DClinPsychol as *temporality* and *desirability*. During this stage, individuals share a preoccupation with the duration, or *temporal properties*, of their passage. These are so ill defined that they generate considerable uncertainty and anxiety. At the outset of this passage, these men and women have no idea how many years it will be before they are accepted for clinical training or, indeed, if this will ever happen. However, individuals also share, to varying extents, a conviction that the efforts they are making to get accepted for clinical training are justified because that goal is intrinsically worthwhile, or *desirable*. Despite their

criticisms of colleagues and the profession in general, none of my respondents had concluded that it was undesirable to proceed to trainee status or they would have dropped out of the selection process.

In the following section, I will focus primarily on the experiences of these individuals in assistant psychologist posts as they attempted to define their roles. Despite the wide range of "relevant" experience acquired by trainees before they commence the DClinPsychol, this focus on assistant posts is defensible for two reasons. Firstly, these experiences are representative (22 of the 25 trainees in Cohorts A and B worked as assistant psychologists at some stage); and secondly, this is where most of the anticipatory socialisation into the profession's mores occurs. At various points in the discussion I will also introduce respondents' reflections on their pre-course experiences in other posts, where this process of comparing and contrasting sheds light on the socialisation process.

As noted in 4.1 iii., assistant psychologists work in a range of clinical areas; most commonly, these respondents worked in learning disabilities or adult mental health. Their experience also differed in other ways: for some, these jobs were well-supervised introductions to clinical work, while others received inadequate supervision and support. As a consequence, their intellectual and affective responses to their work varied considerably. I will begin by discussing these responses in relation to two key concepts identified earlier as relevant to role acquisition in human service workers: role ambiguity and person-role conflict (see 2.5 above).

## 5.2 i. Assistant Psychologists' Experience of Role Ambiguity.

In my interviews, I asked respondents about their roles as assistant psychologists and whether these had been clearly defined. Predictably, assistants who were least well supervised or supported had struggled most in this respect. Nearly half of the respondents whom I interviewed for this study reported difficulties in these posts stemming from a combination of heavy workloads, role ambiguity and poor supervision. However, it is important to note that only three assistants characterised all/most of their assistantships as problematic in these terms, while the rest reported periods of strain within generally satisfactory posts.

One woman spoke of the difficulties of being the only psychologist in a clinical setting when you are very inexperienced. In this case, she was the sole psychologist in a multi-disciplinary team:

K: What were you actually doing day-to-day? What was your work consisting of?

R: Well, um, it took quite a long while to actually sort of know what that was, um, the team I don't think really had had an assistant before and didn't know what I was for. The team was a consultant psychiatrist, em, there was a senior social worker, but she left the team, a nurse therapist, a teacher; and there were, em, SHO's....

K: So who supervised you then?

R: I was supervised by the head of department in psychology.

K: Right, but you went into the team where there wasn't a psychologist?

R: Yeah, yeah, mm-hmm. My work was, er, co-working basically with the team members, em, and I would, I could do cognitive assessments...or if there was a behavioural intervention we thought might be more appropriate, then I would kind of put that together and start that. That was, it took a while to get that right.

K: Yeah, it would be difficult in a team, a multi-disciplinary team, I think.

R: Yeah, especially with no kind of role model, if you like, there. I mean supervision was very helpful and very good, em, from psychology, but it would have been so much better if there'd actually been someone there who could see what I was doing. Um, sometimes it was very difficult to know what a psychologist would do, um, in a team like that. (A12:1)

This woman, in her first assistant's post, was essentially left to "fly solo" in a situation that many qualified clinical psychologists find challenging. As I shall discuss later in this chapter (see 5.3 ii.), multi-disciplinary working often provokes rivalry and territorial disputes between professionals. This assistant, like others in her peer group, struggled to define her role within the team without any model to emulate.

Similarly, another assistant in her first job spent most of her working hours as the sole psychologist on wards with nursing staff. She describes the supervision she received from a senior clinical psychologist at the departmental base as excellent but infrequent. Here, she speaks of her initial inability to apply a psychological framework to the work she was asked to do with learning disabled patients:

I found it difficult to see how it was psychological. I really struggled with that a lot. It's like, you know, really all I'm doing is being like a nursery nurse. I couldn't see how psychology came into it at all, which made it hard. And I kind of thought how on earth can I apply for the clinical course, you know, because I've got no clinical experience at all...I didn't know what was expected, there was nobody else there to tell me... (A6:1)

She felt that the nurses treated her "like an extra pair of hands" and she floundered in an ill-defined role until she discussed her difficulties with a newly qualified clinical psychologist:

I didn't spend much time in the department, I was in the ward all the time...I spoke to one of the recently qualified staff and she sort of went through it all with me and said ' ah, you're doing this and you're doing that, and you're doing a more behavioural approach obviously. I mean there's no cognitive work there, but you're definitely using psychological principles',

> and she sort of drew out, or dragged out, how different I was from the nurse therapists or occupational therapists, and it was very helpful....and also a couple of areas where I was lacking and not being a psychologist but I could be. (A6:1)

A third respondent describes a similar struggle to define her role as an assistant psychologist while working at a separate site from her departmental base:

> ... there weren't a lot of psychologists on site at that time, and nurses would be like "what's clinical psychology?" And I'd see someone coming in with a smile, and I always looked younger than I was, and I used to think, "what are you going to do?" Then some people thought I was a clinical psychologist so they thought I was going to come and wave a wand, which qualified people couldn't do. Other people, as soon as they heard the word "assistant", thought all I did was carry the video camera. So it was really challenging...I wasn't supervised for months after I started and I was given cases and I didn't have a clue what was going on, and because I was the person on site I was getting the phone calls, and I understood why because my supervisor was so short-staffed that she was all over the place, but I don't really think it helped promote psychology at all because we seemed really incompetent just letting things roll on and nothing happening. I found that really stressful because I felt really responsible. (B5:1)

At a later stage, this respondent was able to compare notes with better-supervised assistants. As a result, she reallocated this responsibility. However, other interviewees who had struggled through assistantships without adequate supervision, described similar feelings of inadequacy when the demands of their jobs exceeded their abilities.

These accounts highlight the confusion and lack of confidence typically experienced by inadequately supervised assistants whose uncertainty about their role may be compounded by their inability to identify the psychological principles informing their work. Psychology assistants (like the psychiatry trainees studied by Bucher *et al.*, 1969a: see 2.6 i), report that their undergraduate courses, which aim to provide a foundation for diverse applications, teach them only a limited amount of relevant theory and no appropriate clinical skills. They are, therefore, particularly reliant on clinical supervisors to demonstrate these skills and identify their theoretical rationale. When this does not occur, assistants are left struggling to implement techniques without fully understanding how or why. Without guidance, this deficit is difficult to remedy:

> R:...I really think my knowledge from my undergraduate degree, I really think it's quite bad. I don't remember an awful lot from it. That concerns me because I think there's a lot of basic things I've got to, I have to learn.
>
> K: Do you think you've picked up information in the last three years [as an assistant] or from your undergraduate days about the different therapeutic models that people use?
>
> R: Em, no, this is another bug-bear that again ----- [another assistant] and I have dreamed up, um, particularly after the [course selection] interviews. Because you think, God, you know? All this, we're sitting in interviews going 'yes, body of knowledge, we work from it' and we're thinking, God Almighty, you know! Just things like being direct. We've asked,

> you know, when you give an assistant a case, can you direct them to some references? You know, talk through, you know, if you're using a model what model it is. Em. I mean I'm just, I haven't a clue to be honest, really, and I think that's pretty bad. I just assume I'll just learn it on the course, but I just feel like I haven't added to my sort of theoretical base at all. I mean if I was to sit down and write a very sort of coherent account of like behaviour modification and all that sort of stuff, I'm sure I'd make loads of mistakes because that hasn't really been what I've been doing. (B5:1)

Unfortunately, some assistants were only able to make sense of the work they had been asked to do once they began the DClinPsychol and were introduced to theoretical models through the course. This person describes her reaction to a lecture during the first teaching block:

> It was really funny today, for example. There was somebody talking about anger management in learning disabilities and I realised I spent 8 months working with someone in anger management as an assistant, and it didn't actually strike home to me that I'd been working in a cognitive way with her. Ridiculous as that sounds, I didn't really make the links properly, yet that's what I was doing, and I think had I really been aware of that and what the approach I was taking was actually aimed at, as opposed to just making things better, I might have been more effective. I don't know. And I also might have been clearer about when to say enough's enough. (B6:2)

Her inability to identify the theoretical base for her work made it impossible for her to establish appropriate therapeutic goals and assess outcome. Under such circumstances, assistants can become seriously demoralised.

Obviously, the individuals I interviewed were not sufficiently disenchanted with clinical psychology as a result of these experiences to reconsider their career choice. Others do make this decision (see Rezin & Tucker, 1998: 9.1 below). In the present study, respondents who had endured particularly unsatisfactory assistantships preserved a sufficiently favourable view of the profession they wished to enter by convincing themselves that their circumstances were exceptional, thus minimising their own cognitive dissonance. Typically, they had also reflected on their roles, especially in relation to those of other professions. The first respondent quoted above sought clarification from a qualified colleague as she tried to reframe her work in psychological terms; the other two attempted to achieve some clarification themselves. As we shall see in the next chapter, this reflection (like that prompted by role conflict: see below) has an effect analogous to stress inoculation in preparing individuals for the later challenge of defining their roles as trainees.

5.2.ii. Assistant Psychologists' Experience of Person-Role Conflict.

As noted in 2.5 above, Cherniss (1980) describes person-role conflict occurring when a role requires behaviour that is inconsistent with the role-player's abilities, motives or moral values. While individuals are completing their professional training it is predictable, if not inevitable or even desirable, that they should experience some doubts about their abilities. Person-role conflict resulting from role requirements that are at odds with the individual's motives or moral values is a more complex phenomenon. Cherniss, among others, observes that the personal identities of health care staff merge with their professional identities to a greater extent than occurs in other occupations. The manner in which individuals experience and manage conflict between their motives or values and the requirements of their role is therefore central to the socialisation process.

Before I proceed to discuss instances of person-role conflict experienced by psychology assistants, I must place these observations in context by acknowledging that some people were encouraged to pursue clinical psychology training because they had experienced person-role conflict outwith the profession. Several individuals told stories of poorly structured jobs in the voluntary sector and social work settings, where their responsibilities for patients/clients' welfare far exceeded their level of skill. The confusion, guilt and impotence that they experienced as a result convinced them to seek professional training. It is also true to say that most of the trainees and future trainees who had previously held full-time research jobs referred to their powerlessness to intervene in patients' problems as an influential factor in their decisions to become clinicians.

Psychology assistants' accounts of person-role conflict experienced prior to commencing the DClinPsychol often concerned the difficulties they had had in establishing "professional" relationships with patients without compromising their own values. One woman, who had previously worked in social work settings as well as a clinical psychology department, explained:

> ...sometimes it makes things easy if you put on a psychologist's hat, and the person doesn't really matter. With other people I work by just being a person they can speak to, and just try and build up a rapport and trust. (A4:1)

Asked how it felt different for her when she wore the "psychologist's hat", she replied that "distance, immediate distance" intervened between herself and the patient when she assumed this identity. She said that she was most likely to adopt this persona with "middle-aged, middle-class ladies...I find I can get more from that type of person by not trying to be on any sort of level with them, other than just communicating; that seems to be the way they prefer you to be" (A4:1). For this respondent, the role of psychologist felt alien and appeared incompatible with her aim of behaving genuinely and empathetically in therapeutic encounters. Other interviewees expressed similar discomfort with the

distancing implicit in the therapeutic role, but acknowledged that their attempts to avoid hierarchical relationships with patients/clients had led to confusion and unsatisfactory therapy outcomes when patients/clients started to relate to them like friends. As noted above, some people had first experienced these dilemmas before they became psychology assistants. One person told me how much she enjoyed meeting her clients down at the pub for a drink when she worked as a volunteer at a drop-in centre. Over time she recognised that this did not enhance her ability to help her clients, and possibly hindered her efforts. One of the psychology assistants spoke of a patient who began to see her as a friend and became very dependent on home visits. When the assistant began to decrease the contact, the patient's problems got worse. With help from her supervisor, the assistant resisted the impulse to increase the contact again and accepted that she needed to act like a therapist rather than a friend.

One woman, who had worked as a psychology assistant but had also completed some formal training in counselling, spoke of the difficulty of "remembering to be a psychologist rather than a non-directive counsellor." She went on to describe the dilemma this raised:

> I had quite a difficulty philosophically really as to whether you should be directive or non-directive...and I was thinking, is it right to be directive? Or how do you be directive by being non-directive? Do you know what I mean? How do you use psychological techniques without imposing them on people? (A1:1)

This person remained exercised by these ethical issues. Later in the interview she voiced her dissatisfaction with the first few weeks of teaching on the DClinPsychol because it devoted little time to the ethics or values of clinical psychology. She felt that trainees should be encouraged to consider how their own values affected their clinical work: whether, for example, a patient's right to autonomy should take precedence over everything else. Her preoccupation with these questions was unusual; in general these dilemmas did not arise for trainees until second or even third year of the course.

Several individuals spoke of person-role conflict arising from demands that were unreasonable given their inexperience. These dilemmas generally occurred as a result of inadequate supervision. The following example is a case in point:

> Between one supervision session and the next [my supervisor] would have forgotten what we talked about so I realised how much she relied on me. That was an ethical decision for me because I felt I shouldn't be making certain decisions. I felt I wasn't qualified and I don't have the experience. This is somebody's life, and I could sit here and say to ---- 'we should do blah, blah, blah' and it would be a load of rubbish, but she would say 'I take responsibility for it'. Presumably I never did anything that awful but I found that difficult and I know other assistants did as well. (B5:1)

Other interviewees also commented on the burden of unrealistic expectations. In some cases, like the one above, they worried about the damage they might do to patients because of their lack of clinical skills. In other circumstances they worried about losing face, particularly with colleagues from other disciplines. Thus, one woman spoke of her uneasiness about assuming the role of "psychologist" in a multi-disciplinary team:

> I felt I wasn't experienced enough to represent psychology...I felt I was an assistant and I wasn't going to do that...I felt I wasn't experienced enough to say this is what I think as a professional, because I wasn't. (B1:1)

Person-role conflict also occurred when assistants felt they were expected to defend colleagues and practices when they privately shared the criticisms. This respondent describes her relief at the prospect of starting the DClinPsychol and leaving these problems behind:

> It's definitely time to move on. I was getting frustrated because I wanted to know more. By August I felt I was ready and that I really wanted to do the course and that I'd get a lot out of it...I want to have control of the number of cases I have. I don't know if that will ever happen, I don't know how these things work, but I wanted to have more responsibility. I was beginning to disagree with the way things were done. Like at ---- we were getting criticised by psychiatry and lots of times I thought, you're right in some ways and this needs to be taken on board...I think the communication and paperwork is dreadful and needs to be tightened up. Some of the cases had been open for a while. You needed to sit down and decide if you were going to do anything and if not, close them and do something constructive. I hated feeling, I was talking to members of other departments and they would making comments hoping it would get back to [my supervisor] and I felt it was my duty to say "this is how people feel" but I felt horrible having to defend our department but at the same time feeling unable to say to them "I agree with you". Like timekeeping. Like [my supervisor] would be late for meetings and I would think, you should have called to say you'd be late, and it set a bad example for me. I think the department as a whole is a wee bit woolly and I think we need to pull our socks up. (B5:1)

This respondent found her loyalty to her profession being challenged by her awareness of colleagues' short-comings. Her efforts to define her role were, to a considerable extent, a reaction against the example set by some of her colleagues. I will expand on the utilisation of role models by psychology assistants in the following section.

### 5.2 iii. Assistant Psychologists' Views of Their Own Identity.

One indicator of the extent of anticipatory socialisation that had occurred by the stage when these respondents were interviewed was the label they applied to themselves. Here, I will confine myself to

a discussion of Cohort B, since members of Cohort A were describing their identities as trainees when I first spoke to them.

Two of the thirteen assistants already thought of themselves as clinical psychologists. Most of the others described themselves generically as psychologists, while three people replied that they did not think of themselves as psychologists at all. One of these respondents explained that she did not see herself "as a true psychologist, but as someone working with a background knowledge of psychology." Later, in reply to my question "How do you decide how to behave with clients?", she replied: "I try to be natural. I don't think I come across as standing back and professional. I try to be friendly and put them at ease" (B9:1). Her reluctance to label herself as a psychologist appears to be associated with her belief that being a professional would prevent her from being "natural" and meeting clients on an equal footing. Another interviewee expressed a similar lack of identification with the role of "psychologist". When asked if she saw herself as a psychologist, she replied: "No, no more than anyone else. Maybe I do know a little more about psychology than the lay person but I wouldn't call myself an expert" (B8:1). This assistant actually began training with some ambivalence towards clinical psychology. She had considered training instead as a counsellor.

There was, then, considerable variation in the group regarding degree of identification with the generic role of psychologist, with one-sixth of the cohort already labelling themselves as clinical psychologists. It is worth noting that the assistants who had not yet labelled themselves as psychologists were not among those with the most problematic posts.

It is relevant to consider here how psychology assistants used role models to help them define either their own roles, or the "clinical psychologist's role". Bucher & Stelling (1977) identify both role playing and modelling as interactional variables that shape the process of professional socialisation. Once more, interviewees were selective in what they took from what was on offer. Some denied identifying anyone as a "role model" during their time as an assistant. An equally small number (see, for example, respondent A2 quoted in 5.3 below) identified particular individuals whom they wished to emulate in every respect. The vast majority of respondents spoke of "copying" specific attitudes or behaviours from supervisors, rather than embracing all aspects of anyone's practice. In some instances the modelling had been negative, and interviewees were also clear about behaviour they did not intend to emulate (see, for example, B5 quoted in 5.2.ii above). However, just as respondents rarely tried to model themselves on any one supervisor, they were unlikely to be entirely dismissive of a supervisor. The following account illustrates how respondents selected different attributes from different practitioners to inform their own practice:

K: Do you think of people you've worked with so far as role models?

> R: It's more bits and pieces from different people. My boss is really organised and I would love to be like that. Another person I worked with was totally chaotic but very empathic with clients and she really managed to get them to talk about what they wanted to talk about, and I'd like to be like that. Another guy I worked with was psychoanalytically trained and I'd like to pick up bits of that as well. (B3:1)

Most individuals justified the selective use of role models on two counts. First, they recognised that clinical psychologists whom they worked with were themselves following a variety of approaches and using different styles. Secondly, as the preceding excerpt shows, they were not so over-awed by these potential role models that they accepted their performances uncritically. Assistants did not generally accept their supervisors' "press releases" (Wiersma, 1988) at face value, but made up their own minds about their authenticity (see, for example, B8 quoted in 5.3.i below).

Another factor that influenced some assistants was explicit encouragement by supervisors for them to develop their own style, although this was less commonly reported. The following quotation describes this experience:

> [My supervisor] broadened my view of the options a clinical psychologist had. He showed me there were other techniques than CBT [cognitive-behaviour therapy]. Before that I only really knew about CBT and psychoanalytic, I didn't think there was anything else....He also uses other techniques which were different. [My supervisor] was good at giving criticism but making me feel I was good at what I was doing. Sitting in with him, I might have copied some of my clinical psychologist role from him, but I was able to adapt it so there was more me than him. He emphasised that you shouldn't try and copy what other clinical psychologists do, but try and develop your own style. (B4:1)

This assistant psychologist felt empowered to develop her own style: she reports that she received clear constructive feedback on her therapeutic work from her supervisor and he also succeeded in "making me feel I was good at what I was doing".

### 5.2. iv. Summary of the Role Negotiation Described by Psychology Assistants.

In summary, then, most members of Cohorts A and B had some experience of role ambiguity and/or person-role conflict in their posts as assistant psychologists. Their accounts of their experiences, illustrated above, demonstrate the applicability of the symbolic interactionist view of the trainee professional "as an active, choice-making factor in his own socialization" (Olesen & Whittaker, 1968, p.300). In some cases, assistants' experiences generated negativity and scepticism about the profession. Other individuals attributed these to local conditions and thus maintained a generally positive view of clinical psychology. Those who had the most difficulty defining their role and

reconciling its demands with their personal values necessarily accomplished a degree of role negotiation that some of their peers did not achieve until they began the DClinPsychol. In the following section I will illuminate other aspects of this initiation into the world of the NHS clinical psychologist by reporting respondents' views of the profession at this early stage in their careers.

### 5.3 Respondents' Views of Clinical Psychology.

Respondents' views of the profession as they commenced the DClinPsychol were further indices of the extent of their anticipatory socialisation. These views were based on personal impressions and were also influenced, to varying degrees, by the rhetoric of colleagues.

Only a small minority of interviewees expressed wholly uncritical views of the profession. The following account contains the most idealised picture. This woman begins by describing her impressions as an assistant observing a senior practitioner, and then proceeds to reflect on the experience of attending case discussions with the rest of her department:

> ...it was the first time I'd seen the rationale of clinical psychology, although you hear snippets here and there. I'd never actually seen somebody who was identifying problems and working out what to do with them by just using their head, using their brain and their training and their knowledge of people, and their own experience as well, and all that meant something, you know, um, it wasn't injections, and it wasn't chemicals, or anything like that, just the fact that someone could sit down and really listen to a person, and identify what the problems were and what options there were for treatment, and I think that was very, I got a lot of encouragement from it. It was the first time I'd seen it in practice, and it's a very, I think it's a very positive subject, or the whole profession's quite a positive thing really, um, and certainly, like on occasions at ------ , to see ten people, and yes, I respected them all, and was very kind of in admiration of them, especially, and I am still in admiration of most of them, but you know what I mean. Like especially when you just start in the field and you see all these people who are so good at everything and, you know, and, er, just seeing everybody working together and helping each other and being totally compassionate and accepting people absolutely for what they are and not really having any preconceived notions or stereotypes, and sitting and working together with their training and their brains, and working out what's wrong and how to solve it, and being compassionate. And no other profession's offered me the chance to be scientific, which I was always appealed to, um, but also to have a love of people, and I think most psychologists do. (A2:1)

Her identification of clinical psychology as a profession that combines a humanistic and scientific ethos was, in fact, unrepresentative. More commonly, her peers emphasised either its humanistic values or its scientific basis. As I shall show in the following section, their difficulties reconciling the two paradigms generated person-role conflict for a number of individuals.

The respondent quoted in the previous passage can best be described as a convert. She appeared to be fully persuaded of the profession's efficacy, uniqueness and ethical probity. More frequently, interviewees expressed ambivalence, and some that spoke optimistically about the future of clinical psychology were also critical of its weaknesses. For example, two of the assistants were concerned about burn-out as an occupational hazard, based on their observations of qualified colleagues (this point will be developed further in the next chapter). This concern had prompted them to contemplate moving out of full-time clinical work into management/consultancy work as soon as practicable after qualification. Thus, they entered clinical training with the expectation that the job for which they were training would be unsustainable. One of these women explained why she was so pessimistic:

> I've got a couple of friends who are clinical psychologists and they've only been at it a couple of years, and they seem to hate it. It really gets them down at times, they're over-worked and stressed. The day-to-day stress is workload but people also worry about changes in the NHS, and the Trusts and so on. (B11:1)

She went on to say: "I think just seeing patients day after day would be soul-destroying, the lack of variety...to work five days a week as a conveyor belt would drive me insane" (B11:1). Her plan to avoid being consumed by the system was to work abroad post-qualification, or combine NHS and private work. However, she also expressed the belief that clinical psychology is changing, that it is becoming more proactive in defining its role.

As a group, Cohort B was more critical of the profession than Cohort A: half the respondents in Cohort B expressed negative views about clinical psychology compared with only one-sixth of the other group. This may represent random variation between different intakes of trainees, or reflect Cohort A's greater identification with the profession when these interviews took place. As noted above, Cohort A were first interviewed shortly after commencing the DClinPsychol, while Cohort B were first interviewed before the course began.

Between the sceptics and the converts lay the largest group: the agnostics. They held generally positive views of clinical psychology but commenced the DClinPsychol with a number of concerns about how they would reconcile their own values and experiences with the demands of clinical training. Critics in the two cohorts focussed on two areas of concern: the scientist-practitioner model and the questionable uniqueness of clinical psychologists' skills. I will now present their doubts in greater detail.

5.3. i. The Scientist-Practitioner Model.

All the respondents were aware of the significance of the scientist-practitioner in the profession's self-definition. They were fairly evenly split between advocates and critics of the model. The following excerpt represents several similarly positive views. This was one woman's answer to my question about what differentiates a clinical psychologist from a nurse therapist or psychiatrist:

> I think it's the time not spent in direct patient contact that makes us different and how that time is spent. I think as a profession we're more, we have a greater tendency to take stock and to, to think about things, and to make plans, and test hypotheses, and actually take time out to think, rather than – my experience of a lot of other professions has been this kind of head-on rush towards, to get the next patient in and do the next step, and – rather than take time out to actually think "why am I doing this, and is it proven effective, and where am I planning to go, and is this what the patient wants?" and I suppose I've had quite bad experiences of that not happening, and I think that maybe psychology's the profession that does it most. (A10:1)

She had seen evidence of the scientist-practitioner in action and believed that the model was essential to effective practice.

Within the opposing view, concerns over the scientist-practitioner model fell into two categories. As noted above, some respondents were ambivalent about the model itself and saw it as incompatible with the humanistic approach they wished to adopt. Others accepted the model as a desirable one for clinical psychologists to emulate but were sceptical about how much it influenced the practice of qualified clinical psychologists.

One interviewee who exemplifies the first view also cast doubt on the existence of the scientist-practitioner:

> K: Do you aspire to be a scientist-practitioner?
>
> R: No. I think that's a load of nonsense. I've sat in with people who say that's what they're doing and I wondered why that should be science. I haven't been very impressed by what I've seen. I think it's a real shame. Clinical psychology is striving to be scientific and rigorous and robust and it's nonsense. I wouldn't have so many misgivings about it if it wasn't held to be the be-all and end-all of clinical psychology. (B8:1)

This respondent later expressed further reservations about the model, and disclosed that she had considered training as a counsellor instead of a clinical psychologist

> ...because that feels more humane to me. If I had a psychological problem, and I went to see a clinical psychologist who was using scientific principles, I wouldn't find that helpful. The

> people who I spend time with who are scientific-practitioners are the last people who I'd want to share any psychological problems with. Counselling seems more humane and effective. I chose clinical psychology because there are more jobs for clinical psychologists, and I have a degree in psychology and maybe I can use that. (B8:1)

Others articulated similar attitudes. One person acknowledged that she could see the value of the scientist-practitioner paradigm, continuing "...but I concern myself slightly that it's a little restrictive to always have a scientific answer to a human problem" (B6:1). A future class-mate commented:

> And I don't know if clinicians really work that way, and I don't even know if they should. Different patients have different problems, and different approaches might be more appropriate, and I don't know how that fits with the scientist-practitioner model, seeing how it goes and getting to know the person and seeing what's best for their problems. (A8:1)

Believers in the validity of the scientist-practitioner model would doubtless claim that these individuals have misunderstood how the model influences practice, that skilfully applied it is neither restrictive nor lacking in humanity. However, these counter arguments are not relevant here. In this analysis, the beliefs held by these interviewees as they commenced clinical training are of intrinsic interest, whether contestable or not. The relationship between these beliefs and the normative values of clinical psychology is an indicator of the extent of trainees' professional socialisation.

Some respondents spoke of the scientist-practitioner as an ideal that was generally unachievable in the NHS, with the pressures of waiting lists. There was an assumption that being a scientist-practitioner reduces one's efficiency because time is diverted away from patient care and into research:

> I think we are scientist-practitioners, but if you're employed by the NHS you're more of a practitioner because you're being employed to see clients, not to do your own research or to spend days in the library to clarify one point. You have to work within time constraints. Yes, you should have time to do your own scientific work, to use your own theories and look up theoretical points, but in the NHS you're a practitioner first. (B3:1)

Other respondents echoed this view and some made the point that scientist-practitioners probably existed only in academic posts, thus invoking the dichotomy of the ivory tower versus the real world. Despite the doubts expressed about whether the clinical psychologist as scientist-practitioner was alive and well in the NHS, most interviewees did accept that this model was a desirable one for the profession to emulate. Their support for the model was often explicitly linked to their desire to identify a firm theoretical basis for their work. One woman, who had experience in another field of applied psychology, explained that she had decided to do a clinical training "to feel there was a firmer basis for what I was doing, and if I wasn't sure, I could look up some books and talk to people till I felt on firmer ground" (B11:1). I shall return to the relationship between theory and practice in the

following two chapters when I discuss trainees' experiences on the course and, later, their adjustment to qualified status.

5.3. ii. What is so Special about Clinical Psychology?

Most psychology assistants displayed awareness of territorial disputes between clinical psychology and other mental health professions, particularly psychiatry and nursing. A further indication of their socialisation was the generally negative view of psychiatry that most of the assistants espoused, echoing the sentiments of many of their qualified colleagues (see, for example, Johnstone, 1993; Gelsthorpe, 1999). This assistant, describing the course selection interview, articulated the most establishment view:

> R: One question was: "How do you see the skills of a clinical psychologist being distinct from...?" That's straight-forward really, Level Three skills and all that, but I went on to say that we need to sell ourselves. I don't think psychologists do sell themselves. At the --- there were OTs [occupational therapists] and social workers and psychiatrists who were all trying to do the same job and that gets on my nerves because you can't all do the same job, you get OTs and social workers trying to be psychologists.
>
> K: Do you get psychologists trying to be something they shouldn't be?
>
> R: Not in my experience, but possibly. (B2:1)

Referring to the Level Three skills of clinical psychologists, this interviewee is quoting the report submitted in 1989 to the Manpower Planning Advisory Group by Derek Mowbray (a clinical psychologist himself), representing MAS: the Management Advisory Service to the NHS. This document, generally known as the MAS Report (MAS, 1989), identified Level One skills as those used to establish rapport or conduct simple interventions like stress management. Level Two skills are used in more complex interventions, but are reducible to manual-based techniques that can be followed like recipes. Mowbray argued that clinical psychologists share Level One and Two skills with other professions. However, the MAS Report also proposed that only clinical psychologists possess Level Three skills: the ability, as applied scientists, to problem-solve using a broad base of psychological knowledge.

This assistant's reference to Level Three skills, together with her resistance to the encroachment of other disciplines into clinical psychology's domain, evokes the profession's expansionists at their most bullish. Indeed, she goes on to justify the replacement of Masters courses with Doctorates in Clinical Psychology by referring to another of the MAS Report's recommendations: that

psychological services should be led by consultant clinical psychologists modelled on their medical counter-parts.

> I think going over to doctorates is very good for psychology. I'm not aware of the underlying ethos for doing that. I would like to think it's to increase the status of psychology in line with the MAS Report, this parallel between psychologists for mental health and doctors for physical. I think we're a long way from that, if indeed it will ever happen, because the medical is still very dominant, but I'd like to think with the doctorate we'll get increased status. We have a lot of status anyway, but increased salary. (B2:1)

One of her future class-mates also referred to the MAS Report (which she calls the MPAG) in relating how she prepared for her selection interview, and acknowledges how helpful this "indoctrination" has been in allaying her anxieties about her choice of profession:

> R: In order to do the interviews I borrowed three years of Clinical Forums, I looked up the MPAG or whatever it was, and asked people what I needed to know....and now I feel I'm much more indoctrinated with the sort of idea that these are our skills as they're set out and only we have these higher level skills, Level Three or whatever it was, integrating different sorts of knowledge and things, which gives me a wee bit of confidence to be able to justify what we do.
>
> K: Do you believe all that?
>
> R: Yes, I do actually, to some extent. I'm a bit nervous about nurses or counsellors being trained up to do one little programme, a couple of little techniques, and then trying to treat patients. It's not so bad if someone says first, in my educated opinion, this person needs, so go off and do that technique with them. But to just go in and maybe not use the appropriate technique. And because there are so few of us and our area's being encroached upon, we're more defensive as a result. I'm still not completely sure how we fit in with psychiatry in the NHS. (B12:1)

This interviewee, who like me had worked with doctors before applying for the DClinPsychol, returned to these themes later in the interview:

> I rote-learned material from MPAG to prepare for the interviews and it reassured me that clinical psychology did have a role. I believe we're much more useful that CPNs with certain therapy skills, or a counsellor or hypnotherapist, though they have roles, but more in mild neurotic disorders or confidence-building disorders. I think I would be more respected if I were a psychiatrist, at least by medics, but other people are just so impressed that you're a doctor of psychology. I think I've had my confidence dented by working with such an elite group. (B12:1)

Many other respondents also spoke of the rivalry and role overlap between different professions in the psy complex. However, most of them were less persuaded by the rhetoric of the MAS Report. Indeed, there was widespread scepticism among respondents about clinical psychology's claim to have exclusive rights to Level Three skills. The following extract exemplifies this attitude:

K: Do you have a sense of what is different about clinical psychology. that makes it distinct from the other mental health professions? Or have you come to the conclusion that there isn't anything that differentiates it?

R: Um, it's confusing, because there are so many things, you can get into the whole clinical psychology versus counselling, or even nurses debate. Um, I think it's very distinct from psychiatry, but I think I'm probably biased in that my department and the psychiatry department have a long-running feud going because the clinical director of the service is a psychiatrist and was quite, psychologists are down there with the cleaners sort of thing, which caused a lot of problems, obviously. For example, there was a huge big argument and debate and memos were written left, right and centre about whether psychologists could call themselves consultants and the psychiatrists said 'no', only psychiatrists can call themselves consultants, which obviously left a lot of bad feeling, which meant there was a lot of, not a lot of harmonious working, to be quite truthful.

K: And it sounds as though the psychologists stuck to their guns and did it anyway?

R: Yeah, yeah (laughs)

K: Which has happened elsewhere in the country, hasn't it?

R: Um, there's definitely a difference, but the thing is, when you're all working towards the same ends, um, you can't help but feel that everyone should be working together and saying, oh yes, you're different in this way, or this is what you should be doing, or it would be beneficial for the patients if the CPNs have got these special skills and clinical psychologists have got these special skills, but I think too much of the debate is over rank, not over actual differentiations, which I think only masks the debate. I think clinical psychologists definitely have individual skills that only clinical psychologists have. But I think it's only because, it's not even that they're more advanced, it's just that they have a broader background, um, in some things. But then you've got the risk that it's too broad and other professions are more specialised in certain things.

K: Do you have any sense of what sort of knowledge clinical psychologists have which differentiates them from other professions?

R: Oh. It depends which professions.

K: Well, I was interested in you mentioning the CPNs, for example, um, I wondered if you had observed any overlaps between clinical psychologists and CPNs. and if, on the other hand, you'd observed things that were different about them?

R: There does seem to be an overlap, especially I'd say in our department because the CPNs actually held clinics in clinics. One of the CPNs ran a counselling service for a GP fund-holder practice and they ran all sorts of things like stress management groups and eating disorder groups, and things, which again caused a bit of aggro because a lot of people felt they weren't actually qualified to do that and they were taking on board things that were other professions', they were treading on toes.

K: And was that a psychology-CPN bit of friction?

R: No, not just psychology, psychiatry and social work as well. There was quite a lot of friction. Everybody felt that were trying to encroach on their own territory, whether they were psychiatrists or social workers or psychologists. I don't know, I think a lot of this is possibly specific to the place I was working at. I don't really know because I can't compare it to anywhere else. It's difficult to say what special skills psychologists have that other people haven't, because it sounds as though you're saying psychologists have better skills

than other people, which isn't the case at all. There's all the debate about whether One, Two Three Level skills, um, CPNs have only got Level Two, and clinical psychologists have got Level Three, I think, (laughs), I can't remember which way round it goes. I don't know. I don't even know if you can just say we've got longer training, therefore we must know more. It's all very vague, isn't it? (B3:1)

Later in the interview, this respondent returned to the subject of professional status. She had recently attended a Division of Clinical Psychology conference where eminent members of the profession had debated its future. She describes her amazement at the lack of consensus between these figures and her frustration over what she calls the "precious" behaviour of her colleagues:

R: It was fascinating, just to see that if you get any more than two psychologists, doesn't matter which ones, they'll disagree on everything. I don't think anybody agreed with anybody all day...it was interesting, there doesn't seem to be a consensus of opinion as to where the profession is going and nobody seemed able to agree whether the fact that more and more people are training in mental health fields, counselling qualifications and that sort of thing, was a good thing or a bad thing. There seems to be a lot of worry that it's going to undermine the value of clinical psychologists as more people can say 'well I can do that and I'll charge you less money for it', which seems to be a major worry I think, they're obviously worrying where their salaries are going to come from.

K: And what's your view about that? Do you think clinical psychologists are right to be concerned about that?

R: Um, I think they should come to some sort of consensus of opinion about it. Um, I don't think they have to see it as a threat. I don't think having people who are specifically bereavement counsellors or whatever is a threat to clinical psychology. I don't think you should see it as a threat. Um, but, I think I can understand why they do because for so long clinical psychologists have been, you know, up on the ivory tower, there've been 200 in Scotland or whatever, very specialised, in great demand, you finish the course and you're able to get a job wherever you want to go, and get a huge big salary, um, and I think people are bound to be worried that that situation's going to come to an end. But if all the status and the salaries are artificially inflated, and if there's a demand for people to do that kind of work, if clinical psychologists can't get their act together and can't get the training sorted out, someone else is going to come along and take the work and that's just the way it goes. I don't think we can expect anything else just because for so long it's always been that way...I just think that psychologists have got to stop being so precious, I think they have to stop thinking, um, we have to have this huge big long training, therefore we deserve the status and respect and the high salary and they should actually just go out and do their job. (B3:1)

This perception of clinical psychologists as "precious" was shared by another psychology assistant, who also commented that the profession is overpaid and "risks pricing itself out of the market" (B7:1). Other interviewees criticised the elitism and defensiveness of clinical psychology. One commented that "psychology hides behind a big cloud which allows people to get paid a lot of money to do their own thing and get away with it" (B8:1), while another explained:

...a lot of the time I think clinical psychologists have a kind of snobbery about being a psychologist and not being a counsellor and not being this and not being that, as if we have a

> lot more knowledge than anybody else, but I'm not sure that's actually true, really (laughs). I think, when I was working as an assistant, my supervisor was very anti behaviour therapists. And I wasn't sure why at the time, but, I mean, I think the psychologists felt quite threatened by the behaviour therapists in the team and felt that they didn't know what they were doing. But these people had, they were nurses in training, and they had done the 18 month training course at the Maudesley, which is recognised now, I think, by the BPS, and I think they had more training in behaviour therapy than we do. We've had one and a half hours or something, two hours of teaching on what behaviour therapy is about (laughs) and, you know, they're probably more qualified than we are! (laughs) OK, we maybe have a more wide-ranging way of looking at things and so we can then choose whether to do behaviour therapy or not. But I think once we've made that decision I don't see any difficulty in giving it to a behaviour therapist to do, or, you know, that's a pretty patronising way of looking at it, but I think they're probably more qualified to do that than we are, or just as qualified as we are. (A1:1)

These respondents remained unconvinced by the discourse of self-justification that they had heard within the profession. In their view, clinical psychology cannot justify its elitism.

