

***‘How I came to be a Clinical Psychologist’: An Explorative
Study into the Experiences of Becoming a Clinical Psychologist
when from a South Asian Background***

**A thesis submitted in partial fulfillment for the
Degree of Doctorate in Clinical Psychology**

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I would like to thank the participants of this study without their contribution would have not made this study possible. I hope the product serves us and those we wish to help well.

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A big thank you to my cohort who have made the journey to my final career destination a memorable experience, who one day I hope will move on in their cultural experiences from the 'onion bhaji's and curry and chips' to knowing of the many spices that make up the curry.

Finally I thank my loving husband, without his support my journey into this profession would remain incomplete.

With love to my kids Arjuna & Anjni.

Structure and Word Count

<u>SECTION A</u>	Thesis Abstract	(328 words)
<u>SECTION B</u>	Literature Review	(5598 words)
<u>SECTION C</u>	Research Report	(12,312 words)
<u>SECTION D</u>	Critical Appraisal	(4297 words)
<u>SECTION E</u>	Appendices	N/A
	Tables, Figures, and Reference Lists	(8486 words)
<u>ADDENDUM</u>	Interview transcripts	N/A

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Declaration

This thesis has been submitted in partial fulfillment of the degree of Doctorate in Clinical Psychology. It is based on work conducted by the author in the Department of Clinical Psychology at the University of Leicester between October 2006 and May 2009. All of the work recorded in this thesis is original unless otherwise acknowledged in the text or by references. None of the work has been submitted for another degree in this or any other University.

A note on use of terminology

Within this thesis references will be made to published literature that often uses conceptual frameworks based on Eurocentric and ethnocentric ideals, which makes making comparisons between studies and drawing conclusions difficult. Furthermore, limitations on the use of studies can be encountered when terms used have different meanings in other cultures. The meanings of specific terms used in the thesis are for the purpose of clarity presented in Appendix 1. Where the researcher cites published literature that specifies ethnicity or has used terms that differ in meaning to those given in the appendix, reference will be made to it in the text.

SECTION A

THESIS ABSTRACT

Thesis Abstract

TITLE: *'How I came to be a Clinical Psychologist': An Explorative Study into the Experiences of Becoming a Clinical Psychologist when from South Asian Background*

AUTHOR : Dipti Pradumal Thakker

Literature Review:

A qualitative literature review was conducted investigating the training experiences of minority ethnic students pursuing health careers. The review identified that various challenges can be experienced by the minority ethnic student. The following themes were consistently found across the studies: a fear of challenging culturally insensitive practice or ethnocentric theories; being considered the cultural expert; a lack of cultural competency by peers and faculty tutors; difficulties in balancing academic priorities and family obligations; loss of confidence and motivation due to internalisation of negative stereotyping. Recommendations include provision of a culturally sensitive pedagogy and mentoring as supportive interventions.

Research Report:

Semi-structured interviews were used to explore the career trajectories of nine South Asian clinical psychologists and analysed using Interpretive Phenomenological Analysis. All of the participants in this study were the only South Asian in their cohort on the DClinPsy training course; eight were the only minority ethnic student. Participants described unique classroom experiences relating to their cultural identity including feelings of isolation and being perceived by staff and peers as the 'cultural expert,' consistent with the literature. Furthermore, gendered pressures included balancing academic and cultural responsibilities for the female participants. Socio-cultural factors such as family expectations and a value for traditional careers within the individual's community posed challenges for choosing clinical psychology as a career. Participants' descriptions of 'being different' to their South Asian peers suggest issues of self-identity related to career choice. Once qualified, being a South Asian clinical psychologist created subtle tensions when professional roles and responsibilities challenged cultural roles within the participant's own community.

Critical Appraisal:

Reflections in this paper consider the research process and the impact of the participants' narratives on the researcher and of her personal and professional development. Considerations are also given to the researchers' impact on the project.

SECTION B
LITERATURE REVIEW

**From Student to Practitioner; the Training Experiences of Minority Ethnic
Students in Pursuits of Health Careers: A Review of the Qualitative Literature**

*Target journal¹: The Internet Journal of Allied Health Sciences and Practice
(IAHSP.nova.edu)*

¹This literature review has been written in accordance with the requirements of 'The Internet Journal of Allied Health Sciences and Practice. See Appendix II for 'Notes for Contributors' for the journal. Guidelines for contributors have been adhered to where possible unless they contravene the University of Leicester requirements for a thesis submitted in partial fulfillment of the Doctorate in Clinical Psychology.

1. ABSTRACT

Purpose: To review the literature regarding the experiences of minority ethnic undergraduate/post graduate students/trainees in pursuit of a health career and to identify the influences on their social and academic experiences.

Method: Relevant studies were identified using a systematic search strategy. A robust narrative synthesis of the findings was produced using thematic analysis.

Results: Thirteen studies were identified across various health disciplines. As the career route of each discipline varied, the participants identified ranged from undergraduates (medical, dental and nursing students) to postgraduate students (training for genetic counselling and clinical psychology). The following seven themes were common amongst the studies identified: *professional issues; marginalisation, prejudice and discrimination; classroom and cohort experiences; balancing priorities; personal impact; managing /coping and support and needs.*

Conclusion: Students were found to experience cultured, gendered and racial experiences. The findings suggest developing culturally sensitive pedagogy that promotes the retention and success of minority ethnic students.

2. INTRODUCTION

Recruitment and retention of minority ethnic² students is problematic for many health professions such as clinical psychology, speech and language therapy (SLT), occupational therapy, physiotherapy and nursing (Darr, 1998; Greenwood & Bithell, 2005; Greenwood, Lim & Bithell, 2005; Greenwood, Wright & Bithell, 2006; Oh & Lewis, 2005; Stapleford & Todd, 1998; Turpin & Fensom, 2004). Supportive interventions by academic institutions and health organisations have been criticised for focusing on improving academic ability without adequately addressing factors within the wider socio-cultural context (Greenhalgh, Seyan & Boynton, 2004).

2.1 Recruitment and retention issues

Concerns regarding a lack of representation of minority ethnic students pursuing undergraduate and postgraduate training courses for health professions have led to a growing body of literature attempting to understand the career preferences of minority ethnic students. Whilst factors such as knowledge of the profession, financial burden and lack of role models have been persistently implicated as barriers to recruitment (Chevannas, 2001; Craig, 2007; Greenwood et al., 2006; Helm, 2002; Stapleford & Todd, 1998; Williams, 2002; Wong, 2007), socio-cultural factors such as family, peers and the wider-socio-economic context are slowly gaining recognition (Brown, 2004; Greenhalgh et al., 2004; McHarg, Matrick & Knight, 2007). A review of the barriers presented to South Asians³ in the UK, which focussed on the issue of underrepresentation in the nursing profession (Darr, Atkin, Johnson & Archibong, 2008), found that amongst minority ethnic communities health professions are valued differently, which has been highlighted in the literature (Cheshire & Pilgrim, 2006). Of

² See Appendix 1 for researcher's use of this term

³ See Appendix 1 for researcher's use of this term

particular interest is the suggestion that whilst in training negative experiences make the career unattractive to prospective students (Darr et al., 2008).

