

**Women entering clinical psychology: Q-sort narratives of career attraction of female
clinical psychology trainees in the UK**

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Abstract

The great majority of the UK clinical psychology workforce is female, and this fact prompted an examination of the various ways clinical psychology might be seen as attractive to women – a neglected research topic. Female clinical psychology trainees from a variety of training programmes Q-sorted statements of potential job attractors. The process of analysis is outlined, before most of the article is devoted to explicating the five narratives of attraction generated: making a difference, waiting for what I want, idealising challenge, identifying with distress, and acknowledging power and privilege. Two super-ordinate ‘stories’ spanning the narratives are suggested – an over-riding attraction to the profession, and a rebuttal of the suggestion that this attraction may be based on any overtly gendered grounds. In the absence of previous empirical data of women’s attraction to clinical psychology, the small but significant contribution to understanding the profession made by the analysis is acknowledged – as is the need for further research to confirm and develop the findings.

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Key words

Career attractors, clinical psychology, female workforce majority.

Key Practitioner message

- Appreciating how female trainee psychologists rate job incentives is a further step towards greater knowledge of workforce attractors.
- There is a general narrative of job attraction to clinical psychology, and other more specific ones, where clear attractors for some trainees are equally clear disincentives for others.
- While data from broader samples of colleagues are required, the findings have implications for more targeted clinical psychology recruitment, at both pre- and post-qualification levels.
- The findings also have agency as a stimulus for self-reflection.

Introduction

Achieving gender desegregation within the number of people with jobs in psychology (*e.g.*, Ostertag & McNamara, 1991) was, at least for clinical psychology, a passing phase towards the re-segregation of the workforce (Snyder, McDermott, Leibowitz & Cheavens, 2000). The feminisation of the UK clinical psychology workforce seems to have been driven by a less crude impetus than that of many other jobs during the 20th century – things like women being hired simply to make up for a wartime male shortfall, or because they could be hired at significantly lower rates of pay (Reskin & Roos, 1990). The ‘tilt’ (Goodheart & Markham, 1992) in the gender balance of clinical psychology from male to female has taken

place fairly rapidly, over the past three decades, and has been reflected not simply at the point of hiring, but throughout an educational trajectory spanning psychology at A-level and at undergraduate level, during pre-training occupational experience, and during postgraduate training – as well as at eventual appointment as qualified professionals (BPS, 2004, 2005; Holdstock, 1998). At each point, women now noticeably outnumber men.

The main focus of research and commentary on this phenomenon has been upon trying to understand and redress the efflux of men (*e.g.*, Baker & Caswell, 2010; BPS, 2004) with the goal of bringing about a workforce more representative of the population served, *i.e.*, greater numerical equality between the sexes. However, little attention has been paid to why women have been attracted to psychology, and to clinical psychology in particular.

What has been written may fairly be categorised within three themes that Young and Collin (2004) suggest encompass the study of careers generally. Firstly, a ‘dispositions’ framework (*e.g.*, Su, Rounds & Armstrong, 2009) has been used – Snyder *et al.* (2000) predict changes that a female-majority clinical psychology workforce will bring about, in terms of psychometrically-demonstrated ‘tendencies’ of women. For example, they suggest that because women score higher on ‘empathy’, their preponderance in the workforce will continue to increase as they are better equipped both for psychotherapeutic work, and for teamwork. Secondly, a ‘contextualising’ discourse of the power environment surrounding career choice and development has been employed, providing societal analyses of the position of women working within clinical psychology. For instance, Philipson (1993) contends among other things that media popularisation of psychodynamic and client-centred ideas has stereotyped ‘emotion work’ as definitive of psychotherapeutic work, and that emotional care is increasingly experienced from childhood as emanating from women rather than men; and one of the arguments in Ussher and Nicholson (1992) is that while the

workforce may be predominantly female, its knowledge base still emanates from male-dominated academic psychology. However, as far as we are aware, no studies based on the third discourse, that of ‘subjectivity and narrative’, have been undertaken examining accounts of clinical psychology produced by women themselves.