## 5.4 Expectations of Clinical Training.

Respondents differed in how informed they were about the course before they started it. Half of the twenty-five individuals in Cohorts A and B selected for the DClinPsychol had previously worked, or were currently working, as assistants in psychology departments that offer clinical placements within the course. Like the medical residents interviewed by Bucher *et al.* (1969a; 1969b), these individuals were already familiar with at least some aspects of the system that was to provide their postgraduate training. As I shall show in the next chapter, this familiarity can ease their transition onto the course, but it can also produce particular stresses resulting from trainees' expectations of themselves and their trainers. However, less equivocally, the insiders' expectations were more realistic than those of recruits from outwith the system, since the insiders had prior contact with trainees and staff involved in the DClinPsychol. This respondent provides a representative account from the realists' perspective:

> I do know trainees on both the Edinburgh and the Glasgow courses, and they seem to have different styles but I don't think I could put the differences into words. I'm pretty happy with Edinburgh. Most people have said don't expect too much of it. They're never very specific, but it's like "It's OK and I'm enjoying it, but don't get too excited about it, it's not going to be as fascinating and exciting as you expect." And there are negative comments about organisation. Nothing very specific. Because you go through such a long and stressful process to get on the course, right up to the interviews, it inevitably builds up your expectations. For me and for a lot of people it was something I felt was hardly obtainable. I've been put off by so many people about how difficult it is that you create this image of the

course as being this amazing intellectual endeavour and I'm sure it can't possibly live up to that. (B6:1)

Through these contacts, some assistants had even become acquainted with the "folk taxonomy" (Atkinson, 1977) of clinical placements developed by previous trainees They began the course with firm opinions about the clinical supervisors with whom they wished to work, or avoid. During our conversation two months before the course began, this woman told me of her intention to work with a particular supervisor during her first clinical placement. She was hoping to influence the usual procedure, whereby the clinical tutors arrange who will supervise each trainee:

R: I've already chosen my adult supervisor. I thought I'd better do it so I got what I wanted.

K: Do you think you'll be able to do that all the way through?

R: No, but I will express my preferences. Also, I know people which helps, and they know what I can do, because I didn't come here fresh-faced and innocent. I can do a lot more than some assistants and I think the department is using that, which I value. (B11:1)

Another interviewee told me of her "confidential agenda" (also determined before she began the course) to move out of the region where her training was to be based in order to do one of her clinical placements. She had been thinking about other options because she did not "feel entirely happy" about the local supervisor. These trainees, and some of their peers, had not only formed opinions about their prospective trainers, but were already planning to shape the training to meet their own needs. Here, once again, we find evidence of the individual "as an active, choice-making factor in his own socialization" (Olesen and Whittaker, 1968, p.300).

Some of the respondents who had no first-hand knowledge of the course and its institutions had obtained advice and information about it from trainees or staff. However, they necessarily relied on the idiosyncratic views of those consulted, or official "press releases" (Wiersma, 1988). One woman spoke of the "idealism" in the version conveyed by the courses themselves: "it's this big cloud in the sky that you can't get onto and it's all so unachievable and wonderful...I don't even know if that's explicitly in them saying things, but more in the way it runs and the way that the interviews are run" (A2:1).

Finally, several interviewees, both insiders and outsiders, spoke of the way that the competition for places had raised their expectations of the course, as well as their anxieties about their own abilities. The following comment typifies a widely-shared view: "I'd been so worried that everyone was going to be like the crème de la crème, and everyone's going to be so intelligent, and I might not match up...and I've just crept in accidentally" (A4:1). I shall explore these fears, and the tensions associated with insider versus outsider status among new clinical psychology trainees, in the following chapter.

### 5.5 Summary of Anticipatory Socialisation Experienced by Psychology Assistants.

In conclusion, these early interviews revealed that respondents had experienced extensive *anticipatory socialisation.* It became apparent that most of them were cognisant of the issues that currently dominate the profession's discourse, such as the validity of the *scientist-practitioner model* and *role overlap within the psy complex*, even if their knowledge of the arguments was superficial. In addition, most of them had some experience of the type of *role negotiation* that provides individuals with insight and opinions about these issues. Finally, it was striking how few converts there were at this stage in the process of professional socialisation. Unlike the nursing students investigated by Davis (1975), who began professional training in a state of innocence (see 2.4), *the majority of clinical psychology trainees were sceptics or agnostics when they commenced the DClinPsychol.* In the following chapter we shall see how they managed the transition to trainee status and how they attempted to resolve some of the dilemmas raised by their previous experiences.

# CHAPTER 6

## RESULTS: ENTERING CLINICAL TRAINING

This chapter presents an analysis of the transition to trainee status and respondents' first reactions to clinical training. The accounts reported here are drawn from the initial interviews with Cohorts A and C, and follow-up interviews with Cohort B. The timing of the interviews for the study is summarised in Table 6.1; the interviews that provide the data for this chapter are denoted by bold print.

**Table 6.1: Interview Data Presented in Chapter 6.**

| COHORTS | 1st INTERVIEW | 2nd INTERVIEW | 3rd INTERVIEW |
|---|---|---|---|
| A | **Start 1st Year: 1st clinical placement** | End of 1st Year: 2nd clinical placement | Mid 2nd Year: 3rd clinical placement |
| B | Pre-course | **Start 1st Year: 1st clinical placement** | |
| C | **End 3rd Year: Final clinical placement** | 12-18 months post-qualification | |

Thus, the interviews with Cohorts A and B reported here were conducted during their first clinical placement.[17] Interviews with Cohort C were conducted at the end of their final year on the DClinPsychol. Unlike the interviews with Cohorts A and B cited here, those with Cohort C represent retrospective accounts of the period covered in this chapter.

The specific objectives of this chapter are:

i. to describe the transition from psychology assistant (and the other roles filled by individuals before starting the D Clin Psychol) to clinical psychology trainee
ii. to describe trainees' views of their professional identity at the beginning of the course
iii. to describe the emotional impact of the transition to trainee status.

[17] For purposes of comparison, a few quotations from the initial set of interviews with Cohort B are also incorporated in this chapter.

The following section addresses the first objective. Here, I will explore the meaning of this transition for these respondents and attempt to relate their experience to both structural and situational factors. The theoretical construct that provides focus and clarity for this discussion is that of the status passage (Glaser & Strauss, 1971).

## 6.1 The Transition to Clinical Psychology Trainee: An Examination of the Status Passage.

By any reckoning, the transition from assistant psychologist (or other role held prior to entering formal training) to trainee clinical psychologist, qualifies as a status passage. It is the clearest transitional point negotiated by each individual on their passage towards professional status until they pass from trainee to qualified practitioner. As we shall see in the next chapter, the intervening status passages during formal training are less clearly defined. However, before I examine the ambiguities of those transitions, I will first consider the transition to trainee clinical psychologist and I will begin by discussing the *direction* of this passage.

### 6.1 i. The Direction of the Passage to Trainee Status.

Most of my respondents confirmed my expectations and described the transition from the job they were doing before they started the course to the position of trainee clinical psychologist as an ascending passage, or increase in status. Several of them employed the metaphor of climbing up another rung on the ladder towards full membership of the profession. They expected to have more responsibility as trainees, and also more rights regarding clinical supervision. In most cases, this is what transpired. However, a small number of trainees described the change of role as akin to a lateral move in an organisation. In their view, their title had changed but not their status. I will explore the reasons for this in 6.1.iii below, when I consider the clarity of this status passage. Finally, five people experienced the transition as a descending passage, or drop in status. Given that all trainees felt de-skilled and disorientated at times, these individuals faced the additional challenge of convincing themselves that this new role was worthwhile.

The five respondents who believed that they had lost some status in the transition to trainee focussed on their loss of autonomy and responsibility when describing what this meant. In three cases a drop in salary compounded those losses.

One woman spoke of the qualms she had experienced when she gave up a research post where she enjoyed "a certain amount of respect in terms of being a member of staff and being able to order books and supplies... to go back to being just a student with a massive drop in status and salary for three years" (B12:1). Another respondent focussed on the loss of status that accompanied her assumption of the student role on teaching days. She viewed the academic component of the course as a "necessary evil" and resented the expectation of the academic staff that she should be a "good little student" and attend the teaching days (B11:2). The other trainees who experienced a loss of status when they began the course also felt dis-empowered in their clinical placements. One woman explained that she had felt like a "professional, grown-up person" before she started the course. However, on placement she found that non-psychology staff treated her "very much as a child, not a child, but a psychology student who doesn't know anything" (C9:1). Meanwhile, a colleague struggled with the feeling that her clinical work was of no value:

> R: I like it, it's a bit of a sabbatical. On the other hand I miss feeling that people need me. I've got a feeling that it doesn't really matter whether I'm here or not...In [my previous job] there's constantly people demanding your time and attention and there is responsibility for taking on staff, sacking staff, admitting residents or otherwise...I never felt that I was really on top of it and in control and everything was organised, and I like that. I'm the kind of person, already I'm doing it...leaving everything to the last minute so I've got pressure to work to deadlines...
>
> K: Have you had any doubts since you started the course that you've made the right decision?
>
> R: Yeah.
>
> K: Where have they stemmed from?
>
> R: This feeling of not really doing anything, like it doesn't matter. But the way I have to, the way I've kind of come round to that is by thinking, well I'm going to get a qualification at the end of it so I'm not likely to feel particularly important till I've finished. I guess it's kind of giving up the identity I had before and starting again at the bottom with a new one...I feel a lot better now than I did at the beginning of the course. I mean I had doubts in the first week....at the back of my mind I am sure I'm going to complete it but it doesn't stop me thinking "what am I doing?" (A4:1)

This respondent, who also spoke of the distancing effect of putting on "a psychologist's hat" (see 5.2 ii above), struggled to convince herself that "starting again at the bottom" would ultimately prove worthwhile.

It is significant that three of the four trainees quoted above had never worked as psychology assistants before entering the course, and were therefore arguably less well prepared for the constraints of the trainee role than their peers. However, the following excerpt reveals that the transition from psychology assistant to trainee can also be experienced as a demotion. As an assistant, this respondent had considerable autonomy and worked within a multi-disciplinary team where she had carried out some staff training. The transition from teacher to student was difficult:

> R: I think that in starting the course I moved backwards to some extent and I think in some ways I lost that definition of what my role maybe was and was less sure of my place and what I should be doing, as I certainly was towards the end of my time there, because I was there for a year, and I was working on the one unit quite intensively, and so I had time to develop a role, and the unit was setting up as well.
>
> K: So it was like losing some clarity of role when you started the course?
>
> R: I think so, yes.
>
> K: What caused that to happen do you think?
>
> R: I'm not sure. I think within the course there's a certain amount of disempowerment. I think within my role at the unit I felt quite empowered and supported. I think the course, at least in the early stages, took that away to a certain extent. It was very much back to being a trainee, to being a person who wasn't very sure of themselves and questioning what I was doing, which is healthy, but [unintelligible on the tape].
>
> K: In what way did you feel disempowered and where was it coming from?
>
> R: I'm not entirely clear where it came from.
>
> K: Did it start before you began your first placement?
>
> R: It's difficult to think back. I think it possibly did because we were being cast far more again in the role of the student and ...there was not a huge amount of emphasis on us as individuals, it was just about how to get the numbers into the profession. (C8:1)

While this trainee had experience of working in an NHS clinical psychology department before she began the DClinPsychol, she was still unprepared for the stripping away (Goffman, 1968) of her identity that occurred during this status passage. Cogswell (1967) identifies the first stage in the socialisation of novices as the abandonment of the previous role that is to be replaced. It is therefore noteworthy that while many other trainees reported feeling constrained and/or de-skilled as they began clinical work (see below), the majority retained their sense of travelling an ascending passage towards a coveted goal.

6.1.ii. The Centrality of the Passage to Trainee Status.

As noted earlier (see 5.2 above), the passage of these individuals *before* their transition to trainee status was distinguished by its *desirability*. This property continues to define the trainees' passage (albeit tempered with ambivalence in the case of the five individuals described previously), together with its *centrality*: how significant it is to each individual. The significance of the passage can be understood from several perspectives.

The centrality of this status passage in part derives from its desirability: it is the final stage in a journey towards professional status that some respondents have been making for many years: through school, university and beyond. Asked if she had any doubts about doing the DClinPsychol, one woman replied: "No, no, it's the end point of what I've been pursuing for nearly ten years" (A7:1). Even individuals who decided to pursue a career in clinical psychology much later in their lives spoke of getting a training place as a major turning point in their lives. In the following extract, one trainee describes her elation when her application was successful, coupled with her sudden recognition that the next stage in her journey would have its own challenges:

> Since I made the decision in 1992 [three years previously] to go for clinical psychology I haven't had any doubts that I'm doing the right thing. I was delighted when I heard I had a place on the course. Before you get a place that is the be-all and end-all. After I heard I had one I thought, what the hell have I done? How am I going to cope with the practicalities? (B13:1)

The demands of the training course (practical, intellectual and emotional) also contribute to its centrality.

In terms of immediate impact, starting the DClinPsychol means a commitment to a challenging, three year, full-time, postgraduate programme. With the exception of rare extensions to the three-year period for individuals on medical grounds, the system does not allow for breaks in training or extensions. Some trainees move away from a partner for the duration of their training, and, as described above, several accept a drop in income. While trainees negotiate other personal status passages within these three years (for example, some marry, some separate from partners, a few become pregnant, and some suffer a loss/bereavement), many consciously postpone those life events they can control until after they qualify. For all these reasons, the individual's commitment to start professional training is of immense personal significance, and may also impact on partners and family members. When I asked respondents whether they had any doubts about starting the course, most of those expressed concerned their ability to make the grade and honour their commitment to a three-year course. The following response is typical of many:

> There were also self-doubts about doing the course, about whether I could do it and about it being hard...I was shying away from the challenge of clinical psychology, and from the three-year commitment, and the idea of a career, and also I was thinking about having children and that kind of thing. (A8:1)

Given that the mean age of the respondents in this study was 27 (range 22-36), and that the majority are women, it is not surprising that some have doubts about making a commitment that may cause them to delay having children.

In addition to trainees' concerns about whether they could cope with the intellectual demands of the course, they also expressed some apprehension about the assumption/increase of clinical responsibility. Even those individuals who had been doing supervised clinical work as assistants recognised that their degree of responsibility for individual patients had increased once they became trainees. In many cases this reflected a change in working practice. Trainees were generally tackling all aspects of a patient's therapy, rather than, for example, taking on someone for anxiety management as an assistant while a qualified clinician worked with that individual on more complex co-existing problems. However, the increased sense of responsibility also reflected an increase in trainees' expectations of themselves:

> I expect to have to work harder than I have since fourth year undergraduate. I suppose the responsibility is new. I can be held liable for what I've said because I am seen to a certain extent as professional now, so I'm taking on, I think I've always tried to do what's expected of clinical psychologists but always before it was just something I felt, whereas now it's almost like a code of conduct, and responsibility is there and you may be having to think before you leap. (A11:2)

One consequence of this shared increase in expectations and trainees' belief in the centrality of this passage was that trainees felt stressed and let down when their first placement failed to challenge them as much as they had expected:

> ...my placement so far has been quite unsatisfactory, so in a way, that's not what I expected. I mean I expected to be busy, I think I expected to be very busy all the way through, and just hard work from day one right through to the end, which it hasn't been so far. So in a way that feels a bit odd, and a bit dissatisfying in a way because I'd sort of psyched myself up for it...it's quite stressful not. sort of wanting to get going and, and seeing other classmates away off and seeing masses of patients, it's sort of quite demoralising when you're not, when you haven't got stuck in there yet. (A3:1)

Similarly, trainees felt aggrieved and complained or tried to persuade their supervisors to give them more difficult cases when they felt that they were getting clinical work that was too straightforward. One trainee who had treated patients with anxiety disorders while she was an assistant was determined to see people with different disorders, and ones that she expected to be more difficult to treat:

> R: One thing that I didn't really expect, which I found a bit odd, is that I've actually had to fight for the cases. I wanted to go on my adult placement and have quite a diversity of cases, so if it could be helped I wanted to get like an OCD, a PTSD, phobia, panic, depression – maybe a couple of depression. But it didn't really work out like that because the sort of cases I was being given were a lot of panic attacks and GAD, so I've actually like sought out phobias and depression, which is fine, you know, supervisors have been absolutely OK about that.
>
> K: Did you have the sense that there was some kind of policy behind giving you the anxiety and panic cases?
>
> R: No, it's just that it was primary care, it was just "this might be a suitable case for a trainee." (B2:2)

Most people, then, welcomed this increase in responsibility as an indication that their status had changed, even if it also caused them some apprehension. Only one trainee did not, and she expressed general concerns about assuming a professional role. Here she speaks about her previous experience of that role in academic settings (though she had not completed any prior professional training):

> But I have had experience of being a professional, or being switched on all the time. I knew what that was like and that it was hard. You can't just get up in the morning and not think about it, and you can't switch off at night, and it takes up a lot of your mental energy. And it's to do with being very aware of what you're doing, and being on time, and being presentable, and managing people all the time, and being a psychologist all the time you're speaking to everybody. (A8:1).

I shall comment further on the significance of this atypical response later in the chapter, since this trainee took the unusual decision to drop-out of the course at the end of her first year.

Two other trainees displayed similar ambivalence about making the transition to trainee clinical psychologist. It is not surprising to note that they belonged to the small group who experienced the transition as a downward status passage, nor to find that they denied the significance of the status passage for themselves and viewed themselves as outsiders among the trainees. One of these women (A4) was quoted in 6.1.i above. The other remarked:

> I don't have as much invested emotionally in doing this course as everyone else does...I'll do it and I'll do it well, or at least to the best of my ability, and I'll enjoy it, but I don't have the huge emotional investment in getting on it and wanting to do it and wanting to be a clinical psychologist. (B11:2)

As we shall see later in this chapter, the centrality of this status passage, the amount of investment that most trainees have in the status they have achieved, has a number of important implications for the process of professional socialisation.

6.1 iii. The Clarity of the Passage to Trainee Status.

Another property of significance in the analysis of this passage is that of *clarity:* the signs of passage that indicate trainees' progress to both themselves and observers. Glaser & Strauss (1971, p.5) note that the clarity of these signs within a status passage ranges from "great" to "negligible". As we shall see in the next chapter, they are often unclear to the clinical psychology trainees as they progress through the DClinPsychol course. When they are also unclear to observers, trainees have an even greater struggle to establish their professional identity. Before considering the clarity of the passage *through* the course, let us first consider the clarity of the passage from psychology assistant to trainee.

One-fifth of the trainees in Cohorts A and B (five individuals) said that they initially experienced little difference between the role of psychology assistant and that of trainee. Four of these women had returned as trainees to the same department where they had worked as assistants. However, other trainees who did the same effected a very clear status passage. Furthermore, some people emphasised the benefits of this continuity, saying that it was less stressful to begin as a trainee in a department where you were known, and where you knew your future supervisors and the way the department worked. Others experienced the lack of clarity in the transition more negatively. I shall now consider some of these variations in more detail.

One woman, who agreed that this continuity was helpful, reported that her transition to trainee status had been clearly marked by her department. When I spoke to her before she started the course, she told me that her supervisor had already talked to her about her imminent change of status and offered her some guarantees:

> I'll go back to the same supervisor as a trainee. I could be getting a very narrow view but I'm not naïve in that respect and I have been in other departments...When I left my supervisor said everyone has to forget you were ever here when you come back here in November. Before when the [other] psychologists thought it was something I could do they'd hand it over, and now my supervisor will be in charge of the diversity of my caseload, and she was making it clear that the others would have to understand that I wasn't to be used as a dumping ground. I never thought I was particularly, but my supervisor obviously has very clear views about this. (B13:1)

When I re-interviewed the same woman during her first placement on the course, she confirmed that these promises had been kept. Her role in the department had changed and she was quite clearly viewed as a trainee:

> ...because I've been here before and I've done simple phobias and anxiety and everything. [my supervisor] felt I should move on a bit, so in that respect I've had a bulimic, I've had somebody who turned out to be personality disordered, I've had a blood phobic....a couple of people on the wards who've been severely depressed. Yes, a lot more interesting than

> being an assistant....[my supervisor had said] it may be a difficulty coming back, and it's to be very clear that it will be different, and it has been different, and in terms of her as well. Where she would pop down before and say "quick, quick, make this chart", I've had, apart from sitting in obviously on other people's sessions, I've had absolutely nothing to do with doing the leg work for other people's clients. That's worked very well. (B13:2)

Certainly, those trainees who missed out on a clear transition of roles did not generally complain that they were being treated like assistants in terms of being given bits of other people's casework to do. What they did miss out on was a clear statement from the head of department/supervisors about their change of role, and a redefinition of their relationship with the qualified staff.

Departments undoubtedly differed in how they reacted to the arrival of trainees – both those known to them previously and those who were entirely new to the department. Some departments (or individual supervisors) organise quite a formal induction for their trainees when they arrive for any clinical placement, not just their first one. When this does occur in a first placement, it certainly helps to mark a clear status passage for trainees. At the opposite end of the spectrum, trainees arrive to find little/no preparation has been made for them. When this happens to a trainee who is returning to a department where she worked as an assistant, the change of roles becomes further obscured. Several people described the problems this posed for them when they realised that members of the psychology department were making unwarranted assumptions about how much they understood of its business. One woman was able to tackle this directly with her supervisor; another discreetly asked secretaries and other trainees what she needed to know; while two others became quite stressed as they attempted to mask their insecurity with a competent façade. I will explore the issue of impression management (Goffman, 1959) in greater detail below when I analyse trainees' views of themselves as they commence clinical training.

As the preceding discussion shows, lack of clarity in the passage from assistant to trainee was an obstacle for some trainees but not for others. Similarly, the clearest transitions covered a spectrum ranging from the positive, reassuringly well-structured induction into the trainee role described by respondent B13 above, to aversive experiences where the transition was so dramatic that it equates with what Kramer (1974) has called "reality shock". Kramer studied this phenomenon in newly qualified nurses and found that one of the main contributors to reality shock was role deprivation: the mis-match between an idealised role conception and the role operating and sanctioned in the workplace. Extrapolating from that finding, we would expect that most of the clinical psychology trainees would be protected from reality shock by their experience as assistant psychologists. Equally, we would predict that the few who do not work as assistants in NHS clinical psychology departments before they begin their training would be more vulnerable to reality shock because they start their first placement with no previous experience of that work environment.

Respondents' accounts bore out these predictions. One woman who had no experience as a psychology assistant described the emotional turmoil she experienced as she struggled to find her feet in her first placement:

> K: So far does this appear likely to be a rewarding line of work for you?
>
> R: I don't know. I must admit when I first came back [to the university], that first day in December when we came back, and everyone was saying "how's your placement?" I actually think I only vocalised it for the first time then, and I meant it, and I felt since the age of 12 this was the first doubt I'd had about being a clinical psychologist. It's what I'd always wanted to do and I was so miserable and so down, just sort of feeling that I was out there on my own...and I felt I was out of my depth....I know I have to finish clinical. I'm not a defeatist. When I start something I always finish it. And I know if you go into research it's very useful to have. But I think I'd probably, and I know I said this before, but I think I'd be even more tempted, to know that I wouldn't want a 9 to 5 caseload, that I'd want three days NHS, two days university, something like that, because I'm not sure I could handle day in, day out, this work. (B12:2)

Another trainee, similarly without experience as a psychology assistant, spontaneously described the emotional impact of her first clinical placement as a "shock":

> K: Once you began the course, was it what you expected?
>
> R: It was a real shock.
>
> K: In what way?
>
> R: The theoretical stuff was OK, that was fine, it certainly wasn't above the level you would have expected. But the clinical side was quite a shock, you know, the first placement, the adult placement. I think it was partly the travel because I was the [name of Health Board] trainee, and I felt so tired. I've been tired for three years. I think that's what I remember most about the whole thing, it's just so tiring. And that's what I found: it's very draining because you're always trying to be ready for patients and problems you're not familiar with. I found that very draining. (C3:1)

The potential ramifications of reality shock can be judged by the outcome in a third case. One of the respondents in the study dropped out of the course at the end of her first year, saying: "It feels like I wouldn't have applied for the course if I'd got to know what clinical psychology was like beforehand" (A8:3). She was unhappy throughout her time on the course and found the demands of the clinical work, of being a professional, and of working within the NHS bureaucracy unacceptable[18].

[18] This respondent is readily identifiable since it is so uncommon for trainees to abandon the course. It would therefore be unethical for me to discuss her professed motivation in greater detail. However, I will return to the issue of trainee disaffection with the NHS bureaucracy in the next chapter to discuss clear instances of a form of person-role conflict that has been termed "professional-bureaucratic conflict" (Cherniss, 1980).

The preceding discussion has considered how factors external to the trainees influenced the clarity of this status passage. Since trainees influence the process as well, I will now discuss what the interviews revealed about their contribution. The fifth member of the group who reported that the trainee role initially differed little from her assistant psychologist role had not changed roles within the same clinical psychology department. She began her clinical training with very clear ideas of what she wanted from the course and was prepared to be assertive in order to get it. She spoke of her "fight" to get the diversity of cases she wanted in her first placement (B2, quoted in 6.1 ii. above). Her language at the beginning of the course contrasts with that of most of her peers in its reliance on what Bucher & Stelling (1977) call the vocabulary of competence. Her interview is peppered with themes of mastery. She spoke casually of one of her cases ("that's straightforward panic, absolutely classic, textbook panic disorder") and later explained how well-prepared she had been for her first placement because of the work she did as an assistant:

> K: Do you think that the first teaching block prepared you for the first placement?
>
> R: It's quite a difficult question because I was working in, with me working in ---- in clinical work then I was sort of already prepared anyway. I mean I was very. very keen to relearn and get out of bad habits, but in terms of preparation, I suppose that would be best answered by someone who'd done a PhD for three years or something.
>
> K: Do you think it added to the preparation you'd had as an assistant in terms of your first placement?
>
> R: Not really. (B2:2)

Certainly, this trainee acknowledges that she has much to learn, but she also displays a confidence in her knowledge that contrasts with most of her classmates whose language is characterised by a vocabulary of self-doubt. For example, another woman with more clinical experience as an assistant, described her lack of confidence as she began her first placement:

> I don't know if it's me but for every person I seem to be doing so much preparation because I'm not quite confident. When I finished after doing this for a year [as an assistant] I felt quite confident, although I was really only doing anxiety cases, but I felt quite confident at that. But now when I'm doing different things, and even with the anxiety stuff, I feel as though I need to do a lot of work beforehand. (B4:2)

She described the teaching as overly-theoretical but, rather than relying on her previous experience to get her through her first placement, she found herself "...reading up on every individual person...even though we've had all this teaching and gone over the [therapy] models. I'm doing it all again" (B4:2).

In the case of trainee B2 quoted above, this minimisation of the impact of changing roles appeared to be related to the considerable degree of anticipatory socialisation that she had experienced as a psychology assistant. As we saw in 5.3 ii above, she identified strongly with the profession while she was still an assistant and had developed more sophisticated views about the clinical psychologist's role than many of her peers. In 6.2 iii., we shall see how her view of herself as she began the DClinPsychol again revealed the extent of her professional socialisation at this stage in her career.

In contrast, some trainees responded to the change in roles in a way that would accentuate the clarity of the transition. For example, one trainee with a lot of previous clinical experience explained:

> K: Has it felt like a transition? You've done a lot of clinical work before in different settings.
>
> R: Yes it has. I've tried to accentuate the differences too because I didn't want to come in with my own baggage and take that right through the course, and come out the other end without having picked up anything along the way. So I've been trying to look at the differences and play them up almost. (B7:2)

One of her class-mates echoed this sentiment and related the change of role to an increase in her expectations. In her job as an assistant psychologist she had a larger caseload than she did in her first placement on the course, and she had spent much of her time advising clients with multiple social problems about services. As a trainee she set out to develop an identity as a therapist and looked for learning opportunities:

> R: I think my role here has been more a therapist than in --- , although I was seeing quite a few more people there, about 25 at a time, which is loads for an assistant, again with supervision.
>
> K: Has it felt like a definite transition, that it's not the same as being an assistant?
>
> R: Yeah. It's been the same in a way as well, because I feel reasonably independent. I think I can do what I want to do, although I wouldn't take on too many complicated cases...But it's different in the work itself, for me personally, because I feel a trainee, I want to feel a trainee, I don't want to be an assistant. And I don't mean that in terms of a hierarchy. I mean that in terms of the opportunity to learn, to get as much support as I can. And I think that is happening. (B1:2)

This attitude towards the transition to the trainee clinical psychologist role, this emphasis on making a fresh start, was shared by many of the interviewees who chose to define themselves as "beginners' and thus maximised their learning opportunities. I shall expand on trainees' views of their own identity below.

## 6.2 Trainee Clinical Psychologists' Views of Their Own Identity at the Beginning of First Year.

As we saw in the previous chapter, assistant psychologists differed in the labels they applied to their identity at work: most described themselves with the generic title "psychologist', while two people already thought of themselves as clinical psychologists. When trainees were asked how they saw themselves at the start of their professional training, responses varied again. By that stage in their professional socialisation, the question of identity has become even more complex. New trainees not only continue to wrestle with whether or not they are psychologists, but also have to accommodate the roles of student and employee in their identity. In addition, they typically become much more concerned about impression management than they were as psychology assistants, and the question of labelling therefore becomes important. I shall consider these issues in more detail in the remainder of this section.

### 6.2 i. Travelling Alone or in Company?

Glaser & Strauss (1971) point out that people proceed through passages *alone, collectively* or in *aggregate* (in a cohort with little/no cohesion). In their analysis of the professional socialisation of medical students, Becker *et al.* (1961) highlight the student culture that defines the collective passage of the trainees. Olesen & Whittaker (1968) did likewise in their account of the "studentmanship" that nursing students employ to deal with the demands of their training. This emphasis on the collective passage of professional trainees is characteristic of the symbolic interactionist approach to professional socialisation, although these studies also stress the heterogeneity of the group.

Most of the clinical psychology trainees in this study emphasised their group membership when speaking about their class. Indeed, for some it was a source of pride:

> K: Has there been a sense yet [two months into the course] of the trainees using each other for support as far as the course is concerned?
>
> R: Definitely. I think we've actually got a bit of a reputation already, you know. Yeah, I don't know whether everyone else perceives that when they're going through it, but yeah, I think we are quite a cohesive lot, and we all stick together...people have been coming in and saying: "You're a very calm lot, you don't get very stressed out do you? And I was teaching on the Glasgow course last week, and they're all very intense, and you're very laid back". (laughs) (A10:1)

In contrast, the small group who displayed least evidence of anticipatory socialisation prior to commencing the DClinPsychol emphasised their *solo* passages as trainees. One of these women, who felt little kinship with her fellow trainees, described the isolation of trying to "pass" (her term) as someone committed to clinical training while secretly harbouring extreme ambivalence about her career choice. Thus, there were some outsiders who did not share the sense of a collective identity that provided security and reassurance for most trainees as they confronted the demands and ambiguities of clinical training.

### 6.2 ii. Students or Employees?

As I observed in 4.2 iv above, trainees assume a tripartite identity: they are full-time post-graduate students; salaried employees of Edinburgh Healthcare Trust; and members of clinical psychology departments distributed among seven Health Boards. Maintaining these roles simultaneously can be disorientating for trainees, since each role generates different expectations. In particular, the movement between student and trainee can be difficult.

One woman (B11, quoted in 6.1 i.) explicitly attributed the downward status passage she travelled in the transition to trainee to the constraints of the student role and her perception that the academic staff expected her to be a "good little student". Other respondents did not share that reaction, but most agreed that it was difficult to move easily between the two roles. The following account is typical of many:

> K: Do you think of yourself now as a student, or as a trainee professional?
>
> R: I tell people that don't know about clinical psychology that I'm working in – but I'm on a training course. I am a student when it counts... I mean I think everybody has this crisis of they are and they aren't, and when it comes to council tax and things you're a student! .... I don't think of myself as a student as such because I think I'd done so much being a student before...trainee is the word that I use.
>
> K: Does it feel as though you have to change roles between the time you're on placement and when you're in Edinburgh for teaching?
>
> R: Yes. I think probably not so much this time because they knew we'd all been doing a placement, although it still wasn't exactly taken for granted, but at least the lecturers could say "in your clinical work" and know that we'd all done some clinical work, whereas in the first block nobody really knew what we'd all done. Lots of people asked, but it's difficult to remember, and everybody hadn't done clinical work...In some ways I found going from having worked last year to going back to sitting in a class, of being taught, I mean I know

they have to re-cap, but being told " this is classical conditioning, this is an unconditioned stimulus", was like being back in first year, you know? And it is quite stressful, and I was talking to --- and she does too, going back. You've been working here for a month and suddenly while we're back in Edinburgh we're living in student role...and then the next day you have to be back here and interviewing a patient....

K: What do you expect to find most difficult about the training?

R: Just combining all the different roles: the role of being a student in Edinburgh and then being away from home, being here and being a professional and being back at home...I think that will take some getting used to.

K: What is the difference? Is it between what you have to do or the way you behave?

R: Not that much for me, it's more how you are treated by other people. Just that there you're sitting there and people are telling you things... whereas here you're the one sitting in sessions with patients and you're the one who's supposed to be doing the teaching, the one with the knowledge. I don't think I probably personally behave that differently. I know a lot of the others on the teaching blocks sort of go in in their jeans, and I don't so much because I'm quite happy that now, once I took the job last year, that was the end of my student days. (A9:1)

While the previous excerpt suggests that the student role is primarily a matter of other people's perceptions, rather than the way the trainees perceive themselves, other respondents disagreed. One woman told me, with embarrassed amusement, that "you accept the fact that in the university you're students, not on an individual level with the course staff, just on a general level, and I suppose it's chicken and egg, but you seem to adopt this immature student role" (C4:1).

Most of the trainees do see themselves principally as NHS employees rather than postgraduate students. Their time at their university base is tightly scheduled with meetings and teaching, and trainees rarely participate in university life beyond the course, or mix with postgraduate students on other courses. The main significance of their student role is that it gives them a collective identity. Since they are working for different health boards throughout the east of Scotland when they are on placement, the only time the classes routinely congregate is during the teaching days at the university. During their teaching blocks, a class of trainees is together for three-four days a week (9.30am-5.15pm) for five weeks. Over this period, individuals based in health boards distant from the university often share accommodation. In contrast with this sustained contact within each class, there is relatively little contact between different classes because the teaching blocks do not generally coincide (partly due to limited numbers of classrooms and facilities at the university). Bonding between trainees therefore tends to occur within year groups.

Given that most interviewees identified more strongly with their trainee role than their student role, it is important to recall that their trainee role entails accountability to several NHS bodies. All trainees are contractually accountable to Lothian Healthcare Trust: their employer. However, more than two-

thirds of each class complete their clinical placements in other health boards (see 4.2 iv. above). Those trainees who were not based in Lothian viewed themselves as members of the clinical psychology departments where they worked: their identity as Lothian Healthcare Trust employees was not meaningful for them.

This perception had implications when there were disputes between trainees and their line manager (the Head of the Funding Consortium: see 4.2 ii above). Even though their line manager was representing the clinical psychology Heads of Service/Representatives, when her decisions were unpopular (for example, when travelling expenses and out-of-region placements were disputed) this organisational structure meant that the trainees' disaffection was focussed on their line manager. As a result, their disgruntlement was deflected away from their local Head of Service/Department. It can be argued that this mechanism served a useful purpose and sometimes assisted departments to retain trainees after qualification. However, there was also a less positive outcome: the separation between trainees' line management and professional/clinical base had the potential to leave trainees feeling unheard, despite their representation on the Training Committee. This sense of disenfranchisement typically waxed and waned according to whether or not trainees felt their needs were being met and, in some cases, surfaced very early in the course. One trainee in her first placement expressed the following view; it represents the sentiments of trainees at their most disaffected and articulates professional-bureaucratic role conflict (see 2.5 above):

> The NHS side, the Trust side, whatever it is, it just feels like they're not even remotely interested in you as a trainee. That's demoralising. It ties in with the whole specialist placements, accommodation, all this stuff. They don't give a monkey's. All they care about is saving a few quid as far as I can tell. And that, I know it's a reality, but it's really disappointing, because it's your training, it's your one chance to try and get yourself in a position of being a useful practitioner and people are not prepared to try and be flexible, and that really is the way it seems. (B6:2)

In contrast, two of the three trainees who were seconded from their Health Board onto the course, and whose line manager was therefore their local Head of Department, reported that this arrangement contributed to their sense of being valued by their NHS employer. One of them explained:

> Within --- I was very much made to feel you're our trainee, and made to feel very important, and when everyone was having problems with their accommodation, --- would say to me "right, here's the money, go and book something and give me the receipt". So I was totally spoiled. (C11:1)

It is not hard to imagine that seconded trainees might also feel powerless and unheard if their needs were not met by local line managers. However the separation in the current system for most trainees between their line management and their work base contributed to their sense that they were part of a vast bureaucracy. This was exacerbated, particularly for trainees in large clinical psychology

departments, by their six-monthly change of placements, which involved moving to a new base (and sometimes a new Trust) and meeting new colleagues. These structural factors undoubtedly impinged on trainees' development of their professional identity.