Greenhalgh et al. (2004) suggest that the lack of academic ability or knowledge has been implicated for far too long as the reason for the unsuccessful academic pursuit of minority ethnic students. Furthermore, this has created a 'knowledge deficit model' upon which many interventions aimed at improving recruitment, completion and success of minority ethnic students are based. The assumption of a lower academic ability within minority ethnic students is often reinforced by empirical evidence. A systematic review of minority ethnic medical students found that they underperformed academically compared to their White⁴ counterparts (Ferguson, James & Madeley, 2002). A lower academic ability is also suggested in minority ethnic applicants to clinical psychology (Scior, Gray, Halsey & Roth, 2007). Greenhalgh et al. (2004) suggest that the knowledge deficit model creates negative stereotyping of minority ethnic students. The authors further suggest that within the social and academic experiences socio-cultural factors for academic success are yet to be fully explored. Blunstein, Kenna, Murphy, DeVoy and DeWine (2005) suggest that 'complex layers of *social, cultural and political* meaning' (p. 356) need to be considered when attempting to understand career choices and experiences. The researchers advocate the use of qualitative methodology to understand the experiences.

Systematic reviews can contribute to evidence-based practice (Dixon-Woods et al., 2002). The conclusions of systematic reviews of research conducted on the experiences of 'international nurses' highlight the benefit of qualitative studies for understanding social and cultural determinants on their work experiences (Alexis & Vydelingum,

⁴ See Appendix 1 for researcher's use of this term

2005; Konno, 2006; Likupe, 2005; Xu, 2007). A systematic review of the qualitative literature focused on the social and academic experiences of minority ethnic students/trainees in pursuits of health careers would be beneficial; it may offer further insight into recruitment and retention issues. To the researcher's⁵ knowledge, such a review has not yet been attempted.

2.2 Aims and Objective of the Systematic Review

The aim of this systematic review was to identify the issues related to the meaning and experience of being a minority ethnic undergraduate or post graduate student/trainee in pursuit of a health career. The objective of the review was to provide a robust interpretative synthesis of the findings of the qualitative empirical evidence for the experiences of minority ethnic students/trainees. The specific research question was: 'What are the social and academic experiences of minority ethnic students/trainees and how does culture, ethnicity and race influence their experiences?'

⁵ Researcher's background: The researcher is a South Asian third year clinical psychology trainee at Leicester University, UK. The literature review forms a part of her doctoral training. The researcher has been working in the National Health Service (NHS) for the last eight years and was a health promotion specialist prior to pursuing a career in clinical psychology.

3. METHOD

3.1 Inclusion and exclusion criteria

The review considered qualitative studies published in English between 1887 (earliest inception date of the databases) to February 2009 (the date of the researcher's last electronic search). Studies from any health discipline that addressed the minority ethnic student's social and/or educational experience were included. However, studies that specifically focused on international students' experiences were excluded⁶. All studies that used a qualitative method in which the participants (either current trainees, or practitioners) had expressed their training experiences in their own words were included. Given the paucity of studies within the topic area, studies that had used a mixed method design (an overall quantitative design with a qualitative component) were also included but only the qualitative findings were considered for synthesis. The researcher, however, was mindful of the implications, mainly that the included studies would be compromised by issues relating to quality and rigour and would therefore require the researcher to hold in mind the context and position of the included studies when conducting the synthesis.

3.2 Search Strategy⁷

Searches were conducted in consultation with an experienced health sciences librarian using the following databases: PsychINFO; Web of Science; MEDLINE; Cumulative Index of Nursing and Allied Health Literature (CINAHL); British Nursing Index (BNI),

⁶ International students have been excluded on the basis that their experiences may be compounded by transitional issues and that systematic reviews have been identified (e.g. Alexis & Vydelingham, 2005; Konno, 2006; Likupe 2006; Xu, 2007).

⁷ The development of the search strategy, key terms, synonyms and the number of citations returned by each database are given in Appendix III.

EMBASE; Cochrane Library and Social Science Citation. In addition the strategies listed below complemented the database search:

1. Searching reference lists of all relevant papers and reviews
2. Citation searches on retrieved papers
3. Searching using the Google search engine (www. Google.com)
4. Hand searching targeted journals that had published on the topic.
5. Consulting authors of relevant research in the field to identify further and ongoing studies.

Figure B1 shows the steps by which articles were included for the review.

Seven hundred and thirty seven citations were returned by the databases and complementary searches. Duplicate papers, reviews and opinion papers were excluded. The titles and abstracts of 136 potentially relevant studies were retrieved and 32 papers were judged as meeting the inclusion criteria. After scrutiny, 20 articles were found to be ineligible based on the inclusion criteria. Thus, 12 papers were considered for the synthesis and comprise this review.

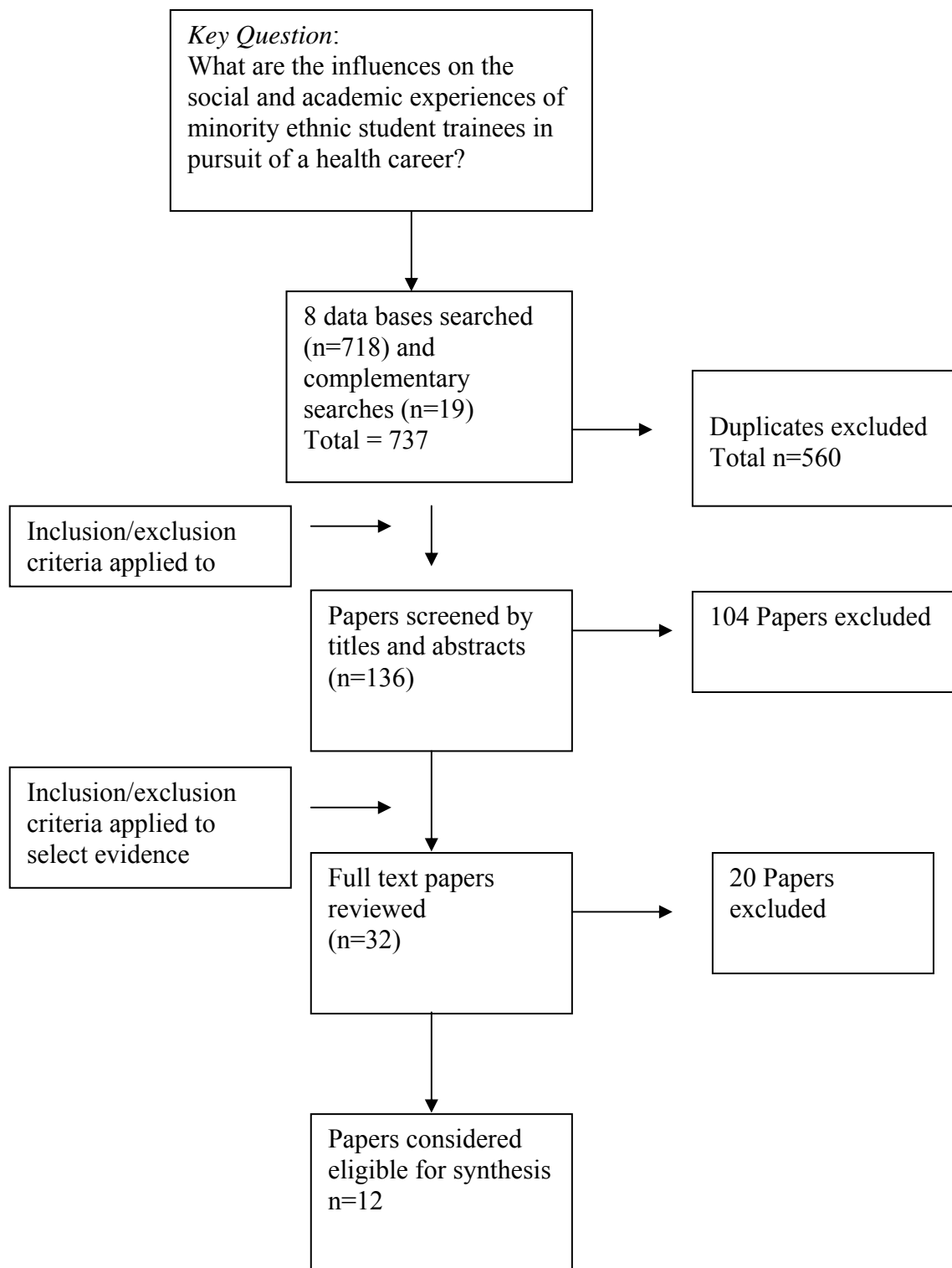
3.3 Quality Appraisal

The quality of the studies was critiqued using the criteria described by Meyrick (2006).