The present study examined the narratives of female UK clinical psychology trainees regarding what had attracted them to join the profession. Q-methodology – “designed to explore the subjective dimension of any issue towards which different points of view can be expressed” (Stenner, Watts & Worrell, 2008, p. 215) – was chosen to achieve this.

Method

Choice of methodological approach

Q-methodology was described by Stephenson (1935) as the ‘inverted factor technique’ – factor analysis of a data matrix by rows rather than columns, so that individuals, instead of tests, constitute the variables (Kitzinger & Stainton Rogers, 1985). A thorough account of Q-methodology is outside the scope of this article, but several are readily available (*e.g.*, Shemmings, 2006; Watts & Stenner, 2005a). It comprises both a sorting procedure, and an analysis of pattern.

Sorting Procedure

Participants are given a pre-determined set of statements (a ‘concourse’) about the research topic in question and asked to sort these statements along a rating scale and on a grid representing a quasi normal distribution (see Figure 1). Somewhere between 40 and 80 statements, that are comprehensive of the topic in question, is generally considered

satisfactory (Curt, 1994; Stainton Rogers, 1995). The number of participants is less important; Stenner *et al.* (2008) cite 40-60 as typical.

- Figure 1 about here -

Analysis of pattern

Although numerical analysis is employed, it is “participant-led subjective expressions and viewpoints” (Watts & Stenner, 2005a, p. 69) that are the goal. Each factor identified indicates a way of rating the concourse statements that is a social construction of the subject matter, shared by the particular sub-group of participants loading significantly onto that factor. A particular arrangement of the Q-sort items is created, weighted by these participants’ individual sorts, and from this arrangement of the statements, the meaning of the factor is interpreted. In the case of statistically distinct factors that express some semantic similarity, Q-methodology highlights subtleties of attitudinal difference that are sufficiently distinct to emerge as different factors (Shemmings, 2006). We deemed it particularly suitable for examining the multiple narratives that female trainees may hold about a career in clinical psychology.

Development of statement concourse

The set of statements was elicited from relevant literature and from the talk of several first and second year female clinical psychology trainees (one in-depth individual interview was conducted, and a focus group of five people) about their attraction to the profession. An initial pool of 56 statements was modified and reduced to 46 following emailed feedback on appropriateness, coverage and balance (Stainton Rogers, 1995) from eight further trainees. None of the women concerned took any further part in the study. The final set of statements

is listed in Table 1, below; it covers such themes as salary, status and job security¹, the influence of family and role models, fulfilment of personal/social values, and difficulties associated with entering the profession. Only five items referred specifically to gendered issues.

Participants

Women from all UK clinical psychology training programmes were, with staff permission, circulated with study details. Thirty-seven returned fully completed Q-sort grids, representing a 62% return rate from the 60 people to whom research packs² were sent.

Procedure

Written instructions asked the trainees to rank on a scale from –5 (least) to +5 (most) the 46 statements, within the fixed quasi-normal distribution of Figure 1, according to how much each one attracted them to clinical psychology. On completion they were asked to transfer the statement numbers into their position on a small copy of the distribution grid to be returned to the second author. In addition to the Q-sort task, participants were also invited to submit written comments about any statements, as they wished.

Analysis

The 37 completed Q-sorts were analysed using an established Q-methodology computer package (Schmolck, 2002) – factors were extracted (eigenvalue>1) and rotated

¹ The data were collected before the UK Government's plans for cuts in public services were announced in 2010.

² Packs comprised: information sheet, consent form, instructions for completing the task, 57 small cards (46 statement cards, and eleven ranking cards numbered from -5 to +5), participant response form, feedback sheet and freepost envelope. Although well over 180 people volunteered, Q-methodology specifies that the numbers of concourse statements and of Q-sorts should ideally not be too discrepant (Watts & Stenner, 2005a). Stopping recruitment at 60 yielded an eventual 37 completed sorts, compared to 46 statements.