### 6.2 iii. Professionals or "Pretend Psychologists"?

One important aspect of developing a professional identity is impression management. At the start of the course trainees self-consciously adopted a professional persona for their contact with patients. Many spoke of themselves as "pretend" psychologists and worried about patients exposing their lack of knowledge:

> K: Do you feel different now than you did when you started the course?
>
> R: I feel different if I put my jacket on! (laughs) No, I don't think I feel different from when I started the course. I still feel I need to know more stuff, but I think that the more times I see people, the more people I see, the more confident I am that I have something to offer them, rather than that I'm just masquerading in a jacket and pretending to be a psychologist, that I do know something. (B3:2)

Lack of clarity about trainees' designation added to their insecurity. Different departments have different policies about the designations trainees should adopt. Some insist that trainees sign their letters "psychologist'; others stipulate "trainee clinical psychologist" or "clinical psychologist in training"; while "clinical psychologist" is used elsewhere. Trainees themselves express considerable ambivalence about choice of title. Most of them felt very uncomfortable in situations where their training status was not made explicit to patients, because they felt this was misleading to patients and also because this increased their anxiety about exposure. At the same time, they faced other difficulties when their training status was misinterpreted by other professionals/members of the public. The following scenario is representative. Here, a trainee describes a problem she experienced early in her first clinical placement:

> A member of staff at the health centre where I work came in and said: "Who are you? What are you doing here, and does anyone know you're here?" She was very confrontational even though I'd booked the room properly and told reception about my patients. I said politely that I was a trainee psychologist and she obviously felt then that she was justified in being so confrontational. When I went away and spoke to other people, I decided that if I'd said I was a registrar she would not have spoken to me in that way at all. The word "trainee" gives the wrong impression, as though you're a student and don't know anything, whereas you've had six years experience. Because I look young maybe people don't believe I've done that much work. After that I decided to go into the surgeries and just say "I'm the psychologist who's working here today", and so far that's had a much better reception. I would never mislead a

> patient or a GP about being a trainee, but I just think it gives the wrong impression. It was hard. I don't think that woman should have spoken to me like that but I let her, and I'm not going to let someone do that again because I'm a professional and she didn't have any right to speak to me like that. (A6: 1)

In other words, individuals sometimes felt disadvantaged by the trainee label, and oscillated themselves between feeling like "pretend psychologists" and like professionals who were entitled to some respect.

Soon after the respondents in Cohort B began their training, a heated debate took place between four members of the class regarding the title "doctor". Half the group argued that they would never use the title after they completed the DClinPsychol because it was associated with use of the medical model and "infers a power imbalance" (B8;13:2), while the others argued that "doctor" was a title and privilege they would be entitled to after qualification. A member of the latter group went further, asserting the importance of clinical psychologists differentiating themselves from other "therapists:

> It's like whenever anybody says we're therapists, it like cringes – the hairs on the back of my neck – I go no! If anybody said my next door neighbour's a therapist, I'd go no, I'm a psychologist, and OK, I've obviously got personal issues with that, but I think it's because we need to distinguish ourselves away from that huge collective...anyone can call themselves a therapist. (B2:2)

The proponents of the title "doctor" seemed to favour it because of the status it confers. However, the disagreement appeared to go beyond the question of status and legitimacy. In the previous chapter (5.3. i) I reported that psychology assistants were divided between advocates and critics of the scientist-practitioner model. One of the participants in the "doctor debate" (B8) who opposed the use of the title, was quoted in that earlier section, where she claimed that counselling was more "humane" than the clinical psychology of scientist practitioners. The doctor debate seemed to be an extension of the scientist-humanist debate, with the medical model replacing scientific detachment in the eyes of its opponents as the mooted impediment to an essentially humanistic approach to clinical work. Conversely, the trainees advocating the use of "doctor" explicitly promoted the scientist-practitioner model elsewhere in their interviews.

## 6.3 The Emotional Impact of the Transition to Trainee Status.

In 6.1 iii above I described reality shock: the most dramatic example of the emotional impact that trainees experience during the early stages of the course. While a significant and disabling degree of

reality shock affects relatively few trainees, it is important to recognise that *most* trainees find the transition emotionally demanding in ways that they had not anticipated. Clinical psychologists do not, of course, carry out invasive procedures that will cause their patients physical pain, but we certainly witness a great deal of psychic pain. Indeed, we frequently watch our patients experiencing increasing distress in the course of therapy, as they wrestle with the issues maintaining their difficulties. Our "guilty knowledge" (Goldie, 1995: see 2.5 above) is less likely to involve deliberate non-communication of an uncertain or negative prognosis than may be the case for some health care workers because of the open, collaborative relationship that is central (for most of us, most of the time) to our therapeutic work. However, clinical psychologists have their quota of guilty knowledge: for example, foreseeing difficulties for our patients that they have not yet identified, based on privileged information from other sources or our knowledge of psychological processes. Clinical psychologists also suffer the emotional (and sometimes disciplinary and legal) consequences of "getting it wrong" (Goldie, 1995), and certainly must confront the ethical dilemmas accompanying the privilege of therapeutic work.

Given that these issues are central in all aspects of health care work, it would be naïve to imagine that one could begin clinical psychology training without experiencing some sort of emotional reaction to the demands of the new role. In 6.2 iii. above, I highlighted the role strain experienced by many new trainees who feel they are "play-acting" as "pretend" clinical psychologists. Another type of strain comes from trying to process and formulate all the information that emerges within a clinical session, while maintaining rapport with one's patient, as this trainee describes:

> ...developing the skill of being able to listen to somebody but also thinking about what you're going to say next and formulating the thing in your head, thinking about what the family interaction processes are and watching their body language, or whatever it might be. There are fifty different things going on in your head when you're trying to listen to somebody in a clinic, and almost in a way, I was not able to switch that off for a while and so everything was just sensory overload... (A1:3)

The dominant affect among trainees in the early stages of the course is anxiety. One woman admitted: "I used to have massive anxiety attacks before I went into work every day in adult [the first clinical placement], just because this person was going to ask me what to do with their life and it was just so scary" (A6:1). This anxiety seems to stem from the sense of fraudulence many trainees experience as they assume the professional role, as well as the increase in responsibility and expectations accompanying the new role:

> You know, I think I accept my own limitations...when you're sitting there, and the patient's asking all these questions, you know, and I keep thinking to myself, it's OK, you know, you're only a trainee, but – you can only – but it's really difficult because whatever they teach you in theory, it doesn't prepare you for the way that some patients have these questions that they just want answered. And they make, I mean they're valid questions, but

> you're just like, oh, you're not meant to have that much insight, don't ask me these things, it's too difficult! (A7:1)

Trainees not only struggle with patients' expectations, but they also struggle with their own. Even those who are able to give themselves permission to assume the learner role worry about how much autonomy and initiative they should display. I will develop this point below when I discuss trainees' efforts to shape their training.

Respondents often spoke of feeling "drained" when describing their early clinical placements and attributed this to both the intellectual and emotional demands of their clinical role. As one individual expressed it: "sometimes you think '...my God, what can I possibly offer?' You feel overwhelmed with this suffering" (B1:2). Even individuals who had done a reasonable amount of clinical work as psychology assistants acknowledged in later interviews that they had been unprepared for these demands. When they tried to account for this naivete they typically related it to the much higher volume of clinical work they saw as trainees, coupled with the increased complexity of the cases. Describing the beginning of her first clinical placement, one woman recalled:

> ...my first three weeks was a mad panic because I had so many people to see and read up about. I didn't have a chance to sit back and think what I had done so far. It was just a question of getting through each crisis. I'm just stepping back from it now. At the end of a session it's difficult to know what you should have done or what other people would do. There isn't enough time in supervision to talk about all that. (A1:1)

As we saw in 6.1 ii above, trainees were also aware of increased clinical responsibility and this added to their panic when they were unsure how to deal with a clinical dilemma. An additional contributing factor, which few had foreseen, was that a comprehensive "how to" manual was not forthcoming from the course staff. As one first year trainee remarked:

> ...I was panicking about the prospect of seeing patients and not having any sort of recipe book to follow...I didn't realise perhaps how much of what I've done before and what I know myself that I would have to bring...although I didn't expect to be spoon-fed because you never do, but to some extent I expected perhaps for it to be more structured and for there to be less, that there would be less emphasis on what you'd done before and things. (A3:1)

Uncertainty about "what to do" in clinical sessions appeared to be the main stressor for trainees. This uncertainty gave rise to the greatest anxiety, as well as frustration and disappointment, in the early stages of the course because of trainees' expectations that the course would "answer everything" (A9:1). The lack of clarity that trainees are reacting to arguably derives from three sources: the indeterminacy of professional knowledge; the absence of a central task in clinical psychology (Mollon, 1989) and the lack of clarity in the training course itself in terms of feedback given to trainees about their progress. I shall explore these issues in greater detail in Chapters 7 and 9.

First, however, let us consider how trainees initially responded to the emotional impact of their clinical work. Most of the clinical psychology trainees I interviewed were more open and articulate about the emotional impact of their work than some first year medical students whom I interviewed some years ago who denied, for example, being affected by their initial encounters with cadavers. Their relative maturity and the study of psychology gave the clinical psychology trainees the language to describe their experience that the medical students arguably lacked. Very few of the clinical psychology trainees displayed the flippancy, bravado or extreme detachment that was commonplace among the medical students, so when this did occur it was quite striking. One trainee, for example, projected a flippant, somewhat cynical manner. She explained that "...there's so much work to be done it's a matter of running through to your books and photocopying a few things to throw at your patient, and then doing it for the next one. But that seems to be the nature of the game..." (B11:2). She went on to say:

> R: ...I'm quite hard. I actually think that's a prerequisite. Certainly one of my colleagues said "I want to help people" and I thought "Well why don't you do social work?" You know, I don't, I think you have to be quite hard to be a clinical psychologist.
>
> K: You don't see clinical psychologists as helping people?
>
> R: Yes I do, but I think in order to do that you have to be quite objective and not get involved. So when people go home and say they think about patients and lie in bed and worry, I think that is really bloody unhealthy.
>
> K: And that hasn't happened to you?
>
> R: Well no, well maybe on a Saturday if I'm sitting there not doing very much, or perhaps I'll read something in a newspaper and that will trigger, you know, thinking of a patient, and I'll wonder what I'll do them next week, but problem-solving, yeah. (B11:2)

In fact this trainee became visibly upset later in the interview when she acknowledged some painful resonances between her clinical work and her personal life. It therefore appeared as though her work was affecting her more than she had acknowledged.

Most of the other respondents (for example, those quoted at the beginning of this section) acknowledged their anxieties more directly or, more accurately, confessed to them when I asked. Typically, they declared their reluctance to share anxieties about their clinical work with supervisors because they expected that this would adversely affect their assessment at the end of the placement. Some trainees reported that particular supervisors had facilitated discussion of these personal issues in a way they found very useful for their own development as therapists. However, other trainees found this focus intrusive. The following response is representative of several similar answers, and

was given when I commented that a few supervisors offer the opportunity to discuss the emotional impact of clinical work:

> Yeah, but when they do it's really threatening, it's not nice. And I had one say something to me once about something and I just went "ooh", because you just think, no, this isn't right, because it's for assessment, you're assessing me, you know, it's like showing weakness. It shouldn't be like that. I think supervisors should be supervising work only, and counsellors should be provided. (C3:1)

A small number of clinical psychology training courses are offering/requiring that trainees undertake personal therapy as part of their professional training. I therefore asked my respondents for their views about this option, as another way of dealing with the emotional impact of training. No one was opposed to it in principle, although many expressed reservations. For some it was unnecessary "navel-gazing", or, as one woman said: "Why would it be any more relevant for us than for an accountant?" (B3:1) Most trainees were sceptical, if not actually hostile, about the idea of personal therapy as a mandatory part of their training, but the vast majority was positive about it as an option. Very few respondents were in favour of trainees receiving this therapy in groups, arguing that this would be too threatening and would make it difficult to work with fellow trainees as colleagues in future. While most people preferred the idea of individual therapy there was little agreement about who might offer this. Most trainees thought it should be someone outwith their own department, but some people thought this support should come from outwith the profession altogether so that these therapists would not be future colleagues.

The ambivalence that many trainees displayed towards personal therapy, and the idea of addressing personal issues in supervision, seemed to stem from two sources: anxiety that their inadequacy would be discovered and confusion about what behaviour is appropriate within their professional role. Here, a trainee describes how some qualified clinical psychologists behave in a manner that denies the emotional impact of the work:

> There's some people that I've met, some qualified people, going "Oh well, when the door shuts then that's the end of the day, you know." Come on. I think the interpretation of the scientist-practitioner model is sometimes taken too far, whereas some people, you know that you can't be a hard-nosed white coat wearing practitioner really. Some people's definition of that model's a bit skewed sometimes. We're human beings and as such we can have reactions....maybe it's one of the negative things of having a scientist-practitioner model. CBT [cognitive-behaviour therapy] is such a technical, sometimes you feel like a technician rather than a human psychologist. Sometimes the scientist can go too far, so that you're made to feel like some sort of robotic entity, and the emotional, personal side of it gets left to another department if you like. (C2:1)

It is significant that this sceptical reaction to the model of the "hard-nosed white coat wearing practitioner" came from a third year trainee. As we shall see in the next chapter, trainees become

increasingly and predictably discriminating in their response to potential role models. However, early in the course these judgements are more difficult for most trainees to make.

One of the developmental processes that trainees must negotiate is learning to create professional boundaries. Boundaries that function most effectively to facilitate good therapeutic work, while protecting the therapist from becoming overwhelmed by patients' distress, rest on the therapist's self-awareness and awareness of the dynamics in the therapeutic relationship, together with a clear understanding of relevant ethical and professional issues. Some trainees, particularly in first year, find it very difficult to switch off from clinical work and equally difficult to get out of therapist mode at the end of the day. The following comments from a woman in her first placement are representative of many. She did not, in fact, begin personal therapy while she was on the course, but discusses it here as an option she has considered to help her clarify her boundaries:

> I started here with loads of clients and I felt really stressed and I didn't want to be on the phone all the time looking for therapy from my peers. It's not their job. So I thought therapy would be useful from that point of view, to stop me taking work home with me. I think that's something you learn. When I worked that year after leaving school I took everything home with me. I didn't know how not to be involved with people I was working with. I had to learn how to distance myself, but I'm still learning it. Also, coming home and not wanting to hear about your friend's or partner's troubles, and finding yourself being a psychologist with your friends and then feeling that's not right. So therapy would be useful for many reasons and then I could be me again. (A1:1)

In this account we learn that the trainee had struggled "to distance" herself in her first job after she left school and still finds this difficult in clinical work. Her first (voluntary) job was in a drop-in centre for people with "long-term mental health problems" where she had a "very vague role" and therefore found it difficult to set boundaries (A1:1). This experience was shared by a number of fellow trainees before they began clinical training and also caused them difficulty in redefining their relationship with patients once they began the course. For example, another woman who had worked as an assistant in a community-based learning disabilities service, spoke of how much she had been influenced by the staff in residential centres who maintained very loose boundaries in their work with their clients and socialised in a "natural way" with them. At the time, this respondent was very impressed by this non-judgemental, non-hierarchical approach and tried to emulate it. However, by the end of her first year on the course she admitted:

> Now I'm doing learning disabilities again and I see the advantages of boundaries in this job. As an assistant, having fewer boundaries let you get a clearer picture, but now keeping boundaries lets you get through the work...At present it wouldn't be right not to have boundaries, it's a safety thing, it allows you to keep your distance while you learn what to do. (A5:1)

As trainees progress through the course, their accounts reveal increasing acceptance of the need to maintain some "distance" from patients' distress, but the difficulty of keeping these boundaries remains an issue after qualification, as Chapter 8 will demonstrate.

## 6.4 Disclosure of the Researcher's Expectations and Responses to the Interviews Reported Above.

In Section 5.1, I presented the theoretical rationale for progressive disclosure of my predictions and reactions to the data in the interests of transparency. I will therefore proceed to provide this context for the results reported above to enable readers to take this into consideration as they examine my interpretation of the findings (Stiles, 1993).

First of all, I had not anticipated the degree of dislocation and anxiety that most respondents said they experienced during the transition to trainee status. I did not foresee this because it did not match my experience. In the light of these findings, it is arguable that my own background prior to clinical training – the fact that I had never worked as a psychology assistant – should have left me susceptible to reality shock when I began the course (see 5.1). The truths of that period are difficult to establish now with any reliability. Since then, I have experienced eight years of professional socialisation. However, I do recall that any intellectual security I had during the early stages of my training came from my knowledge of psychiatric classifications and treatment models in the field of adult mental health.

My first clinical placement, in adult mental health, was with one of those rare individuals: the clinical psychologist who has completed a psychoanalytic training. Most of the initial shock I recall in that placement was the result of struggling with an alien view of psychological disorders after spending six years in a milieu dominated by the medical model and a cognitive-behavioural approach to psychotherapy. I remember feeling utterly disorientated and bewildered by the psychoanalytic terminology my supervisor employed and his tendency to run supervision sessions like therapy sessions, with the expectation that I would provide the focus. However, despite beginning the placement full of scepticism about the psychoanalytic model, as the weeks went by I was astonished to find myself valuing the insights it offered. It turned out to be one of the most valuable placements I did in my clinical training and challenged a number of ill-founded prejudices I had held.

While I remember feeling isolated at times (it was a very small department and I spent time at different bases), and overwhelmed by a large caseload, I suspect that I was protected from reality shock in that first placement by two factors. I had done a small amount of individual therapy, supervised by psychiatrists, before I started the course, so for me (unlike trainee B12) this was not entirely new. Secondly, in that placement I actually had very little exposure to the reality of working in a clinical psychology department: my supervisor defined himself first and foremost as a psychoanalyst. I do not recall attending any departmental meetings or hearing any discussion about professional issues. Those experiences were not to occur until I began my second placement and by then, six months into the course, my professional socialisation was well underway through my contact with other trainees and clinical psychologists on teaching days.

The second finding I had not anticipated in this stage of data collection was my discovery that individuals had generally failed to consider the emotional demands of their forthcoming training and eventual career. Perhaps I expected my respondents to demonstrate more awareness of these issues than either my peers or I had done at that stage in our careers. Certainly, these issues had not emerged in my earlier interviews with Cohort B (reported in Chapter 5) before they began the course. This lack of anticipation and readiness contributed to the emotional impact of the transition to trainee status. Furthermore, it seemed to add to trainees' difficulty in granting legitimacy to the feelings they experienced in reaction to their work.

My own view of trainees' responses to the emotional impact of their work is coloured by internal comparisons with interviews I conducted fifteen years ago with first year medical students (alluded to above) for a prospective study of stress in junior doctors. That interview schedule included questions about life events and stressors during training and I remember being struck by the phlegmatic tone of most of my respondents. Even when individuals were recounting experiences which objectively seemed extremely stressful (like their first encounters with cadavers for dissection), most students denied the emotional significance of the experience or defended against it with a display of machismo. To some degree these responses undoubtedly reflect the age of the medical students (averaging eighteen years), but they also appeared to reflect the students' socialisation into the medical culture where expression of distress was discouraged in students[19]. Similarly, the ambivalence of clinical psychology trainees' about discussing the emotional impact of their work appears to be another index of their professional socialisation. One of the legacies of clinical psychology's struggle to establish its legitimacy and escape medical dominance is that it has adopted

[19] Times, of course, have changed and enlightened medical schools no doubt pay more attention to their students' needs these days. It is also true that "a necessary psychological task for the entrant into any profession that works with people is the development of adequate professional detachment" (Menzies Lyth, 1988, p.53).

some of the attitudes we associate with traditional medicine. These include an equation between detachment, or scientific objectivity, and professionalism: an attitude that is prevalent though by no means universal in clinical psychology.

## 6.5 Summary of the Transition to Clinical Training.

In conclusion, we have seen that most, but not all, respondents experienced the transition to trainee status as an *ascending status passage. Its desirability, centrality, and (generally) its clarity distinguish this passage*. In the next chapter, I will examine the passage of trainees through the DClinPsychol course and see that one of the defining features of that passage is its lack of clarity. I will argue that this characteristic of the course limits the ability of individuals to shape their passage through clinical training, and thus impedes the development of their professional identity.

In this chapter we have also considered instances of *role ambiguity* and *person-role conflict* that contribute to *role strain* for new clinical trainees, and I have discussed the *anxiety and confusion* of individuals commencing professional training. In Chapter 7 I will continue to explore trainees' emotional responses to their clinical work. I will also consider further instances of role strain, and the efforts made by trainees to master professional skills, despite these difficulties.

# CHAPTER 7

## RESULTS: THE PASSAGE THROUGH CLINICAL TRAINING

This chapter presents an analysis of trainees' experiences on the DClinPsychol course, described graphically by one respondent as "the big cloud in the sky that you can't get onto" (A2:1). The accounts reported here are drawn from three sets of interviews with Cohort A and one set of interviews with both Cohorts B and C, denoted with bold print in Table 7.1:

**Table 7.1: Interview Data Presented in Chapter 7.**

| COHORTS | 1st INTERVIEW | 2nd INTERVIEW | 3rd INTERVIEW |
|---|---|---|---|
| A | **Start 1st Year: 1st clinical placement** | **End of 1st Year: 2nd clinical placement** | **Mid 2nd Year: 3rd clinical placement** |
| B | Pre-course | **Start 1st Year: 1st clinical placement** | |
| C | **End 3rd Year: Final clinical placement** | 12-18 months post-qualification | |

In the previous chapter, I described how respondents experienced the status passage of the transition onto the DClinPsychol, and how they viewed themselves in the very early stages of clinical training. In this chapter I will proceed to analyse trainees' experiences as they progress through first, second and third year of the course. I will begin by looking at the efforts made by trainees to shape this passage and achieve the necessary degree of mastery in terms of professional knowledge and skills. From there, I will proceed to consider how lack of clarity concerning training objectives impinges on these attempts. As I shall demonstrate, this lack of clarity reflects confusion within the profession about the work of its members, as well as characteristics of both British clinical psychology training courses in general, and of this training course in particular. Finally, I will describe the workshops that I introduced in my capacity as lecturer on the University of Edinburgh/East of Scotland DClinPsychol

course within the Professional Issues teaching module, with the aim of facilitating trainees' passage through clinical training.

The specific objectives of this chapter are:

i. to describe trainees' efforts to shape their passage through clinical training, consistent with a symbolic interactionist view of professional socialisation
ii. to describe the strategies used by trainees to manage the demands and dilemmas of clinical training
iii. to describe trainees' evolving views of their professional role and responsibilities
iv. to describe the structural and situational factors influencing trainees' trajectory through this stage of their professional socialisation
v. to describe my intervention into the professional socialisation of these trainees.

The following section addresses the first objective. Here, I will examine how trainees shape their passage through formal training, both collectively and individually.

## 7.1 Shaping the Passage Through Clinical Training: Trainees' Use of Studentmanship.

Referring once more to Glaser and Strauss' (1971) taxonomy, we can identify *control* as one property that distinguishes the trainees' passage from those they made before starting the DClinPsychol. Most individuals feel that they have relatively little control over their trajectory through psychology assistants' jobs, research jobs and the other posts they take prior to being selected for clinical training. At its most fundamental, lack of control is about lack of choice: both actual and perceived. Before they are accepted for clinical training, large numbers of psychology graduates compete for a limited number of jobs that will provide the experience they need. If these jobs prove unsatisfactory, individuals are reluctant to complain in case they jeopardise their chances of getting a good reference to assist their application for training. For the majority of individuals, the control they exercise is mostly limited to their choice of private responses to their experiences. However, as we saw in Chapter 5, the range and strength of these responses should not be under-estimated. This private experience provides the starting point for developing the "*art of studentmanship*" (Olesen & Whittaker, 1968) that trainees use to shape their formal training.

Once they start the DClinPsychol, trainees share a sense of entitlement about what the course should deliver. As one individual explained: "There's a feeling that you have to be wonderful and excellent to get on the course and when you do, you expect to find out the answers to everything" (A9:1). These expectations are driven by trainees' awareness of how much they have to learn: "...it's your training, it's your one chance to try and get yourself in a position of being a useful practitioner" (B6:1). Since they embark on their professional training with these expectations and concerns, it is not surprising that trainees take an increasingly active part in shaping their own passage. Themes of control – taking it, losing it, and wanting it – are dominant in trainees' descriptions of this passage. I will begin by briefly discussing how trainees exercise control over the practicalities of their training, and then examine in greater detail how this theme emerges in their response to the complexities of clinical work and supervision.

Strategies employed by trainees to shape their passage through the course are examples of studentmanship, defined by Olesen & Whittaker as:

> ...a form of underground student behaviour that plays a prominent part in shaping interactional styles, operational values, and staunchly-held attitudes among students...These norms, inherent in the life style of all students, exert recognizable influences on the manner in which students cope with the educational situation. Studentmanship, therefore, functions to suggest answers to a perpetually problematic issue: how to get through school with the greatest comfort and the least effort, preserving oneself as a person, while at the same time being a success and attaining the necessities for one's future life. (Olesen & Whittaker, 1968, pp.149-50)

The authors note that the art of studentmanship allowed the individuals whom they studied "to exercise some control over the business of becoming a nurse" (Olesen & Whittaker, 1968, p.150). As we shall see, the respondents in the present study managed to exercise considerable control over the business of becoming clinical psychologists. In their study of professional socialisation in biochemists, psychiatrists and internists, Bucher & Stelling (1977) also recognised the importance of studentmanship.[20] They conceptualised this as one dimension of *mastery* and concluded that the experience of mastery is essential if trainees are to develop a professional identity and a commitment to their profession.

Collectively, the clinical psychology trainees shaped their passage by complaining formally/informally about the status quo and asking for change. Recent examples of trainee-led changes in the course structure are changes in the timing of examinations within first and second year, and an altered third year timetable that allows more time for trainees to work on their dissertations and has a much smaller teaching component. Another example of a trainee initiative that

[20] Bucher & Stelling use the term "studentship", but I will follow Olesen & Whittaker and use "studentmanship" throughout this text for consistency

relates back to the discussion of trainees' support needs in the last chapter concerns an experimental support group. During their second year, Cohort C decided to set up their own group:

> ...at the time it was a statement that we need this, and we're jolly well going to do it ourselves type thing, and a bit of anger at the course for not thinking, for not supporting us, not actively supporting us. But it was a difficult one, well, one because it had to be done in our free time...I think probably what I wanted was some therapeutic work, but recognising that I wasn't going to get it, and the group was the next best thing, but the group wasn't really therapeutic. (C4:1)

Certainly, this experiment illustrates some of the difficulties surrounding personal therapy in training. A clinical psychologist who lectures on the course and provides clinical supervision for trainees, offered to facilitate the group. The group was optional and open to members of that class only. Less than half the class attended. Those who did not explained that they felt uncomfortable about revealing vulnerabilities in front of classmates. Those who did attend had mixed views about the group's usefulness. There was debate during its inception about whether the group would function as a therapy group or a discussion group to consider training-related concerns/dilemmas, without the expectation of much personal disclosure. The group's participants opted for the latter, and this satisfied some but left others feeling that the "real" issues had still not been addressed. The group only ran for a year, and nothing similar has been tried since, but its existence provides another example of how a collective expression of trainees' needs produced a response from the system: in this case, from a clinician within the training network.[21]

On an individual level, trainees shape their passage through the course in numerous ways: for example, they choose their own research topics and exercise varying degrees of influence over choice of research and clinical supervisors. The latter is worth examining in more detail because trainees generally consider choice of clinical supervisors to be the most important factor in determining the quality of training. As a result, the most serious clashes between interviewees and course staff occurred when there were disagreements over placements or supervisors.[22] In order to avoid these disputes and get the placements they want, trainees frequently lobby Clinical Tutors (who organise the placements), Heads of Service/Departments, or individual clinical supervisors. These negotiations can be protracted and may involve extensive manoeuvres "behind the scenes" by trainees to get the decision-makers on side. Indeed, those with "insider knowledge" of the system from their days as

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[21] Of course trainees did not always find the system so responsive. In 7.4 ii. below I shall discuss instances where trainees experienced the training organisation as resistant to their efforts to effect change. Much of the doubt and disillusionment experienced by trainees results from the clashes between trainers and trainees for control of this passage.

[22] While many of these disagreements occurred because trainees valued particular placements more than other ones (judgements that were generally based on opinions of previous trainees), they were not always motivated by the desire to get the best possible training. Trainees' choices were

psychology assistants typically plan at least some of their placements before they begin the course. For example, one woman whom I interviewed before the course began spoke of her "confidential agenda" to do an out-of-region placement in second year because she was sceptical about the expertise of the local clinical psychologist working in a particular field. She eventually managed to arrange this placement, bringing months of planning to fruition. Similarly, one psychology assistant told me that she had already "chosen" her first supervisor, although she had not yet started the course, while other assistants told me that they knew who to seek out and who to avoid among potential supervisors. Trainees who begin the course less well acquainted with the folk taxonomy (Atkinson, 1977) of clinical placements typically become more proactive as they acquire this knowledge from classmates.

The art of studentmanship practised by clinical psychology trainees in their clinical placements is elaborate and allows them to exercise considerable control over this experience. Trainees need and want to learn as much as they can from their clinical supervisors, but are wary of revealing too much of what they do not know. Similarly, they all need and want support of various kinds at some stage during the course, but are wary of appearing too needy or dependent. The observation of Olesen & Whittaker regarding their nursing students aptly describes the task these clinical psychology trainees defined for themselves:

> It was the business of the students, given the aspiration to be professional persons, not only to become, but also to convince the faculty that they *were* becoming. Therefore, discrepancies, which by definition imply inability to become, slowness in becoming, or just sheer recalcitrance, had somehow to be softened, diluted and hidden, if not altogether overcome. The arts of studentmanship were paramount here. (Olesen & Whittaker, 1968, p.150)

In addition to *studentmanship*, Bucher & Stelling (1977) identified two other dimensions of *mastery: (1) mastery of the knowledge and skills required by one's profession, and (2) mastery that is measured by "mood": by feeling confident and comfortable with one's progress and level of competence.* The following section examines how clinical psychology trainees develop all three types of mastery in the context of clinical work and supervision. Since clinical work forms the core of their professional training, it seems appropriate to give it primacy in this report of trainees' experiences.

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sometimes entirely pragmatic and based, for example, on how much commuting a placement would require.

## 7.2 The Development of Mastery in Clinical Work.

I will begin this section by examining trainees' use of studentmanship in their relationships with their clinical supervisors. As I shall demonstrate, this aspect of mastery has a complex relationship to the other two: acquisition of knowledge/skills, and development of confidence in one's professional role.

### 7.2 i. The Art of Studentmanship Applied to the Supervisory Relationship.

While trainees acquire mastery in terms of clinical confidence and professional skill incrementally over the three years of the course, they display considerable mastery in terms of studentmanship right from the outset. This is not surprising in its application to the management of demands and expectations inherent in the student role, such as those discussed above. After all, these individuals have all been students before. I predicted, however, that trainees would exercise studentmanship less extensively and confidently within clinical supervision, since most are self-evidently novices within this context. That is, I expected trainees to be less active in trying to exercise control within the supervisory relationship. This prediction was not supported by the accounts I received. These interviews revealed three main strategies used by trainees to manage the supervisor-supervisee relationship: (1) selective use of role models; (2) discounting of negative feedback; and (3) impression management.

In 5.2 iii above, I reported that psychology assistants used senior colleagues as *partial role models*: they selected particular attributes to emulate from a number of different individuals, rather than using anyone as a complete model. In this respect, the assistants emulated the trainees studied by Bucher & Stelling (1977). Given these earlier findings, I expected that the clinical psychology trainees would be discriminating in their response to clinical supervision, but I did not expect the degree of selectivity I found early in the course. One third year trainee retrospectively reported:

> In the first two years, definitely, you become your supervisor, you talk in the way they talk, you use the phrases they use and the style they use, totally. But again , in the third year, you do develop your own style, you're left more to your own devices, and I think there's more of your own character comes through in third year, you're able to rely on your own style, and your own style's kind of a mish-mash of a lot of your supervisors. (C11:1)

In fact, her recollection of modelling herself so closely on her supervisors during the first two years does not match the accounts provided by the other respondents.[23] This may represent a genuinely idiosyncratic response for reasons that are unclear, or may be a retrospective distortion of events. The other trainees whom I interviewed denied going through this stage, and instead reported that from the beginning of the course they continued to behave as they had while they were assistants. From the outset, they demonstrated considerable independence of thought and action but, particularly during the first year, took pains to disguise this from their supervisors.

The following example is representative of many, and it is worth noting that this trainee was not overly confident or generally resistant to learning new skills or perspectives. It is also significant that she had worked as a psychology assistant for about two years before she began her DClinPsychol but had no previous experience in adult mental health prior to her first clinical placement in that core area. Given these setting conditions, I was surprised to hear her early in her first placement rejecting a procedure modelled by her clinical supervisor and implicitly claiming the superiority of her own judgement. Here, the trainee is talking about her supervisor's practice of routinely checking for co-morbidity during initial assessments. In this example, the trainee disagreed with her supervisor over screening for obsessive-compulsive disorder when a patient presented with an anxiety disorder, although she accepted that she should have checked for depression:

> ...I'd sat in on [my supervisor's] initial interview, and it was quite different in some respects from the books' initial interviews in that she went through a checklist of, of what could be sort of co-morbid things. And, um, I didn't do that...because I remember being sat in her initial interview, thinking if I was the patient and she was asking me do I check things or do I keep lists, and there seemed to be a lot of questions that the patient was saying "no, no, I don't, no, no", and I was thinking if I was the patient I'd be thinking, oh, she's really off on the wrong tracks, she doesn't understand this at all. And I remember thinking at the time, ooh, I don't know if I'd have asked that, but the more I thought about it, I thought OK, fair enough, you didn't ask about checking behaviours and stuff, but the patient had anxiety, you should've definitely covered depression, and I didn't really....I think I still have a little concern about...going into all that OCD stuff in the initial interview...because as well we've been taught that if someone has anxiety and depression and also OCD, that you tackle the anxiety and depression and hope that the OCD diminishes, and if it doesn't, then you tackle that...So I suppose I still have reservations about that, and I'd probably ask for the period of my placement because I think that my supervisor will say "and what did they say when you asked?", and if I'm constantly saying I didn't ask, it will look really bad...But it's hard, I think, to get a balance of trying to be independent and trying to not, because you feel so sort of unknowledgeable, and that everything they're saying must be right 'cos they've been doing it so many years and, and you feel like you know nothing, and then on the other hand you think, well come on, you still have to have some initiative and some knowledge otherwise you wouldn't be here. And it's trying to get a balance, I think. (A10:1)

[23] Silverman (1993), among others, recommends the reporting of deviant cases to enhance the validity of qualitative data analysis. In Chapter 9, fuller consideration will be given to the significance of some of the deviant cases in this study.

This account illustrates the trainee's awareness of the need for *impression management* – of appearing to follow her supervisor's advice -- while she makes an early attempt to exercise some clinical judgement and display some independence. In 7.3 below, I will return to the subject of clinical judgement and discuss some of the difficulties that trainees encounter as they try to develop this skill.

Sometimes trainees deviate from their supervisors' guidelines because they disagree with them on technical or ethical grounds, but on other occasions it is a question of personal style. Most of these respondents acknowledged the importance of "finding their own style" from their first clinical placement onwards. One woman, for example, described the differences between herself and her first supervisor (whom she liked, respected and described as "very professional") saying: "she's got that spiritual, touchy-feely side to her, she's very soft and gentle and very solution-focussed in her leanings...and I'm much more, right, thought records, cognitive-behavioural...I see myself as more practical" (B12:2). This (clinically inexperienced) trainee's acceptance of their different styles was typical of the responses from other first year trainees when they observed their supervisors, and by second year this acceptance of individual differences is increasingly superseded by a self-conscious development of personal therapy styles (see 7.2 ii. below).

Predictably (and appropriately) trainees become increasingly selective in their use of clinical supervision. Once they reach second year, they are able to judge their current experience on placement by comparing it with two completed clinical placements. Second year trainees typically describe increasingly assertive relationships with their clinical supervisors as they become more confident about their own abilities. Some people openly questioned or disputed elements of supervision, while others did not challenge their supervisors directly but ignored aspects of their advice/criticism. Within the cohorts studied here, *discounting of negative feedback* by trainees occurred from the first clinical placement onwards, but became significantly more frequent and robust by the second year. Here, a trainee speaks about her third clinical placement at the start of second year:

> R: I suppose there's only one supervisor I did feel I had problems with, but that wasn't a difference of approaches but I suppose a difference of style. I found her very critical of me, and of patients to some extent, mainly of me, and I often didn't agree with what she was saying. Like she would criticise me on whatever point and it was difficult to take that criticism when you actually don't agree with it without it turning into an argument or becoming awkward.
>
> K: So what strategy did you adopt to deal with that?
>
> R: I suppose I spoke up for myself most of the time. If it was something I disagreed with that I didn't think mattered anyway, I would maybe listen to what she said in supervision but maybe not bother changing some of the points in the actual written report, and she would

> still sign it for me anyway. She thought I was probably too assertive. which I don't think I was at all. I'm not overly assertive in general, but she thought I was towards her. (C13:1)

Similarly, another second year student who certainly did not consider herself assertive described how she tackled her supervisor. This trainee had been feeling progressively deskilled because her supervisor had not allowed her to see any patients on her own and was taking independent treatment decisions about patients whom she had allocated to the trainee:

> ...I felt like --- wasn't giving me the responsibility that I should be getting at this stage in my training, and I was getting more and more frustrated, but I wasn't saying anything to her so it was mostly my own fault....I kind of had planned all the different ways I could bring it up. I tried so many different times. I tried a couple of times and landed myself worse in it because she made comments like "if you've got any concerns at mid-placement visit, it means we're not talking properly" and that made me feel even worse, and it was just dreadful, so I suggested to her...that I should take the end of placement evaluation form and ask her to go through it with me so that I could get some feedback, because she'd not been giving me any feedback, so I suggested that, and then she came up with this comment again about how if we had anything to say at mid-placement visit then it meant we weren't communicating properly, and I said "Well", and then just went into it all, and said "You do this, and I don't know why you do that, and I think I should have X, Y and Z. (A6:3)

This trainee was emphatic that she could not have challenged a supervisor in this manner in her first year (and this was certainly my impression from my visit during her first placement when she was extremely anxious about her ability to do clinical work). She said that she needed the experience of two successful placements to develop confidence in her own skills before she was able to begin shaping her supervisor's behaviour. During these earlier placements both supervisors and patients had contributed to her sense of legitimacy as a professional, and by her third placement she was therefore able to provide sufficient self-validation to challenge this supervisor.