The criteria were used to develop a data extraction pro-forma (Appendix III).

Methodology, epistemology and theoretical position, reflexivity and transferability were addressed.

Figure B1: Search Process and Study Selection



4. RESULTS

4.1 Overview of the studies

4.1.1 *Description of the studies*

Generally the published empirical qualitative research focusing on minority ethnic students/trainees experiences of training for health professional careers was limited.

Table B1 provides an overview of the studies:

- 13* studies published in 12 papers between 1994 and 2008 were included in the review.
- Studies were identified in various health disciplines with the majority emanating from nurse training. As the career route for each discipline varied, the participants identified ranged from undergraduates (medical students, dental students and nursing students) to postgraduate students (training for genetic counselling and clinical psychology).
- The studies ranged in terms of their foci on the experience of being a minority ethnic student. Some studies considered how factors within the socio-cultural context and ethnic identity of the student impacted on the academic learning and social interactions with peers. Other studies focused specifically on how the cultural stereotyping of minority ethnic students by peers and faculty had influenced the student's social and academic experience.

* Maville & Huerta (1997) presented findings of two studies in one paper. The studies used two separately defined student groups; the qualitative data made available were expressed in the paper as one set of findings but their recommendations were based on an amalgamation of the findings. This paper will be referred to as 1997a and 1997b.

Table B1: Overview of the studies identified for the review

Health Discipline	Number of studies	Author/year/country		
Nursing Education	7	<ul style="list-style-type: none"> • Snyder & Bunkers • Jordan • Maville & Huerta (2 studies) • Gardner • Amaro, Abriam-Yago & Yoder • Dyson , Culley, Norrie & Genders 	1994 1996 1997 2005 2006 2008	US US US US US UK
Medical Education	3	<ul style="list-style-type: none"> • Lempp & Seale • Odom, Roberts, Johnson & Cooper • Woolf, Cave, Greenhalgh & Dacre 	2006 2007 2008	UK US UK
Health related Psychological disciplines	2	<ul style="list-style-type: none"> • Schoonveld, Veach & LeRoy^a • Rajan & Shaw^b 	2007 2008	US UK
Dentistry	1	<ul style="list-style-type: none"> • Veal, Perry, Stavisky & D'Abreu Herbert 	2004	US

^a Genetic counselling

^b Clinical Psychology

4.1.2 Methodology of studies

Four of the 13 studies used phenomenological approaches (Dyson et al., 2008; Gardner, 2005; Jordan, 1996; Rajan & Shaw, 2008). A general descriptive design (i.e. a qualitative design but without identifying specific research design) was used by 6 studies (Maville & Huerta, 1997a; 1997b; Odom et al., 2007; Schoonveld, et al., 2007; Snyder & Bunkers, 1994; Veal et al., 2004; Woolf et al., 2008). Grounded theory was used by two studies (Amaro et al., 2006; Lempp & Seale, 2006) and one study used a mixed method design (Maville & Huerta, 1997a).

4.2 Quality of the studies

The methodological critical appraisal is summarised in Table B2 and detailed below.

4.2.1 Epistemological position and theoretical underpinnings

Six papers provided no overt coherent epistemological position to understand how this influenced their methodology (Maville & Huerta, 1997; Odom et al., 2007; Schoonveld et al., 2007; Snyder & Bunkers, 1994; Veal et al., 2004; Woolf et al., 2008). In contrast, Jordan (1996) provided a detailed account of their Hermeneutic approach. The remaining six studies gave fairly congruent epistemological positions. Five studies provided details on the theoretical underpinnings to their enquiry (Amaro et al., 2006; Jordan, 1996; Lempp & Seale, 2006; Schoonveld et al., 2007; Woolf et al., 2008).

4.2.3 Reflexivity

Little detail was provided to assess reflexivity in terms of the researcher's assumptions and engagement with the material. Whilst Dyson et al. (2008), Rajan & Shaw (2008) and Woolf et al. (2008) acknowledged their own role, Jordan (1996) stated that the researcher's ethnicity ('being Black⁸' p. 383) may have influenced the data collection i.e. the interviewing process. All the studies lacked detail on the researcher's own experience.

4.2.4 Sampling issues and ethnicity

Ten of the studies deployed purposive sampling. Convenience sampling, snowballing and random sampling were deployed by Dyson et al. (2008), Maville and Huerta (1997a; 1997b) and Lempp and Seale (2006). Studies that recruited participants from different institutions gave their reasons for doing so i.e. to increase the size of the sample and/or to match the local ethnicity constituency.

⁸ See Appendix 1 for researcher's use of this term

Ten of the studies stated that the ethnicity was self-defined i.e. according to the choice of the participant. Only one study (Woolf et al., 2008) stated that the 2001 Census had been used by the participants for self categorisation. The UK papers varied in their specificity; two studies (Dyson et al., 2008; Woolf et al., 2008) had specified the ethnicity of the South Asians as Indian and Pakistani, whilst Lempp & Seale's (2006) study lacked ethnic specificity altogether with students being differentiated very broadly as White or non-White. In the US, three studies gave individual participants' ethnicity (Amaro et al., 2006; Gardner, 2005; Snyder & Bunkers, 1994).

4.2.5 Data Collection

The majority of the studies used semi structured interviews; one used open ended biographical interviews (Jordan, 1996). Only two studies provided a list of the questions asked and the interview guide (Maville & Huerta, 1997; Odom et al., 2007). Three studies used focus groups of which one study used focus groups in addition to interviews as a means of triangulation of the data (Woolf et al., 2008).

4.2.6 Data analysis

Five of the studies used content analysis (Maville & Huerta, 1997a; 1997b; Odom et al., 2007; Schoonveld et al., 2007; Snyder & Bunkers, 1994). The following types of analysis were used by the remaining studies: content and thematic (Lempp & Seale, 2006; Woolf et al., 2008), constant comparative (Amaro et al., 2006) and thematic (Dyson et al., 2008; Gardner, 2005; Jordan, 1996; Rajan & Shaw, 2008). Veal et al. (2004) failed to provide details on their analysis.

Of the six studies that used independent coders/other team members to improve internal validity and provide investigator triangulation, only three of these studies (Schoonveld

et al., 2007; Snyder & Bunkers, 1994; Woolf et al., 2008) stated that there was some disagreement between the raters during theme generation. Only two studies (Jordan, 1996; Schoonveld et al., 2007) provided explicit detail on their analysis enabling the reader to gauge the rigour of their studies. Respondent validation assures a 'fit' between the participants' views and the researcher's construction and this was used in three studies (Gardner, 2005; Jordan, 1994; Lempp & Seale, 2006).