(varimax rotation). Within Q-methodology, for a factor to be interpretable as a social narrative it must possess a minimum of two Q-sorts loading significantly and uniquely upon it. Five factors met this criterion at the 0.01 level (full data are available in Nash, 2009). The ratings for each statement of the Q-sorts significantly and uniquely associated with each factor are weighted by their loadings and merged to yield a z-score. Statements are positioned from highest to lowest onto the quasi-normal distribution, producing a single exemplar Q-sort which serves as a ‘best-estimate’ of the item configuration characterising that factor. Pattern analysis is based on these merged arrays, the ratings of each exemplar (see the columns of Table 1, below) being interpreted as a ‘gestalt’. In the present study, the eight statements rated most positively, and the eight rated most negatively, form the basis of each of the five narratives created, which are supplemented by participant comments. They are intended to communicate in everyday language “something of the nature of each gestalt” (Watts & Stenner, 2005b, p. 94).

Results

Following the format of Watts and Stenner (2005b), the results are presented in numeric, then in narrative form.

- Table 1 about here -

Statement ratings across all Factors

Some general observations may be made of statements across the merged factors, by examining the ‘rows’ of Table 1. Using a binary distinction between ratings of 2 or less (*low*) and 3 or more (*high*), six statements were rated low over all factors, but none universally high (though two received ‘four out of five’ high positive ratings – item 23 *a rewarding job* and item 35 *a job that helps others* – consistently rated as incentives to clinical psychology; no statements received such consistent arrays of high negative ratings – none were across-the-board disincentives).

Of the five specifically gendered items in the concourse, none were amongst the uniformly high- or low-rated items. However, three of the gendered items appeared within a group of ten statements that were noticeably differently-rated, i.e., at least one high positive and at least one high negative rating – contentious issues, to be returned to in the Discussion.

Narrative interpretation: the ‘gestalt’ of each merged Q-sort Factor

Factor One: It’s not status; it’s not gender; it’s ‘making a difference’

The Q-sorts of five participants loaded significantly and uniquely onto Factor One (another nine loaded significantly but not uniquely). The factor accounted for 47% variance (eigenvalue 17.52). Four of the five participants were in the second year of training, one in the first.

The Factor One narrative comprises three main features. Firstly, there is a clear rejection of the status quo. Status markers such as succeeding in a competitive field (1, -3)³, achieving doctoral qualification (29, -4) and having reasonably well-paid employment (28, -5) were rated complete failures as attractors to clinical psychology. On the other hand, working in a job that permits one to challenge the status quo and adopt a critical stance was rated as attractive (31, +3), as was the personal challenge that such work brings (22, +4).

Secondly, and perhaps most strikingly, four out of the five items of the statement concourse that specifically mentioned gender, were given high ratings (i.e., within the range 3 to 5) in Factor One – but all in the negative direction. Apart from having to postpone things like pregnancy and motherhood (40, -4; and similarly 10, -3), other disincentives were, working principally with female clients (38, -5), protection from male intimidation (39, -3), and training within a female-majority cohort (37, -3). There was some indication in

³ In brackets, the first number represents the item within the statement concourse, the second its rating within the merged Q-sort.

participants' comments on these items that negative ratings were connected with a desire for an equal gender ratio in the workplace:

“Personally, I would prefer to train and work in a more balanced profession, in terms of gender” (P27⁴)

“I didn't really want to move into a female-dominated arena... [though also] the very thought of training with *lots of* men is unattractive” (P4, emphasis added)

Thirdly, in stark comparison, the anticipated reward of the work (23, +3) as positively and humanely assisting in a broad cross-section of psychological distress received a ringing endorsement: helping a wide range of people in a healthcare setting (35, +5; 33, +5; 21, +3; 19, +3), drawing upon personal learning as well as professional (16, +4). Thus presented, Factor One could, we suppose, be playing out something of a threefold rhetorical device: ‘if you want to know what attracted us into this job, it was not to do with the trappings of status and power, it was not to do with having a critical mass of women involved in our work, it was our thoroughgoing desire to use clinical psychology for making a difference to people's lives’.