Trainees also exercised studentmanship through *impression management* in these supervisory relationships. I noted one aspect of impression management above when I quoted Trainee A10 who spoke of the importance of appearing to follow her supervisor's advice. Another aspect of impression management is the dissembling that trainees engage in to conceal their difficulties from their evaluators, particularly clinical supervisors. Among the cohorts of clinical psychology trainees whom I interviewed, individuals varied considerably in their willingness to disclose problems and insecurities. Few trainees were prepared to tell their supervisors when they were struggling, and the following observation is therefore atypical:

> ...my supervisors have been flexible enough that I felt quite able to have a good moan if I needed to, or if I'm struggling. I never have a problem with admitting when I'm struggling and thankfully the environment's been such that I wouldn't have, because I'd hate to think that I've got to try and pretend that I'm coping if I'm not, so maybe it's partly me but I hate that, I hate the pretence that goes along with that. (B6:2)

More typically, trainees concealed their doubts because they feared that individuals who were assessing their clinical competency would consider them inadequate. The following quotation is therefore more representative than the previous one:

> R: ...because you are getting assessed essentially by the same people that are your supervisors, this was a discussion we had in class, if there are personal issues, certainly there are things in this Block that I, similar to what I felt in Learning Disabilities, that there is a power imbalance and it's quite judgemental in some areas, and I have quite a hard time with that, but I wouldn't enter into a discussion with my supervisor about it in case, you know, that was interpreted as me having a problem, or becoming defensive, or, I just don't want to get into that...I did that in my first placement because I suppose it was just really the way --- made supervision really sort of easy and I felt comfortable and I did discuss personal issues with her, but that was on the assumption that , we were both aware of this, that it wasn't going to be passed on to [the Clinical Tutor] at a mid-placement visit or anything like that. I would certainly never do that here. Not that I think anyone would object, or there would be any problem, but I just, I think that looking back, the best way to get through this training is to work really hard at developing a sort of professional front, or attitude.
>
> K: What do you have to do to do that?
>
> R: Shut up and get on with it I think! Certainly not discuss personal issues.
>
> K: It means disclosing less?
>
> R: Yes, absolutely, yes.
>
> K: Because you'd be taken advantage of in some way, or seen as wanting?
>
> R: Yes. I don't think anyone would take advantage, but I think there is a definite feeling that although we are all doing psychology, I think if you were in a position where you had to seek help for an issue or, I mean I know other people in the class that I'm friendly with have, but I would be concerned that that was being viewed as "She's just too. not resilient enough" or how's this going to look in ten years time in practice? It's just too risky. (A4:3)

This reluctance to disclose personal or ethical issues/dilemmas (in this case, concerning the trainee's discomfort about the power relationship between herself and patients) because one might then be assessed less favourably was shared by most of the trainees. I will discuss the implications of this stance in 7.3 below, when I consider the factors that obscure the passage through clinical training. Before turning to those issues, I shall examine how trainees develop mastery in terms of clinical skills and clinical confidence.

## 7.2 ii. Acquiring Therapeutic Skills and Confidence in One's Clinical Work.

First and second year clinical psychology trainees share a number of preoccupations. In 6.2 and 6.3 above, I reported that new trainees frequently described themselves as "pretend" psychologists, and experienced considerable anxiety about being exposed as novices by their patients. The first and second year trainees whom I interviewed were certainly preoccupied with establishing their credibility, primarily with patients but also with colleagues. At this stage, they typically assess their own credibility and competency in terms of "*knowing what to do*": of being able to answer patients' questions and being able to apply appropriate therapeutic techniques.

### 7.2 ii. (a) Dominant Themes in the Interviews with First Year Trainees.

The theme of *control* frequently emerged during my interviews with trainees who were completing their first placements. In Section 6.3, I quoted trainees whom I interviewed at this stage of the course, including the woman who struggled with patients' questions ("you're not meant to have that much insight, don't ask me these things, it's too difficult!" A7:1), and the person who admitted: "I was panicking about the prospect of seeing patients and not having any sort of recipe book to follow" (A3:1). Individuals spoke of feeling out of control in therapeutic interactions, and also described their attempts to take control of clinical sessions. Here, a trainee who had some experience of clinical work as a psychology assistant is reflecting on the first six weeks of her initial placement:

> R: I've got about six cases...the first week or two I sat in with [qualified clinical psychologists]. I've done assessments on my own and I felt quite confident about that, rightly or wrongly. It's the rest of it I need help on.
>
> K: I always think the second session can be a bit difficult.
>
> R: Yeah, that's what I'm finding. I'm not sure what to do in that session yet. I think I'm learning that I really should just relax a bit. I still feel I should have some kind of definite plan and tell people stuff, and I know I should just be relaxing and letting things happen and not being quite so directive. I don't know where I feel this pressure from, but I feel I should be doing techniques and I should be giving information and be able to write down exactly what we've done. I'm trying to relax a bit more and have the confidence that I'll be able to deal with it.
>
> K: So you don't know where those expectations come from?
>
> R: No. I think it's partly me and partly that I'm aware I'm being assessed by the course. and having to account for everything you do, and be able to describe it, and not just say "Well, we chatted for forty-five minutes", it sounds a bit vague.

> K: You're also saying that you're trying to relax and not put so much pressure on yourself. Where's that idea coming from? That there's a different way of going about it?
>
> R: Just observing other people again after a gap, just recognising that it's not the right way to do it, having a definite plan ahead of what you expect from the person. It doesn't work that way and it's not good for the person. That's very directive and I don't think that's the way to do it. And it doesn't feel particularly comfortable if I do do it that way, it's quite anxiety provoking. (B4:2)

This respondent provides a clear account of the dilemma that trainees encounter when they embark on clinical work. They are trying to live up to the expectations of themselves. their patients and their supervisors. and give an account of what they have "done" in the session that distinguishes their professional activity from a "chat". Discriminating between the two can, in itself, be confusing. Another trainee described her concerns that she was being "too informal" in her efforts to put patients at their ease and avoid being put "on a pedestal" herself: "I do worry that I'm not being professional. I don't know where the dividing line should be" (B12:2). As we can see from the extended quotation above, Trainee B4 responded to her anxieties by being directive, but discovered that her strategy was "anxiety provoking", that controlling the session "doesn't feel particularly comfortable".

The emphasis placed on techniques by first year trainees is understandable: these are the aspects of therapeutic work that are explicit and quantifiable. As such, they are more accessible to the novice than those aspects of work that draw on experience or clinical judgement. However, another dilemma that confronts all clinicians, and one that presumably arises more frequently when one is inexperienced, concerns how and when to use specific therapeutic techniques:

> I mean it is difficult and I sometimes think I make it up as I go along. And they say on the course that what you do must be based on the theoretical background. but I can't seem to do that all the time, probably because I haven't got the theoretical background and because when you see real people they don't always fit. (B3:2)

The challenge of linking *theory and practice* can be problematic at any stage in one's clinical career, but is particularly so in the early stages of training and can leave individuals feeling de-skilled and inadequate. One trainee spoke of the "continual strain" of working with cases where she found it "difficult...to apply any real theory as such, and it's much more about using fairly general principles" (B6:2). She acknowledged that these were the people whom she saw for the longest, although she failed to make any progress with them. She also recognised that her lack of experience limited her conceptualisation of these cases (particularly her understanding of interpersonal processes in the therapy sessions), and this limited her effectiveness. In the following account, she is speaking about two cases where she was unable to work effectively on a technical level because of difficulties in the therapeutic relationship that she was unable to address:

> ...I've become, you know, I became really aware of the therapeutic relationship, and how significant it is...There was one person I couldn't, I could never really get underneath his skin. I could never really figure out what was going on...I don't think I'd clicked with this guy very well and it therefore was harder for him to really open up. I don't know, but I think these things are hugely significant and I'm not sure that apart from a small element of lecturing how aware I was of that [previously]...Another one I hadn't really, I'd always felt there was something going on if you like in the therapy sessions that we had, and I was able to talk to my supervisor about it and, I always felt that this woman always was one step ahead of me, and it was really curious. I couldn't work out what to do but it certainly made me feel inadequate a lot of the time. And to do a joint session [with my supervisor] at the end was excellent. It certainly clarified a lot of my feelings, that it was almost like [the patient] was in the role of somebody in therapy...I realised that I'd been fairly well manipulated throughout the course of this in a kind of passive way. I'd kind of played the game and gone along with it all. I suppose at the time my reasoning was to try and engage and get as good a kind of contact as possible, in order to be useful, had I ever managed to become more focussed. which I don't ever really think I did. (B6:2)

This trainee's delayed recognition of ill-defined process issues that were impeding progress was an experience shared by many of her classmates, as was her experience of feeling manipulated and losing control in these sessions. Another woman expressed the frustration and resentment that this loss of control can produce:

> And there was another occasion when I saw someone a few times and he brought in his mum, who was very controlling, very over-powering, and she insisted on coming into the session and giving her opinion about how she felt things were going with her son, who was thirty and still lived at home, and that was hard to deal with, someone who didn't criticise you as such but basically said "It's not working so far. What else can you do?" And you sit back and think 'Right, OK, well, try and be as polite as possible, thank someone for their opinions, and see what you can do with it', whatever, but at the end you think 'Shit! This is not what I was waiting for! I'm in charge here!' That's hard to deal with, if someone's very powerful, or a direct character, that can be perfectly alright but, perhaps I have to get used to that, try not to be too defensive. (B1:2)

Throughout their careers clinical psychologists, like other therapists, struggle to understand and then work with these interpersonal processes. However, the task is especially difficult at the beginning of one's training when one lacks the conceptual framework to assist interpretation.

While the behaviour of patients (and their relatives!) sometimes threatens the shaky confidence of new trainees, Atkinson (1981) observes that *patients can also function as "legitimators"*. They may legitimate the trainee in a general sense by accepting him/her as a professional person, or as a psychologist. More specifically, patients provide positive feedback about specific skills that the trainee is practising. Early in their clinical training, the examples of this legitimation that trainees identified often concerned rapport: patients said or did something to reassure trainees that they had inspired trust. Respondents did not volunteer these stories and I heard them in response to my enquiries about experiences that had helped them to feel more clinically confident:

R: Yeah, so I was quite reassured by the fact that there was something I'd actually said that she'd responded to and wanted to tell me something, which I thought "oh!" Because it proved that people do listen to what you say and accept what you say and trust what you say, so you know, that's quite reassuring, that she decided she could confide in me or whatever.

K: Uh-huh.

R: I mean, it was nothing dramatic. ( A7:1),

When these "success stories" did emerge, they were often told with a little embarrassment, as the disclaimer in the last sentence suggests. It seemed as though trainees were unsure whether or not to admit that these experiences enhanced their sense of legitimacy in case this admission confirmed their novice status.

7.2 ii. (b) Dominant Themes in the Interviews with Second Year Trainees.

By the time trainees begin their second year of clinical training, most are beginning to believe a little more in themselves as "real psychologists". They are also becoming more confident about their ability to interview patients and conceptualise their difficulties. While "being in charge" and "taking control" were dominant themes in interviews with first year trainees, "*being flexible*", "*being relaxed with patients*" and "*trusting one's own judgement*" become more important themes in second year. Trainees began to report more instances where they felt confident enough to trust their own judgement in clinical situations and diverge from treatment manuals or protocols. In the following representative excerpt, a second year trainee is speaking about cognitive therapy, the model that receives most emphasis on the Edinburgh course:

...maybe I am more able to say "Well, I like this bit, but I don't like the whole thing"...I think in the first placement, my adult mental health, I would try and use the whole thing as they said in the book, that's the way you do it. And maybe that's what I wasn't comfortable with, because I wasn't comfortable to know that you could maybe go away from that a bit and it would still be OK. So maybe now I am more able to do that, or try it, or more willing to try it without thinking "Oh no!" (A5:3)

Not only do trainees report more flexibility in their use of techniques, but they also report feeling less pressured to be "doing techniques", unlike Trainee B4 quoted above in her first placement. Thus, Trainee A5 goes on to compare her behaviour in her first placement with her responses to patients in her third placement:

...at the beginning...you are so worried about what you are going to do when the person walks through the door...I still worry about it, what I am going to do when they come in the

> door, but I am maybe more relaxed when they actually get in. I am more happy with silence than I was before. (A5:3)

While this woman speaks of her increased tolerance for silence in therapeutic sessions, others spoke of becoming better listeners and allowing patients more opportunity to shape the sessions. The growing flexibility and more relaxed style of second year trainees seems to be related to their developing skill at linking theory and practice. I quoted some first year trainees above, describing their difficulties making these connections. Here, a third year trainee reflects on how this skill developed over the first two years of the course:

> ...it took me a long time to be able to formulate properly, and you really had to pin yourself down to think, right, I'm not just seeing this person from the common sense point of view, but I actually am sitting here and I've got this theory base and I've got to train myself to use it. And you can get yourself off the hook almost and say, and just speak to the person from a personal experience point of view or something like that, or what you would do or whatever, and I think in your first year you've really got to pin yourself down and say "No, this isn't what this is all about. This is about having a research theory base and previous people's experience on how to treat that", you know. I had to be really strict with myself and I didn't really learn how to do that properly till I came to my child placement, and that was my third placement. (C11:1)

During their first two years trainees move into an entirely new clinical area every six months and therefore have to keep re-discovering these links while applying their technical skills to different patient populations. For most trainees, this produces a temporary loss of confidence at the start of each of the first four clinical placements, as they readjust. Nevertheless, most of them agreed that these links began to seem clearer by their third placement, at the start of second year.

### 7.2 ii. (c) Dominant Themes in the Interviews with Third Year Trainees.

While the theme of flexibility in the application of theory to clinical practice first emerged in the interviews with second year trainees, it dominated the accounts of third year trainees as individuals described their attempts to "think about people more as individuals" (C10:2). In the following excerpt, a trainee describes how her experience of working with a client-centred approach has altered her view of what it means to be a scientist-practitioner. I will quote it at length because it describes in considerable detail a process that many other third years alluded to, regardless of the therapy model they were applying. In the conversation leading up to this segment, the trainee had been talking about the importance of assessing outcome objectively because "I thought the scientist-practitioner model was all about getting away from this idea of clinical judgement, which is not particularly scientific". The dialogue then continued:

K: Have you had to rethink your view of the scientist practitioner on this placement where you've been working with a client-centred approach?

R: Yeah, I have to a certain extent, actually, in terms of not going in automatically with a set approach. This is the first placement, perhaps because it's the end of my training, this is the first placement where I've gone in where I've not had things jotted down before I go in. I've just gone in and had a chat and to be honest with you, yeah, I find that an awful lot more. It might not necessarily alter the approach I would take with an individual, you know, but it's helped me listen, you know. I think you can become too CBT rigidly orientated, you know? If you go in and just let that individual feel as though it's their session not yours, you get much more. So I think there's scope there to just hand over the reins a little bit more, you know, and then present possibilities, which I think is a lot more what [my supervisor] does, you know. It's not "this is what we shall do", and I've learnt a lot from that to be honest with you. And it's bought me time, if you like, you know, in a session, because I've been listening more. It's made me think about other approaches, that speaking to that individual, hearing their own language, made me think that, well, this therapeutic approach might be better than standard CBT or whatever, so it's been really beneficial. And I suppose sitting in with [my supervisor] I no longer felt, I don't feel uncomfortable now, the idea of somebody just expressing their fears, you know. I mean, you might still want to look at other factors, which might be cognitive influences, but I don't have a problem with just spending more sessions now. Maybe it's just the confidence bit of being more relaxed in therapy, that I can just let people talk if this is what they're wanting to do. And although I still feel uncomfortable if I feel I'm sitting there being a counsellor as opposed to a proper psychologist, there's less of that. I don't feel perhaps as concerned as I would have done if I was applying a rigid approach. I realise there's contradictions in some of the things I've said, but I'm relaxing a bit more and letting people talk and empathising a bit more with non-specific sort of stuff, which is often what they want. You're probably more likely to lose people like that if you take a set approach. (C2:1)

This trainee remained committed to the scientist practitioner model and its promotion of evidence-based practice but describes how she is attempting to reinterpret this paradigm in a way that enables her to take a person-centred approach in therapy. She recognises that there are "contradictions" in her scepticism about clinical judgement and simultaneous recognition of the value of non-specific factors in therapy: the variables that are not manipulated according to a treatment protocol. Her growing awareness of and tolerance for these apparent contradictions was shared by most of her classmates, although a number of them admitted to some anxiety about distinguishing flexibility from poor practice.

While most of these third year trainees were attempting to be more flexible and person-centred, several of them complained that they were constrained by lack of knowledge about alternatives to cognitive-behaviour therapy. Significantly, the only member of the cohort who reported that her confidence concerning her therapeutic skills had actually diminished over the past three years attributed this to her belief that she did not know enough to be flexible in therapy:

I've never been particularly confident in my abilities, but my training's perhaps made me even more unconfident because, again, I feel that the cognitive model has it's limitations and

> because I don't know anything else, if that doesn't work, what's going to work? You know? So I still can't be confident in my abilities to help. (C14:2)

Another theme that dominated these interviews was the necessity of accepting *the ambiguity and complexity of clinical work,* as this interviewee explains:

> ...there are some people that I see that it's very hard to measure what you're doing but you know something's going on as such. I suppose it's just as you do go on in the profession and you get different kinds of cases, you realise how everything's not as black and white as you thought it was when you started, and it's not all about doing cognitive therapy, it's all much more complicated than that. But I still think it's important for the profession to continue to think about what it's doing and measure its effectiveness and think about research and things like that. (C10:2)

Again, this remark refers to the scientist-practitioner model and evidence-based practice, but articulates the trainee's growing awareness of the tension between this model and the real world of clinical practice. Other third year trainees spoke of attending more to the dynamics of the therapeutic relationship. Most of the trainees still felt very under-confident about their ability to interpret these dynamics, and a third of the class commented that the absence of personal therapy or adequate opportunities for guided self-reflection within their training left them ill-equipped to do this.

In summary, then, trainees described a progression over the three years of training from a preoccupation with "knowing what to do" and "doing techniques", to an increasing emphasis on "being flexible" and "trusting one's own judgement". As they move through these different stages, trainees also report gaining confidence in themselves as "real psychologists" and becoming better able to tolerate the ambiguity and complexity of clinical work. Despite these indicators of growing mastery in terms of clinical skills and confidence, trainees still wrestle with doubts and dilemmas concerning the knowledge base of their practice and their professional role. I have noted examples relating to the knowledge base above; in the next section I will discuss trainees' experience of role ambiguity and role conflict.

## 7.3 Role Conflict and Role Ambiguity in Clinical Training.

The previous chapter examined the transition to trainee status and argued that most individuals experienced this as a clearly defined status passage. The status passage through the DClinPsychol is much less clear for the majority and this is noteworthy because the *lack of clarity* can undermine trainees' attempts to develop a sense of mastery regarding their professional skills. Bucher & Stelling

(1977) demonstrated that acquisition of mastery depends on adequate opportunity for trainees to role-play. Of all the situational/interactional variables they identified as influential in professional socialisation (such as modelling, interaction with one's peer group, and coaching), Bucher & Stelling found role-playing to be the most important. Clinical psychology trainees have extensive opportunity to role-play during their clinical placements and the preceding section showed how they developed mastery in the process. Nevertheless, trainees also reported instances of role ambiguity and role conflict that undermined their developing sense of professional identity and, at times, led them to question their commitment to the profession. I will examine some of these instances below.

### 7.3 i. Role Conflict Arising from Trainees' Combined Student-Employee Status.

In Chapter 6, I introduced some of the tensions associated with trainees' combined employee-student status that became evident to individuals soon after they began the DClinPsychol. I noted that trainees identified more strongly with the role of employee than that of postgraduate student and reported that respondents identified the conflicting expectations associated with each role as a source of role strain. I also considered an instance of professional-bureaucratic conflict (Kramer, 1974) when a trainee described the way her needs as a professional in training appeared to have been ignored by the NHS bureaucracy that controlled the training budget. I will discuss further instances of this type of conflict below; Cherniss (1980) identifies *professional-bureaucratic conflict* as one form of *person-role conflict.*

#### 7.3 i. (a) Professional-bureaucratic conflict.

In Chapter 6, I identified the separation between trainees' line management and their professional/clinical base as problematic (see 6.2). As noted in that discussion, the trainees are represented on the Training Committee (see 4.2 i) through their Class Representatives, and trainees have scheduled class meetings with their line manager during the intervening periods. These Class Representatives also have other avenues they can use to communicate trainees' concerns. They can go directly to the class's Year Tutor, who is a member of the academic staff with responsibility for dealing with issues raised by the class, or approach one of the Clinical Tutors if the matter relates to clinical placements. Despite the existence of these mechanisms, the respondents in this study were largely united in expressing their disempowerment within this organisational structure and were

articulate about how this undermined their development of a secure professional identity. During the course of this study, the focus for most of the trainees' disaffection was the constraint imposed by the course on their choice of clinical placements. Many of the trainees became very angry and frustrated about this and saw these constraints, enforced through their NHS line manager, as antithetical to a good professional training.

As noted in 7.1 above, trainees' choices regarding clinical placements were usually based on anecdotal information circulating within the trainee network regarding the "best" placements, but sometimes reflected pragmatic considerations like how much commuting these placements involved. Under the present funding arrangements, each Health Board contributes monies according to a share formula that is used to determine how many trainees are allocated to each region for the three years of the course. In recent years NHS managers have become increasingly interested in how funds are being used, and the attachment of trainees to specific Boards has become increasingly formal as a result. While trainees accept a training post within a particular region in the East of Scotland (Lothian or Grampian, for example) and expect to do their clinical placements within that region, there has been considerable controversy about whether all placements must be within the region. This issue becomes particularly contentious when trainees find that the region they are attached to cannot offer elective placements that they wish to do.

Individuals in all three cohorts studied here became involved in this controversy, but those in Cohort C came into conflict with course staff as a class over placements. The conflict arose when trainees in that class tried to arrange out-of-region placements for their final year. In some cases, these placements were linked with proposed dissertation topics. Not long before their final year began, the class was told by their line manager that out-of-region placements were only possible if the trainees paid their own travelling and accommodation expenses. They were also advised that this practice is not encouraged by the course because the Health Boards want a return for their money in terms of the clinical service provided by trainees. The class responded with considerable anger and expressed feelings of betrayal; the following excerpt is representative:

> R: And we were basically told we either had to, if we wanted to continue to go to the [out-of-region] placements, we could do so but there'd be no expenses for doing that, we had to fund it completely on our own, and if we didn't agree to that then [the Clinical Tutor] would give us a [within region] placement, you know, we were left with very little choice. And there were a couple of trainees who continued on with it and wanted to get legal advice about our contracts and whether they could do that.
>
> K: When you went into it did you find anything in your contracts that backed up your situation?
>
> R: Yeah, well, the contract itself, I think it just stated that we did the majority of our placements in a particular area, it didn't say you have to do all your placements in that area,

> but there was nothing specifically to say that you have the right to do your placement in another area and to get help with your expenses, there was nothing that actually said that, so in that sense they had the leverage, but we'd always been led to believe in the first year, we'd always been encouraged to do a placement outwith the area we were in and people had done up until then and had been funded extra expenses for doing that, so that had always been a thing that had happened. But yeah, it wasn't a very nice time...you're kind of students when it suits but when it doesn't you're an employee. (C9:1)

Her reference to being treated like an employee "when it suits" refers to the fact that the trainees who were contesting the placement arrangements were summoned for interview with their NHS line manager and their personnel manager, and reminded of their contractual obligations.

Within the study period, the clash between course organisers and members of Cohort C over out-of-region placements was reported by respondents as highly significant in shaping their attitudes towards the course. In some instances it also affected individuals' attitudes towards the profession as a whole. The woman quoted above came to her own conclusions about why her class eventually accepted the conditions imposed on them doing out-of-region placements:

> ...I think it's difficult to do the work we do and be the kind of person who can be quite strong and pushy and organisationally-minded and business-minded if you like. I think it is difficult and I find with other trainees, a lot of them don't get as bothered about it as I do, or they're more passive about it, and like they just seem to accept it and go along with it and aren't very political at all about it...so it might just be something to do with this, sort of requirements of the profession... C9:1)

As her comment suggests, the class varied in its response to the dispute and all the trainees found it difficult to sustain their opposition to the ruling because of work pressures. The class was also divided in its reaction to the eventual decision that was made about out-of-region placements: some trainees acknowledged that the Health Boards were entitled to expect a service in return for funding their training. However, trainees were united in their sense of grievance over the way the situation was handled. Despite the mechanisms available for feeding back their views to the course organisers, the class felt that these had been ignored. There was a widespread sense of injustice among the trainees and a belief that the rules had been changed without consultation, together with a strong conviction that financial and bureaucratic considerations had been allowed to compromise the quality of their training. This view is summed up in the following comment from someone who had not personally wished to do an out-of-region placement:

> Yeah, it all seemed so crazy. It just seemed as though they weren't really interested in us getting the best training we possibly could, you know. You've got to stay in your own area because it's too expensive to send you outside. It was such a let down. (C14:1)

The dispute not only affected that intake of trainees, but also had an impact on subsequent years. given the vertical transmission of such stories from one intake to the next. Here. a second year trainee speaks about how the fall-out from the dispute spread from the third year trainees to other years and became entangled with an ongoing dispute over trainees' claims for accommodation expenses:

> R:...there're really a lot of bad changes in the course.
>
> K: Like what?
>
> R: Well, just not moving outside your area and all the accommodation stuff. But it's just kind of blown up at the wrong time. I mean basically people on the course are telling people not to apply because it's such a mess.
>
> K: Really? So morale's pretty low?
>
> R: Yeah.
>
> K: And you think that's throughout the three years?
>
> R: Yeah, especially in third year because they were really screwed up by this. They'd already arranged their placements and then they were told they couldn't go. (A6:3)

She goes on to describe "an underlying attitude of despair" among the three years of trainees at a recent meeting with their line manager, while a classmate whom I interviewed later the same day told me: "it feels like the course is on self-destruct mechanism" (A1:3). The theme of *loss of control* was dominant in many of the trainee's accounts of these events, and the dispute over placements was frequently cited as an example of individuals feeling that their student role undermined their developing professional identity.

### 7.3 i (b) Role Conflict Resulting from the Competing Demands of the University and the Health Service.

As trainees proceed through the course, the competing demands of the health service and the university can make it increasingly difficult for individuals to combine these roles. Cherniss (1980) identifies *incompatible demands on the role player as one source of role conflict.* In third year, particularly, the role of student and clinician compete for the trainee's time and attention, as the trainee works on his/her dissertation while completing the final year placements. This can leave trainees feeling guilty and inadequate. In the following account, a third year trainee reflects on the months leading up to the submission of her dissertation (two months before the end of the course) when she was too distracted by her thesis to concentrate on her clinical work:

> ...when I was [on placement] I was no use, and the assistants here are so good, and I just really felt I was not pulling my weight and nobody understood. You feel awful and you feel. I don't know, I just felt personally, I felt that people felt I was a real moan, on a personal rather than a professional level, that I wasn't much fun to be with, and that people who don't know me, who I'm going to be working with [post-qualification] weren't getting the best impression of me, if you like, on a personal and professional level, and you felt that nobody really understood what it was like. (C6:1)

Her concern about "not pulling her weight" is another indication of trainees' identification with the employee role: trainees are expected to be supernumerary in clinical departments and should not therefore be expected to play an essential role in service provision. However, this sense of responsibility to colleagues and desire to be seen making a useful contribution to the department's work was common among respondents.

While trainees did value the academic component of the course, the majority attached far more value to their clinical work. In practical terms this meant economy of effort in examinations and written assessments, with the exception of the submitted case studies based on patients whom they had treated. Most trainees considered these to have the greatest value compared with the other assessment exercises, for the development of their clinical skills. The research-based dissertation on which they expended considerable time and effort in their third year was not greatly valued by trainees and was instead viewed by many as disconnected from the clinical skills they had been struggling to acquire for three years.

### 7.3 ii. Person-Role Conflict.

In 5.2 ii., 6.1 i., and 7.2 i-ii. above, I presented instances of *person-role conflict*. In Chapter 5, some respondents described conflicts between their own values and the demands of their assistant psychologist's role when they spoke of feeling uncomfortable about distancing themselves from patients and becoming more directive in their approach. In Chapter 6, I focussed on the experiences of new trainees and found that person-role conflict arose for some individuals when their trainee role initially failed to deliver job satisfaction and they felt that they were not helping people as they had hoped. Earlier in this chapter, I identified instances of person-role conflict that arose as trainees progressed through the course. In 7.2 i., a trainee (A4) describes her discomfort with the "power imbalance" between patients and psychologists, and the "judgmental" attitudes that some supervisors/course staff seemed to her to communicate. As that excerpt showed, she chose to disguise the person-role conflict that she experienced by "work[ing] really hard at developing a professional front" (A4:3). In 7.2 ii., I presented examples of trainees feeling constrained by a rigid application of

technique and, in particular, the cognitive-behaviour therapy model. Their response was to become more flexible in their therapeutic work.

Another example of person-role conflict that emerged from interviews with one trainee concerned conflict between her religious values and the demands of her role. Some of these issues emerged early in the course: when her class was instructed in meditation techniques for use with anxious patients, she found this difficult since she saw a conflict between her religious beliefs and the philosophical foundation of meditation. She also gave examples of behaviour – such as divorce, homosexuality, and termination of pregnancy – that patients would be likely to bring into her work with them. While she was adamant that she would not judge them, she was worried about how she would deal with these situations. Her concern was twofold: first, that she was ignorant about these situations and would not respond appropriately; and second, that she did not know how to accommodate the conflict between her patients' needs and her own values.

As the course continued, this trainee confronted more dilemmas. She was asked to do some psycho-educational work with an unmarried patient with learning disabilities. Here, she consulted with members of her church who agreed that she should undertake the task, even though the church did not sanction pre-marital sex. She was also asked to advise on psychological matters concerning individuals in her church and had to deflect these enquiries. This trainee was active in addressing and trying to resolve this role conflict: she conferred with counsellors in her church about how they accommodated religion in their work; she read up on this issue; and she joined a network of Christian psychologists. I will return to her experience of person-role conflict within a broader discussion of this phenomenon in Chapter 9.

### 7.3 iii. Role Ambiguity Arising from Insufficient Feedback on Trainees' Performance.

Cherniss observes that role ambiguity occurs when "the role player lacks the information necessary for adequate performance of the role" (Cherniss, 1980, p.89). Kahn *et al.* (1964) identify insufficient or misleading feedback from supervisors as one source of role ambiguity, and many of the respondents in this study identified the feedback system of the course as problematic for them. They criticised both university and NHS staff in this respect. I will begin by discussing trainees' complaints about the academic feedback.

Trainees were more positive about their teaching sessions than the way the academic component of the course was assessed. Both examinations and written work (four case studies, two placement-based research studies, a third year professional issues essay, and the dissertation) are double-marked internally and a quota are then sent to the external examiner for review. The marking system delays feedback to the trainees, who may have to wait for several months before receiving it. Since the course is officially "pass-fail", the course staff divulge only the grade ("excellent", "very good", "good", "satisfactory" and so on), and not the numerical mark that has been awarded. Some trainees were satisfied with this but many complained that it was too vague, and also complained that the written comments from staff about the content of their submissions were insufficiently detailed.

One consequence of trainees' dissatisfaction with the academic feedback is that it encourages some of them to devalue the academic component of the course and, for many more, contributes to the lack of clarity in the passage through training. At various important stages in the course (for example, following the first year examinations, or at the end of the first year of training) individuals must proceed, sometimes for several months, without knowing whether or not they have passed the last evaluation. Trainees reported that this confusion detracted from their sense of progress and limited their opportunities to derive confidence from their academic performance. In other words, trainees often lack a clear idea of how the course defines a successful student and whether or not they are meeting those criteria.

The delay in feedback regarding the academic tasks is paralleled by the delay that trainees encounter in receiving official notification that they have passed or failed a clinical placement. Course regulations stipulate that the trainee's Directors of Studies (a Clinical Tutor and a member of the academic staff) make this determination based on the recommendation of the clinical supervisor. Trainees may not meet with their Directors of Studies for several weeks after placements end because of scheduling problems. In reality, trainees rarely fail placements and are usually told by their supervisors that they have passed by the time they finish the placement. However, when there is doubt this two-stage process can seem protracted to trainees.

The delays in both placement and academic feedback meant that trainees entered second and then third year of the course without having received the results of all their evaluations and were likely to joke nervously that they were just assuming that they have got through the previous year. Unlike doctors, their designation does not change during the course: they do not progress from Senior House Officers to Registrars and hence to Specialist Registrars like the psychiatric trainees. These changing labels not only notify colleagues and patients of a trainee's changing status, but also signal to the trainee that he/she is progressing through the system. In contrast, the clinical psychology trainees

retain the designation of "Trainee Clinical Psychologist/ Clinical Psychologist in Training" throughout the course.

So far I have examined role ambiguity arising from delayed/insufficiently detailed feedback from university staff regarding trainees' performance. Many interviewees reported that they also lacked adequate feedback on their skills from clinical supervisors. The trainees whom I interviewed reported that their supervisors were often insufficiently transparent regarding the theoretical (or a-theoretical) foundations of their work. Particularly during the first two years of training, this theory-practice gap left trainees feeling confused and disorientated, as we saw in 7.2 ii. above. Many trainees reported the experience of observing their supervisor conducting therapy and receiving no explanation of which therapy model/treatment protocol was being employed. Trainees' own insecurities generally inhibited them from asking if the information was not offered. They reported that their confusion during supervision was frequently compounded by inadequate feedback about their own interventions.

The majority of the trainees whom I interviewed reported that they would have liked more observation of their work and more detailed constructive criticism of their clinical skills. The following comment is representative:

> I thought I'd be observed a lot more [on placement], and in a lot more detail, that people would be picking up on the detail in the therapeutic encounter and stuff like that, and there'd be a lot more interest in that, and I've found that's been quite sadly lacking in the academic part and in the, because that's what I think I need in a training. You know, I know I've got the ability. I know I can get on with people and come to some sort of formulation of their problems, but there's all this other stuff that I'm sure I don't notice and specific strengths and specific weaknesses I have. And I've got that from one or two supervisors but not lots of them and that's what I thought. And rather it's come through a sort of self-knowledge and myself thinking about it, aided by one or two supervisors, but I thought that would be much more closely monitored and it's not. I think someone could go through the whole course and not ever get that and it wouldn't ever really be noticed. (C10:1)

The consensus view among respondents was that their clinical supervisors assumed, without sufficient evidence, that the trainees were delivering competent therapy. Trainees reported that this assumption produced an overly casual approach to supervision from a number of supervisors because of their "expectation that everyone's going to get on fine" (C4:1) and meant that trainees did not always conduct the number of joint clinical sessions with their supervisors (allowing observation of the trainee's performance) that the course regulations stipulate. This typically increased trainees' own anxieties about their competence and led them to devalue the positive feedback they did receive from their supervisors because, as one woman said, "... at the end of three years, I don't really think that anybody really knows what I'm like as a psychologist" (C4:1).

The strength of feeling among some trainees about the deficiencies of their clinical supervision can be gauged by the fact that during the course of this study, four recently qualified trainees sent a report to the Course Director, expressing the hope that their feedback would be helpful to the course. The report contained their reflections on the weaknesses of their training and most of their observations concerned deficits in clinical supervision, such as those reported above. The authors observed that "the pervading presumption which permeates much of the training course is that 'everything is fine'" and argued that "rubber stamping" too often replaced rigorous assessment of clinical skills on placement.[24]

Even when supervisors did observe trainees' performance with sufficient frequency, trainees often felt let down by supervisors' reluctance to proffer criticism, constructive or otherwise. In some cases the absence of criticism also provoked scepticism in trainees about the value of the work that they were doing. First year trainees, in particular, tended to start questioning the usefulness of their interventions if these could be undertaken successfully by self-acknowledged novices. Some of the respondents suggested that this reluctance to proffer criticism stemmed, at least in part, from supervisors' own anxieties:

> ... in all three years there's a slight unspoken rule that if you get on the course you're fine, you know,.. I think the course could be a whole lot tougher and probably produce better trainees if it had more constructive criticism, you know, if it toughened up a little more...you've got to be tough to a certain degree, and I think it's a source of anxiety for some supervisors as well, they don't want, especially perhaps as a trainee goes on in training and has got past the first year or whatever, to actually say "Well, you know, this is needing toughened up", you know, and perhaps the anxiety created by putting a tick in one of the other columns other than the satisfactory one on the evaluation sheet is just too much, you know... (C2:1)

From my own experience as a member of the training course staff, the suggestion that supervisors experience anxiety at the prospect of evaluating a trainee as "unsatisfactory" is a credible one. I have heard this anxiety expressed by a number of supervisors, and have listened to colleagues' accounts of the same phenomenon.

The preceding analysis has focussed on the acts of omission by clinical supervisors and university staff identified in trainees' accounts of their experiences. However, the symbolic interactionist approach to professional socialisation assumes a transactional model in which trainees also exert influence over trainers. The interviews revealed acts of omission by trainees as well. In 7.2 i., I provided examples of trainees discounting negative feedback when it was given, and I also discussed trainees' use of impression management to control the amount of information available to supervisors

[24] In the interests of confidentiality this report will not be referenced.

when making their assessments of trainees. There was, therefore, a lack of transparency on the part of trainees as well.

In the following section, I will explore trainees' responses to the demands of clinical training in greater detail. I will then describe the pilot programme I introduced into the teaching syllabus in an attempt to address some of the difficulties that trainees had reported in these interviews.

### 7.4 Trainees' Personal Responses to Clinical Training.

As noted above, trainees were generally reluctant to share concerns about their performance with course staff and clinical supervisors. Of course, the trainees whom I interviewed varied in degree of defensiveness about revealing ignorance or vulnerability to their supervisors. However, the attitude of trainee A4, reported in 7.2 i., was shared to some extent by most of her peers: the best strategy was to "shut up and get on with it...certainly not [to] discuss personal issues" with one's supervisor. One of the third year trainees whom I interviewed summed up the negative view shared by many of her peers, regarding the likelihood of receiving support from supervisors: "I think it's really easy to feel really inadequate when you're training and you're really lucky if you have that kind of support that you don't feel that way. I think the chances are that you will feel pretty awful at a lot of times" (C6:1). Thus, there seemed to be a self-fulfilling prophecy operating: trainees expected the course to be stressful and expected to feel inadequate. They also tended to perceive supervisors as unsupportive and so hid/minimised their insecurities; supervisors were therefore left unaware of difficulties, and so did not offer support.

In addition to these limited expectations there was, in some cases, actual resistance from trainees towards supervisors who did attempt to provide support because discussion of vulnerabilities was perceived by respondents as "threatening", and "like showing weakness" (C3:1) to someone who is also going to evaluate you. In 6.3 above, I reported on trainees' ambivalence towards the prospect of personal therapy as an integral part of their clinical course, even if it were offered by individuals who were not in an evaluative role. Thus, even when the issues of evaluation and support can be separated, this ambivalence remains and appears to reflect a professional ethos that devalues personal needs.

While the above description represents the attitudes of the majority of trainees, there were notable exceptions to this view of what supervisors could and should offer trainees. A minority of respondents reported instances where they had discussed the emotional impact of their clinical work.

When they dared to expose themselves in this manner, they usually found that their supervisors validated their experiences. These experiences were, of course, immensely varied, but there were discernible patterns across the cohorts in the way trainees responded to their work.

In the previous chapter I commented on my surprise at how little consideration psychology assistants had given to the emotional demands that their training and future career would make on them. When I interviewed first year trainees, they fell into two groups: those who admitted that they were feeling anxious and stressed by their clinical work, and those who denied experiencing any significant emotional impact. Most first year respondents denied that they had changed within themselves since beginning the course; those who did not, spoke of being more stressed or finding it difficult to move out of "therapist mode" at the end of the day.