4.2.7 Transparency & systematicity

Most of the studies lacked transparency in their data collection methods and data analysis. Notable exceptions were the studies by Schoonveld et al. (2007) and Jordan (1996); both provided detail on theme generation and conceptual processes within their data analysis.

Systematicity and transparency run in parallel (Fossey, Harvey, McDermott & Davidson, 2002), with insufficient detail provided in the majority of papers on data analysis. It was difficult to adequately assess whether or not the analysis was systematically undertaken.

4.2.8 Use of data

As transparency was lacking in most studies and none of the studies made explicit if data had been omitted in the analysis, it was often difficult for the researcher to assess if all data had been used.

Odom et al. (2007) and Woolf et al. (2008) did not provide sufficient verbatim quotes from participants to assess whether there was a good 'fit' of the data from which the themes/interpretations were made. However, the majority of the studies demonstrated a

good fit by grounding their conclusions in their data, enhancing credibility of the findings.

4.2.9 Transferability

The majority of the studies stated that the generalisability of their data was limited because of their sample. The study that deployed only one ethnic group (Dyson et al., 2008) also stated that their study could not be generalised to other South Asians and recommended further investigation.

4.2.10 Summary

The majority of the studies reviewed were compromised by key issues of quality, namely: systematicity, transparency, reflexivity and transferability. However, it could be argued that judging a qualitative study within a published paper could be an exercise of judging the written report rather than the research procedure; quality is often compromised by word length limitations posed by the journal (Atkins et al., 2008). This fact then exacerbates the difficulty for the reviewer to use weighting criteria to appraise the studies based on apparent methodological vulnerabilities. With this in mind the systematic synthesis has been conducted cautiously. Common themes were drawn primarily from primary data (themes given in the study's results section) where possible. Therefore themes generated can be concluded with some confidence.

Table B2: Summary grid of papers reviewed: process issues

Key for quality assessment:

Quality Issues	Transferability
<i>T= Lack of transparency in presentation of analysis</i> <i>S= Does not appear to be systematic analysis of the data</i> <i>D= Does not appear to be grounded in data</i> <i>E=some data appears to be have been excluded</i> <i>Q= Quotes not identified</i> <i>C= Credibility issues not addressed.</i>	<i>X= Does not seem transferable to other settings</i> <i>I – Insufficient contextual detail to estimate transferability to another setting</i> <i>A= Transferability issues not explicitly addressed</i>

Study	Coherent Epistemology	Theoretical perspective	Sample ^a	Data Collection	Data Analysis	Reflexivity	Quality Issues	Transferability
Snyder & Bunkers, 1994 (US)	None given	Not given	<i>Size, gender, Age</i> N=9 nursing students 50% drop out 8F, 1M; 23-42yrs <i>Marital status^b</i> : Not given <i>Ethnicity/ religion / Nationality:</i> 1 Jamaican Black, 1 American Black, 1 Mexican, 1 Puerto Rican, 1 East Indian, 1 Japanese, 1 Columbian, 1 Philipino (All raised in the US)	Semi structured Interviews	Content analysis Independent rater	None given	S, T	X

^a N.B Purposive sampling was described by majority of the studies unless otherwise stated

^b Under the heading “gender”: F= female; M= male. Under the heading “Marital status”: M= married; S=single; Sp= separated; D= divorced; W=widowed.

Jordan, 1996 (US)	Phenomenological framework	Tinto's conceptual model of dropout in higher education	<i>Size, gender, age:</i> N=4 nurse students junior or senior year of three year nursing degree course, all F <i>Marital status:</i> Not given <i>Ethnicity/ religion. / Nationality:</i> Hispanics and non Hispanics- unspecified number	Open ended biographical accounts	Hermeneutics thematic analysis	Researcher's own ethnicity considered	None	X
Maville & Huerta, 1997 ^a (US)	None given	None given	<i>Size, gender, age:</i> N=131 ^c Nurse students in 2yr associate degree program at one site; 74x 1 st yr, 57 x2 nd yr, 88.8% F, 97% 20-49yr <i>Marital status:</i> 61% S <i>Ethnicity/religion./ Nationality:</i> 62% Hispanics	Questionnaires with some qualitative semi-structured questions	Content analysis of qualitative data	None given	C,D,E, S, T, Q	I
Maville & Huerta, 1997 ^b (US)	None given	None given	<i>Size, gender, age:</i> N=21 (ex students /dropped out students: mean age 27 yr. <i>Marital status:</i> S / M/ D unclear how many <i>Ethnicity/ religion./Nationality:</i> Not clear	Semi structured interviews	Content analysis	None given	As above	I

^c The demographical profile reported here is for the total sample (N=131) due to unavailability of specific data on the Hispanic students.

Veal, et al. 2004 (US)	None given	None given	<i>Size, gender, age:</i> N=82 ^d 1 st & 2 nd yr dental students from White and Black universities gender not stated <i>Marital status:</i> Not given <i>Ethnicity/ religion./Nationality:</i> N=60 African American N= 22 Hispanics N=10 American Indians	3 Focus groups limited detail	None given	None given	C, D, E, S, T, Q	I
Gardner, 2005 (US)	Phenomeno- logical framework	None given	<i>Size, gender, age:</i> N=15 nurse students across all three years of the program at 4 different pre-dominantly White universities 2M; 13F <i>Marital status:</i> Not given <i>Ethnicity/ religion./Nationality:</i> 3 East Indians, 2 Hispanics, 2 Hmong Laotian, 2 African American, 2 Nigerian, 1 Philipino, 1 Nepalese, 1 Vietnamese, 1 Chinese.	Semi structured interviews	Thematic analysis Independent rater	None given	S, T	A

^d This figure included unspecified number of undergraduates currently studying health science and had applied for dentistry

Lempp & Seale, 2006 (US)	Grounded Theory	Hidden Curriculum model for understanding pressures and processes of constraint outside of academic curriculum	<i>Size, gender, age:</i> 36 Medical students at one British Medical School. In 1 st -5 th year. Sampling framework provided, random quota sampling – 13% drop out rate <i>Marital status:</i> Not given <i>Ethnicity/ religion ./ Nationality:</i> Categorised as ‘White’ and ‘non - White’	Semi structured interviews	Content analysis, NVIVO software program Independent Rater	None given	None	X
Amaro et al. 2006 (US)	Grounded Theory	Yoder’s theory of process of responding and patterns of teaching ethnically diverse students	<i>Size, gender, age:</i> N=17, Registered Nurses recently graduated (6 mths to 2 years post qualification) 14 F, 3 M Age not stated <i>Marital status:</i> Not given <i>Ethnicity/ religion. ./ Nationality:</i> 5 Vietnamese, 3 Philipino, 4 Latino, 2 Portuguese, 4 Latino, 2 African American, 1 African origin	Semi structured interviews	Constant comparison method	None given	S, T	X

Schoonveld et al. 2007 (US)	None given	Social Cognitive Career Theory and Racial Identity Theory	<i>Size, gender, age:</i> N=15, 8 genetic counsellor trainees, 7 practitioners; 5 F, 3 M trainees; 7F practitioners Sampling frame-work provided, age not stated <i>Marital status:</i> Not given <i>Ethnicity/ religion / Nationality:</i> Self identified as underrepresented ethnic minorities	Semi structured interviews	Consensual Qualitative research (CQR) content analysis Independent rater	None given	None	X
Odom et al. 2007 (US)	None given	None given	<i>Size, gender, age:</i> 43 medical students Recruited from six states in America; 1 st – 4 th yr students 72% F; Age not stated <i>Marital status:</i> Not given <i>Ethnicity/ religion / Nationality:</i> 88% Black American-African descent, 10% Hispanics, 2% Asian ⁹	Semi structured interviews	Content analysis using ATLAS software	Unclear	None	X

⁹ The author is using the term as used in the US. See Appendix 1 for the meaning of this term.