Factor Two: Job satisfaction, yes – but a long time comin'

The Q-sorts of six participants loaded significantly and uniquely onto Factor Two (another eight loaded significantly but not uniquely). The factor accounted for 8% variance (eigenvalue 2.77). Four of the six participants were in the first year of training, one in the second, and one in the third.

The narrative embedded within Factor Two has two major components. One speaks of job satisfaction, and is rated positively as an attractor. The other describes an uncertain pre-qualification career trajectory which is rated negatively.

⁴ Participant number

The rewarding component of job satisfaction (23, +5) seems more ‘self-absorbed’ than its comparator in Factor One. It derives from both academic and applied aspects. They include, ‘proving oneself’ academically (2, +3) in a discipline possessing an intellectual draw exceeding that of others (20, +3) which is maintained when the discipline is brought out into an applied setting (34, +4). Added to the satisfaction of working with and helping other people (21, +3; 35, +5) is the bonus of a fulfilled personal fascination with them (30, +4). Post-qualification, the NHS career pathway is clear (41, +3)⁵.

However, while this aspect of the pathway is undoubtedly attractive, the *pre-qualification* pathway is constrained under various negative forces. Prior to training, there is a feeling – in terms of academic qualification and of relevant experience – of being stuck in a groove (6, -3; 8, -3) that seems at times to be getting nowhere (7, -4). Part-time work is a disincentive – as though nothing less than full-on full-time clinical psychology will satisfy (43, -4). Training itself can appear elitist (5, -3). Worst of all, important life goals are anticipated as either sacrificed (10, -5) or postponed (40, -5). As one participant put it:

“Even my wedding has been scheduled for after qualification. It’s like putting a block on any life events for three years” (P24)

– and if someone were still striving towards obtaining a training place, it could be even longer. Item 40 is one of two items referring specifically to gender that are highlighted in Factor Two. The other – reliance upon a female-majority workforce to avoid male intimidation – is also rejected as an incentive (39, -3).

Unlike professions with better-organised entry, clinical psychology training is reached only via an uncertain and often de-motivating route. Factor Two emphasises that well-established positive interest in it can diminish over time unless high ‘resistance to extinction’

⁵ As previously noted, the data were collected and analysed before the advent of the public services cuts imposed by the UK government in 2010.

has been built in, presumably by the intermittent reinforcement of some of those pre-qualification items of anticipated job satisfaction.

Factor Three: I have a dream...

The Q-sorts of two participants loaded significantly and uniquely onto Factor Three (two more loaded significantly but not uniquely). The factor accounted for 5% variance (eigenvalue 1.93). One of the participants was in the first year of training, one in the second.

Disillusion (4, -5) is rated at the most negative end of the Q-sort continuum in the account of Factor Three; NHS salaries for psychologists aren't that high, and they don't attract (46, -5); clinical psychology may not be so worthwhile sacrificing other life ambitions for (10, -3). With respect to gender, having a majority of female clients or of female fellow trainees is also rated unattractive (38, -3; 37, -3), as is being given voice within a female-majority workforce (36, -3). One person retorted:

"I think I would feel reasonably confident voicing my opinion whether the gender split was equal, or even if the profession was male-dominated" (P37)

Concerning all three items 36, 37 and 38, another wrote:

"I have put these as unattractive in that [although] I have never considered them, it would have been unattractive for me to consider myself as being permanently surrounded by women" (P8)

While disillusion may be a major de-motivator, the 'illusion' retains its allure. As with the previous factor, the idea of working part-time is rated a strong disincentive (43, -4) – full-on full-time clinical psychology remains the goal. Although 'proving oneself' academically (2, -4) may have lost its attraction, if it ever had any, nevertheless other ratings show that the challenge provided by clinical psychology has long-term appeal (22, +5), both intellectually (34, +4) and emotionally (25, +3) – and, importantly, it enables the psychologist

herself to be challenging (31, +5). It is rewarding people-work (23, +4; 21, +3), and seeing positive role-models and their careers has been a clear incentive (18, +3; 41, +3).