By second year, however, there was greater convergence among the trainees. Those who experienced "reality shock" at the beginning of the course were generally starting to find their feet, but most of the trainees acknowledged that the responsibilities of their clinical work were affecting them. For some, this realisation caused them to question their choice of career:

> ...sometimes it just seems like it's the wrong career because you're so exposed in some ways, just in terms of working with people, and feeling that you have got responsibility for people, and sometimes I just wish I worked with a computer. (A3:3)

Other trainees denied questioning their career choice, but reported an increasing awareness of their professional identity, which sometimes influenced their behaviour outside work. Here, a second year trainee describes how her new role and her commitment to her work – her developing professional values -- are controlling her behaviour.

> I suppose occasionally I feel, like in my outside life, that I have to be slightly more professional and that. It's strange. I think it's partly to do with thinking that I can bump into clients at any time, kind of this idea that I can't be like uninhibited in case there's someone around that is a client, or will be a client in the next few weeks. There's something like that that controls my behaviour occasionally. But it's more that I feel different at work, that I feel more responsible and pressured. Really, I feel more stressed at work because it feels so important to me. I feel that this is, like I can potentially be quite destructive, so I have to be on my guard and I have to be very aware of what I'm doing and what I'm not doing. That kind of thing. That I suppose has made me feel stressed at times. It's an awful lot of responsibility to be carrying. Until I feel more confident that I'm doing what I should be, I'm going to feel stressed. (A10:3)

Here, a trainee expresses her sense of being constrained in her personal life by her professional life. As noted in Chapter 2, Kottler (1986), among others, has observed that the role of the psychotherapist involves the total personality of the individual. These clinical psychology trainees confirmed that it

was increasingly difficult for them to maintain a clear emotional or intellectual boundary between their personal and professional selves.

As these findings began to emerge from the data, and the possibility that I would join the course team became a reality, I began to consider how Kramer's (1974) idea of integrating workshops into clinical training to minimise reality shock in newly qualified nurses, might be modified to assist clinical psychology trainees to negotiate the DClinPsychol. In the following section I will present a preliminary account of the workshops I devised and piloted during the period of the study. It is included here because this intervention is another outcome of the research.

### 7.4 i. Modelling the Reflective Practitioner: An Intervention.

This section describes the first stage of an ongoing piece of work that began in the summer of 1997, as I prepared to take up the lectureship on the DClinPsychol course. I resigned from the lectureship in February 2000, and returned to a full-time NHS post, but I have retained my position as joint co-ordinator of the Professional Issues module in the teaching syllabus. I am therefore able to continue shaping the content of this module and developing the workshops arising from the present study, which now form part of the module.

My aim is to provide trainees with an integrated series of workshops spanning the three years of the course. These workshops are intended to encourage trainees to become reflective practitioners (Schon, 1983) in their work, while helping them to identify and deal with sources of role stress and strain. This intervention was not part of the original study design and is therefore not yet complete; once this is done, it is my intention to evaluate its usefulness. Although this exercise is unfinished, it seems appropriate to include a brief summary of the work that I have already done as an indication of how this study's findings may be used to improve clinical training.

The first workshop in the proposed integrated series has now been piloted three times: in October 1997, 1998 and 1999. This workshop takes place during Induction Week: trainees' first week on the course, before the teaching programme begins. Most of this week is dedicated to the compulsory NHS Trust staff induction programme, administrative tasks like university matriculation, and introductions to course staff. The workshop that I have run during this week is based on the interviews I conducted with psychology assistants and new trainees, summarised in Chapter 5. It runs for one and a half to two hours, and has been received enthusiastically on each occasion. My

impression of this positive response has been supported by the anonymous, written feedback on Induction Week later collected by staff from the trainees. Participants have reported that the workshop allayed their anxiety about starting the course, normalised their uncertainties about clinical training, and encouraged them to value the experience they bring with them.

The format of the workshop is as follows. I begin by presenting trainees with some of the attitudes that study respondents have articulated when asked how they felt about starting the DClinPsychol. I explain how this information was obtained and also provide participants with the same rationale for the workshop that I have just outlined above. By presenting study respondents' views first, I aim to normalise some of the attitudes I expect participants to hold and reassure them that it is safe to express these in the workshop. For example, I will quote Trainees A2 and A4, using the same excerpts that I did in section 5.4, where they described the course as a "big cloud in the sky that you can't get onto and it's all so unachievable and wonderful" (A2:1) and acknowledged the fear that "everyone's going to be so intelligent and I might not match up" (A4:1). When I present the latter, there is usually a ripple of laughter through the class and expressions of relief on most faces.

The second stage in the workshop requires trainees to write down on separate pieces of paper two or three strengths that they bring to the clinical training, and two or three weaknesses/vulnerabilities. These are recorded anonymously and are then collected into two piles and redistributed among class members. Next, each person reads out an unidentified classmate's responses, so that all the information is shared. These responses are listed by me on the board and form the basis for discussion. My objective in guiding the discussion is to emphasise that everyone in the class has some vulnerabilities, but there is also a wide range of skills and strengths that they bring from previous experiences. I encourage the class to see this repertoire of skills as a group resource. For example, there are always individuals who identify the research requirement of the course as their Achilles' heel, while other trainees claim lack of clinical experience as their weakness. I reinforce the ethos of non-competitive, collaborative learning as the appropriate model for clinical training and encourage them to use each other's prior knowledge to assist their training. Furthermore, I alert them to the finding in this study that matches my own training experience: namely, that trainees primarily depend on each other for support.

As the workshop proceeds, I shape the discussion by bringing in material summarised in Chapter 6. I give examples of trainees initially feeling *deskilled* when they begin the course, and introduce the idea of the *status passage* from psychology assistant to clinical psychology trainee. Specifically, I give examples of trainees who experienced a loss of status when they began the course, as well as those who experienced an ascending status passage. Again, my intention here is to normalise a range of responses to this transition, including the negative responses that tend to leave individuals feeling

most vulnerable early in the course. I also introduce the phenomenon of trainees' *disillusionment* as a recognised reaction to the commencement of formal training, as a form of stress inoculation so that individuals will be less likely to pathologise their own behaviour if they become disillusioned. Finally, I conclude the session by reinforcing what the workshop has demonstrated: that trainees begin clinical training with many skills. I quote the study respondent who was surprised by "how much of what I've done before and what I know myself...I would have to bring" (A3:1, see 6.3 above) and encourage the class to value this prior experience and integrate it into their new learning. Thus, I aim to empower them as they commence training by assisting them to recognise the anticipatory socialisation they have already experienced and encouraging them to use aspects of that prior experience to facilitate their current learning.

In summary, this initial workshop with trainees appears successful and I anticipate leaving it substantially unchanged while I continue to develop the rest of the series. I envisage two per year, totalling six by the time that trainees graduate.

I have so far experimented with a limited range of workshop formats for first and second year trainees. Here again, I have combined reporting of data from the present study with guided class discussion. I have also incorporated some vignettes for discussion that were created by a fellow lecturer, Frank Charlton. These vignettes present a range of dilemmas that trainees could experience: for example, discovering that a friend is depressed; becoming stressed and demoralised during training; and encountering a difficult, defensive supervisor. The vignettes have also enabled me to access themes that have emerged from this research.

With first year trainees' I have focused on their emotional reactions to clinical work, with the aim of encouraging awareness of these responses and validating them as a legitimate source of information that they can use to improve their therapy skills. I have also attempted to normalise individuals' experiences of *feeling fraudulent*, or like "pretend psychologists", by referring them to the study findings. Another theme that proved fruitful was discussion of the difficulty of linking theory and practice. As we saw in 7.2 ii. above, this poses a considerable challenge to first year trainees. Finally, first year trainees have responded well to exploration of the supervisor-supervisee relationship and its potential problems.

With second year trainees, I have again used material covered in 7.2 ii. We have discussed the process of *becoming more flexible* and *trusting their own judgement* described by second year study participants, but have also explored the *ambiguity and complexity of clinical work.* In future workshops, there are opportunities to develop the discussion to compare and contrast the scientist-practitioner model with that of the reflective practitioner (see Chapter 9).

In third year, I have run a workshop on two occasions. The intention of these later workshops is to encourage trainees to reflect on their training and prepare for the transition to qualified status. My aim is to empower trainees to manage this transition successfully by reflecting on the *mastery* they have achieved over the past three years. I have prompted trainees to consider changes in their clinical practice (for example, becoming less technique-focussed) and in their view of themselves. I have also used material from Kottler (1986) to discuss burnout in psychotherapists and how to avoid it. Now that the data summarised in Chapters 7 and 8 is fully analysed, I can refine the workshop content. I anticipate that discussion of the findings reported below in 8.3 ("Factors that Facilitated the Transition to Qualified Status") will help them to be proactive in shaping their post-qualification experience in a way that minimises stress and maximises learning.

Following the format adopted in the two previous chapters, I will now provide a brief account of my expectations and responses to the findings reported in this chapter in the interests of transparency and permeability (Stiles, 1993).

## 7.5 Disclosure of the Researcher's Expectations and Responses to the Interviews Reported Above.

At the beginning of 7.2 i. above, I acknowledged that I had expected trainees to exercise studentmanship less confidently than they do within the supervisor-supervisee relationship. Once I recognised these findings and compared with my own experience, and that of my peer group, when we were trainees, I decided that the findings were not so surprising after all. In retrospect, I conclude that I had come to identify more with the supervisors' perspective than that of the trainees in the years since I qualified and thus under-estimated this effect.

The other finding that I did not anticipate and did not really recognise until the analysis was quite advanced, was that the unifying theme of *lack of clarity in the status passage through training* was the common denominator linking many aspects of respondents' experiences. At the beginning of the study I expected that trainees' experience of ambiguity and conflict would be most influential in shaping their professional socialisation. I expected that the ambiguity would mostly concern the definition of the trainees' role, and this certainly emerges as one important theme in this study. I wrongly anticipated that person-role conflict arising from a mis-match between the therapeutic orientation of the training course (cognitive-behaviour therapy), and the preferred style and

orientation of individual trainees, would also be an important source of role strain. This prediction is not supported by the data. As this chapter demonstrates, some trainees do find cognitive-behaviour therapy too constraining if applied to all cases (see, for example Trainee C2 quoted in 7.2 ii. above), but this did not generate the degree of conflict that I expected and person-role conflict had several different foci in these accounts.

In retrospect, I think I had again confused my own perspective with that of these trainees. The ideas behind this study developed during my first two years post-qualification, when I felt that I lacked sufficient therapeutic flexibility to offer appropriate treatment to people with the range of difficulties that I saw in clinical practice. Some of my dilemmas during that stage in my professional socialisation are reflected in the findings presented in the next chapter, when I describe the experiences of respondents' twelve-eighteen months post-qualification. As we saw above, while individuals are completing the doctoral course, their concerns are different: they are concentrating on becoming more flexible and developing clinical judgement and the questions surrounding choice of therapeutic models become more pressing for some individuals once they qualify. I will return to discuss these findings in greater detail in Chapter 9.

Finally, in the interests of transparency, it is important to record my changing perspective regarding the training course during the period of the study. Table 7.1 above shows those sets of interviews that were analysed for this chapter. Only the interviews with Cohort C were conducted while I was a lecturer on the DClinPsychol course: the others were completed while I was working full-time as a clinician in the NHS (see 3.4 above). The first set of interviews with Cohort C were completed after I had been in the lecturer post for a few weeks; the second set were completed after I had been in that post for twelve-eighteen months. My field notes at the time record my feelings of identification with the trainees on the first occasion and lack of identification with my role as trainer or the training system itself. By the time that I re-interviewed this cohort, my perspective had shifted. By that stage, of course, the respondents were no longer part of the training system themselves – they had qualified and moved on – but my field notes record that I was adopting the trainer perspective more than I had done previously.

The implications of this shifting perspective on the part of the researcher become obvious when one considers the process of data analysis and presentation. The analysis of the data began as soon as the data collection, but I commenced writing up the study more formally at the beginning of 1999 after I had occupied the lecturing post for eighteen months. My bias toward the trainer's perspective became evident from my supervisor's comments on the first draft of the thesis, where there was intermittently a discernible drift away from the perspective of the respondents. Unintentionally, I had stopped telling their story and I was instead documenting the views and objectives of the trainers without

acknowledging that I was doing so. In the redrafting process, I have attempted to reflect more accurately the respondents' realities, while contextualising them within the professional and institutional systems that frame their experiences.

The final stage of this writing up process (since February 2000) has occurred while I am again working full-time as an NHS clinician, so in objective terms, I have returned to the same position in relation to the training course that I had when I began the study. In reality, of course, I retain something of an "insider" perspective while once more assuming "outsider" status. In Chapter 9, I will discuss the advantages and disadvantages of insider versus outsider status for my work in this study.

## 7.6 Summary of Trainees' Trajectory Through Clinical Training.

In this chapter I have shown how clinical psychology trainees *shape their passage* through the DClinPsychol. I have illustrated how trainees demonstrate *mastery*, both in terms of *studentmanship* and in their *acquisition of clinical skills and confidence*. I have also suggested that *a number of factors interfere with trainees' experience of mastery*. In terms of Bucher & Stelling's (1977) model, some of these factors are *internal structural variables* and relate to organisational aspects of the course. Thus, I have demonstrated that role conflict arises from trainees' combined student-employee status, and role ambiguity arises from the course's academic feedback system. Other factors are *situational interactional* and relate to the activities of role playing, modelling and coaching. In this chapter I have, for example, considered person-role conflict experienced by a trainee whose religious values conflicted with those of patients, and widespread role ambiguity experienced by trainees who report insufficient constructive criticism from supervisors. In my final chapter, the discussion will return to examine these themes in greater detail and will also examine the part played by Bucher & Stelling's external structural variables in the professional socialisation of these trainees. In Chapter 9, I will also consider how a clinical psychology training course might maximise trainees' opportunities to achieve mastery in order to develop a secure professional identity.

First, however, let us consider the final phase of professional socialisation that this study examines: the transition to qualified status. In the next chapter, I will consider how the study respondents give up the student role and begin to accommodate the demands of full-time NHS clinical posts.

# CHAPTER 8

## RESULTS: THE TRANSITION TO QUALIFIED STATUS

In this chapter I will analyse the transition from trainee clinical psychologist to qualified practitioner. This chapter begins with an account of third year trainees' reflections on their passage through the DClinPsychol course and their expectations, predictions and concerns about the path ahead. The remainder of the chapter is devoted to an account of respondents' experiences post-qualification. The interviews that provide the basis for this chapter were conducted in two waves. Third year trainees were interviewed during their final three months on the DClinPsychol course. The same group (Cohort C) were interviewed again thirteen to eighteen months post-qualification.

The objectives of this chapter are as follows:

i. to describe trainees' views of themselves, their training and their profession as they approached the end of the course
ii. to describe their experience of the transition to qualified status
iii. to examine the factors that both facilitated and hindered this transition
iv. to describe the reflections of this cohort on their role and their profession at the beginning of their second year post-qualification.

Unlike the three previous chapters devoted to the study's findings, this one does not contain a section reporting the researcher's expectations or predictions. This omission reflects the fact that the findings in this chapter most closely matched my expectations – probably because these respondents were nearer to my own stage of professional socialisation than the psychology assistants or trainees. Section 7.5 above makes reference to this and also declares my position as an insider within the training system when these interviews were conducted.

The following section addresses the first of the objectives listed above. Here, I will report how the trainees perceived their own professional development over the preceding three years and the challenges that they expected to encounter during the year ahead.

## 8.1 Reflections on Clinical Training: The Conclusions of Third Year Trainees.

The following accounts of third year trainees were all collected in their last three months on the DClinPsychol course. By that stage, all of them had completed their dissertations (the final academic requirement) and were awaiting their *vivas* while they completed their last clinical placement. All of them expected to pass the course, given their uniformly satisfactory performance to date and the historically unlikely circumstance of failing the dissertation or final placement. Furthermore, most of them had already accepted their first post-qualification job, subject to passing these final evaluations.

Third year clinical psychology trainees in Scotland, and most areas of Britain, are in the enviable position of being assured of employment after they qualify and usually have a choice of possible jobs. Traditionally, NHS Heads of Service in Scotland begin to recruit third year trainees during their final year because the profession is chronically under-staffed and posts can be difficult to fill. Some posts are formally advertised six-nine months before a class graduates so those potential recruits are not missed. In other instances, Heads of Service first have informal discussions with trainees about likely job opportunities and proceed to formal selection many months later when funding for posts is secured. When I interviewed this group of third year trainees, they were at various stages of formalising arrangements with future employers but no one was seriously concerned about failing to find a suitable job. Given these circumstances, the interviews reported here reflect the views of individuals who are grappling with the implications of an imminent change in status and have begun to consider the likely demands of their first jobs.

### 8.1 i. Third Year Trainees' Evaluations of Themselves and Their Training.

In the previous chapter I described how trainees' acquisition of mastery allowed them to develop confidence in their clinical skills. In these exit interviews trainees typically confirmed that they had become progressively *more confident* about their skills over the previous three years, and reported that this confidence extended beyond their therapeutic role. One source of confidence for these trainees was their recognition of how much they had developed, both intellectually and personally, in the past three years. Many of them reported that they had become more self-aware and had learned, as one woman expressed it: "to use my own experiences of life in terms of my work" (C10:1). Respondents also reported that they had become *more assertive* with colleagues, and the previous chapter provided instances of that behaviour, particularly within the supervisory relationship. Several

people commented that, in retrospect, it was the opportunity to represent clinical psychology to non-psychologists that had particularly helped them to feel confident and "professional". The following remark is representative:

> I can think of a few things during my training which really boosted my confidence...Things like going to a children's panel and that sort of thing, where you really are professional and you have to feel professional and I was really nervous about it, but it was great to have done. Particularly things like that, going to meetings. I suppose it's being with other people that makes you more confident, not other psychologists. Seeing that you can cope well in a meeting or something like a children's panel, it does a lot for you and you do feel a lot more professional there than when you're just running around doing a clinic and in supervision and things. (C6:1)

The consensus view was that the third year of training had allowed them to begin consolidating the learning of the previous two years, as this woman explains:

> At the beginning of third year I thought, "I don't need this third year. I really don't feel as though I need any more experience. I've done as much as I can". But you really do need it, and I feel at the end of it now, the experience of doing the thesis and you really take off I think, confidence-wise, in the third year. I'm totally different now than I was at the end of the second year I think, and I found it really came together for me in third year. (C11:1)

When they spoke about their increased self-confidence, some of the third year trainees explained this in terms of their belief in the value of their work. One woman spoke of having "much more of a purpose in my life now" (C6:1), while another commented: "...I don't want to appear precious about the profession, but it is, you know, it is an incredibly important thing you're doing" (C4:1).

While all of the third year trainees were keen to finish the course and experience more autonomy, several of them were apprehensive about how they would cope with this independence and other people's expectations. The following excerpt represents several similar reports that convey this anxiety. The respondent's allusion to being "more flexible" refers back to an earlier point in the conversation when she told me: "...you're trained that you...should be very rigid and able to explain everything you do in terms of specific therapy or whatever, and it seems to me that's not really what happens":

> R:...I suppose what I'm trying to say is that I feel I still have a lot to learn, you know, I don't feel I've come out of the course ready to start a job and know what I'm doing because I still feel every case brings up things that I don't know about and need to learn about or want to learn about or whatever. I suppose I just want to be able to be a bit more flexible.
>
> K: Did you expect to finish the course feeling more...?
>
> R: Yes! (laughs)
>
> K: That more of your questions would have been answered?

R: Yeah, definitely, yeah, absolutely.

K: So how are you interpreting that at the moment?

R: I worry that it's just me.

K: Have you spoken to your peer group about it?

R: Yes, and I think we all kind of feel that at some level. (C6:1)

Her concern about not being "ready to start a job and know what I'm doing" was echoed by most of the third year trainees. Some of them spoke of the way their expectations of themselves had moderated as they gained experience, as this woman describes: "I'm now more about acknowledging that I can offer people something and sometimes it works and sometimes it doesn't work and if it doesn't work it's not anybody's fault"(C4:1). For others, however, "just generally feeling you've got to help people, that the onus is on you to do certain things" continued to cause "a lot of stress"(C3:1). This trainee spoke of her difficulty in recognising and accepting the boundaries of her professional responsibility:

> I think that's the other thing we're not taught enough: when to say we can't do it and when it's not an appropriate case and when there's really nothing you can do, and to feel OK about that. It's really difficult I think to send someone away from treatment when they want it and you know they're not going to benefit. (C3:1)

As we shall see in 8.2 below, management of complex cases and decisions to terminate therapy did indeed test these respondents once they qualified.

In this wave of interviews, respondents' attitudes towards their training shared little consensus beyond agreement that it had been stressful. The class was split between those who felt it had been inadequate and felt let down, and those who said it had met their expectations and even, in a few cases, said they had enjoyed the course. Among those who were most critical, the focus of complaints was inadequate clinical supervision as described in the previous chapter.

### 8.1 ii. Third Year Trainees' Views of the Profession.

All the members of this cohort finished their training with sufficient *commitment to the profession* to predict that they would remain working as clinical psychologists for the foreseeable future. Despite their commitment, most of the trainees in this cohort were critical of aspects of the profession. While

most of them expressed their belief in the ideal of the scientist-practitioner, most of them also acknowledged that they had found limited evidence that qualified psychologists adhered to this model. Their explanations for this lack of adherence included work pressure in the NHS, and the fact that a significant number of qualified psychologists apparently failed to identify with this model. The latter explanation is articulated here:

> R: I don't see clinical psychologists as one group. I think they differ widely in their views and how they work with people. I think people are maybe more uncertain of what they're doing than maybe at first you think. Not uncertain, but people, like the scientist-practitioner thing, people doubt, at least in my department, some people don't think they work that way, some people do, but that's the bedrock, that's what clinical psychologists have, scientist-practitioner, and I don't know if that's how a lot of psychologists view themselves really.
>
> K: Do you think that's a problem for the profession?
>
> R: I think it's a slight problem, that they feel, that you need to present a very confident persona that this is what we do, and maybe that's not actually the truth. I'm sure that every profession does it to some degree, but maybe psychology more than most just because of what type of work they're doing, because it's more undefinable. (C10:1)

The *uncertainty about the validity of the scientist-practitioner model* expressed by respondents at earlier stages in their professional socialisation and documented in Chapters 5, 6 and 7 is, therefore, still evident in the attitudes of these third year trainees. Furthermore, individuals in this group expressed related concerns, betraying their confusion about their professional identity. One woman remarked that "there doesn't really seem to be any coherent sense of what clinical psychology is or what we should be doing" (C 7:1), while another spoke of the "insecurity" in clinical psychology: "...it's people trying to prove that they're good enough at the job because the status is sort of uncertain still, and I think as a profession we're not sure exactly what we do" (C3:1). Similarly, a classmate referred to one of the current debates in the profession, about whether we should be specialists or generalists, and concluded:

> That's a worry about the profession as well, that people have very different ideas about where we should be working and at our level it's very difficult because we're coming in right at the bottom, and it's very difficult to know what to think. (C6:1)

In addition to their concerns about their own effectiveness as clinicians and the ambiguities of their professional role, a quarter of the cohort were *apprehensive about the prospect of burn-out* in their future career. They based this concern on the behaviour that they had witnessed among qualified psychologists. One woman had given serious thought to how she might protect herself from burn-out by

> Just not taking on, not feeling the pressure to take on everything and everybody that comes your way, and everything you're asked to do. I mean, being very assertive I think is quite

> important. Certainly, a lot of departments I've worked in, there's a culture of martyrdom, people working ridiculous hours and trying to get through ridiculous waiting lists. which I think, well. it's a bottomless pit in some ways. You're not going to. so that's my attitude very much. I'm not prepared to run myself down physically, mentally, whatever, so I'm going to be useless anyway. (C3:1)

A couple of other trainees had already considered making a time-limited commitment to the profession to protect themselves against burn-out:

> I think as a profession we're really guilty of over-working and I don't think you do your client population any favours at all. I don't see myself being a clinical psychologist for the rest of my life. I think you have to give so much of yourself, you get to the stage where you can't give any more. You've got to have a couple of years off or whatever, be it to have children or have a total career change. (C11:1)

Given the chronic difficulty of filling clinical psychology posts in the NHS, and the heavy workload carried by those in post, the implications of these attitudes are obvious. In the following section, we will see whether these attitudes had modified or become more entrenched by the time these individuals had completed their first post-qualification year.

## 8.2 Joining the Profession: Reflections on the First Eighteen Months Post-Qualification.

In Chapter 6, I examined the status passage from applicant to clinical training. to clinical trainee. It became apparent that this passage was distinguished by its desirability and centrality and, in most cases, its clarity. Achievement of trainee status was highly valued by most respondents and generally experienced as a clearly delineated role change. It was also evident that this passage had a significant emotional impact on those who traversed it because of the challenges and responsibilities inherent in the new role. In Chapter 7, I argued that the passage through clinical training. by contrast, was remarkable for its lack of clarity. I identified a number of factors that contributed to this lack of clarity: in particular, role ambiguity and inadequate feedback on trainees' clinical and academic performance. As we shall see below, the transition from trainee to qualified practitioner was experienced by all respondents as a very clear change of status, recognisable by themselves and other people. The centrality, or importance, of this passage was also considerable since it represented the end of the long journey towards professional qualification. The desirability of the passage to qualified status is more complex. In the following discussion I shall examine the difficulties and the rewards of this transition. First, however, I will provide a context for that discussion by briefly describing the first post-qualification jobs taken by members of this cohort.

8.2 i. Post-Qualification Employment: An Overview of Trainees' First Jobs.

All the members of the cohort described in 8.1 above remained in Scotland after they qualified. Eleven of these fourteen individuals accepted (or actively negotiated) split posts for their first job: that is, they worked in more than one clinical area. Table 8.1 shows how these posts were distributed according to clinical speciality:

**Table 8.1: Distribution of Newly Qualified Psychologists According to Area of Clinical Work.**

| Clinical Area | Adult Mental Health: Primary Care | Neuro-psychol. | Older Adults | Psychiatric Rehab./ Severe & Enduring AMH | Learning Disability | Health Psychol./ Physical Rehab. | Child |
|---|---|---|---|---|---|---|---|
| Distribu-tion of Posts [25] | R1<br>R2<br>R3<br>R4<br>R5<br>R6<br>R7<br>R8<br>R9 | R4 | R10 | R1<br>R2<br>R3<br>R4<br>R7<br>R9 | R10<br>R11 | R8<br>R11<br>R12 | R12<br>R13<br>R14 |

As Table 8.1 reveals, most of the class initially joined the Adult service, and Primary Care work was frequently combined with sessions in psychiatric rehabilitation or working with patients with severe and enduring mental health problems. The latter group is typically managed through multi-disciplinary Community Mental Health Teams. As we shall see below, that sort of teamwork brings its own challenges, especially for newly qualified trainees.

[25] Respondents are designated R1-14 in this Table. The numbers assigned do not correspond to the numbers assigned to respondents who are otherwise designated C1-14 in this chapter. This is intentional, to protect respondents' confidentiality.

Eight of the fourteen graduates remained in the Health Board regions where they had trained once they graduated. In terms of the ease of transition from trainee to qualified status, there was no consistent difference between those who moved and those who did not. Some of the respondents who had moved said they wanted to make a fresh start and thought it might be more difficult to leave their trainee status behind if they stayed in the same department. However, the people who did not move did not identify this as a problem and said it reduced the stress of the transition to progress within the same department. In the following section I shall describe how respondents experienced this transition, before proceeding to discuss the factors that facilitated the process.

### 8.2 ii. The Transition to Qualified Status.

Despite the shared apprehension in the class about the transition to qualified status, respondents were eager to embark on the next stage in their careers. Once they had begun their first jobs, they confirmed that their change in status had many attendant benefits. In addition to their increased salary, they welcomed the freedom from constant evaluation of their work and the opportunity to work more autonomously:

> I suppose the general thing has been feeling good that I am out working on my own and having responsibility for things. All that side of it is a positive aspect. The more negative aspects are the added responsibility and the stress that carries with that, and the type of work that I have been doing is very demanding. (C9:2)

The *increase in responsibility* was perceived as both a plus and a minus. Predictably, it was most burdensome when the new graduates felt inadequately supported by senior colleagues.

Although these respondents welcomed the transition from trainee to qualified practitioner, it proved difficult for most. For two people in this class of fourteen, it was largely unproblematic. They reported that they were well-supported by colleagues during this period, did not feel overwhelmed by the demands of the new job, and felt able to cope with their new responsibilities. For the rest of the class, *significant problems of adjustment* marked this transition. In the early weeks of their first jobs, many individuals experienced the phenomenon of *reality shock* that had accompanied the transition to trainee clinical psychologists for some of the respondents in Cohort B (see Chapter 6). One woman describes how she reacted early on in this phase:

> In your final year you have a session on the transition to Grade A[26] and sort of warnings that come from previous trainees about what it's like and how difficult this is and how difficult that is. So in some ways you felt as though you were prepared for it. but I was quite surprised how difficult I did find it. And I think I had been in the post maybe a couple of, maybe two or three weeks before I met with --- for my sort of first supervision and the first thing I did I think was say that I just wanted to talk about how I was feeling sort of thing, and I think I made a joke of it, and --- said "Oh, what do you mean?" and I burst into tears and said "Oh my God, I am feeling completely lost", and I was blubbering in front of this person who had just employed me to do this job, but after that it wasn't too bad. (C4:2)

This woman indicates that the job got better after a difficult start, but that was not always the case for others in the cohort. Individuals reported that they felt very low at different stages in the first eighteen months post-qualification and no clear temporal pattern emerged across the group. There was consensus in the group about the major challenges and stressors. These were identified as the *increased workload; the greater complexity of the cases; lack of experience in dealing with termination issues in therapy; lack of experience in case management; the increase in clinical responsibility; and the strain of being perceived as an expert while considering oneself to be inexpert.* Most of the class reported that they habitually felt drained and tired during their first post-qualification year and acknowledged that they had not been prepared for the emotional impact of full-time clinical work.

Respondents commented that it was only in retrospect that they saw how protected they had been as trainees, when their clinical workload was much lighter and they saw relatively few complex cases.[27]Once qualified, they had to cope with a much bigger caseload and quickly encountered a lot of clinical problems that they had not attempted to treat before. For some people this leap seemed even bigger because they had chosen jobs in clinical areas that they had not worked in since first or second year of the DClinPsychol. In the interim, they had developed many more clinical skills but had not applied these to the patient population with whom they were now working. However, even for those who remained in same speciality during the transition from third year to post-qualification, the learning curve was very sharp.

The challenge was made greater by their limited time for private study. Most clinical psychologists in the departments where these respondents worked roughly adhere to the model of three/three and a half days per week face-to-face clinical work, with the remainder of the time split between varying

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[26] Grade A embraces all qualified clinical psychologists except those in senior managerial posts: see 9.2 ii (a) for discussion of the hierarchy and use of designations in clinical psychology.

[27] Their limited exposure to complex cases (characterised by co-morbidity and chronicity of symptoms, and/or co-existing social problems) is largely a consequence of the fact that they change clinical placements every six months during the first two years. Trainees are therefore generally allocated cases that are likely to respond to a brief intervention. In third year they are supposed to do

degrees of administration, management, teaching, supervision and research. Many of the new graduates found that they lacked the skills required both to maintain boundaries around their clinical sessions and to control the volume of referrals they were accepting. Part of the problem was that their inexperience with negotiating an end to contact with patients meant that they were probably slower to discharge patients than their more experienced colleagues:

> There's that thing that if you had a difficult case in training, you knew you were going to get rid of it at the end of placement and hand it on to somebody. You've got no way of doing that. You've got to decide when things have, what do you do if you don't progress and nothing changes? And when do you decide that you've done everything that you can do and you can't think of anything else? (C12:2)

Their inexperience also made it difficult for them to say "no" to patients or fellow professionals, as this woman, working in the child service, describes:

> I was just overwhelmed with all these urgent cases. [My predecessor] had left me with loads of urgent cases to start with and then there were GPs phoning up saying "You've got to see this person, you've got to see this" and I was thinking I just can't see anyone else...And then the mothers would phone up or the GPs would tell the mother "You phone her up personally and you harass her" and I'd have the mothers harassing on the phone as well. Then once you get the mother on the phone, you just, it's so hard to say "I'm sorry, I just can't see them". Then they tell you the situation and you just think, this is awful, and then you'd arrange to see them, and it was awful...I'm seeing like seven people a day and I'm staying after work and I'm running around like some mad loon. (C12:2)

As a result, most of the new graduates reported that their clinical sessions spilled over into their administration time and they were left with very little opportunity to read up on unfamiliar clinical presentations. They habitually felt under-prepared for their patients and this contributed to their sense of inadequacy. As noted above, most of these new graduates had split posts covering two (or in one case, three) clinical areas. Split posts were popular because they offered people a chance to try different specialities before committing themselves to one. However, the drawback of the split posts was that they required the new graduates to extend their knowledge in different areas and they sometimes ended up feeling that they were not doing anything properly.

Half the class became quite seriously demoralised at some stage in these first eighteen months because of the demands they faced. The following remark is typical:

> I don't know how serious I was about it but I was sort of thinking this just isn't the sort of job that I want, it's just totally depressing. I think it was because I didn't seem to be getting, well, I was just totally overwhelmed with the amount of people I had to see, the fact that I wasn't allowed to, it felt like I wasn't allowed to prepare for them because I didn't have

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at least a part-time placement that lasts all year, but this may be in a different clinical area to the one they work in post-qualification.

> enough time to prepare for them. And it was just a bit overwhelming and I thought "No, I just want to give up and maybe go, or maybe just move somewhere else, go and live in New Zealand and do it there and that would help!" I don't know, I don't know what you'd do instead. I think once you've had a break from it you remember how much you enjoy reading about it and that you actually enjoy doing it and you enjoy seeing the individual people. I think it's when they are all together and you've got this image of your day and you think "I can't cope with that" or "I'm not getting anywhere with you people." I suppose there might be little things that happen in sessions that make you think, but overall you sort of have this blurred image of "Oh God, it's awful". (C12:2)

This woman identifies the increased caseload as the major stressor. Other pressures arose from the responsibility of caring for people who were very distressed and, in some cases, self-harming or suicidal. As one respondent observed: "I don't think I was very well prepared for...the emotional impact and the responsibility and thinking 'I hope I don't go in on Monday and find out they are dead'" (C9:2). In addition to concerns about patients' safety, some of the new graduates found themselves identifying with their patients' feelings of being out of control and struggled to maintain any belief in their professional skills:

> On the whole I have enjoyed it because they are the kind of clients that I like working with but there are definitely times when I look at my week and I think everybody has got worse and I am doing nothing of any value, and I am getting really disillusioned and fed up. And then you get a couple of people who have got a wee spark and it kind of makes you feel a bit more confident. But I have certainly much more often gone through a week where I have just thought "No, I can't do this. I am not doing any good here and people are getting admitted [to hospital]". I had about a month, I think it was January, when I was just so demoralised that I absolutely wanted to give it up and never do it again. I would do research or do something that didn't make you feel such a complete and utter fool. I just felt really out of control with what was happening, and there was a lot of people, because their lives were just so chaotic, I suppose you are just picking up what they are feeling: a complete lack of control. It was their life, but it was frightening. (C5:2)

The experience of becoming deskilled and overwhelmed was shared by most of the cohort at some stage. In this case, the respondent quoted above decided to protect herself from further demoralisation by seeking a change of job to one that required less direct patient contact.

While individuals were getting to grips with the increased demands of their clinical work, they were also adapting to their roles as full-time NHS employees without the parallel student role that they occupied as trainees. Although the constraints of the student/trainee role had provoked resentment and frustration (see Chapter 7), it had also provided the reassurance and security that group membership provides. As I shall discuss below, some newly qualified trainees did attempt to maintain links with their class, but many of them still described a new and unwelcome *sense of isolation* as they adjusted to their first posts.

For most people, this isolation was not only the result of reduced contact with classmates and course staff. In many cases, the type of posts individuals had taken had the potential to exacerbate the problem. Twelve of the fourteen respondents had accepted posts within child or adult mental health that required at least part-time work in primary care settings. This sort of work typically involves running clinics in several GP practices or Community Health Centres where the degree of integration between the psychologist and the rest of the primary care team is variable. Where the integration is most minimal, the psychologist is, in effect, running an out-patient clinic in these premises and may have little/no contact with the GPs or other health professionals who work there. The major stressor experienced by staff working within this model is professional isolation. They typically have little contact with other psychologists outside the sessions that they spend at their departmental base for administration or meetings. As I noted above, this time is particularly likely to get squeezed when people are newly qualified and struggling with time management. While professional isolation is also a common complaint among experienced clinicians working in this model, it is especially difficult for new graduates who are feeling in need of additional support from senior colleagues. One woman, who changed jobs after a year partly because of the isolation she experienced in Primary Care, describes what it was like:

> I was also very isolated in --- in a Health Centre, with no reception and nobody else there. I wasn't meeting anyone during the day except people coming to see me...I think, in particular, where I worked was a clinic which was in quite a deprived area and it was a really run-down building. I didn't even feel safe, let alone anything else. The car park was always vandalised and glass smashed. Just basic things like even your safety didn't feel right and, as I say, you'd go through a whole day without seeing a soul. I used to have to lock the front door at lunchtimes, just to make sure people weren't coming in and out. Sometimes there were other people there, but generally there weren't. It was a bit miserable. (C6:2)

Although she worked on other sites as well, and had good supervision and support within her departmental base, this (particularly bleak) Primary Care setting contributed significantly to her job dissatisfaction. Other respondents acknowledged that the autonomy of Primary Care work could compensate for the isolation:

> ...particularly when things are going badly, one is more aware of the isolation of the experience of being in primary care settings, one to one, with somebody who is not getting better, whereas when things are going well, I think that's the time when I value being autonomous and doing my own thing and getting on with it. (C11:2)

While most of the class experienced a degree of isolation, some members of the cohort also had to adapt to the demands of close inter-professional relationships when all or part of their job involved working in multi-disciplinary teams. Although some of them had had limited experience of this before, either as psychology assistants or trainees, their role in the team was now very different. As assistants they were so junior that they did not expect to have much influence and as trainees they

were only in a team for a short period before moving on again. However, as qualified clinicians they expected to contribute much more to the teams and were acutely aware of the teams' expectations of them. This was the situation in which individuals felt most under scrutiny and experienced most pressure "to be experts":

> In the team I am meant to be the psychological expert but when you're learning yourself and you haven't really worked very much in a team it's a completely new thing for you...nothing is as black and white as you think it's going to be. I mean you can have a certain knowledge base but trying to apply that to an individual person that is discussed at a team meeting can be quite difficult at times, especially when you're not sure if psychology is going to have a great effect there because nothing very much will. (C10:2)

In the above excerpt, this woman also describes the difficulty of trying to make sound treatment decisions in front of an audience of non-psychologists and represent psychology when she is unsure if it has anything to offer. One of the challenges that several new graduates commented on was learning to recognise when there was nothing you could offer a patient:

> I think I was very idealistic before I started the course and I got a bit less idealistic and now I think I'm even less idealistic...maybe that's not such a bad thing that you've got a more realistic assessment of what you can do with people and what the limitations are and that they have to want to do something themselves as well. (C3:2)

In summary, then, this transition to qualified status was a considerable reality shock for most respondents despite their direct clinical experience as trainees. Most of them reported that they had become significantly stressed during their first eighteen months post-qualification. Six of the fourteen had seriously considered changing jobs within the profession because of stress and dissatisfaction. In one case this had already happened, and another person was in the process of pursuing a new post with reduced patient contact. Four of the six who were most unhappy in their jobs admitted that they had thought of leaving the profession but said they would try another post before taking that step. Several of the others expressed hopes that their work pressure would reduce in the near future. As one person said: "It's challenging, but it's so stressful. Do I really want to be working at this pitch all the time?" (C9:2). There was considerable consensus in the group about which factors had contributed to their difficulties, as well as those that had mitigated them. I will consider the latter in the following section.