Dyson et al. (2008) (UK)	Phenomenological framework	None given	<i>Size, gender, age:</i> N=17 nurse students, 12 on BSN course, 5- diploma recruited from one location. Snowballing used, all females; 19-42yr <i>Marital status:</i> 1 married <i>Ethnicity/ religion /</i> <i>Nationality:</i> South Asian: Indian, Pakistani, 15 Sikh; 2 Hindu	Semi structured interviews	Thematic analysis, Independent rater	Researchers own position considered	S, T	X
Rajan & Shaw, 2008 (UK)	Phenomenological framework	None given	<i>Size, gender, age:</i> N=8 Clinical psychology trainees, all female 26-30 yrs <i>Marital status:</i> Not given <i>Ethnicity/ religion/</i> <i>Nationality:</i> 2 Black British, 5 British Asian, 1 dual heritage	Semi structured interviews	Thematic analysis	Researchers own position considered	C, S, T	X
Woolf et al. 2008 (UK)	None given	Theory of stereo-typing threat	<i>Size, gender, age:</i> N=27, 3 rd yr London medical school students; Sampling frame-work provided; 5M & 10F minority ethnic; 1M & 5F White. <i>Marital status:</i> Not given. <i>Ethnicity/</i> <i>religion /Nationality:</i> Indian / Pakistani /Bangladeshi. Unclear of ethnicity of individuals taking part in interviews. Focus groups contained 5 Indians, 2 Pakistani, 2 Bangladeshi, 6 Whites	12 semi- structured interviews; 6 with minority ethnic students, 6 with White students(5F, 7F), followed by 5 focus groups	Content and Thematic analysis Independent rater	Researchers own position considered	D, E	X

4.3 Synthesis of qualitative data

Figure B2 pictorially describes the process of synthesis which loosely followed a meta-ethnographic approach. Meta-ethnography is an interpretive approach to synthesis of qualitative data. The approach involves thematic analysis and reciprocal translation analogous to constant comparison in primary qualitative research (Noblit & Hare, 1988, cited in Atkins et al. 2008).

4.3.1 Identifying themes and concepts

Table B3 shows the themes and conclusions/outcomes from each paper. Concepts, themes and metaphors were identified in each paper by reading and rereading the included studies. The participants' responses reported mainly in the results section of the included studies formed the primary themes. The authors' interpretations of the participants' responses found mainly in the discussion and conclusion section of the article were considered as the secondary themes.

Figure B2: Systematic review and synthesis process

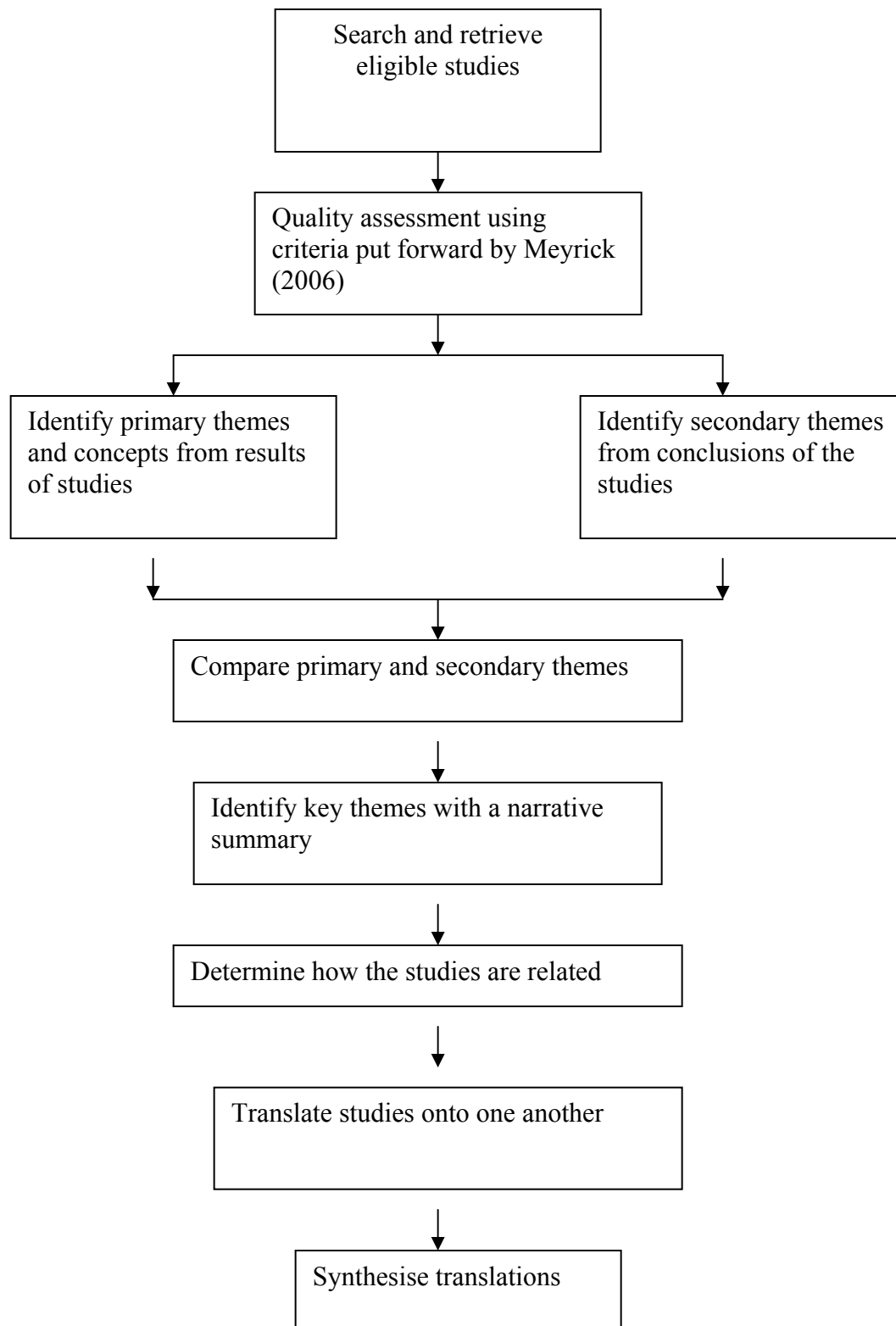


Table B3: Summary grid of papers reviewed: content issues

Author	Stated Aims	Themes	Conclusions
Snyder & Bunkers 1994	To identify facilitators and barriers to admission and successful completion of a nursing program	1) Personal factors 2) Undergraduate education 3) Support systems - family & friends 4) Support systems- employer 5) Graduate faculty and graduate program/university	Strategies suggested; 1) Student mentorship; faculty mentorship; orientation program with a focus on helping students understand academic expectations 2) Support with integration of demands of family and academic responsibility 3) Provision of achieving program objectives without depending on academic writing 4) Respect for individuality related to diversity
Jordan 1996	To understand how does being Black in predominately White nursing education program hinder students ability and desire of education goals	Three themes: 1) Seeking identity: being different/being the same 2) Student as teacher: Surrogate pedagogy 3) Resoluteness; I'll see you at graduation	1) Nursing programs need to understand what it means to be Black 2) Being Black does matter- Blacks do not share the same vantage point
Maville & Huerta 1997	Relationships of stress and social support to academic achievement in predominately female Hispanic Nursing program <i>(study a; specific aims Stress and academic achievement)</i> <i>(study b; social support and retention of Hispanic Nursing students)</i>	1) More socio-economic stress felt by Hispanics and a fear of failure 2) Over burdened by balancing family domestic and job/course responsibilities	1) Hispanics reacted to life stressors differently; stressors can reduce their academic ability. 2) Identification of socio-economic status associated with a fear of failure in Hispanics; strong family obligation i.e. family comes first; difficult to give personal commitment; sacrifice of personal resources; support systems reduced progress academically and do not seek help from faculty.