The possibly idealistic notion of flourishing under challenging conditions distinguishes this factor from others. What might be unattractive within a narrative of ‘easy living’ or ‘having a quiet life’, is in Factor Three envisioned as attractive (though not too ascetically, given the negative rating for salary level).

Factor Four: Not advantaged by social background

The Q-sorts of two participants loaded significantly and uniquely onto Factor Four (two more loaded significantly but not uniquely). The factor accounted for 4% variance (eigenvalue 1.46). One of the participants was in the first year of training, one in the third.

In the account of Factor Four, clinical psychology promises more than more traditional academia (20, +5), and is a well-paid and respected career (28, +3) that is challenging both to oneself (22, +3) and to the status quo (31, +3), and helps other people (35, +4); the criticism that clinical psychology services may be ‘too little, too late’ is rejected (26, -3) – P18 was very clear about this:

“It’s never too late to improve someone’s quality of life” (P18)

If the profession does tend to lock its members into pursuing it, this is not resented – far from it (7, +3). The commitment to clinical psychology originates internally: other people are specifically *not* rated as positive influences or role models. In fact, they have been the opposite, whether peers (male or female), acquaintances, or family (11, -5; 37, -3; 13, -5; 14, -4). This independent stance extends to standing up for oneself, too: relying on a female-majority workforce in order to stave off male intimidation is not an attractor (39, -3).

The most distinctive aspect of Factor Four is the high positive rating given to having experienced disadvantage oneself (17, +5); and an unashamedly high value is put on financial

necessity while training (44, +4). Status is rated as unattractive, whether conferred by joining an elitist 'club' (5, -3) or by having shown oneself to be better than others (1, -4). Much of the narrative thus sets itself apart from the comfortable middle class stereotype often associated with the profession's membership.

Factor Five: Women of privilege and power?

The Q-sorts of two participants loaded significantly and uniquely onto Factor Five (one more loaded significantly but not uniquely). The factor accounted for 4% variance (eigenvalue 1.45). One of the participants was in the first year of training, one in the third.

The account provided by Factor Five is in several respects quite different from the preceding narratives. Initially, it does not appear distinctive: clinical psychology is rated as highly rewarding (23, +5), is definitely not simply one career option among many (9, -4; 27, -4), and is people-work of high social relevance (35, +3). But Factor Five highlights three of the five specifically gender-referenced statements, and in contrast to each previous account, these statements are rated positively. Female solidarity in the workforce is openly valued as protective against intimidation by men (39, +5) and against being silenced by men (36, +4). Spending the long duration of professional training (in itself, seen as attractive; 42, +3) in the company of a majority of women, is welcomed (37, +4). The status of the ensuing doctoral title and career (28, +3; 29, +3) are further incentives. P18 did not seem in too much of a dilemma when she wrote about item 29:

"It's so wrong – but I can't deny it!!" (P18)

The idea that there could be any positive motivation deriving from one's own experience of distress/disadvantage, is almost violently dismissed (16, -5; 17, -5). Personal acquaintance with clinical psychology trainees or staff in related professions has not acted as an incentive (11, -3; 13, -3). The critical notion that clinical psychology services may come 'too little, too

late' is a de-motivator (26, -3), as is clinical psychology's NHS salary level, when compared to that of other available careers (46, -3).

Each of the factors demonstrated some high-value ratings on the items making specific mention of being female – which is not unexpected, given the research focus of the Q sort undertaken, for which all participants had been sufficiently interested to volunteer. But the distinctive of Factor Five is that these ratings are *not negative*: a clear positive value is placed upon them. In addition, we incline towards the view that this narrative tends to endorse the 'comfort zone' of the profession, and to eschew personal acquaintance with the distress of its clientele.