## 8.3 Factors That Facilitated the Transition to Qualified Practitioner Status.

Respondents identified *clinical supervision* as the most significant determinant of the quality of their immediate post-qualification experience. There was considerable variation between individuals in terms of how much supervision they received in their first post. Four of them had a formal supervision session on a weekly basis with a senior colleague in the first months of their first job, and three of those individuals subsequently moved to fortnightly supervision. Another respondent began with fortnightly sessions, then moved to monthly sessions, while four individuals received supervision monthly from the outset. The remaining five individuals were not given regular supervision, despite promises that this would occur. All those psychologists took steps to arrange better supervision. When it was not forthcoming from senior colleagues, they set up peer supervision/support groups with other recent graduates.

Inadequate supervision, combined with the heavier workload and more complex cases, left the new clinicians feeling deskilled and demoralised. Four of the five psychologists who reported feeling particularly distressed and under-confident about their work (for example, see C5 and C12 quoted on p.9 above) had no regular clinical supervision, and the fifth person had only received this monthly from the outset. If we examine the opposite case – the psychologists who received close supervision – it may not be coincidence that the individual who had the most frequent supervision sessions (weekly for one year) also described the smoothest, least stressful transition from training to qualified status. Her account is strikingly different from those excerpted earlier:

> R: I have never, touch wood, had any problems at all with any of the clients or case management. I have never been under pressure to take more than I could have coped with. There have never been any problems at all.
>
> K: It has really been an easy transition?
>
> R: It has been, you know. Any of the problems have maybe just been in terms of interpersonal things. Maybe the way they used to do things because they have been here for a while and trying to fit in with that sort of thing...but in terms of cases themselves, I have never felt myself at all floundering. But I think that's because of the support network that has gone on which has been second to none. (C2:2)

The other psychologists who received regular supervision at least fortnightly from the beginning of their first post-qualification job were also much less concerned about meeting their clinical responsibilities than those who received sporadic or less frequent supervision.

From the accounts of these respondents it became clear that good supervision not only provided guidance with treatment decisions, and support, but also assisted them to pace their work so that they would not become overwhelmed. One psychologist reported that she was encouraged to begin with

five sessions (two and a half days) of face-to-face clinical work per week, building gradually up to six sessions per week as the maximum, with the remainder of her time split between administration and research. She was also advised to limit each session to three appointments, giving her an eventual maximum of eighteen patients per week. The situation was very different elsewhere. One woman, who had no formal supervision opportunities, also had sole responsibility for a waiting list that greatly exceeded the department's target waiting time when she inherited it. This generated considerable pressure and she frequently found herself working late.

There was agreement within the cohort that formal (with dedicated time and a clear agenda), regular supervision sessions were essential during this stage, but many people reported that informal supervision, merging into collegial support, was also valuable. Opportunities for this arose with variable frequency. As I noted above, individuals seeing patients on lots of sites often found it difficult to meet up with colleagues outwith prearranged meetings. One department had responded to this problem by agreeing that it was appropriate to telephone colleagues at home outwith office hours if there was an urgent clinical situation that needed discussion. This option allowed a new graduate to get rapid assistance with a difficult case and she regarded her senior colleagues as supportive.

As noted above, the new graduates also established peer support/supervision groups. This was obviously most feasible when individuals worked in the same geographical region, and only half the cohort belonged to these groups. The most important function of the groups was normalising the experiences of its members: people felt able to discuss their anxieties more openly here than with senior colleagues and welcomed the opportunity to compare their reactions to their new roles. They compared workloads and perceived expectations of colleagues, and this process assisted them to re-evaluate their own situations. While the supervision aspect was new, in other respects the groups continued the mechanism of peer support that these individuals had developed when they were training together. Within these groups, members retained a corporate identity that was no longer defined by trainee status but distinguished them from colleagues who had been qualified for longer. The normalising function of these groups was sometimes also fulfilled by formal/informal supervision from senior staff. Discussion by senior colleagues of their clinical dilemmas was reassuring for new graduates: "It makes you realise that other people are struggling as much. People that are a lot more experienced and a lot more skilled are probably still struggling a wee bit. So it makes you feel less that you are a complete fraud." (C5:2)

While good clinical supervision clearly emerged as the most important means of facilitating this transition, individuals gave other instances of experiences that had fostered their sense of competency and value. One woman had the experience of joint working with a more experienced clinical

psychologist, where both of them assessed patients together and agreed a formulation of the patient's difficulties and the follow-up they would offer. This degree of joint working is uncommon among qualified psychologists, and this respondent found it reassuring as she developed her skills and attempted to work as a scientist-practitioner:

> K: Do you think of yourself working as a scientist-practitioner?
>
> R: Yeah, and I think that is really important to hold on to. And that is why I kind of get a bit irritated that I don't get enough time to read stuff that I really want to read because I think that is so important to keep that in your head, that that's the way you're supposed to be working. It's not just a case of advice giving or general tips and that sort of thing. I think that's what keeps me thinking psychologically if I think I am working as a scientist practitioner, other wise I would just become this, I don't know. I would lose that psychological side of things if I started thinking that's not the way I am working. I would just become a general advice giver or whatever.
>
> K: How do you know when you're working as a scientist practitioner?
>
> R: I think when I am formulating a case. That's when I know it's not just a case of writing what I know about this family and we are actually basing it on psychological theory. And I think when we were on assessment clinics and we were in pairs. That is really, really important because in terms of pure scientist practitioner model of working, you keep each other pure in that way. (C11:2)

As well as modelling and guidance, these new graduates benefited from opportunities to prove to themselves that they were no longer trainees. Since the casework had become so much more challenging, *mastery experiences in other domains helped to counter demoralisation* about their clinical ability. A few people had early opportunities to teach or supervise psychology assistants, trainees from other professions or other qualified professionals. Some new graduates were also asked to provide limited input to clinical psychology trainees: for example, allowing the trainees to shadow them. Teaching other qualified professionals was very anxiety provoking for most new graduates because they perceived their audience to be more expert than themselves. However, those who taught or supervised the other groups reported that this increased their confidence as they became aware of how much knowledge they had acquired over the previous four years.

Another opportunity for developing and demonstrating new skills that was less commonly available to new graduates was service development or consultancy work. These tasks usually fall to more experienced clinicians but occasionally confronted the new graduates. For some these felt like additional burdens they were unprepared to assume, but for a few these challenges engendered a sense of empowerment. One woman who was asked to join a policy advisory committee and was also involved in some training for other professions had complained of how disempowered she felt as a trainee. Now, she said, it felt very different:

> Oh, it is completely different. It's very good actually. It gives a certain amount of freedom. You really don't have to worry about [not being listened to]. You feel that you can make a difference.You can say something and people will listen and you are making contributions all the time and there is so much opportunity to do things. (C9:2)

It appears, then, as though additional challenges beyond those contained in clinical work can, under certain circumstances, facilitate the transition to qualified practitioner by helping the new graduates to become more aware of the difference in role between trainee and full professional. In the following section I will examine how the new graduates perceived that professional role and what they thought of the profession they had joined.

## 8.4 New Graduates' Views of the Profession and Their Role Within It.

If we examine the accounts of the new graduates obtained a year to eighteen months after they qualified, we find that *their assessment of themselves as psychologists is largely equated with how they assess themselves as therapists.* Opportunities to assess their skills in other areas, such as those described above, were relatively infrequent. Individuals who had been most closely supervised during their first post-qualification year not only reported that the year had been less stressful for them than it had for the others, but were in general more confident in their professional and therapeutic roles. The exceptions to this general rule were two people in split posts who were still negotiating their roles and lacked confidence about their skills. Most people in the cohort confirmed that they had a stronger sense of their professional identity since qualifying, and several people attributed this to the "Doctor" title they had acquired as well as the increased expectations that other professionals had of them.

Views about the knowledge base for their developing skills varied within the cohort. Most people in the cohort spoke of their concerns about lack of time to read up on cases and one woman connected this explicitly with her desire to work as a scientist-practitioner, as we saw in 8.3 above (see C11:2). However, other members of the group were still questioning how they could be scientist practitioners. Some respondents argued that they were too inexperienced to select the optimal evidence-based therapy for each patient since they had only been trained in cognitive-behaviour therapy. Others spoke of their growing awareness of the impact of social and environmental factors on their patients' mental health and the importance of adapting the therapeutic models they had learned to accommodate these factors. One woman, working in a deprived urban area, explained:

> I take more account of the social factors [than before]. I can't work in such a classic and cognitive way with everyone. I probably negotiate quite small goals and work towards them. and working with increasing their motivation. And so I am sometimes working in a quite behavioural way...and then much later on we might look at some of the cognitive type things, but a lot of them are not keen on filling in automatic thought diaries...I am probably still working in a cognitive behavioural way with people but it's a lot more drawn out...It's led me to question the way that it is written about in textbooks that you can work with people. I don't think the way it is written in a lot of textbooks it would be possible to work with people, not everybody, but with some of the people that I work with and it's not because they are not intelligent. It's just because it's like a foreign language to them in a way. So I don't know. It would be nice to see some textbooks that acknowledge that in an age with social difficulties and poverty there is other things going on and that you can't really work in quite the same way with people. (C10:2)

The dominant theme in these interviews, as in my earlier conversations with this cohort at the end of the DClinPsychol, was the necessity of adapting theory and models of clinical practice to fit the real world. The new graduates described themselves struggling to keep up with the demands of patient work, and only one person had begun to extend her role beyond that of therapist to any significant degree. She had taken on training responsibilities (for other disciplines) and was participating in a policy-making group. By the end of their first post-qualification year only two of the fourteen psychologists had begun to plan any research, while a few others were still intending to write up some of their doctoral dissertation for publication.

Most people's views about the profession had not changed appreciably between the time I spoke to them at the end of the course and these follow-up interviews. At the end of their first year post-qualification, the group was divided in its attitudes towards the profession. A third of the group were sceptical about the profession's effectiveness, and the following quotation represents their sentiments:

> I think that's something that was on the course. Clinical Psychology, certain people will have you believe like it's a cut above everything else. We are the experts on this, we are the experts on that and we have a research background and we do this and we do that. Then you sort of get out there and you think, well, do we know about this and that and are we better than them at this? ... I think the course sometimes leads you to believe that you do have the answer above other people...it doesn't prepare you for the fact that you are not. (C12:2)

The rest of the group was more positive about what clinical psychology had to offer, although these individuals were not necessarily confident about their own skills.

Given how hard these individuals had worked to gain their membership of the profession, these interviews were remarkable for the absence of references to this membership. Two individuals spoke of their new-found sense of responsibility to the profession: one person expressed her intention to do some research to "put something back in" to the profession (C11:2), while another explained:

> This is my profession and I have concerns about it and I want it to be as good as it can be. I want it to be improved. I think that's the first time that I really felt strongly that this is my profession and I have responsibility if you like to some extent in maybe changing how things are or improving things or taking the responsibility of how things are. (C4:2)

These two instances stand out because the other respondents did not articulate this sense of responsibility to the profession or convey any awareness of professional issues beyond the local level. No one in the group had attended a national clinical psychology meeting since they had qualified or begun to develop a role in any national professional bodies. The emphasis in these conversations remained on how individuals struggled to cope with the demands of clinical work and how these threatened to erode the practices they believed defined them as professionals, as this respondent describes:

> R: I think I felt more effectual as a trainee, definitely.
>
> K: What's that about do you think?
>
> R: I think it's the type of patients partly and also volume of patients, because you haven't got the time necessarily to sit and think between each one about what you're doing, and somebody to talk to, and reading, the theory to come back to all the time. You do worry as well, I do worry about getting out of touch already with the profession. (C3:2)

At this stage in their professional socialisation, these recently qualified clinical psychologists generally appear to have identified to only a limited extent with their professional body, the British Psychological Society, and its concerns. There was virtually no research activity among the cohort: the focus of the new graduates' attention was elsewhere as they honed their skills in clinical work.

## 8.5 Summary of the Transition from Trainee to Qualified Clinical Psychologist.

In this chapter I have illuminated the dilemmas and challenges that confronted these newly qualified clinical psychologists. I described the *increased confidence in their clinical skills* that respondents developed during their three-year training, and their *continuing commitment to the profession and the NHS.* I also reported that these individuals began their professional careers with *eagerness and apprehension as they contemplated greater clinical autonomy and responsibility.* From the above discussion, it was also evident that most of these newly qualified practitioners were *critical of aspects of the profession.* In particular, they expressed *doubt about the reality of the scientist-practitioner* and *concern about professional burn-out.*

When this cohort was interviewed 12-18 months post-qualification, *the majority reported significant problems adjusting to their new roles. Increased work load and responsibility, more complex cases, isolation, and inadequate clinical supervision* were the main sources of stress and dissatisfaction for the new practitioners. At this stage in their careers, these clinical psychologists were almost exclusively *preoccupied with developing their clinical skills, to the exclusion of research activity or involvement in wider professional issues.* In the following chapter, I will explore the implications of these findings and of those previously reported.

# CHAPTER 9

# CONCLUSIONS

In this chapter I will endeavour to draw together the findings reported earlier and discuss their significance with reference to the relevant literature. In 2.7 above, I identified my initial research questions as follows:

1. Does anticipatory socialisation influence professional socialisation during clinical psychology training?
2. Do clinical psychology trainees experience person-role conflict? If so, how does this arise?
3. Do clinical psychology trainees experience role ambiguity? If so, how does this arise?
4. With reference to Bucher & Stelling's (1977) model, what are the structural and situational variables that influence clinical psychologists' professional socialisation?

As the study progressed and analysis of the interview data began, the theory of status passages (Glaser & Strauss, 1971) became increasingly useful for the way it illuminated the socialisation process. While Bucher & Stelling incorporated the status passage into their socialisation model, they confined their use of it to identification of " clearly marked points of transition which inform the trainees about where they are in their movement or development" (Bucher & Stelling, 1977, p.25). In my analysis I extended the application of Glaser & Strauss' theory to consider in detail the properties of the different status passages experienced by my respondents, some of which were far from clear. Indeed, the lack of clarity in the passage through the DClinPsychol course was its most salient characteristic and very much influenced the trainees' experience of professional socialisation. As my analysis continued, it became evident that the concepts of role ambiguity and person-role conflict were best understood as instances of the lack of clarity in the training passage, reflecting tensions and ambiguities within the profession itself.

In the discussion that follows, I will:

i. show how the concepts contained within the initial research questions, together with the theory of status passages, elucidate clinical psychology trainees' experience of professional socialisation
ii. offer some reflections on the current state and future direction of the profession, and their implications for clinical training
iii. offer some recommendations that are intended to improve clinical psychology training and ease trainees' transition to qualified status.

## 9.1 Anticipatory Socialisation in Clinical Psychology Training.

In Chapter 5, I demonstrated that the *status passage* of individuals through assistant psychologists' posts is characterised not only by its *desirability* because it leads towards trainee status, but also by its *uncertainty*. Assistants cannot predict how long this stage will last before admission to the doctoral course is achieved. Respondents identified uncertainty as a major stressor during this phase in the socialisation process, but it also enhanced the scarcity value of the training places and thus contributed to the desirability of the next stage in their passage. The passage through assistants' posts was further characterised by the limited amount of *control* that individuals felt able to exert over their situations because of their junior rank in psychology departments and their reluctance to rock the boat and alienate potential referees among senior colleagues.

As predicted, interviews with psychology assistants and new trainees revealed that they had experienced considerable *anticipatory socialisation* before they began the DClinPsychol course (see Chapters 5 and 6). There were several aspects of this preliminary phase in the socialisation process. Firstly, assistants were well versed in most aspects of the profession's public discourse about the special qualities that distinguish it from the other mental health professions. This knowledge was acquired by listening to senior colleagues, as well as reading journals and papers articulating these issues. While some of this knowledge was acquired unintentionally as a by-product of the assistants' immersion in the clinical psychology milieu, most of it was acquired intentionally and systematically as they prepared for DClinPsychol admission interviews. Thus, assistant psychologists were aware of the scientist-practitioner paradigm and the profession's claim that the Level Three skills[28] of its

[28] The ability to problem-solve using a broad base of psychological knowledge: see 5.3 ii.

practitioners were exclusive to clinical psychology. However, most respondents did not accept these claims uncritically. The majority was unconvinced that clinical psychology had exclusive ownership of Level Three skills. The cohort also expressed scepticism about the scientist-practitioner as the dominant paradigm in clinical psychology. While most of the group believed that the model was a desirable one for the profession to emulate, only about half the cohort believed that the model was routinely adhered to in clinical practice. Furthermore, some respondents questioned the appropriateness of the model itself because they believed it was incompatible with the humanistic values they wanted to promote in their own clinical work.

The scepticism expressed by these respondents about the validity of aspects of the profession's self-presentation is consistent with a symbolic interactionist approach to professional socialisation. From that perspective we approach this process with the expectation that each individual will be " an active, choice-making factor in his own socialization" (Olesen & Whittaker, 1968, p.300). Just as most psychology assistants did not accept the profession's self-presentation uncritically, they were equally discriminating in their attitudes towards senior colleagues as role models (see 5.2 iii. above). They did not choose to model themselves on particular individuals but instead identified specific attributes from a number of qualified staff that they wished to emulate. Bucher & Stelling (1977) described the same practice in the trainees whom they studied and called this "partial role modelling". I had anticipated this discrimination in clinical psychology trainees, but I did not expect to find psychology assistants being so selective in their response to modelling. In 5.4 above I considered another example of assistants taking their own path: we saw that some psychology assistants had already begun to plan their trajectory through the doctoral programme based on their prior knowledge of the system.

My interviews with the psychology assistants revealed that the majority had experienced role confusion and role overlap in multi-disciplinary settings. These experiences, together with their observations of colleagues, contributed to the assistants' awareness of territorial disputes between clinical psychology and other professions, particularly psychiatry and nursing. Thus, the theme of *role ambiguity*, which I shall expand on below, emerged during this initial stage in the process of professional socialisation and led respondents to question the specialness of clinical psychology.

The accounts of assistant psychologists also contained reports of *person-role conflict*. This conflict arose for a variety of reasons. In some cases it attended the "distancing" that individuals experienced between themselves and patients when they attempted to conform to their own expectations of the psychologist's role. In other cases, it arose when assistants felt they could not satisfy the requirements of that role, or felt inhibited from expressing themselves honestly because of the role. These reports of person-role conflict, together with those of role ambiguity and the expressions of scepticism about

the profession's public presentation, suggest that the majority of psychology assistants were aware of the profession's norms and values but had not yet internalised them.

The difficulties that these respondents experienced as psychology assistants were exacerbated by *inadequate supervision* from qualified psychologists. Concerns about supervision of assistant psychologists have generated a number of articles in recent years in Clinical Psychology Forum.[29] I will discuss the Division of Clinical Psychology's response to these concerns in 9.5 below, when I present my recommendations for the improvement of clinical training. However, in order to provide a context for my own findings, I will briefly refer here to two recent national surveys of assistant psychologists that have appeared in this journal. These surveys provide information about the experiences of assistants in other areas of the United Kingdom and reveal that the difficulties experienced by the assistants in my own study are not confined to that cohort. In Rezin & Tucker's (1998) survey, 31% (N=174) of their respondents said they did not receive enough supervision, while Taylor (1999) found that 18% (N=74) of her sample were dissatisfied with the amount of supervision time they were allocated.

Of course, the amount of time given to supervision is only one of the significant variables. Taylor (1999) describes considerable variability in the way this time was allocated to specific supervisory tasks with her respondents. Some of these assistants found that their sessions provided nothing other than an opportunity for the supervisor to allocate duties. Opportunities for assistants to discuss individual patients or more general issues of personal or professional development were therefore limited. Taylor also reports considerable variability in the type of duties assigned to assistants, from clerical duties to responsibility for complex clinical cases, and she comments that "feelings of exploitation were prevalent" (Taylor, 1999, p.26).

Rezin & Tucker (1998) detected two types of "problem assistant posts". They define Type A as "under-used" and found that 20% of problem posts fitted these criteria. Type A assistants lacked a defined role, as well as sufficient work or training. Type B ("too much") made up the remaining 80% of problem posts. Those assistants received inadequate supervision, were given inappropriate referrals for their level of training, and may have had negative or frightening experiences with clients as a result. Rezin & Tucker comment that both groups suffer from a lack of confidence in their abilities. Assistants in Type A posts typically feel isolated, while those in Type B jobs feel under-valued although they consider that too much is expected of them.

[29] Clinical Psychology Forum is produced monthly by the Division of Clinical Psychology of the British Psychological Society and is the primary source of articles, letters and news about professional issues of relevance to Division members.

Nearly half of the respondents whom I interviewed about their work as psychology assistants had experience of "problem assistant posts" (see 5.2 i. above). However, while the difficulties they described corresponded with those identified by Rezin & Tucker, their accounts could not easily be categorised into Types A and B. None of my respondents reported that they had been "under-used". Instead, the lack of a defined role co-existed in the most difficult posts with considerable work demands and poor supervision. Even those individuals in the least satisfactory assistants' posts attributed their problems to local factors, such as under-staffing. This response allowed them to maintain a generally positive view of the profession and retain the expectation that their working life would improve substantially once they left those particular posts and began the doctoral programme.

While there are no available data on the attrition rate among psychology assistants, Rezin & Tucker remind us that there are casualties before formal training begins. Their report includes the following response from an extremely disillusioned assistant:

> I always thought I wanted to be a clinical psychologist but this job has really put me off...I am now pursuing an alternative career...it has caused me a great deal of stress...I have never felt that there was anybody who would be prepared to listen. (Rezin & Tucker, 1998. p.41)

This view represents a possible outcome at any stage in the process of professional socialisation: people can, and do, leave the profession. As we shall see later in this chapter, some individuals remain highly ambivalent about their commitment to the profession throughout their training but may not decide to abandon it until they have obtained their clinical qualification.

In summary, the anticipatory socialisation that occurs in psychology assistant posts refers to the process of psychology assistants becoming familiar with the professional milieu and the manner in which the professional establishment portrays itself and its functions. The extent of anticipatory socialisation experienced by most individuals before they begin clinical training means that most of them enter the DClinPsychol course with a fairly clear idea of the attitudes and behaviour they need to display to meet the expectations of their trainers. However, despite their commitment to the work of clinical psychology, many assistants begin training unpersuaded by the rhetoric of the profession.

## 9.2 Professional Socialisation During Clinical Training.

Bucher, Stelling & Dommermuth observe that anticipatory socialisation "... seems to be related to the amount of 'trouble' that trainees encounter, to disruption of the system and to failures and

defections among trainees" (Bucher, Stelling & Dommermuth, 1969b, p.220: see 2.4 i.). In the present study, the data suggest that anticipatory socialisation certainly facilitates the transition from psychology assistant to trainee but does not prevent trainees running into "trouble" of various kinds. Like Bucher and colleagues, I interpret some of this trouble as both unavoidable and potentially desirable. Cogswell (1967) has written about the sequential nature of socialisation and notes that novices must abandon the old role before they can identify with a new one and eventually integrate this into their total constellation of roles. This process of redefining the self may actually be aided by individuals encountering challenges, or even problems, as in the case of psychology assistants with poorly defined roles (see 5.2 i.). However, too much trouble does indeed increase the risk of disruption to the system and defections by trainees, who may either abandon the course, or fail to make a commitment to the profession.

Those outcomes were, in fact, reported by trainees in this study. As we saw in the previous chapters, trainees also described the strategies, including impression management that they developed to manage the difficulties they encountered. I will discuss these responses below, but I will begin by considering their experience of the transition to trainee status and the effect of anticipatory socialisation on the way they negotiated this stage.

### 9.2 i. The Transition to Trainee Status.

In Chapters 6 and 7, I presented trainees' accounts of their transition to the first year of the DClinPsychol and subsequent passage through the three-year course. In Chapter 6, I established that the actual transition to trainee clinical psychologist was a *clear and significant status passage* for most people. For the majority of trainees it was also experienced as an *ascending* status passage, although I provided data demonstrating that this was not so for a minority of respondents. This minority experienced the transition as a descending status passage marked by a loss of autonomy, responsibility and, in some cases, a drop in income.

While most respondents experienced the transition to trainee status more positively, it still provoked *widespread anxiety*. In some cases, trainees' reactions were sufficiently extreme to warrant the descriptor "reality shock" used by Kramer (1974) in her study of professional socialisation of nurses, although the nurses experienced this in the transition from training to their first job post-qualification. The new clinical psychology trainees described feeling overwhelmed by patients' expectations and distress. They also struggled to meet their own expectations and those of their patients while feeling

much of the time that they were "play-acting" as psychologists. These reactions to the commencement of formal training are not just a local phenomenon. Gorsuch, reflecting on her first six months as a clinical psychology trainee on one of the London courses, speaks of her own "difficulties...in acknowledging [her] confusion as a new trainee and in adopting a professional identity as a psychologist" and the "considerable uncertainty and anxiety" of her peer group (Gorsuch, 1994, p.10). She goes on to explain her own experience of reality shock:

> Not only do the textbooks in no way prepare the new trainee for the raw pain of clinical encounters and the disturbing feelings brought into sessions, they actually try to sanitize these aspects of the interaction by using the most bizarre, emotionally vacant terminology. My favourite expression, cognitive-speak for hopelessness, is "generalized negative expectancies". (Gorsuch, 1994, p.11)

Of course, these disturbing encounters are not limited to the early months of training but continue to be a feature of clinical work throughout one's working life. However, as the process of professional socialisation continues, trainees learn different ways of responding to the pain of clinical encounters and revise their expectations of both themselves and their patients. I will return to this point in 9.3 below when I discuss the perceptions of Cohort C eighteen months post-qualification.

Other investigators have written about the *identity confusion* and related anxieties of new trainees. Allen, Austin, Palmer & Street, describing a new tutor system introduced by staff on the South Wales clinical psychology course, report that this was implemented in recognition of "a need for more attention to be paid to the developmental nature of trainees' clinical experience over the whole course of training" (Allen *et al.*, 1994, p.19). The authors present a pilot study of a "developmental tutor" system. I will describe this system more fully in 9.5 below, when I make my own recommendations for improving clinical psychology training. However, the findings of Allen *et al.* concerning the initial tasks of trainees are relevant here. In their developmental model of the training experience, the authors identify the first stage as "joining":

> The initial preoccupation of trainees was with whether or not they had successfully joined the trainee group, the profession or the accompanying culture. There was also a concern with what sociologists would call "passing": would they look to others as if they were clinical psychologists? The task was to find a way of belonging and fitting in. (Allen *et al.*, 1994, p.20)

In addition to anxiety and identity confusion, the phenomenon of *trainee disillusionment* following the commencement of clinical training is well recognised among course staff and clinical supervisors. Some of this disillusionment seems to stem from instances of trainees feeling disempowered and deskilled in their new role. In Chapter 6, I cited examples of individuals feeling insufficiently challenged by their first placement, and of others feeling let down when they did not receive a "sort of recipe book to follow" (A3:1). Allen and colleagues reported that new trainees on the South Wales

course also spoke of feeling deskilled. The investigators identified the second task that confronts trainees in the developmental process as learning to cope with this experience:

> The second phenomenon we noticed was a widespread sense of being deskilled. This was particularly noticeable for trainees who had extensive experience of working, often with minimal supervision, as psychology technicians or assistants. Trainees found themselves thinking, "I thought I was good at something but I'm not." The task here was to find a way of letting go of their professional past and "beginning at the beginning." (Allen *et al.*, 1994, p.20)

Bender (1995) considers other aspects of trainee disillusionment and asks whether it is preventable. He suggests that trainees may be more idealistic and more intellectually able than their lecturers, given that competition for training places has increased over the years. He also suggests that trainees may be closer to "the reality of client care" (Bender, 1995, p.38) than their tutors because of their recent experience of full-time work in settings where patients are less highly selected than those seen by teaching staff. Finally, Bender suggests there may be some cognitive dissonance associated with the experience of being "lottery winners" in the selection process and he highlights the difficulty of resuming the student role after a period of work.

Certainly, applicants for clinical psychology training must be more highly qualified now than they had to be twenty years ago when many course staff trained. The claim that the trainees are more idealistic than their lecturers is debatable and perhaps owes more to a stereotype of entrants to professional training being characterised by "initial innocence" (Davis, 1975) than it does to reality. As we saw in Chapter 5, many of the individuals whom I interviewed were pragmatic, if not sceptical about the profession they wanted to join. In considering the significance (or *centrality*, to use Glaser & Strauss' term) of the transition to trainee status and the emotional impact of this experience, I returned several times in Chapters 5 and 6 to trainees' expectations of the course. Trainees alluded to the "idealism" in the self-description that the course presented to applicants. However, in the interviews with psychology assistants and new trainees it also became evident that half these individuals had considerable "insider knowledge" of the training course before they joined it and had heard about potential difficulties and stresses. The accuracy of Bender's assertion that trainees may be nearer the reality of client care than their tutors is also debatable. There are undoubtedly some tutors who see few routine NHS cases and whose patient contact is confined to carefully selected research subjects, but practices vary widely across the courses. Certainly, most of the staff on the Edinburgh course also did clinical sessions in non-specialist NHS/state hospital settings. However, if we consider Bender's hypotheses about trainees' unease at being lottery winners, and the discontinuity between the student and employee roles, we find support for these interpretations in the present study. In 5.4 above, I reported respondents' expectations that the course would be wonderful because of the difficult selection process they had negotiated to win a place, and their fears that they

"might not match up" (A4:1). Finally, the tension between the role of student and employee was a dominant theme throughout the interviews and I will consider this point in more detail below.

In summary, then, many individuals experienced the transition to trainee status as a time of *anxiety, uncertainty, and disillusionment* despite the *clarity, centrality and desirability* of the transition itself. As individuals proceeded through the doctoral course, they found that their passage became less clear but they also became increasingly skilled at taking *control* and managing their trajectory through clinical training. In the following section we will see that the experience of clinical training was characterised by this tension between trainees' efforts to shape their passage and the constraints they encountered in the form of both structural and situational factors.

### 9.2 ii. The Passage Through Clinical Training.

In this section, I will examine the factors that facilitate trainees' smooth passage through the doctoral programme, and those that interfere with this process. In the course of this discussion, I will argue that some of these impediments are both inevitable and helpful in assisting trainees' socialisation into the clinical psychologist's role. I will begin the analysis at a structural level, by returning to the subject of how trainees' joint student-employee status shapes their passage through training. As I showed in 2.6 ii., this dual role is one outcome of the profession's increasing reliance on the university system to legitimate its status by awarding degrees to its trainees. Following this discussion of trainees' dual role, I will proceed to examine aspects of role-playing in clinical training and the relationship between trainers and trainees, where both structural and situational factors are implicated.

#### 9.2 ii. (a). Combining the Student and Trainee Professional Roles: Role Conflict and Role Ambiguity.

In 6.2 ii. and 7.3 i. above, trainees described *role conflict* as they juggled the obligations of the student role and the responsibilities of NHS trainee clinicians. Trainees' attitudes towards their academic work are complex. They generally did not reject or denigrate the academic component of the course in the manner that Salisbury (1994) observed in a group of experienced but untrained

further education teachers who embarked on a university-based certificate of education. Salisbury reported that this cohort made frequent comparisons between the "real world of further education" where they had experience and the "ivory tower" represented by the course organisers, whose approach was viewed as unrealistic, idealistic and unworkable. Although most of the clinical psychology trainees began the DClinPsychol with experience of the "real world" of clinical psychology, this dichotomous view did not prevail.

As we saw in 7.3 i.(b), trainees valued the academic component of the course, although they thought that the clinical work was more important. This may partly reflect the blurring of roles among course organisers, who all do clinical work as well as teach and conduct research, as well as the combined roles of clinical supervisors, who contribute to the course's taught component. It may also be another marker of trainees' professional socialisation, since the scientist-practitioner model promotes the value of research and academic activity. However, despite their acknowledgement that academic work mattered, I also reported the frustration and self-criticism of third year trainees who found that their dissertation was interfering to a considerable extent with their clinical work.

In 7.3 i.(a) we saw that a dispute between trainees and course staff over out-of-region elective placements was frequently cited by trainees as a further example of the conflict between the student and trainee role. As students they wanted to maximise training opportunities through these elective placements, while as employees they were being asked to consider their contribution to local service needs. This dispute highlighted the tension between trainees' student and employee roles, and was presented by respondents as an instance of *professional-bureaucratic conflict*. The NHS bureaucracy (represented by their line manager) was blamed for shortfalls in their training: "...they're not even remotely interested in you as a trainee...all they care about is saving a few quid" (B6:2, quoted more fully in 6.2 ii. above). In contrast, the role of the university course staff in the dispute was interpreted as benign but ineffectual:

> K: What seems to be the relationship between the academic staff and the NHS [stakeholders]?
>
> R: I don't think they have any contact whatsoever. The academic staff all sympathise with our position but don't seem to have any power to do anything about it. They don't seem to have any power whatsoever except maybe over the content of the lectures. (B4: 2)

Trainees' accounts predominantly presented the academic staff as embattled and essentially powerless upholders of professional standards, pitted against a powerful bureaucracy that is obsessed with cutting costs and maximising output. However, a minority of trainees rejected this analysis, which assumes consensus within each camp. These respondents offered speculation and anecdotal

evidence in support of their hypothesis that the NHS Heads of Service were, in fact, divided on the question of out-of-region placements.

Davies (1983) highlights the importance of avoiding simplistic assumptions about professional-bureaucratic conflict that fail to consider a number of theoretical objections. These objections include the assumption that professional and bureaucratic roles are necessarily incompatible. Davies observes that some individuals "occupy with apparent ease and satisfaction combined professional and bureaucratic roles". The organisational structure of the clinical psychology course demands that both NHS and university stakeholders (most notably, the trainees' line manager, the NHS Heads of Service, and the Course Director) combine professional and bureaucratic roles, and collaborate to provide an economically viable training course that will retain accreditation by the BPS. However, it is not surprising that trainees sometimes find the compromises necessitated by these economic constraints unacceptable.

As we saw in Chapter 7, trainees not only contend with the difficulties of combining the roles of post-graduate student and trainee professional, but also *lack clear markers of their progress through the doctoral course*. Delayed feedback about placement and academic performance contributes to this lack of clarity. As I noted in 2.5 above, individuals are likely to experience *role ambiguity* when they lack sufficient information from supervisors regarding their performance. In 7.3 iii., I presented trainees' accounts of this form of role ambiguity, as they described their lack of confidence in both their academic and clinical work and their dissatisfaction with the course's evaluation system.

The use of the same designation (Trainee Clinical Psychologist/ Clinical Psychologist in Training) throughout the three years also contributes to role ambiguity for trainees. Hardy notes that although role ambiguity has been defined in a variety of ways, "the definitions have a consistent central theme of vagueness, uncertainty, and lack of actor agreement on role expectations" (Hardy, 1978, p. 82). The absence of any titular distinction between first, second and third year trainees contributes to this lack of agreement on role expectations between trainees and the people with whom they work. As we saw in 6.2 iii. above, the trainee designation is widely misinterpreted by the public and colleagues from other professions, usually to the disadvantage of the psychologist whose knowledge and experience may be under-estimated. The potential mis-match between the trainee's knowledge and experience, and the expectations of individuals outwith the profession, becomes greater as the trainee moves from first to third year of the course. The issue of trainee designations has recently been debated by the Group of Trainers in Clinical Psychology (GTiCP). GTiCP considered alternatives such as "Psychology Registrars", but eventually decided to stay with the existent nomenclature because "the title 'Trainee Clinical Psychologist' gave an accurate representation of trainees" (Minutes of the GTiCP Meeting, July 1999).

The lack of differentiation among trainees in terms of designation reflects the situation in the profession itself. The titles that were in common use until the recent NHS reforms and emergence of Trusts (such as "Basic Grade", "Principal" and "Top Grade") referred to different professional grades under the Whitley Council pay agreement. In most areas these titles have fallen out of use and within the profession only one differentiation is now generally made: between "A Grade" (the vast majority of clinical psychologists) and the more senior "B Grades" who have managerial responsibilities. Individuals mark their own progress within these grades through their pay rises, but their increasing seniority is not signalled to others within the profession or beyond by a changing title. Thus, a newly qualified clinical psychologist may have the same designation[30] as someone with perhaps eight or more years of experience who has not yet attained B Grade status. When individuals do achieve promotion, use of the B Grade designation is usually limited to official documents circulating within the profession. In wider circles, this mysterious title would have no meaning anyway. Ironically, given the profession's efforts to remove itself from medical hegemony, the presence or absence of the title "doctor" is the only means of distinguishing between psychologists for those outwith the profession.[31] Some senior clinical psychologists have attempted to communicate their seniority to the public and other professionals by calling themselves "Consultants" in line with their medical colleagues. This move has met with opposition from both physicians and some clinical psychologists, who view this as conceding to medical dominance.