Veal et al. 2004	Explored racial differences and variables that influence entry to dentistry, current training environment in dental school and access to resources to support, retain and help success of minority ethnic students	<ul style="list-style-type: none"> 1) Difficult and isolating experiences; African Americans felt if had more numbers could connect better; peer to peer monitoring perceived positively by all 2) Faculty not perceived supportive; all minority ethnic felt were graded harder; could not seek advice from tutors felt lacked knowledge of individuals culture; felt marginalised 3) Lack of representation in the faculty staff and school impacted learning and socialisation 4) Family, God and peers perceived as main support for African Americans 	<ul style="list-style-type: none"> 1) African Americans perceived additional challenges compared to American Indians and Hispanics. This was attributed to them looking physically different compared to Hispanics, American Indians and majority White students. 2) Larger numbers/increased representation meant feelings of being a minority were lessened and there were more opportunities for socialisation and peer support 3) Lack of minority ethnic tutors in faculty impacts negatively on learning through lack of culturally appropriate support
Gardner 2005	To document ethnic minority student nurses experiences in a predominant White nursing program. Exploring factors on graduation - role of culture on social integration and education	<ul style="list-style-type: none"> 1) Loneliness 2) Differentness 3) Absence of acknowledgements 4) Peers/lack of understanding and knowledge cultural differences /pressures e.g. family obligations 5) Desiring support from teachers 6) Coping with insensitivity- difficulties linked with discrimination 7) Determination to build a better future. 8) Overcoming obstacles 	<ul style="list-style-type: none"> 1) Educators to be role models of empathy and caring, 2) Faculty to have an increased understanding of how cultural background impacts on educational success; family obligations; sensitivity to differing priorities 3) Help minority ethnic students express these cultural attitudes in classroom 4) A need for minority ethnic support groups

Lempp & Seale 2006	To investigate the experiences of students in relation to gender and ethnicity and in the context of the 'Hidden Curriculum.'	<p>Ethnicity and gender stereotyping: Non Whites perceived differences and disadvantages</p> <ol style="list-style-type: none"> 1) Independence from the family 2) conflicting loyalties of culture of family and demands of course and social life 3) lack of role models 4) Not fitting in perceived 5) Ethnicity perceived affect career prospects 6) Religion not addressed adequately 7) Asian female students seen as 'Quiet females' and are ignored 	<ol style="list-style-type: none"> 1) Non White students have difficulties in balancing independence from their parents 2) Cultural differences; family obligations /relationships have negative impact on social and learning 3) Black African females experiences negative and different, this warrants more research 4) For female Muslim girls religious beliefs are not acknowledged by staff 5) Gender differences not perceived but extrapolated from opposing accounts
Amaro et al. 2006	Determine ethnically diverse students perceptions of education barriers	<ol style="list-style-type: none"> 1) Personal needs; lack of finances, insufficient time, family responsibilities 2) Academic needs; managing study workload, a need for tutors, need for study group, experienced prejudices 3) Cultural needs; better communication, develop assertiveness, more role models 4) Encountering barriers; prejudice and discrimination from staff and cohort 5) Coping with barriers; increased persistence, increased self motivation, the importance of having supportive teachers, developing peer support, joining an appropriate ethnic minority association 	<ol style="list-style-type: none"> 1) Both negative and positive effects on educational experience were dependent on relationships with family, peers and faculty 2) Family obligations and pressures-financial burden to support family and often large families 3) Family expectations came first 4) Some teachers 'open door' policy was perceived as supportive and motivational

Schoonveld et al. 2007	To learn from experiences of current trainees and practitioners of what barriers exist for choosing genetic counselling and what are the experiences during training and what are the experiences in the field	<p>Main domains:</p> <ol style="list-style-type: none"> 1) Choice to do genetic counselling based on helping others and intellectually challenging 2) Barriers to career progression; main subthemes were financial; lack of information; lack of confidence 3) Family reactions to doing career; mixed feelings, supportive, offering and encouragement and discouragement 4) Being a minority ethnic student led to: differing theoretical perspectives; loss of cultural identity¹⁰; feelings and emotions described (alone/isolated/marginalised/angry/frustrated) 5) Ambivalence related to voicing opinions and questioning other peers and teachers 6) Pressures experienced: being seen as the expert; having to represent one's cultural group; challenging peer and staff misconceptions; justifying ones place on the course due to academic ability not ethnicity 7) Interacting with others from similar background was a helpful coping strategy 8) Building trust and rapport was important when underrepresented 	<p>Complex experiences:</p> <ol style="list-style-type: none"> 1) Withdrawing of opinions and fear of not standing out in class 2) Isolating and loneliness in experience is emphasised 3) Greater negative impact if in larger White cohort 4) Peer relationships with other minority ethnic students are important 5) The need to seek out others of similar cultural background described as coping strategy 6) Acculturation and socialisation challenges exist
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¹⁰ See Appendix 1 for researcher's use of this term

Odom et al. 2007	To explore the barriers and facilitators experienced by ethnic minority medical students achieving personal and professional success	<p>1) Success was defined as; financial, professional, academic, happiness, identity, self determination and balancing in home-life</p> <p>2) Facilitators for completing course identified as; finance, social support (e.g. family, friends and colleagues/peers, professional support e.g. mentors, multicultural/multiethnic faculty and role models</p> <p>3) Inhibitors for success perceived as: finance; lack of support by culturally insensitive staff/ peers; lack of appreciation for sharing experience; lack of cultural representation, increased self consciousness, loss of confidence</p> <p>4) Key barriers; loss of confidence and self-efficacy¹¹</p> <p>5) Students had internalised negative views held about them by faculty staff resulting in loss of self-efficacy</p>	<p>1) Quality of career is based on it preserving family and work values</p> <p>2) Support from family and friends is important</p> <p>3) Race perceived as an obstacle for achieving academic and social support</p> <p>4) Pressure to dispel negative cultural /racial stereotypes by others</p> <p>5) Lack of self-efficacy is created in the student by perpetuating self-doubt</p> <p>6) Cultural beliefs are perceived incompatible with dominant culture of the institution and of the White majority students</p>
Dyson et al. 2008	Explore the experiences of nurse students to identify difficulties related to cultural values	<p>1) Strong family obligations in relation to cultural role</p> <p>2) Gender related cultural pressures e.g. to get married as a priority to education</p> <p>3) Interpersonal relations; relating to others from similar culture easier because there were no issues of cultural misunderstanding and differences</p> <p>4) Lack of support or a personal tutor to help with academic failure or pressure of failing because of cultural difficulties</p>	<p>1) Midwifery and nursing not perceived in South Asian culture as a high status career, this results in higher pressures/stress to complete career</p> <p>2) There are common needs but some needs are related to specific cultural needs relating to family obligations /pressures that take priority over education and affect success; need support to balance priorities</p> <p>3) Teaching needs to be refined according to cultural needs</p>