In comparison to Factor 5, the ratings of Factor 4 are so different on both the social disadvantage and the gendered issues, that the factors form a contrasting pair. Perhaps not as different as tragedy and comedy theatre masks, the pathos and power they represent reminded us of a somewhat similar contrasting pair within the accounts in a previous study of trainees' attraction to clinical psychology, this time, those of men (Baker & Caswell, 2010): one eschewed power and privilege, the other contained elements of 'old school' traditional male authority.

Discussion

We wanted to generate several accounts of female trainees' attraction to clinical psychology, and employing Q-methodology ensured that multiple narratives were indeed generated. To that extent, the aim of the study was achieved, and the five narratives about the participants' attraction to clinical psychology are worthy outcomes in and of themselves.

However, within the multiple accounts identified by the factor analysis, there were two dominant cross-factor themes. At the risk of doing an injustice to the complexity of the standalone narratives, we offer a suggestion for an overview of the analysis comprising two super-ordinate stories. Both were foreshadowed in the first subsection of the Results, but are

developed here from the factor narrative accounts, in the format of a theme, followed by variation on the theme.

The first story concerns a theme of intrinsic and taken-for-granted value ascribed to the activity of the profession, and may be approximated as follows: participants rate clinical psychology as positively engaging, because they view it as socially relevant and as intellectually challenging. This is scarcely novel, being similar to what most qualified colleagues would anticipate, and it confirms part of our previous data from samples of male trainees (Baker & Caswell, 2010) and minority ethnic psychology undergraduates (Meredith & Baker, 2007). It also recapitulates for the most part, the issues presented in a UK clinical psychology recruitment video (CHPCCP/DCP, 2005), and we chose the phrase ‘making a difference’ to echo this point in the title of Factor 1, which most clearly presents the theme.

Variations on the theme are found in Factors 2 and 3. Within Factor 2, ‘intrinsic value’ is presented as somewhat frayed at the edges by the tortuous process of entry into the profession. Having succeeded in marketing itself as worthwhile, clinical psychology is entered in the UK only by a restricted route negotiated by those who successfully compete for one of a relatively small number of over-subscribed NHS trainee posts. This has produced an entry bottleneck of waiting and frustration. Within Factor 3, ‘intrinsic value’ is reflected through a different lens. Disillusionment is refused as the most rejected of disincentives, and ratings indicate high positive anticipation attributed to challenge. In combination, we found these to be an idealistic, possibly unrealistic, variation on the attraction of ‘making a difference’.

If the first super-ordinate story is one about attraction, the second is, in contrast, one about non-attraction. The theme is a significant part of Factors 1, 2, 3 and 4. It involves the five Q-statements specifically attributing attraction of the profession to ‘gendered’ concerns of women. Throughout the first four factors, these concerns were rejected as incentives,

sometimes quite emphatically. The five Q-statements were originally derived from the data of a focus group of female trainees, and although the group's members were recruited from one training programme only, it seems unlikely to us that they articulated particularly unusual views about women's attraction to clinical psychology. Nevertheless, when the Q-sort participants – who after all volunteered on the basis of their interest in the topic – considered the statements in print, they broadly 'kicked into touch' the notion that any of the vividly articulated gendered issues had drawn them to the profession, and rated them almost as though such things are regarded as incidental, or even positively off-putting.

The variation on this theme is its inverse. Found only in Factor 5, clear positive acknowledgement is given of the incentive value of several of the gendered issues. In addition, the sense of power and status accruing as part of being a clinical psychologist is welcomed. As an overall account, it was difficult not to see the variation on the theme as rather comfortable with a stereotype of a clinical psychologist as a middle class woman exercising power and privilege. Is this an account silenced by the more voluble theme, dismissive of such claims? How easily do the theme and its variation co-exist within members of the workforce? Answering such questions is not possible from the current data set.