In summary, then, these clinical psychology trainees had to cope with the competing demands of their student and clinician roles, and found it difficult to evaluate their competence in both spheres. They also lacked clear markers for their passage from one stage of training to the next, and their uniform designation obscured differences in experience between them for all but immediate colleagues. This mirrors the situation in the profession itself and, in my view, this levelling of distinctions between

[30] "Clinical Psychologist" or "Chartered Clinical Psychologist" for those who have voluntarily applied to join the BPS Register of Chartered Psychologists, and have been vetted and accepted by the Membership and Qualifications Board. This Register was authorised by the Privy Council in 1987 following the failure of the BPS to obtain government support for legislation to enforce full registration of psychologists. The case for statutory registration has since been accepted and legislation is now pending. Registration as chartered psychologists will be compulsory by 2001(Blackburn, 1999). Chartering has been highly controversial within clinical psychology: one of the many criticisms articulated by its opponents is that it represents an ineffective attempt at professional closure. For a full discussion of these issues, see Pilgrim & Treacher (1992).

[31] In fact, this simple distinction obscures meaningful differences between practitioners. Until the last few years, most clinical psychologists who were "doctors" had PhDs, acquired before or after their clinical training. Some of these doctorates represented clinically relevant research while others were obtained in other fields of psychology. By the mid 1990's, all the clinical psychology training courses in Britain had converted from Masters degrees to Doctorates. "Doctor" may now designate a newly qualified clinical psychologist, while an experienced clinician may lack the title because he/she completed training at a time when Masters degrees were awarded as clinical qualifications,

qualified clinical psychologists reflects the absence of clear career paths in the profession. It is therefore arguable that both the experience of professional-bureaucratic conflict. and that of role ambiguity in relation to professional designation, are examples of the "trouble" encountered by trainees that serves a useful function within their professional socialisation in preparing them for post-qualification reality as NHS employees. I will return to this issue in a broader discussion of the future of clinical psychology in 9.4 below.

### 9.2 ii.(b) Role Playing in Clinical Training: Use of Studentmanship, Partial Role Models, and Discounting of Negative Cues.

Based on their own study of professional socialisation, Bucher & Stelling (1977) deduced that the experience of *mastery* is essential if trainees are to develop a professional identity and commitment to their profession (see 7.1-7.2 above). They identified three types of mastery statements in the accounts of their respondents. One of these categories included statements of studentmanship: accounts of how to manage the training programme. In Chapter 7, I identified examples of studentmanship employed by clinical psychology trainees. In addition to overt instances, such as trainee-led changes in examination schedules or lobbying of Clinical Tutors over placements, I considered how trainees exercised studentmanship in their relationships with clinical supervisors. The other types of mastery statements identified by Bucher & Stelling were: 1) statements of mastery regarding acquisition of knowledge and skills; and 2) statements of "mood" describing feelings of confidence and competency in relation to the work undertaken by trainees.

Bucher & Stelling also concluded that acquisition of mastery depends on adequate opportunity for trainees to role-play. Indeed, referring to their own model of professional socialisation they identified role-playing as the most important of all the situational variables that influence professional socialisation. Mastery, they argued, develops from trainees' opportunities to evaluate their role performance and become self-validating rather than continuing to depend on supervisors for this reassurance and approval. Clinical psychology trainees do, in fact, have extensive opportunity to role-play during their clinical placements. Unlike Melia's (1987) student nurses, who had very limited autonomy and responsibility and therefore assumed a role on the wards that bore little resemblance to that of qualified nurses, clinical psychology trainees assume clinical responsibility and some degree of autonomy from the outset and these increase over the three years. As a result, clinical psychology trainees do generally report a growing sense of mastery as they progress through the course.

Even though the trainees said that they frequently felt anxious and confused about their clinical work, they reported considerable independence of thought and action from the beginning of first year. and this increased as they progressed through the course. If we compare these clinical psychology trainees with the psychiatry trainees studied by Light (1980), we find that the psychologists demonstrated more autonomy at an earlier stage of training. The psychiatrists, for example, typically began to recognise the importance of developing their own therapeutic style only after completing the first year and a half of training.

Trainees utilised their supervisors as *partial role models* in the same way as the assistant psychologists. However, the trainees described this selectivity as a more deliberate activity, involving comparisons between supervisors and reference to what they had been taught in the academic blocks. As we saw in 7.2 i-ii above, trainees deviated from what their supervisors' modelled or advised for a number of reasons. Sometimes they justified this on technical grounds: arguing, for example, that whatever was being modelled was not "best practice". On other occasions, they justified their own departures as a result of differences in personal style and we saw how trainees' accounts revealed an acceptance of different styles among their clinical supervisors. The ability of first year trainees to tolerate different models of expertise, even in their first clinical placement, may be a further indication of the anticipatory socialisation they experienced before starting the doctoral course. Individualism is highly valued within the ethos of the profession, and it is arguable that this is one of the norms internalised by psychology assistants. Alternatively, it may be that a process of self-selection takes independent, autonomous individuals into assistants' posts and those characteristics are then validated by the professional milieu. It is also arguable that the independence displayed by new trainees derives from the scepticism or agnosticism that the majority shared regarding their future profession (see 5.3 above). Thus, trainees begin by selectively modelling their own practice on specific aspects of their supervisors' behaviour and progress to an increasingly intentional development of personal therapy styles during second and third year.

In 7.2 ii, I also considered another aspect of trainee behaviour that supports the symbolic interactionist view of professional socialisation as a passage shaped by both trainers and trainees. In this study there was ample evidence that individuals challenged and sometimes ignored the instructions of clinical supervisors from their first placements onwards. Bucher & Stelling (1977) and Light (1980), among others, have previously reported the *discounting of negative cues* in trainee professionals. Bucher & Stelling conclude that the socialisation process does not promote attitudes and behaviours conducive to effective self-regulation by the professions. I will return to the issue of professional self-regulation in 9.4 below, when I discuss the future of clinical psychology in Britain.

In their relationships with their clinical supervisors, trainees were not only selective in what they took, but also in what they gave. They exercised studentmanship through impression management to "convince the faculty that they *were* becoming [professional persons]" (Olesen & Whittaker, 1968, p.150; italics in the original). While this behaviour is predictable within a symbolic interactionist model of training, an analysis of this impression management is nonetheless informative because it revealed what trainees believed to be both acceptable and unacceptable behaviour for clinical psychologists. These beliefs reveal the extent of their socialisation into the norms and values of the profession, and I will consider them in 9.2 ii.(c) below.

## 9.2 ii.(c) Conflicts and Constraints in the Relationship Between Trainees and Clinical Supervisors.

In this section I will focus on what is arguably the most important of the relationships between trainees and trainers because it deals with the substance of clinical work itself: the relationship between trainees and their clinical supervisors. I will begin this discussion by considering a hitherto implicit assumption within this study: that clinical supervision actually fulfils a useful function.

The recently published Handbook of Psychotherapy Supervision (Watkins, 1997) provides a comprehensive review of the field of psychotherapy supervision, covering a wide spectrum of psychotherapy models. Watkins introduces the text with this operational definition of supervision:

> An intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients she, he or they see(s), and serving as a gatekeeper for those who are to enter that particular profession. (Bernard & Goodyear, 1992, p.4; quoted in Watkins, 1997, p.4)

Thus, regardless of the therapy model being supervised, the clinical supervisor has responsibilities to the supervisee, to the supervisee's patients and to the profession. He/she meets these responsibilities by evaluating the supervisee's performance and ensuring that appropriate standards are maintained. Satisfactory supervision therefore protects the profession and the patient from ineffective/dangerous therapists while assisting practitioners to develop their skills.

Lambert & Ogles (1997), in the same volume, discuss how supervision enhances the professional functioning of supervisees. They identify the goals of supervision as skill development (improvement

of trainee interviewing skills, interpersonal skills and technical skills); and personal growth. They propose that personal growth incorporates numerous changes in cognition and affect: for example, the trainee becomes more confident and self-aware and resolves internal conflicts. These changes are self-evidently desirable for both the practitioner and the patient. However, the authors note that the evaluative role of the supervisor may conflict with his/her supportive, mentoring role.

Lambert & Ogles acknowledge that outcome studies are limited in the field of psychotherapy supervision. There are numerous rating scales of variable validity that assess trainees' observable skills, but achievement of personal growth through psychotherapy supervision has not been adequately researched. The authors also address the question of whether psychotherapy supervision makes therapy more effective. Reviewing the research in this area, they conclude that there is some evidence to link the two variables (Burlingame, Fuhriman, Paul & Ogles, 1989; Henry, Strupp, Butler, Schacht & Binder, 1993; Strupp, Butler & Rosser, 1988). Nevertheless, Lambert & Ogles advise that further investigation is required to clarify the relationship between specific components of psychotherapy training (teaching versus supervision) and patient outcome.

In conclusion, the evidence base demonstrating the efficacy of psychotherapy supervision in terms of outcome for both patient and trainee remains limited. In one sense, the goals of supervision are therefore largely aspirational. Yet the evaluative and monitoring function of supervisors have an ethical and, in some circumstances, a legal mandate, and are of paramount importance for the safe practice of psychotherapy.

The preceding discussion distinguishes several different functions of clinical supervision. The respondents in this study were primarily interested in being told and shown what to do with patients. The issue of support for personal growth is more complicated, as I shall now demonstrate. In Chapter 7, I presented data suggesting that shared defensiveness often results in sub-optimal utilisation of the relationship by both parties. This, in turn, undermines trainees' efforts to achieve mastery. I will argue here that this behaviour is best understood as a response by trainers and trainees to both situational and structural factors within the professional training context.

Reporting the outcome of informal discussions with clinical psychology trainees and supervisors, Pratt (1999) presents "a wish list of attributes and skills that trainees and supervisors would ideally like from each other". From the trainees' perspective:

> The ability to make clear and explicit theory-practice links is seen as extremely important. Trainees hope that supervisors will guide them in theory and formulating their clients' difficulties. In order to do this, it is essential that supervisors are clear about what theories they are drawing from and their own particular orientation. (Pratt, 1999, p.46)

Pratt observes that, despite the variation in theoretical models of supervision, there is general agreement about the essential elements. These include "giving feedback clearly, directly and constructively" (Pratt, 1999, p.46). McCrea & Milsom investigated how trainees on the Leicester University clinical psychology training course characterised "effective" supervision using the critical incident technique. They found that trainees did indeed value "detailed, clear and honest (yet supportive and encouraging) feedback", while non-specific assurances that "everything seems fine" were categorised as highly ineffective (McCrea & Milsom, 1996, p.36). Their findings indicate that failings in supervision are not unique to the University of Edinburgh/East of Scotland course being studied here. McCrea & Milsom report that the Leicester trainees rated slightly more than half of the critical incidents used to obtain a functional description of supervision as "ineffective".

The psychologists in the present study shared the expectations of Pratt's respondents regarding clinical supervision. However, as we saw in Chapter 7, these expectations were often not met. Trainees identified the following problems in supervision: lack of transparency about theory-practice links; insufficient observation of their practice by supervisors; and a lack of constructive criticism regarding their interventions. Some trainees hypothesised that supervisors experience anxiety at the prospect of conveying criticism to trainees, and I noted my own experience of hearing this anxiety expressed by colleagues.

There are a number of possible explanations for this behaviour. Menzies Lyth (1988), providing a psychodynamic interpretation of the anxiety experienced by nurses and the institutional mechanisms used to contain it, observes:

> In order to reduce anxiety about the continuous efficient performance of nursing tasks, nurses seek assurance that the nursing service is staffed with responsible, competent people. To a considerable extent, the hospital deals with this problem by an attempt to recruit and select 'staff' – that is, student nurses – who are already mature and responsible people. This is reflected in phrases like 'nurses are born, not made' or 'nursing is a vocation'. This amounts to a kind of idealization of the potential nursing recruit... As a corollary, the training system is mainly orientated to the communication of essential facts and techniques and pays minimal attention to teaching events orientated to personal maturation within the professional setting. (Menzies Lyth, 1988, p.61)

Her analysis is not entirely satisfactory if applied to clinical psychology training. There is no tradition in clinical psychology of promulgating the role of its practitioners as a vocation. In fact, since clinical psychology training courses emerged in Britain in the 1940's, the profession has been increasingly keen to emphasise that clinical psychologists are "made" through a process of rigorous training. This emphasis has been an important aspect of the profession's efforts to establish its legitimacy and promote its members as scientist practitioners capable of working independently alongside the medical profession. However, I think there is "a kind of idealization of the potential [clinical

psychology] recruit" and this is arguably one way that the profession defends against the anxiety produced by inherently stressful work and continuing lack of confidence about its own efficacy (see, for example, Moorey & Markham, 1998).

If we look beyond the psychodynamic interpretation offered by Menzies Lyth, it is possible to identify structural factors within the profession that contribute to this idealisation of trainees among qualified psychologists. First, it is encouraged by the over-subscription for training places and the subsequent opportunities for trainers to cherry-pick from a pool of highly qualified applicants. Secondly, many clinical supervisors are aware that their own formal training was far less extensive than that being completed by their trainees, and in some cases this undoubtedly contributes to their anxiety and reluctance to criticise trainees. A related issue, identified by Allen & Brazier, is "that many of our best and most committed supervisors feel desperately deprived of good-enough supervision for their own work" (Allen & Brazier, 1996, p.38). This in turn leads to further demoralisation by qualified psychologists and encourages individuals to devalue their own training and skills.[32] The ensuing idealisation of trainees not only has a negative impact on the supervisory relationship, but in conjunction with the scientist-practitioner model, contributes to the lack of emphasis on "teaching events orientated to personal maturation" in many, if not all, of the clinical psychology training courses in Britain. As noted above in 7.1, with reference to the trainees' initiative to establish a personal therapy/support group, the dearth of these events was noted and criticised by many of this study's respondents.

In addition to the negative impact of the above factors on clinical supervision, other obstacles arise because trainees are reluctant to disclose their difficulties in case they are negatively evaluated. Pratt reports that the supervisors whom she interviewed wanted trainees "to be clear about their needs" and claimed to "value openness and the ability to raise any difficulties as soon as possible" (Pratt, 1999, p.47). As we saw in 7.3 iii., feedback from trainees suggests that these expectations are unlikely to be met in many supervisory relationships.

The pervasive defensiveness among trainees and their general perception that it was not safe or acceptable to share their vulnerabilities with supervisors is a significant cause for concern because it is likely to impede their professional development. Walsh & Scaife put the case succinctly: "Whilst

[32] Allen & Brazier are reporting conditions in South Wales, but concerns among those qualified psychologists about lack of peer supervision are echoed in many departments throughout the country. In part this reflects the pressure on individuals in the under- resourced NHS to see patients to the exclusion of all other activities, and in part it is symptomatic of the profession's "delusion of omnipotence" discussed below.

personal growth is not a primary goal of training, it is an instrumental goal that works in the service of making the trainee a better clinical psychologist" (Walsh & Scaife, 1998, p.21). Furthermore, the BPS guidelines on clinical supervision (Committee on Training in Clinical Psychology [CTCP], 1991) specifically recommend that supervisors should facilitate discussion of relevant personal issues by trainees:

> Supervisors should be prepared to discuss seriously and sympathetically with the trainee any general issues of relationships with patients or staff that arise during clinical work. Supervisors should be sensitive to any personal issues that arise for the trainees in relation to clients and be prepared to discuss these in a supportive way when they are considered to affect the trainee's work. The range of personal issues that can be raised by clinical work is wide and includes, for example, over-involvement, dealing with anger and despair, workload and time management. (CTCP, 1991)

Despite this recommendation from the CTCP, the findings of the present study, together with anecdotal evidence obtained from recent graduates of other clinical psychology courses, suggest that this aspect of supervision is often neglected.

Trainees' defensiveness and wariness about disclosing their vulnerability could be explained in terms of individual (both trainee and supervisor) psychology and pathology and/or studentmanship. However, these explanations fail to consider the influence of professional mores on the behaviour of both trainees and supervisors. Mitchell, Coogan, Ormrod & Prescott (2000) observe:

> ...it is striking from our experience and from previous articles that have appeared in **Forum**[33] that psychologists often struggle to give themselves permission to engage in professional activity designed for their own support and professional development. (Mitchell *et al.*, 2000, p.19)

Mollon (1989), like Menzies Lyth, offers a psychodynamic explanation of this behaviour. He argues that the role of the British clinical psychologist evolved from that of psychometrician to therapist without adequate evolution in the profession's culture and training. He concludes that the profession's emphasis on cognitive and behaviour therapies makes it possible to:

> ...distance oneself from [the despairing person in pain], to apply a technique to him or her, to manipulate the person out of or into some behaviour, all these may contain elements of a manic defence against mental pain. Whenever this manic state of mind predominates the profession may be regarded as essentially fraudulent, based on illusion and mental trickery. (Mollon, 1989, p.9)

Mollon discusses the implications for clinical psychology training of "the delusion of omnipotence" that he believes is endemic within the profession. In discussion groups with newly qualified

[33] Clinical Psychology Forum: see footnote 29.

psychologists at the Tavistock Institute, Mollon learned that many of them felt they were being discouraged from expressing doubts or anxieties by their clinical supervisors. The probationers experienced "pressure to assume a stance of omnipotence and denial of doubt" and felt that they were also being discouraged from seeking personal therapy themselves, as though that would be an admission of inadequacy (Mollon, 1989, p.10). Mollon suggests that formalisation of clinical psychology training into a relatively brief post-graduate course[34] without an equally formal structure for continuing professional development after qualification both reflects and fosters these omnipotent attitudes. As someone who trained in psychoanalytic psychotherapy after he had completed his clinical psychology postgraduate degree, Mollon is advocating wider opportunities for "genuine growth and learning" (Mollon, 1989, p.11) within clinical psychology training to safeguard the profession, individually and collectively, from fraudulence, omnipotence and perversity.

Walsh & Cormack (1994) offer support for Mollon's central thesis but extend his analysis to consider in greater detail both organisational and professional barriers to British clinical psychologists seeking support at work. The authors investigated attitudes and practices of clinical psychologists regarding support at work. Only half of the 95 respondents in their study were in receipt of any form of support at work, and 63% of the cohort believed that their managers were ambivalent or antagonistic to the support-seeking behaviours of staff. These psychologists felt the need to justify support time, given the pressures of growing waiting lists and organisational changes in the NHS. "Legitimate" reasons for seeking support cited by respondents included: clinical dilemmas, political/management issues, information gathering and research, and dissatisfactions about pay and conditions of service. "Illegitimate" areas were identified as those focussing on personal difficulties relating to work. In justification for this reluctance, respondents articulated their belief that seeking support brought with it the "stigma of failure"; that work colleagues may be untrustworthy; and that acknowledging difficulty might threaten job security.

Walsh & Cormack concur with Mollon that prevailing values within the profession contribute to these attitudes. They suggest that the marginal position of clinical psychology in the NHS encourages "overcompensation" by its practitioners: "...the role psychologists occupy within the NHS has created a defended professional ethos in which personal needs are perceived as detracting from the current professional climate and are therefore devalued" (Walsh & Cormack, 1994, p.106). Their findings provide a context for understanding the defensiveness of trainees and supervisors in the present study, and remind us that many of these supervisors are under-supported themselves. The authors conclude:

[34] Since Mollon wrote his paper, virtually all of the clinical psychology training courses in Britain have changed from two to three years duration. However, I think his point remains valid.

> At the professional level, training courses need to monitor the messages that they provide clinical psychology trainees, concerning the nature of professional behaviours. We must ensure that we furnish these new professionals with the permission to acknowledge having support needs without guilt and fear. (Walsh & Cormack, 1994, p.109)

From the evidence of the present study, most trainees and new graduates still seem unable to grant themselves this permission.

One of the challenges for trainers in clinical psychology is, therefore, to assist trainees to identify their own support needs without confusing clinical supervision with therapy. In a small, exploratory study, Hirons & Velleman (1993) investigated attitudes of first year trainees towards clinical supervision and discovered that they rated "the trainee being talked to as if he or she were a client" as the factor most likely to block effective supervision. Richardson (1996) observes that trainees often feel relatively powerless in supervisory relationships, and concludes that trainers must assume responsibility for maintaining appropriate boundaries.

In summary, examination of the relationship between trainees and trainers reveals that trainees frequently feel under-supervised regarding their clinical work and believe they would benefit from more constructive criticism and clearer theory-practice links. The preceding discussion also identifies the influence of professional mores in shaping the behaviour of both trainees and their supervisors and in inhibiting both parties from expressing their vulnerabilities. This under-utilisation of the supervisory relationship is identified by trainees as an impediment to their development of clinical mastery. However, the implications are yet more far-reaching, since trainees are also being socialised into a model of supervision that they may adopt when they eventually become supervisors themselves.

Before leaving the subject of clinical supervision, I will consider an additional factor that makes satisfactory clinical supervision such a challenge for both participants. In the following section, I will argue that ambiguities within the knowledge base of clinical psychology can frustrate trainees in their pursuit of mastery and make it very difficult to achieve transparency in the supervisory process.

## 9.2 ii.(d) The Indeterminacy of Professional Knowledge: Training for Uncertainty?

During my analysis of trainees' accounts, it became increasingly apparent that one of the most influential factors in their professional socialisation had not appeared in Bucher & Stelling's (1977) model, namely: the nature of professional knowledge. Pilgrim (1997a) observes that recent intellectual trends within the academic discipline of psychology challenge the rhetoric of the scientist-practitioner. He cites the weak theoretical base of cognitive therapy, and the emergence of social constructionism as examples of rivals to the positivistic, empirical model of the applied scientist. Pilgrim notes that these approaches join the earlier threats to the traditional knowledge base of clinical psychology posed by psychoanalysis and phenomenology, and concludes:

> Given this turmoil, and the incommensurable discourses of experimentalism and deconstruction, it is likely that it will become more and more difficult for clinical psychologists to sustain a credible unified persona of the 'applied scientist.' (Pilgrim, 1997a, p.3)

Pilgrim's analysis suggests increasing diversity among the psychological therapies and thus implies increasing indeterminacy within the knowledge base of clinical psychology (see 2.6 iii.).

As noted in 2.6 iii. above, Macdonald (1995) has questioned the sustainability of an indeterminate knowledge base for any professional body "because they would have to acknowledge the primacy of scientific knowledge if they were to maintain their legitimacy in the modern world" (Macdonald, 1995, p.165). In 9.4 i. below, I will discuss how this quest for legitimacy is, indeed, apparent in clinical psychology's most recent reinterpretation of the scientist-practitioner paradigm: the evidence-based practitioner. I will also demonstrate that there is not universal support for this model within the profession (see Nieboer, Moss & Partridge, 2000; Orner, Avery & Stoltz, 2000; Zadik, 1999).

While some psychologists favour a move towards increasingly proscriptive treatment protocols to deliver evidence-based treatment, others continue to promote a more flexible response to individual patients. Although the latter group has been criticised by the former for valuing "mystery over mastery" (Gambril, 1990, cited in Long & Hollin, 1997, p.77), their support for the indeterminacy of professional knowledge is consistent with the rhetoric about Level Three skills used by the leadership to promote clinical psychology within the NHS. It is against this background of vigorous debate about the appropriate knowledge base for clinical practice that trainees try to learn their craft. However, it is arguable that they are more likely to experience the indeterminacy of their knowledge base as problematic than senior members of the profession, who may value the opportunities and mystery it confers.

From their accounts, it is evident that the relationship between theory and practice is not always clear to trainees (see 7.2 ii.). However, it would be unfair and misleading to present this finding as though it is simply attributable to sub-standard clinical supervision, given the lack of consensus within the profession about that relationship and the continuing support from many psychologists for the principle of indeterminacy. Instead, trainees' experiences of the "theory-practice dilemma" are further examples of "trouble" they will experience during their professional socialisation that is both unavoidable and potentially productive. Through confronting this dilemma, trainees may begin to form their own responses to the continuing debate within the profession concerning its knowledge base. I will return to that debate in 9.4 below.

In this section I have considered how lack of consensus within the profession regarding its knowledge base contributes to lack of transparency in the supervision of trainees. In the next section I will provide further context for the other finding presented above in 9.2 ii.(c) regarding trainees' experience of clinical supervision: namely, that trainees feel under-supported during training. The stress reported by respondents in the present study is not atypical among clinical psychology trainees, as two recent studies demonstrate.

### 9.2 ii. (e) Support Needs of Clinical Psychology Trainees.

The present study was not designed to investigate or quantify occupational stress. However, the trainees' reports of feeling emotionally drained by their work, and the issues that arose when trainees spoke of their relationships with clinical supervisors, necessitate a brief discussion of their occupational stress and support needs. There is little available research data on stress in clinical psychology trainees. Studies by Cushway (1992) and Kuyken (1997) that have investigated this area support the view that clinical psychology trainees feel under-supported by course staff and clinical supervisors.

Cushway (1992) surveyed all 377 individuals in training in U.K. postgraduate clinical psychology programmes. Based on a 76% response rate, she found that 59% of her sample met criteria for psychiatric caseness according to the General Health Questionnaire. This compares with other studies that reported 50% for junior house officers (Firth-Cozens, 1987); 30% for medical students (Firth, 1986) and 34-36% for executive civil servants (Jenkins, 1985). Cushway reminds her readers that GHQ caseness indicates "just significant clinical disturbance" and does not imply that intervention is necessarily required. She also notes that the GHQ may produce false positives among psychology

trainees "who are selected partly on the basis of their personal sensitivity to others" (Cushway, 1992, p.176). However, she acknowledges that a self-report stress scale showed that 75% of her sample were moderately or very stressed as a result of clinical training, and there was a moderate and significant correlation between the stress survey and GHQ scores.

Cushway describes increasing stress with number of years in training. She rank ordered stressors by percentage of trainees reporting each one as follows: poor supervision (37%); travelling (23%); deadlines (22%); lack of finance and moving house (19% each); separation from partner and academic work (17% each); uncertainty about own capabilities (16%); too much to do and changing placements (15% each). In terms of the unsatisfactory supervision, her respondents identified negative criticism and insufficient positive feedback as problems. A factor analysis of the stress questionnaire identified course structure and organisation as the largest contributor to the stress burden. The most frequent suggestion from respondents (60%) for alleviating stress was "more support by course organisers and supervisors" (Cushway, 1992, p.174).

Kuyken (1997) surveyed fifteen U.K. clinical psychology training courses and examined psychological adaptation of trainees at two time points one year apart. Based on a sample of 183 trainees (60.2% response rate), Kuyken found that significant numbers[35] of the trainees surveyed reported problems with self-esteem, work adjustment, depression and anxiety. Forty-two percent of male trainees and 13% of females scored above scale cutoffs for substance abuse. In line with Cushway, Kuyken found that "trainee clinical psychologists experienced increasing stress, work adjustment problems, depression, interpersonal conflict and decreasing positive feelings over the three years of their training" (Kuyken, 1997, p.4). Kuyken's study investigated trainees' methods of coping and found that, in addition to psychological strategies and social support, work adjustment was facilitated by "emotional support" from both clinical supervisors and the course as a whole.

The findings of Cushway (1992) and Kuyken (1997) are therefore consistent with those of the present study: the respondents whom I interviewed reported that the training process was stressful and that they frequently felt unsupported by both course staff and clinical supervisors. Furthermore, this investigation, like that of Cushway, highlighted the detrimental effect on trainees of unsatisfactory supervision. The present study also reports the stress of the initial transition to trainee status, and the transition to qualified status, which was not highlighted by the two earlier investigations.

[35] "Significant numbers of trainees" was defined by the author as 25% scoring at least one standard deviation above the standardisation mean on a World Health Organisation multidimensional assessment of psychological adaptation.

Cushway cites "speaking to other trainees" as the coping strategy most frequently employed by her respondents, and individuals in the present study also relied on each other for most of their support. Just as trainees found it difficult to discuss their vulnerabilities with clinical supervisors, many of them were reluctant to talk openly to anyone connected with the training course. The Edinburgh course has a Personal Tutor system that provides trainees with a list of clinical psychologists in the East of Scotland who have volunteered to take on a supportive role. Trainees can choose anyone from that list and are able to select a Tutor who will not be evaluating them at any stage. However, historically, the uptake is very low. Trainees generally believe that even consulting a Personal Tutor may be viewed as evidence of weakness: "...there's that stigma, you know, if you contacted your personal tutor, that's a bad sign" (C3:1). In fact, these relationships are confidential and the course staff would not be informed about such contacts, except in rare circumstances (for example, if a trainee appeared unfit for clinical work), and only then after discussion with the trainee. Unfortunately, assurances from course staff about the confidentiality of the Personal Tutor system appear to have little effect on trainees' reluctance to access this support. I will return to the subject of trainee stress and support needs in 9.5 below, when I discuss my recommendations for improving clinical psychology training.

### 9.2 ii.(f) Summary of the Professional Socialisation that Occurs During Clinical Training.

Perhaps the crudest outcome measure of professional socialisation is whether individuals defect during training or complete membership requirements. Only one person dropped out of clinical training from the study sample of 39. To date, the NHS has lost a further four qualified clinical psychologists from this group. One person who worked in social work settings before training as a clinical psychologist went straight into a social work position after she qualified. Two other individuals moved overseas after they qualified and began clinical psychology jobs there. Finally, one graduate decided to write a book (about clinical psychology) straight after completing the course and it is not yet clear if she will return to the NHS. It would compromise confidentiality to discuss these individual decisions in more detail since these people are readily identifiable to colleagues. However, it is obvious from this minimal account that the person who dropped out of training and the woman who returned to social work were influenced least by the process of professional socialisation and eventually rejected the role of clinical psychologist. In Chapter 7, we saw that the opposite case – that of the convert – was equally unusual. The vast majority of trainees occupied the middle ground

between the position of convert and defector, but identified sufficiently with their profession and their role to seek employment as clinical psychologists in the NHS once they completed the doctoral programme.

The preceding sections identify *lack of clarity* as the most salient feature of trainees' passage through the doctoral programme. Some of the contributory factors are structural, such as: (1) the organisation of the course that endows trainees with the dual student-trainee professional role and determines the feedback system that operates; (2) the lack of differentiation between trainees in terms of designation in line with BPS policy, reflecting the situation among qualified psychologists; (3) the lack of consensus in the profession regarding its knowledge base; and (4) the indeterminacy of that knowledge base. The first of these factors also produced role conflict that the trainees presented as professional-bureaucratic conflict. Situational/interactional variables that contribute to the lack of clarity are: (1) ineffective supervision and (2) trainees' impression management that interferes with frank discussion of their difficulties.

The above discussion also identified the *lack of support* experienced by the respondents in the present study as part of a wider problem within clinical psychology training. Both cultural and organisational (ie structural) factors were identified as contributors to this problem. In line with previous research on clinical training in Britain, the present study found that respondents experienced their passage through the doctoral programme as stressful. *Reality shock, identity confusion, disillusionment and anxiety* were commonly reported.

Despite these obstacles and constraints, it is evident that trainees are proactive in shaping their training experience through the use of *studentmanship.* As the course progressed, trainees developed an increasing sense of professional *mastery through roleplay in clinical situations.* Their *selective use of role models and discounting of negative cues* is consistent with the symbolic interactionist view of professional socialisation. The finding that they tend to rely most on each other to support themselves through training is also consistent with that view. This support is less readily available once they qualify, and its withdrawal contributes to the difficulty of the transition to post-qualification work: the subject of the next section.

## 9.3 The Transition to Qualified Status

In Chapter 8, I reported that respondents experienced the transition to qualified status as an *ascending status passage* and welcomed the increased autonomy. However, I also reported that the transition gave rise to *reality shock* for many individuals. It became evident during the analysis that the main contributors to these difficulties were the substantial increase of clinical workload and greater complexity of cases that greeted the new graduates. The demands of split posts and multi-disciplinary work, together with their lack of skill in protecting administration time from incursions by clinical work, added to the stress of these respondents. Finally, I identified *professional isolation* as a stressor that affected most interviewees.

*Clinical supervision* emerged as the single most important determinant of the new graduates' immediate post-qualification experience. This finding is consistent with other reports in the literature. Gelsthorp & Allen (1989) and Clare & Porter (2000) also found that new graduates rated supervision and support by colleagues as critical for negotiating this transition. On the basis of the findings in the present study it appears as though supervision should be offered to new graduates at least every two weeks, while weekly supervision is probably preferable. In Chapter 8, I also reported that new graduates benefited from the *opportunity to demonstrate mastery in domains other than clinical work*. In particular, teaching and supervision of individuals whom they perceived as less qualified than themselves boosted the confidence of these respondents. I will return to these issues in 9.5, when I examine the implications of the present study for future clinical psychology trainees.

In examining the accounts of new graduates, it became evident that their assessment of themselves as psychologists is largely synonymous with their evaluation of themselves as therapists. Certainly during the first eighteen months post-qualification, individuals were entirely preoccupied with the business of seeing patients and developing their clinical skills. There was virtually no research going on within the group. One of the criticisms of the scientist-practitioner paradigm is that adherence to the model may be an aspiration rather than a reality. Various studies in both the USA (for example, Barrom, Shadish & Montgomery, 1988) and Britain (for example, Agnew, Carson & Dankert, 1995) have demonstrated that clinical psychologists typically have low research involvement and productivity, and the respondents in this study appeared to be following suit. The absence of research activity was acknowledged by respondents with expressions of guilt or defiance, implying "I feel that as a scientist-practitioner I should be doing research", or "How can I be expected to do research as well as everything else?!" I will return to this point in 9.4 ii. (d) and 9.5, when I discuss the evolving role of clinical psychology in the NHS and suggest how training courses may respond to these changes.

In Chapter 2, I introduced the concept of *professional segmentation* (Bucher & Strauss, 1961). The new graduates gave a stronger sense of identifying with the clinical speciality (such as adult mental health or learning disabilities) they had joined in their first jobs than the profession as a whole. No one was active in any of the BPS sub-groups or committees and several individuals expressed concern that they were already "getting out of touch" with their profession and its concerns because of the pressure of clinical work. Indeed, for some individuals engaged in extensive multi-disciplinary work, more time was spent with members of other professions (for example: nurses, psychiatrists/other doctors, and occupational therapists) working in the same field than with psychologists.

Respondents also described another type of segmentation. Several of the third year trainees reported that they felt constrained by the cognitive-behaviour therapy model but lacked training in any other approach. New graduates coping with complex cases were even more aware of the need to be flexible in their approach, but also felt they lacked alternative models to apply. This form of professional segmentation characterises all the mental health professions: these psychologists were socialised into a particular therapeutic orientation and the same would be true for psychiatric trainees and other para-medical professionals who receive psychotherapy training.

In 2.5 above, I referred to the study by Vasco and colleagues (1993) that found that psychotherapists experienced *person-role conflict* when they trained in a therapeutic orientation that was incompatible with their world-view. I predicted that the clinical psychology trainees who contributed to this study would share this outcome. Instead, it became evident that during the doctoral programme most trainees are primarily preoccupied with assuming a professional identity and developing basic therapeutic skills. Some of them expressed dissatisfaction with the narrowness of their training, but the individuals who were most dissatisfied with their training related it to wider concerns, typically including professional-bureaucratic conflict and the constraints of the mental health professional's role within the NHS. The accounts of the new graduates, however, suggest that for some individuals person-role conflict resulting from a perceived mis-match between the therapy model they have learned and their own needs as therapists, as well as the needs of their clients, begins to emerge post-qualification. The most common response to this conflict was the decision by individuals to seek further training in other therapeutic approaches: psychodynamic or cognitive-analytic therapies were the most popular choices.

In summary, the transition to qualified status was experienced as stressful and difficult by the majority of respondents. *Professional isolation, increased workload, increased clinical responsibility, and greater complexity of cases* were the main contributory factors to these difficulties. The first two reflect structural/organisational factors, while the latter two factors are inevitable results of leaving

the trainee role, but can be mediated by good post-qualification clinical supervision. In this study, respondents generally reported that they had received *insufficient supervision* in their first post-qualification year.

At this stage in their professional socialisation, most new graduates assessed themselves as psychologists in terms of their performance as *therapists*, while research activity was virtually non-existent. Any sense of identification between respondents and the wider professional body was usually confined to the *segment* or clinical speciality they had joined. At the end of their first post-qualification year, about one-third of the group remained sceptical about clinical psychology's effectiveness and their professional identity thus seemed less robust than that of their peers.

As noted in Chapter 1, professional socialisation is neither synonymous with the professional training that leads to membership, nor complete by the end of the first post-qualification year. Instead, it is a continual process throughout one's professional life. In the next section I will consider some of the factors that are likely to influence this ongoing process for the cohort studied here, as I discuss the future of clinical psychology.

## 9.4 The Future of Clinical Psychology in Britain.

This study has examined the socialisation of three successive intakes of Scottish clinical psychology trainees during the mid 1990's, and I have argued that many aspects of their socialisation reflect wider issues within British clinical psychology. Before I examine the implications the findings of this study have for future clinical psychology trainees, it is therefore necessary to consider where the profession is heading and which issues are likely to influence the socialisation and working lives of those individuals. There are three such issues that I wish to consider: (1) the increasing emphasis on clinical protocols and evidence-based practice in the health professions; (2) self-regulation within clinical psychology; and (3) the role of clinical psychology within the changing NHS. I will deal with these issues in turn.

### 9.4 i. Clinical Protocols and Evidence-Based Practice.

In the current political and economic climate, clinical psychology, like the other health professions, is under greater pressure than ever before to demonstrate its efficacy. The implementation of Clinical Governance (Department of Health, 1998), Research and Development initiatives and Quality Assurance measures in the NHS signal the arrival of protocol and evidence-based practice (EBP). Lawton & Parker (1999) identify three reasons why clinical protocols are being promoted: risk management; facilitation of more rapid implementation of research findings; and standardisation of practice to produce more cost-effective and efficient health care. This trend towards increasing proceduralisation of health care is not confined to the NHS, but reflects the zeitgeist in other Western countries. In the USA, private health-care providers are increasingly demanding evidence-based practice guidelines and these determine which treatment packages they will cover. The American Psychological Association has recently published the findings of its task force, created to investigate "empirically supported treatments" for a range of psychological disorders (Dobson & Craig, 1998).

Within clinical psychology, the issue of clinical protocols has so far received less attention than that of EBP, and the response to EBP has been mixed. Certainly, it has aroused considerable debate, and a recent issue of Clinical Psychology Forum (November 1999) was devoted exclusively to the subject. In the editorial prefacing this issue, Derek Milne argues that the scientist-practitioner model is not inter-changeable with that of the evidence-based practitioner. He contrasts the evidence-based practitioner who "is more likely to be funded by the NHS to engage in collaborative research of direct relevance to local and national practice" with the traditional scientist-practitioner "struggling alone and heroically to draw on and contribute to research, which occasionally results in personal guidelines to improve practice" (Milne, 1999a, p.5). He acknowledges that it is too early to say if the NHS Research and Development initiatives will adequately support EBP. The tone of the article is, however, positive about the potential benefits of EBP and encourages the profession to "reconfigure" itself accordingly.