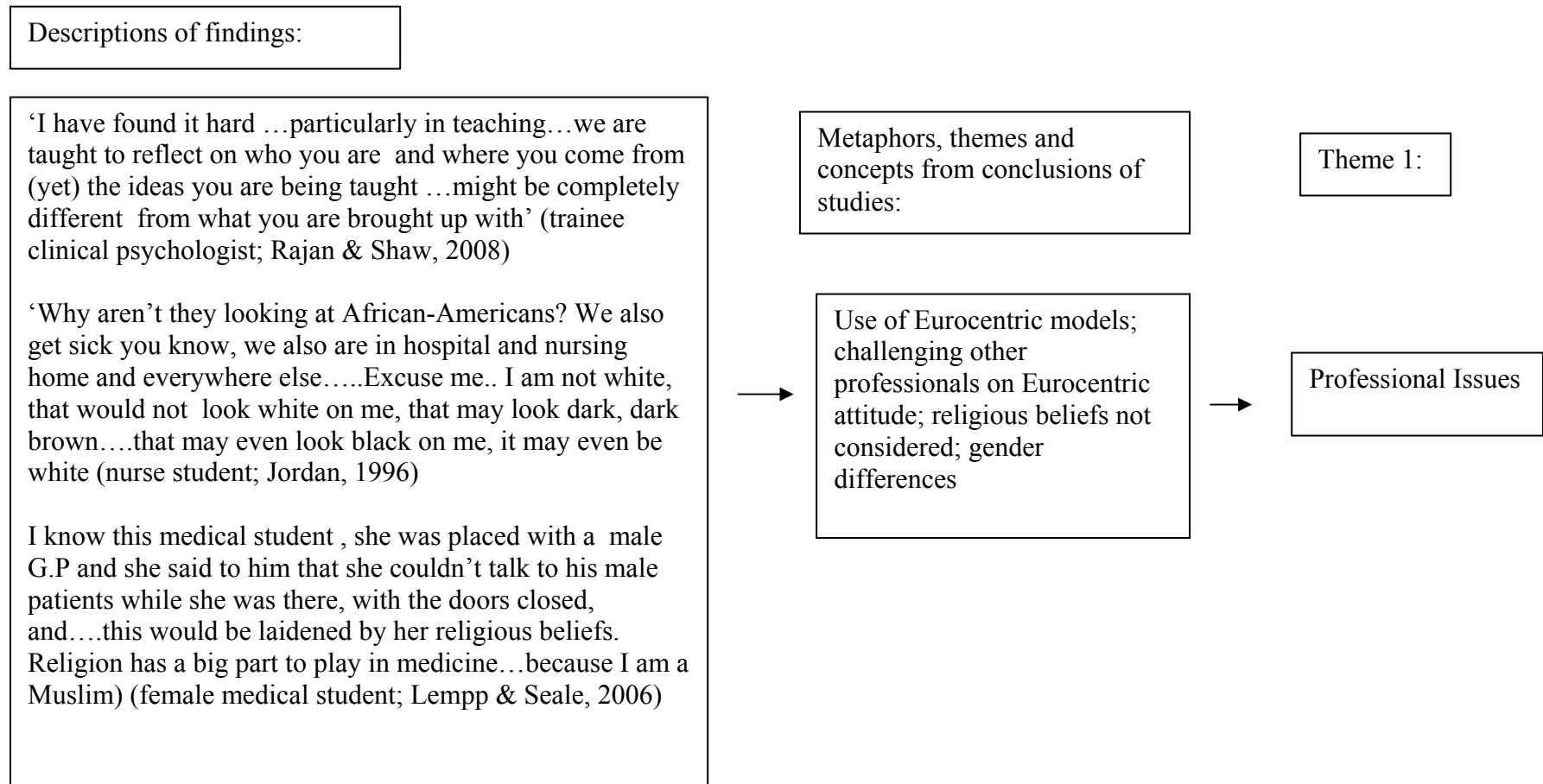
¹¹ See Appendix 1 for researcher's use of this term

Rajan & Shaw, 2008	Explore needs and perspectives pertaining to being Black and minority ethnic in clinical psychology training	<p>1) Professional issues; use of Eurocentric and ethnocentric theories;</p> <p>2) Cohort and classroom experiences; lack of challenging in learning environment /ambivalence over speaking out/ feeling of having personal risks if challenge others /feeling isolated/marginalisation/ labelling difficulties or attributing them to student's culture</p> <p>3) Personal impact of training-difficulties over integration of personal /cultural/ethnic identity vs. loss of self-identity¹²</p>	<p>1) Ethnicity may have been an advantage to get in but asserting cultural needs was struggle thereafter</p> <p>2) Challenging Eurocentric theories or speaking out came with a personal cost of marginalisation, being seen as different/loneliness</p> <p>3) Pressure to be the cultural expert because of cultural identity and minority ethnic status</p> <p>4) Dominant group values have an impact on training</p> <p>5) Mentoring with a mentor of the same culture will be culturally supportive and provide a safe place for reflection</p>
Woolf et al. 2008	To explore the impact of stereotyping of UK ethnic minority students in context of the issue of their underachieving	<p>1) Asian¹³ female students had internalised the negative stereotypes</p> <p>2) Attributes for White students were positive, perceived as autonomous and confident team players. Asians were stereotyped as bookworms, the 'quiet Asian female,' perceived as unmotivated because had chosen medicine because of parents pressure.</p>	<p>1) The negative stereotype amongst faculty and nursing staff reduced academic performance and learning in minority ethnic students</p> <p>2) The negative stereotype had been internalised by Asian students and acknowledged by White counterparts</p> <p>3) Positive stereotypes existed for White students</p>