Two further limitations must be acknowledged. Firstly, task instruction requested neutral ratings be assigned should statement wording be found unclear or inapplicable; however as apparent from P8's comments in the account of Factor Three above, this was not always followed. Secondly, three of the factors were drawn from the uniquely-loading Q-sorts of only two participants. Although within Q-methodological theory, such numbers are not the criterion for Q-factor extraction (Brown, 1980, p. 43), two does represent a minimum claim for factors to represent social accounts.

Thus there is considerably more to be clarified by research into subjectivity and narrative in clinical psychology as a career, with data from more broadly-based samples of women than was achieved in the present study. If further research is to generate further understanding, participants should include women studying psychology at undergraduate level, practising at pre- and post-training levels, both within the UK and – given the ‘internationalisation’ agenda – elsewhere. Nevertheless, despite its small scale dimensions and novel status, we incline towards seeing the study as a helpful contribution to articulating women’s narratives of attraction towards the profession of clinical psychology.

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Figure 1: Sample grid used in Q study.

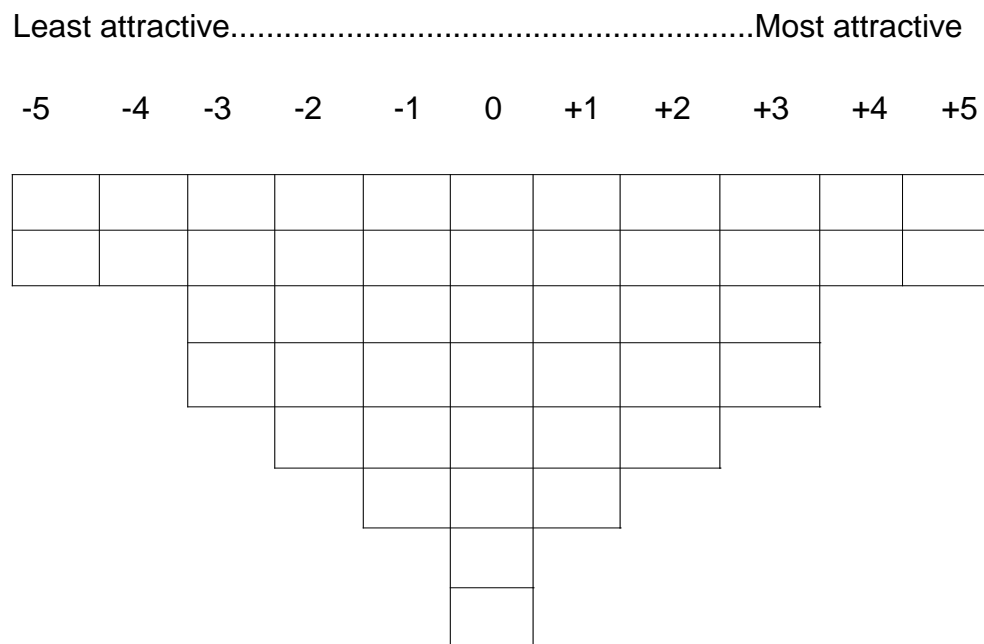


Table 1: by-factor ratings for merged Q-sorts

Concourse Statement	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
1. Clinical psychology is a career that offers more status because it's competitive	-3	+2	+1	-4	-1
2. I was aware of an internal competitiveness/drive to prove to myself that I could do something high status and academic	-2	+3	-4	0	0
3. Clinical psychology is competitive and that makes it more of a challenge	-2	+2	+1	-2	-1
4. I got disillusioned when applying for clinical psychology training	-2	-2	-5	0	0
5. The path to qualification of a clinical psychologist can appear elitist	-2	-3	-2	-3	0
6. I did psychology A-level and/or degree so it made sense to continue on to do clinical psychology	0	-3	+1	+2	0
7. Once on the treadmill towards a career in clinical psychology it was hard for me to step away from it	0	-4	0	+3	-1
8. It was difficult for me to know how else I might be able to put pre-training experience (e.g. support work/assistant post) to use in other careers	-1	-3	0	+1	0
9. Clinical psychology was only one of many careers I could have opted for that would have been equally as satisfying	+1	0	+2	0	-4
10. The length of time to qualification can mean putting other parts of life/life goals on hold	-3	-5	-3	-1	0
11. My peers were doing clinical psychology and they influenced my decision	-1	-1	-2	-5	-3
12. My parents/significant others approved of a career in clinical psychology	0	0	0	0	-1
13. A family member/friend worked in mental health which made me interested in the field	0	-1	-1	-5	-3
14. People outside the family network (e.g. teachers, managers in work roles) motivated me to pursue a career in clinical psychology	+1	-1	+2	-4	-2