A letter in the same issue of Clinical Psychology Forum raises concerns that the government-led EBP initiative within the NHS may not be sufficiently flexible to accommodate other approaches to determining good practice. Zadik reports that he was unable to find information on EBP relevant to his clinical area (group support for carers of dementia sufferers) because the research needed to answer his questions has not been done. He lists the practical obstacles to doing research in this area and articulates the hope that representatives of the newly established National Institute for Clinical Excellence will "accept and disseminate a broader view of what is valid evidence" (Zadik, 1999, p.3). A similar objection to EBP is stated in a more recent issue of Clinical Psychology Forum:

> For all the disquiet it engenders. Forum's November 1999 themed issue on evidence-based practice is to be welcomed for giving voice to practitioners' perspectives in this important debate. It brings hopeful signs that the era of glib proclamations of professional virtue about evidence-based practice and prostletysing condescencion [sic] from "ideological elites" might be replaced with more sober and truthful assessments of the nature of clinical psychology practice... Our profession, and others too, should now recognize that just because fashionable terms like "evidence-based practice" and "scientist-practitioner" confer a measure of professional credibility (and sound good) they are typically not as relevant at the point of service delivery as political expediency might wish us to think. (Ørner, Avery & Stoltz, 2000, p.2)

The authors go on to make a case for a "more relevant evidence base" that looks beyond the elements of the therapeutic intervention and views outcome more holistically -- considering, for example, how therapy facilitates patients' use of personal and social support (Seligman, 1995).

Reservations about EBP are not confined to clinical psychologists. Several commentators have urged health professionals to consider the ethical issues surrounding evidence-based practice. Bracken & Thomas (2000), two British psychiatrists, argue that "cultural sensitivity" is receiving insufficient emphasis in the debate about clinical effectiveness. They ask whether health professionals determining practice guidelines know enough about their clients, or how to apply their knowledge with different ethnic groups. They question whose evidence is used as the basis for practice and how it is determined. As an example, Bracken & Thomas cite the use of the concept "schizophrenia" by predominantly white academic psychiatrists and psychologists to describe the experiences of black people in a manner that representatives of ethnic minorities have considered culturally insensitive and fundamentally unhelpful. As a further example, the authors comment that the considerable mental health problems of the Irish population in Britain have been overlooked in debates about ethnicity and health because the black-white dichotomy has dominated the debate. Thus, Bracken & Thomas propose that an ethical debate acknowledging the power relationships between health care providers and their clients, particularly those in ethnic minorities, should precede discussion of EBP and aim to provide those clients with a voice in that discussion. Otherwise, they caution, "'clinical effectiveness' will only serve to reinforce the perspective, and thus the power, of traditional psychiatry" (Bracken & Thomas, 2000, p.22).

Ethical concerns about EBP have also been expressed in the clinical psychology press. Niebor, Moss & Partridge address EBP as a social construction:

> As a phrase, "evidence-based practice" is an increasing part of the discourse of legitimacy that some of us well-armoured clinical psychologists can show to the world, and that some of us who feel more naked may fear or envy. (Niebor, Moss & Partridge, 2000, p.17)

Like Bracken & Thomas, these authors argue that EBP is a discourse of "power and restraint" as well as one of clinical rigour. They note that the "evidence" that is granted legitimacy in today's NHS

comes from nomothetic, meta-analytic reviews that assume comparability of research subjects. Niebor and colleagues propose that this discourse is privileged in the current political climate as a way of rationing health care while justifying it as a scientific decision, rather than a moral, economic or political one. They agree with Bracken & Thomas that the client may be ill-served by EBP based on data that assumes users are inter-changeable units, and suggest that an evidence-reflexive approach should inform the determination of best practice. In this model, user and practitioner collaborate to decide what works for whom within a particular cultural and interactional context. Their advocacy of greater user involvement in decision-making is, in fact, in keeping with policy promulgated by the present government (Department of Health, 1997a). May notes that over the past two decades, medical and paramedical discourses have begun to consider the patient "as more than the organic object of clinical attention" (1992a, p.589). The "expanding remit of the clinical gaze" that is implied by the developing subjectification of the patient (May, 1992a; 1993), requires clinical psychologists, as much as any other health professionals, to pay greater attention to the patient's experience and "engage with them as full human beings who have lives as well as symptoms" (Thomas & Bracken, 1999).

The above summary captures the intensity of the continuing debate within clinical psychology concerning its knowledge base and its methods. While its members have so far failed to reach consensus, the leadership of the BPS is responding to the Department of Health's clinical governance agenda by producing protocols for risk management through its Centre for Clinical Outcomes Research and Effectiveness (CORE). The Division of Clinical Psychology (DCP) has established a committee with a remit for clinical effectiveness (QUEST). Meanwhile, the DCP is currently producing review papers (for example, a review of psychological aspects of psychosis) and professional practice guidelines, beginning with documents on management of suspected child abuse, and management of challenging behaviour. Given the current political and economic climate, there is every likelihood that clinical psychology, together with the other health professions, will continue down this road towards increasing proceduralisation of its work and this has implications for the training of its members.

### 9.4 ii. Self-Regulation in Clinical Psychology.

Pilgrim (1999a) observes that the current British government is challenging the health professions to improve self-regulation, reflecting public concern that existing mechanisms are inadequate. Under the auspices of clinical governance, the Department of Health is demanding that the professions monitor

themselves to ensure good practice and is requiring them to be "open, responsive and publicly accountable" (Department of Health, 1997b, para. 7.15). One aspect of self-regulation is the implementation of mechanisms to ensure good practice, and I have reviewed developments in this area in the preceding section. In the following section, I will consider three further issues within the domain of self-regulation that are topical for British clinical psychologists and have obvious implications for professional socialisation: (1) the development of guidelines for the employment of assistant psychologists; (2) voluntary/statutory registration of clinical psychologists and the profession's relationship with the public; and (3) registration of psychotherapists. I will take each of these matters in turn, and begin with recent efforts by the profession to improve working conditions for psychology assistants. While the registration issues involve an inter-play between forces within and external to the profession, development of employment guidelines for assistants is an example of the profession making efforts to put its house in order in the absence of external pressure.

9.4 ii. (a) Development of Guidelines for the Employment of Assistant Psychologists.

The Division of Clinical Psychology published official guidelines for the employment of assistants in January 1998. If implemented properly, these will prevent the abuses of this group documented in the present study and others (for example, Rezin & Tucker, 1998; Taylor, 1999). The guidelines stipulate that assistant psychologists must be professionally accountable to and receive supervision from a qualified clinical psychologist. They also define appropriate roles for assistants: they should not substitute for qualified clinicians; substitute for clerical or care assistants; work in the absence of "highly competent supervision"; or take on inappropriately complex clinical tasks. Assistants should be given a written induction pack and a minimum of a fortnight's induction period, followed by a staged introduction to the work. Finally, the guidelines provide for a minimum of a half-day per week for private study and a minimum of an hour's supervision per week, with detailed recommendations for the content of supervision (Division of Clinical Psychology, 1998).

Miller & Wilson (1998), writing about the plight of assistants six months after the guidelines were introduced, agree that this group has often been exploited. They argue that the profession makes poor use of assistants' potential to contribute to psychology services that are now increasingly based on a skill-mix approach. The authors identify the DCP guidelines as the necessary first step in improving this situation, but urge that additional measures need to be taken. Their suggestions include: development of minimum training standards for assistants; extension of pay scales to overlap with those of trainees; access by assistants to some of the academic modules on the doctoral training

courses; and clearer guidelines from the doctoral courses concerning how selectors assess "clinically relevant experience".

The extension of professional training in clinical psychology that saw Masters courses give way to doctoral programmes over the last decade is, therefore, continuing. Now the focus is on future applicants for clinical training, with potential for the present arrangement of two tiers of non-qualified psychologists – assistants and trainees – to become three or even more. The Mancunian Community Health (NHS) Trust established a new position in 1998: that of associate psychologist (Burton & Adcock, 1998). The post represented an intermediate step between assistant and trainee grade and required a specified level of experience. This may remain an anomalous situation, but with the shortfall between qualified clinical psychologists and available NHS posts, other Trusts may follow suit.

9.4 ii. (b) Statutory Registration of Clinical Psychologists.

The dialogue continues within clinical psychology about how self-regulation might best be achieved and, in particular, whether statutory registration (see 9.2 ii.[a]) would provide the public with better protection against incompetent or abusive therapists (Marzillier, 1999a; Pilgrim, 1999a; Pilgrim, 1999b). The recent case of Peter Slade, who was found guilty of sexually exploiting female patients, has provoked acrimonious debate. Slade, who admitted to these breaches of the profession's Code of Conduct, was allowed by the Disciplinary Committee of the BPS to retain membership and Fellowship of the Society, having undertaken to cease clinical practice (British Psychological Society, 1998). The ruling was unacceptable to many members, including the elected office bearers in the Division of Clinical Psychology, who petitioned for expulsion of the offender. In instances like this, it is not just a question of the public lacking confidence in professional self-regulation, but also a matter of professionals sharing this doubt.

Pilgrim (1999b) argues that there is insufficient evidence to support the position of those, like Marzillier, who contend that statutory registration of psychologists would effectively protect the public. He notes that the

> ...well-tested mature professions of medicine and law are now the focus of consumer disaffection, in part, because their long-established regulatory mechanisms can, and do, lead to the same infuriating sense of unfair leniency witnessed in the Slade case (Pilgrim, 1999b, p.2).

Pilgrim indicates that he has more faith in client empowerment than legislation to ensure adequate professional accountability. Public concern about self-regulation within the health professions continues to be fuelled by high profile cases, such as that of Harold Shipman: the GP convicted of murdering his patients. The recent vote of no confidence in the General Medical Council by members of the British Medical Association suggests that public concern is shared by a significant number of doctors. Within the mental health professions, allegations of therapists creating false memories of childhood sexual abuse and sexual abuse of patients by therapists (Garrett & Davis, 1994) have been the focus of public and media concern.

The issue of client empowerment now appears impossible for the health professions to resist. Not only is the user movement, robust for many years in the United States, now developing rapidly in Britain, but the requirement for professionals to seek user involvement in the development of services is enshrined in various White Papers (for example, Department of Health, 1997a). Thus, by choice or necessity, clinical psychologists will have to be increasingly responsive to the users of their services. In fact, there are indications that the relationship is already being reviewed in some quarters. Long, Newnes & Maclachlan (2000) have published an account of selection interviews for five psychology posts where a service user was included in the selection panel. Gopfert & Mahoney (2000) describe a participative research project with service users designed to produce recommendations to improve those services.

### 9.4 ii. (c) Registration of Psychotherapists.

In addition to the debate about whether or not statutory registration should be required for clinical psychologists, a parallel debate continues concerning registration of psychotherapists in Britain. An attempt to regulate the practice of psychotherapy in Britain led to the establishment of the United Kingdom Council of Psychotherapy (UKCP) as a credential-awarding body. Divisions between the different branches of psychotherapy resulted in splinter groups establishing their own registers. Thus, clinical psychologists who complete post-qualification specialist training in psychodynamic therapy may seek registration with the Confederation of British Psychotherapists, while the vast majority of clinical psychologists (who practice cognitive-behaviour therapy) can now pursue registration with the Behavioural and Cognitive Psychotherapy Section of the UKCP, or the British Association of Behavioural and Cognitive Psychotherapies (BABCP).

At the moment, registration of psychotherapists is proceeding on a voluntary basis in the same way as the registration of clinical psychologists. However, the Alderdyce Bill is expected to be considered by the House of Lords in the next session (Autumn, 2000). The Bill proposes that a new body, the General Psychotherapy Council (equivalent to the General Medical Council) will provide statutory registration for psychotherapists of all schools. Whether or not this umbrella group will incorporate sub-groups covering the different schools remains to be decided.

In a struggle for hegemony, the BPS has sought an "opt out" clause allowing psychologists practising psychotherapy to be regulated by itself rather than the GPC. However, the BPS Standing Committee on Psychotherapies is proposing that registration of Chartered Psychologists Specialising in Psychotherapy will be optional. It is not yet clear whether the Royal College of Psychiatrists will pursue a similar opt out and thus further weaken the regulatory function of the GPC (BABCP, 1999).

The professionalisation of psychotherapy (Pilgrim, 1997b) is, therefore, proceeding and so far appears to be formalising the pre-existing segmentation of this occupational group. Clinical psychologists belonging to one of these psychotherapy schools may experience a stronger sense of professional identity through that membership than they do as clinical psychologists (Mollon, 1989). However, it is noteworthy that while some clinical psychologists are keen to pursue registration with one of these psychotherapy credentialling bodies, others are resistant to what they perceive as an attempt by outside bodies to undermine the status of their professional qualification.

The role of psychotherapist is, of course, only one of those available to clinical psychologists and practitioners vary in how central they consider it to be. I will turn to that question in the next section when I discuss possible future directions for the profession.

### 9.4 iii. The Role of Clinical Psychology Within the NHS.

Under the current Labour Government the NHS is once again being re-structured. The internal market mechanisms established by the Conservative Government are being dismantled and the emphasis is moving away from secondary care towards a primary care led service. This represents both pluses and minuses for clinical psychology. In primary or community care settings there are greater opportunities for psychologists to work more autonomously than was possible in some of the more traditional psychiatric settings where psychologists struggled under medical dominance (Gelsthorpe, 1999). At the same time, clinical psychologists working in primary and community care are more likely to experience professional isolation (see 8.2 ii.).

With the movement away from secondary care, clinical psychologists in Scotland are typically working less closely with psychiatrists and more closely with a range of other health care professionals than ever before. Pilgrim (1997a) notes that the regular meetings between the BPS and the Royal College of Psychiatrists (RCP) during the 1980's stopped during the 1990's when the RCP sought meetings with the BPS together with the other 'professions allied to medicine' and the BPS objected to the new arrangement. Thus, at both grass roots and leadership levels, the two professions continue to disengage. This process of clinical psychology establishing its disciplinary mandate will be both facilitated and signalled by its increasing reliance on psychological models of distress in place of psychiatric diagnostic categories (Pilgrim, 1997a).

Against the background of these structural changes in the NHS, clinical psychology continues to debate its central task. The role of the clinical psychologist as researcher remains equivocal. Despite the government-led EBP movement in the NHS, there are not yet direct incentives for clinical psychologists to engage in research (in terms of pay or promotion), or penalties for avoiding it (such as those now levied against academics through the Research Assessment Exercise). As demand continues to out-strip supply, some psychologists keenly support an increased consultancy role for members of the profession, arguing that this is more cost-effective than individual work with patients (Milne, 1999b; Øvretveit, Brunning & Huffington, 1992). Others are reluctant to pursue that option and instead attach most value to their role as therapists. Meanwhile, a third camp is emerging to promote "community clinical psychology", with the aim of helping people:

1. Understand the connection between the social and economic reality of their lives and their states of health and well-being.
2. Join with others with similar realities to give voice to this understanding.
3. Engage in collective action to change these realities. (Orford, 1998, p.10)

Advocates of community psychology express dissatisfaction with clinical psychology's emphasis on "fixing people" (Orford, 1998, p.7) and instead prioritise preventative work and the empowerment of hitherto disadvantaged groups in society (Clinical Psychology Forum, 122, 1998). In all likelihood this pluralism within the profession will continue, given that the same divergence is evident within the USA (Humphreys, 1996) and the profession has historically trodden a similar path on both sides of the Atlantic. If this prediction is correct, resolution of the role conflict already evident in the professional socialisation of clinical psychologists appears remote.

In the next section I will make some recommendations for improving the training of clinical psychologists in Britain in view of the continuing debate surrounding the profession's knowledge base, the credentials of its members and their evolving role within the NHS. In formulating these recommendations I am once more adopting the trainer's perspective that I assumed mid-way through

this project (see 7.5) and held while developing the Professional Issues workshops for trainees, described in 7.4 i. When I began this study, I did not envisage recommendations for training as one of the outcomes. However, the period I spent as a lecturer increased my understanding of the challenges faced by trainers within the changing professional context described above. It also gave me the opportunity to test out (in a very preliminary way) how a training programme can be developed to address some of the challenges identified in this study that are faced by trainees. While this project is a study of professional socialisation, not professional training, I have nevertheless focussed on the period of formal professional training in my investigation of this process for the reasons identified in 1.2 above. I have gained some insight into what facilitates/hinders individuals' experience of professional mastery during training and, since opportunities to experience mastery are essential to the development of a secure professional identity (Bucher & Stelling, 1977), the following recommendations are intended to maximise those opportunities.

## 9.5 Recommendations for the Training of Clinical Psychologists.

The starting point for this piece of research was my question about how clinical psychology trainees acquire a professional identity. The recommendations in this section follow from that question and the study's findings: it is beyond the scope of this discussion to consider all aspects of clinical psychology training. It must also be acknowledged that the suggestions below may already have been implemented to varying degrees in some clinical training courses in Britain. I will cite known examples to illustrate the way forward.

From the above discussion of the future of clinical psychology it seems reasonable to assume: (1) the profession will continue to divest itself of medical dominance; (2) economic and political forces will continue to steer the health professions towards clinical protocols and EBP; (3) statutory registration of chartered psychologists and registration of psychotherapists will lead to further standardisation of training; (4) the growing power of the user movement will demand increasing accountability from all professions, including clinical psychology, as well as increased responsiveness to the varied needs of individual consumers; and (5) clinical psychology will continue to be a very broad church and an increasingly segmented profession. The latter point is inescapable: not only does clinical psychology have a tradition of eclecticism that has been reinforced by postmodernism, but the external factors it is responding to are pulling in different directions. Consumers' expectations of holistic, individualised treatment from practitioners counter the push towards standardisation of practice, while the continuing disputes between accreditation bodies means that post-qualification registration

of clinical psychologists as psychotherapists will reinforce divisions between the segments. The suggestions below attempt to respond to these competing demands.

One conclusion to be drawn from the present study is that the *scientist-practitioner* model, which dominated the training of these respondents and still dominates the rhetoric of the profession, is insufficiently flexible to guide the practice of clinical psychologists. The University of Edinburgh/East of Scotland course, together with some of the other British clinical psychology courses, has recently included mention of the *reflective practitioner model* (Schon, 1983) in its course description. However, on the basis of this study's findings, this model appears to be under-utilised by course staff, clinical supervisors and trainees. As noted in 2.6 iii. above, reflective practice undertaken by experts should be acknowledged as a legitimate source of knowledge and a paradigm for both generating and testing theory (Cox, 1995; Hoshmand & Polkinghorne, 1992; Schon, 1983).

How can clinical training foster more reflective practice and receptivity to patient's needs? Schon (1983) advocates "repertoire building": practitioners accumulate and describe illustrative cases that demonstrate skilled reflective enquiry, from the initial formulation through revisions to outcome. The case reports that trainees on the Edinburgh course currently produce provide an opportunity for this reflective enquiry, but the task is not currently framed in a way that reliably produces this response. Furthermore, the feedback from the staff who assess the reports is likely to emphasise a range of issues that may obscure this objective. The clinical outcome or chosen intervention may, for example, receive more emphasis than the reflective process. Clinical supervision and teaching workshops are other opportunities for repertoire building.

A further prerequisite for reflective practice is *adequate self-awareness by the practitioner* in relation to their work. Teaching workshops, appropriate support systems, and sensitive but rigorous clinical supervision can all assist trainees towards this self-awareness (and encourage them to continue this work post-qualification). I will discuss these approaches briefly in turn.

A co-ordinated series of teaching workshops spanning the three year doctoral course, such as those I am developing through this research (see 7.4 i. above), could provide an opportunity to normalise individuals' experiences and deal with difficulties and dilemmas as they arise. Commentators have noted that clinical training pays insufficient attention to the way that personal/religious values and life experience affect clinical work (Myers & Baker, 1998; Nichols, Cormack & Walsh, 1992; Richardson, 1996) and some of these issues may be appropriately addressed in a teaching situation without infringing boundaries. Other observers have expressed dismay at the cursory attention paid to the teaching of ethics on most clinical psychology courses (Gale, 1997; Lindsay, 1996; Marzillier, 1999b; Reid & Fawcett, 2000; Wheeler, 1998). Marzillier (1999b) argues that all too often the

teaching of ethics is confined to introducing trainees to the BPS Code of Conduct and some discussion of "professional responsibilities". There is a clear need to develop this aspect of the teaching input in clinical training to cover in greater detail the ethical issues arising from everyday clinical situations.

Self-awareness in clinicians also involves learning to identify personal strengths and vulnerabilities, and responding appropriately to the latter. In the course of this study, I have examined some of the difficulties that interfere with trainees seeking support during training (see 6.3; 7.2 ii.; and 9.2 ii.[e] above). In particular, I have highlighted the difficulty it produces for trainees when staff have both support and evaluative functions. Allen, Austin, Palmer & Street (1994) describe a system adopted by the South Wales Training Course that seems to have many strengths and could go some way towards addressing such problems. The course invites clinical psychologists who are interested in the training experience to be "developmental tutors" or "professional mentors". Each tutor must meet his/her trainee four times a year with the aim of providing

> ...an opportunity for the trainee to review the whole process of training, and to encourage the trainee to think about the development of strengths, interests, and a personal style of practice. Additionally, the tutor is there to help the trainee to resolve difficulties which interfere with training. (Allen *et al.*, 1994, p.19)

The tutors also meet occasionally as a group to review the issues arising from this work.

A developmental model emerged from these reviews that showed trainees tackling tasks within five overlapping stages. I discussed the stages of "joining" and being "deskilled" in 9.2 i. above. A third task, "identifying a model", effectively describes the development of studentmanship and trainees' choice of a path through clinical training that fitted their skills and personal style. A fourth task, "self-evaluation", resembles Bucher & Stelling's concept of professional mastery, while the final stage ("individuation") involves "identifying oneself as a clinical psychologist". The developmental tutor system, as described by these authors, therefore appears to have tapped into core constructs within the training experience. Allen *et al.* report that all trainees who participated in the scheme thought it should be continued with future intakes and it seems worth introducing in other courses.

A major theme in the present study concerned *clinical supervision*: for assistants, trainees, and qualified staff. I have considered expected improvements in clinical supervision for assistants in 9.4 ii.(a) above, and the findings in this study suggest that clinical supervision of new graduates should be offered at least fortnightly, while weekly supervision is preferable (see 9.3). In terms of clinical supervision for trainees, trainers continue to be exercised by shortcomings in existing practices while recognising the competing demands on NHS supervisors. At the Group of Trainers in Clinical Psychology (GTiCP) meeting in November 1999, supervisor training was very much a focus of

concern and suggestions were made that experienced supervisors need to be actively encouraged to assist the course staff in training those who are less experienced.

In response to these concerns, some courses including the one studied here, are developing training workshops for supervisors. Allen & Brazier (1996), describing workshops for supervisors on the South Wales course, report the value of exercises wherein supervisors take turns to give, receive and observe supervision. This approach facilitates reflection on the supervisory process. Hitchin, Gurney-Smith & King (1997) describe another innovative approach. First, second and third year trainees on the Oxford clinical psychology training course ran a workshop for supervisors using the critical incident approach described by McCrea & Milsom (1996): see 9.2 ii.(c) above. All current trainees and supervisors who attended the workshop were asked to provide critical incidents relating to both effective and ineffective supervision. The feedback from both groups was discussed and compared, and workshop participants then carried out some role-plays of problematic supervision situations for experiential understanding of these dilemmas. Both trainees and supervisors reported that the workshop was useful in deepening their understanding of the supervisory process.

The principle of *trainee-directed workshops* for staff on supervision or other professional issues is to be commended as a means of empowering trainees and encouraging them to reflect on their work and professional role. At the November 1999 GTiCP meeting, other pilot schemes designed to teach trainees skills that will enable them to shape supervision more effectively were discussed. The Edinburgh course, presumably like many others, has increased the opportunity for self-directed learning over the past five years, but trainee-led initiatives are a further step in the right direction.

In conjunction with these measures to enhance the quality of clinical supervision, trainers are discussing technical issues such as the use of audiotapes and videotapes as the basis for supervision. Use of these aids is variable at the moment and growing numbers of trainers are urging that this becomes routine. With the move towards psychotherapist registration, training and supervision requirements will become more rigorous and quality of supervision will be scrutinised more closely. Trainees may well begin to collect documentation of psychotherapy training while they are completing doctoral programmes and will have to satisfy standardised requirements regarding number of cases and the supervisory and teaching process. The other implication of psychotherapy registration is that the supervisors themselves will have to satisfy training requirements in both therapy and supervision skills.

Debates regarding *feedback and assessment mechanisms* used by courses also continue to occupy the GTiCP. The lack of clarity in the training passage described by the respondents in the present study appears to be a common experience and a number of courses, including the Edinburgh course, are

reviewing their procedures. In particular, evaluation of clinical competency is under discussion by the Committee on Training in Clinical Psychology. The Edinburgh course is currently assessing a new evaluation form which, it is hoped, will more accurately reflect the core competencies that trainees need to master in relation to their clinical work.

The issue of *research requirements* for clinical trainees deserves comment. The present study found that trainees generally viewed their third year dissertation as an unwelcome distraction from their clinical work, and new graduates were not engaged in research activity. All the clinical courses that select applicants through the Clearing House require research dissertations, but some assess constituent elements (for example, the literature review) separately before third year to help trainees pace their work more evenly. A number of courses also require that the research write-up conform to a journal format rather than a traditional dissertation to improve the chances of trainees submitting their work for publication. These changes are sensible, but it seems preferable to make the mandatory research exercise a critique of existing publications since the ability to evaluate existing evidence is essential in determining good practice. In view of the low research productivity in clinical psychology it is arguable that other research activity should be elective within clinical training. Options could include the traditional dissertation for those who are interested and a collection of small, service-based projects for others.

While some courses have a strong tradition of qualitative research teaching others, like the Edinburgh course, are largely quantitative in orientation. It is to be hoped that qualitative method will continue to influence clinical training, since it facilitates our understanding of patients' phenomenological experience in a manner that quantitative methods do not. As a further development, clinical courses could usefully train individuals in action research, given the government mandate (Department of Health, 1997a) that health professions actively involve the consumer in decisions about services. Indeed, there is scope for further *involvement of users* in clinical training. Some of the most valued teaching sessions on the Edinburgh course are those led by users of mental health services.

It is, perhaps, implicit in the above discussion that clinical psychology training will continue to be a joint NHS-university enterprise. This may not be the case. McPherson (1998) has estimated that it costs the NHS approximately £250,000 to train a clinical psychologist over three years under the present arrangement. Cost alone may drive NHS managers to consider changes. One possible alternative is that clinical psychology will go full circle and eventually return to the situation where the BPS awards professional membership and the university degree, as for psychiatrists, is the research-based optional extra.

Another fundamental shift that we may eventually witness in clinical psychology training is a move away from the generic model we follow at present towards a more specialised approach. As social and political trends increase the demand for professional accountability and clinical psychology heads towards increasing segmentation, the broadness of a generic training may begin to seem less useful than an opportunity to develop more sophisticated skills in fewer clinical areas. If this occurs, the existing pluralism within the profession (Pilgrim, 1997a) will be further accentuated and the process of professional socialisation may be characterised by increasing identification with one's speciality, or segment, at the expense of identification with the profession as a whole.

## 9.6 Concluding Remarks.

This study of the professional socialisation of British clinical psychologists has attempted to situate the accounts of participants within their social and historical context in order to illuminate the structural and situational factors that shaped their experience. The symbolic interactionist framework has proved satisfactory for the task and the qualitative method has allowed me to explore this subject in a manner that would not have been possible using quantitative measures.

The amended design necessitated by my move from the NHS to the university during the study has both strengths and weaknesses. The entirely longitudinal design that I originally devised (see 3.3) would have allowed me to adopt a biographical approach and follow individuals through each stage of professional socialisation from clinical training applicant to new graduate. This would have allowed me to draw further conclusions about how each individual is shaped by the training process. The amended design provided only limited longitudinal data, together with cross-sectional data, and thus lent itself to cross-case analysis. The benefit of this approach, and the increased sample size, is greater breadth of analysis.

The other great benefit, and challenge, of the amended design was that my stint as a lecturer allowed me to study the system from the trainers' perspective as well as that of the trainees. My changing viewpoint created difficulties at times (see 7.5), but produced insights about the process of professional socialisation that would otherwise have been unachievable. In a very real sense my move from outsider, to insider, and back again, facilitated a process of triangulation that I believe adds credibility to this research. Furthermore, this insider status has enabled me to take the study one step beyond a purely descriptive analysis, to consider the practical implications for future training and supervision in clinical psychology.

The experience of conducting my first piece of qualitative research has been a revelation to me. It has allowed me to capture the richness of the data in this analysis: to consider anomalies and contradictions as well as generalities. As in clinical work, the material I have gathered has often seemed untidy and frequently overwhelming, but distinctive themes nevertheless emerged and I have tried to show how these link individual accounts.

As I hoped (see 3.1), the qualitative method has allowed me to engage with these research participants collaboratively and transparently. Judging by the feedback I received from participants (see 5.1), the experience of being interviewed for the study was useful in assisting them to reflect on the processes we were discussing and, at times, served a valuable de-briefing function. Through the intervention piloted in the study, I tried to contribute to the empowerment of these individuals as they developed their professional identity.

The next step in this project on the professional socialisation of clinical psychologists is to develop the Professional Issues module for the training course, and evaluate it. I also intend to feed the findings in Chapter 5 into the continuing debate on employment guidelines for assistant psychologists. Likewise, the data in Chapter 8 regarding the difficult transition to qualified status will be fed back locally and nationally in the hope that departments will, where necessary, develop supervisory and support arrangements for new graduates. On a personal level, these findings will inform my practice as a clinical supervisor of future trainees.

In conclusion, this study has examined the first stage in the professional socialisation of these clinical psychology trainees. This process will continue throughout their professional lives and they will continue to shape this passage themselves, while responding to changes within their own profession, within the structure and ethos of the NHS, and within society itself.

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## APPENDIX A

## PROFESSIONAL SOCIALISATION IN CLINICAL PSYCHOLOGY TRAINEES: INFORMATION FOR RESEARCH PARTICIPANTS

Dear

I completed the Edinburgh University clinical psychology training course 2 years ago and have since spent much time mulling over the experience! As a result, you are now invited to take part in my PhD research on the experience of clinical psychology trainees as they acquire their professional role. I am hoping to include all the trainees in your year on the Edinburgh course. I would like to follow all of you through your three years of training, to see how your view of yourself and the profession evolves.

The research model which I am using is a qualitative one. Within this model, I consider you a potential co-researcher and will share my objectives and interpretations with you as we proceed, rather than trying to keep you "blind" to my hypotheses.

Participation in the study will involve interview sessions at the beginning and early summer of each year of the course. A few weeks after each of these sessions, I will arrange to meet with you to discuss my thoughts about the interviews, and check my interpretations with you. In total, this means a maximum of 6 hours per year spread over 4 meetings. These meetings can be scheduled for a time and place which suits you.

I intend to rely primarily on our discussions but may also suggest we construct a repertory grid relating to the concepts we are discussing, or include some other measure of self-concept. There are no clinical measures: I am not investigating stress or illness.

I would like to audio-tape our discussions to ensure accurate recall. These will then be transcribed and the tapes erased. Transcripts and any other information relating to our discussions will be coded to ensure anonymity. Information disclosed will be treated as strictly confidential. Personal details which might identify you will be omitted when the project is written up.

I very much hope you will take part in the study, as I think it will be interesting for all of us and may highlight ways in which the training course can be improved. However, your participation is entirely voluntary and is not a requirement of the course.

The study has been approved by both the Advisory Committee on the Use of Student Volunteers for Experimental Work and the course staff. It id being supervised by two clinical psychologists: Dr David Pilgrim and Professor Richard Bentall at the University of Liverpool.

I will be happy to discuss the study further with you and can be reached at 01382 580441 extn. 4754, or contacted via Debbie Lawson, the course administrator. If you would like to participate, please sign and return the enclosed consent form, and I will then be in touch to arrange a meeting.

Yours sincerely

Katherine E. Cheshire
Chartered Clinical Psychologist

## APPENDIX B

## RESEARCH PARTICIPANTS' CONSENT FORM

**Title of Study:** **Professional Socialisation in Clinical Psychology Trainees**

**Researcher:** **Katherine Cheshire**
**Tel. 01382 580441 x 4754**

I agree to participate in this research study, described in the attached letter. I understand the nature and purpose of the study and am participating voluntarily. I understand that participation is not a training requirement, and non-participation will not adversely affect my evaluation by course staff.

I grant permission for the data to be used in the process of completing a PhD dissertation, and possible publications. I understand that my name and any demographic information which might identify me will not be disclosed.

---------- Research Participant

---------- Researcher

---------- Date

## APPENDIX C

## QUESTIONNAIRE FOR FOCUS GROUP TO ASSIST DEVELOPMENT OF SEMI-STRUCTURED INTERVIEW SCHEDULE

1. Did the course emphasise a particular theoretical orientation/therapeutic approach?

Yes / No (circle one) If "No", skip to Q.7

2. If "Yes", which one? (tick one)

Person centred/Rogerian
Psychodynamic
Cognitive/Behavioural
Systems/Family
Other ( please specify)

3. Did you know that this was the predominant theoretical orientation of the course before you started the course?

Yes / No (circle one)

If "Yes", how did you find out about this?

4. If you answered "Yes" to Q.3, was this an important reason for applying to the Edinburgh course?

Yes / No (circle one)

If "Yes", what influenced you to favour this therapeutic approach?

5. Were other theoretical orientations also presented during the course? (tick those that apply)

No other orientations presented
Person centred/Rogerian
Psychodynamic
Cognitive/Behavioural
Systems/Family
Other ( please specify)

6. If alternatives to the predominant bias of the course were presented (tick all that apply)

a) Did you value this as an opportunity to evaluate other approaches to psychological treatment?
b) Find it confusing because the different approaches are based on different premises about the genesis of psychological problems and treatment goals?
c) Find that you were able to synthesize the different approaches into a coherent view of psychological disturbance?
d) Find yourself unable to integrate the different theoretical orientations into a coherent view of psychological disturbance?

7. Have you selected your own theoretical orientation yet?

Yes / No (circle one)

If "Yes", which?

8. If you answered "Yes" to Q. 7, what influenced your choice (tick all that apply)

a) Knowledge acquired from undergraduate psychology courses?
b) Bias of colleagues I worked with prior to commencement of clinical training
c) Personal experience of a particular therapy
d) Academic content of clinical training
e) Bias of supervisors on placement
f) Clinical area in which I plan to work after qualification
g) Other: please specify

9. If you have not yet selected a theoretical orientation, how do you expect this to occur?

(tick one)

a) It will happen naturally through experience.
b) I will need to attend further courses to make up my mind about the different approaches and their clinical utility.
c) I do not expect to choose a particular theoretical orientation and intend to be an eclectic clinician.

10. Do you think that personal therapy should be a required part of training?

Yes / No (circle one)

a) If "Yes", individual / group, with other trainees? (circle one)
b) If "Yes", why?

11. If you answered "No" to Q.10, is this because you think personal therapy..... (tick all that apply)

a) Does not enhance a clinician's efficacy and is therefore not worth including in clinical training?
b) Would be too demanding in addition to the other demands of training?
c) Might reveal personal information to staff assessing you on the course if confidentiality is not maintained?
d) Other: please explain.

12. Has your view of the role of the clinical psychologist changed over the past 3 years?

Yes / No (circle one)

If "Yes", how has it changed?

13. When did you first begin to think of yourself as a clinical psychologist?

a) Before I began my clinical training.
b) During the 1st year of the course.
c) During the 2nd year of the course.
d) During the 3rd year of the course.
e) I do not yet think of myself as a clinical psychologist.

14. Do you consider yourself to be primarily (tick one)

a) An applied scientist?
b) A therapist?

15. Is it necessary to be trained in research methodology to be an effective clinical psychologist?

Yes / No (circle one)

If "Yes", why?

16. During your training, have you had any doubts that this is the right occupation for you? (tick one)

a) Serious doubts.
b) Slight doubts.
c) No doubts.

If a) or b), what were they?

17. What attracted you to the profession of clinical psychology? Please identify the most important factors.

## APPENDIX D

## SEMI-STRUCTURED INTERVIEW SCHEDULE USED IN INITIAL INTERVIEWS WITH COHORT A, & ADAPTED FOR INITIAL INTERVIEWS WITH COHORTS B & C.

BACKGROUND:

When did you first decide to train in clinical psychology?
Influences: people and experiences.

Where did you do your undergraduate degree?
Any postgraduate/professional training prior to clinical psychology?

Where did you work before starting the course?
Were you working with clinical psychologists or other professionals/lay people?
(Any other relevant experience?)

Was there anyone you met in that job who you consider an important and positive role model regarding your professional role?
Was that person a psychologist?
Could you describe the attributes of that person which you would like to develop yourself?

Were there any people you worked with who were negative role models? In what way? How has that influenced you?

Did you have any doubts before you began the course about pursuing this training?

Age?

CHOOSING THE COURSE:

Why did you choose the Edinburgh course?

How much did you know about it beforehand and how did you learn about it?

Which Health Board selected you?

THE COURSE:

So far, has the course been what you expected? Any surprises?

Do you think of yourself as a student? As a trainee professional? All/some of the time?
Do you have to change roles?
How does that feel?

Do you think of yourself as a psychologist/clinical psychologist?
If "yes" to clinical psychologist, since when?

Have you had any doubts about doing the training since you started? How have you dealt with them?

What do you expect to find most difficult in the training process?

Is it clear to you what is expected in terms of standards and performances? How do you/did you decide this?

How do you see the relationship between the academic component of the course and the clinical placements? Do they seem to fit together?

Are you aware of identifying any member of the clinical/academic staff as a potential role model? What attributes of that individual are particularly important?

Does the approach taken by the course so far seem to fit with your view of the world and of psychological disorders? If not, how is it different?

Do you know yet which clinical area you are likely to specialize in after training? Why?
Do you know which therapeutic approach you are likely to favour? Why?

THE PLACEMENT:

Do you have any choice about which placements you do?
What is important to you in choosing them?

Has the clinical work been different to what you expected?

Have you started seeing patients alone yet?

Have you had any contact with other professions on placement?
Has this been useful/important?

Since starting the placement, have there been any times when it has been difficult to put theory into practice? How have you resolved that?

Can you recall a particular event since starting your placement that seemed particularly reassuring or encouraging, perhaps when you were feeling a bit apprehensive?

What about an event which had the opposite effect and left you feeling more unsure of yourself? Did you discuss this with anyone?

If you had any concerns at any stage about your competency, or wanted to discuss the way a particular patient was affecting you, who, if anyone, would you be likely to talk to about this?

Some courses have introduced some form of personal therapy, usually in a group format, as a training requirement. Other courses offer optional individual therapy to trainees. What do you think about these alternatives?

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