15. Psychologists are seen as 'other' by the public (e.g. idea of reading peoples' minds, being aloof)	-2	-1	-1	0	-1
16. Personal experience of my own/other's mental distress motivated me to pursue a career in clinical psychology	+4	+2	+1	-1	-5
17. I experienced disadvantage while growing up and this motivated me to achieve in my career	0	0	0	+5	-5
18. Working alongside a clinical psychologist made me think the career looked really interesting	+1	0	+3	+1	0
19. I was interested in a career in the health professions	+3	+2	0	0	-2
20. I wanted a subject that was more 'interesting' than others (e.g. maths and science)	+2	+3	-3	+5	0
21. I wanted to work with people	+3	+4	+3	+2	+1
22. Clinical psychology is a job that I thought would continue to be demanding throughout my career	+4	0	+5	+3	+1
23. The work of a clinical psychologist is rewarding	+3	+5	+4	+1	+5

24. Clinical psychology provided me with a framework to understand myself and others	+2	+1	0	-1	+1
25. The work of a clinical psychologist is emotionally demanding	0	-2	+3	-1	+1
26. Clinical psychology is of limited value as intervention comes too late	-1	-1	-2	-3	-3
27. Clinical psychology was one of a number of careers I considered	+1	-2	-1	0	-4
28. I thought that clinical psychology would be a career that offered money and status	-5	0	0	+3	+3
29. Having the title of a doctor is a tangible form of status that allows others to recognise how hard I've worked	-4	+1	+2	+2	+3
30. Clinical psychology satisfies my fascination with people	+2	+4	+1	+1	+2
31. Clinical psychology allows me to challenge and be critical and thoughtful	+3	+2	+5	+3	+2
32. Clinical psychology is appealing because there is no 'right' answer	0	-2	+2	-2	-2
33. Working within a range of different clinical areas during training and beyond attracted me to a career in clinical psychology	+5	+1	-2	+1	+1
34. The job is intellectually demanding	+2	+4	+4	+1	+2
35. I wanted a job that allowed me to help people	+5	+5	+1	+4	+3
36. I feel more able to speak my opinion in a female-dominated profession	-1	0	-3	-2	+4
37. I liked the idea of training within a female dominated cohort	-3	-1	-3	-3	+4
38. Clinical psychologists mainly work with female clients within mental health services and this is appealing	-5	0	-3	-2	-2
39. It would have been intimidating if men were in the majority in clinical psychology	-3	-3	-1	-3	+5
40. The long route to qualification can mean women may have to put other life goals on hold	-4	-5	0	-2	-1
41. Clinical psychology is a 'career' with a clear path of progression	+2	+3	+3	+2	+1
42. The duration of clinical psychology training is long	+1	+1	-1	0	+3
43. The flexibility in terms of hours, part time working etc were appealing factors in choosing clinical psychology	-1	-4	-4	-1	-2
44. Minimising the cost of training was important to me therefore paid training was an advantage	0	+1	+2	+4	-1
45. The job prospects are good, including the salary	+1	+1	-1	+2	+1
46. The salary of a clinical psychologist is not very high compared to other career options that were available to me.	-1	-2	-5	-1	-3