¹² See Appendix 1 for researcher's use of this term

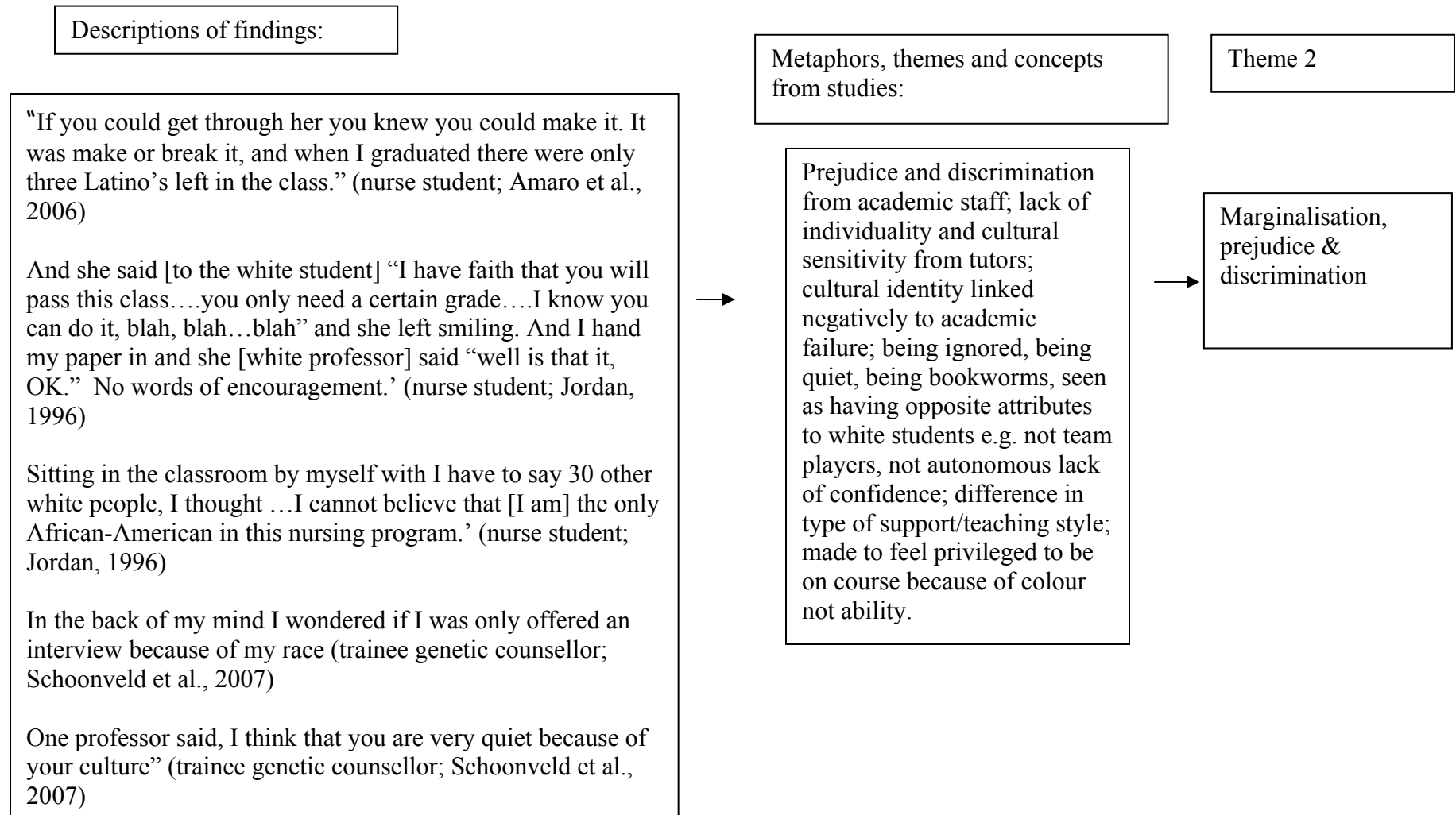
¹³ The researchers are using this term as a synonym to the term South Asian, as used in the UK.

Figure B3: Example 1 of thematic synthesis of the findings from the included studies¹⁴



¹⁴ The examples of the descriptions of participants responses taken from the studies are not exhaustive but provide an illustration of the thematic synthesis phase of the review

Figure B4: Example 2 of thematic synthesis of the findings from the included studies¹⁵



¹⁵ The examples of the descriptions of participants responses taken from the studies are not exhaustive but provide an illustration of the thematic synthesis phase of the review

4.3.2 Determining how the studies are related

Thematic analysis was used to develop categories inductively from the primary themes and secondary themes. Figure B3 and B4 provide examples of the thematic generation.

4.3.3 Reciprocal translation of studies

Each paper was arranged chronologically to facilitate reciprocal translation. The themes in one article were compared to the themes in the next and the synthesis of the two papers was compared to the next paper and so forth. The categories or overarching themes in the above process were used but additional themes were added as they emerged. In the process of comparing studies explicit differences between the studies were also noted.

The seven overarching themes synthesized from the primary and secondary themes are presented in Table B4 below; a descriptive and interpretive report follows.

Table B4. Themes synthesised from the findings of the reviewed studies

	Themes
1	Professional Issues
2	Marginalisation, prejudice and discrimination
3	Classroom and cohort experiences
4	Balancing priorities
5	Personal Impact
6	Managing /Coping
7	Support and Needs

4.4 Evidence from the qualitative data

Seven overarching themes were identified from studies and will be described below.

4.4.1 Theme 1: Professional issues

The theme ‘professional issues’ related to the difficulties and challenges faced by minority ethnic students either from culturally insensitive practises and/or the use of ethnocentric theories by their profession. For example, for clinical psychology trainees, difficulties related to the ethnocentricity of the teaching material used by the profession: *‘I have found it hard ...particularly in the teaching...we are taught to reflect on who you are and where you come from (yet) the ideas you are being taught ...might be completely different from what you are brought up with’* (Rajan & Shaw, 2008). For minority ethnic medical students, difficulties were experienced in their placements and when their religious beliefs posed practical difficulties. This quote highlights how raising issues were often: *‘I know this medical student, she was placed with a male G.P and she said to him that she couldn’t talk to his male patients ...with the doors closed, and....this was harder for her because of her religious beliefs’* (Lempp & Seale, 2006).

4.4.2 Theme 2: Marginalisation, prejudice and discrimination

Majority of the studies highlighted examples of marginalisation, prejudice and discrimination by academic staff and this led to unequal modes of teaching and support and perceived success (Amaro et al., 2006; Gardner, 2005; Jordan, 1996; Lempp & Seale, 2006; Odom et al., 2007; Schoonveld et al., 2007; Snyder & Bunkers, 1994; Woolf et al., 2008). Examples of experiences of being marginalised were prominent for nurse students in training, for example: *‘Being shunned...ignored by the rest of the class because of my culture is most disturbing. They don’t interact with me ...if I have to*

study then I have to do it alone' (Gardener, 2005). Members of the medical and genetic counselling profession were perceived as having negative cultural stereotypes for example a medical student said: *'People get places [in medicine] because of who they know, and I don't appreciate that.'* (Lempp & Seale, 2006). In three studies there was a theme of the *one* member of staff the students had difficulties with, who was perceived as a barrier for succeeding (Amaro et al., 2006; Jordan 1996; Odom et al., 2004).

Paradoxical feelings also existed; feeling proud to represent the ethnic group (Jordan, 1996) and being chosen only to make up numbers as opposed to having the same ability as their peers: *'Application forms...you knew it was the kind of thing they wanted to hear. I've heard feedback...oh yes they'll like that bit of cultural relevance and diversity'* (trainee clinical psychologist; Rajan & Shaw, 2008).

4.4.3 Theme 3: Classroom and cohort experiences

Challenging

For many students within the classroom challenging teachers or peers over issues was at times perceived as a difficulty for example: *'I'm a bit frightenedin that some of the trainees' views of the world is not representative but it's not being challenged.'* (trainee clinical psychologist; Rajan & Shaw, 2008). Speaking out was seen as having an element of personal risk of being further marginalised: *'you do feel kind of responsible for holding the flag up and educating the people. I want to but honestly, I am split half way. If I have got it then I should share it....then the other part of me feels I didn't come on the course to do that. I don't want to be pigeonholed'* (trainee clinical psychologist; Rajan & Shaw, 2008). Insensitivity and ignorance in addressing cultural diversity issues by peers conversely led to feelings of anger from stereotyping (Jordan, 1996).

Expert/Non expert

Being placed as the expert by White students and teachers not only created feelings of ambivalence but also resistance: *'It feels like I am carrying the burden of the whole culture on my shoulders... I am the other teacher, I am not teaching about the culture but that's not my responsibility'* (trainee clinical psychologist; Rajan & Shaw, 2008).

Cultural incongruence and socialisation processes

Many of the studies identified students experiencing nuanced and complex patterns of seeking identity. The theme 'differentness /being the same' identified paradoxical positions of identity. Gardner (2005) highlights how these feelings for the students develop not in isolation but within the psycho-social and cultural political context that imposes on the social environment within academic institutions, for example:

'Sometimes I wanna say "how would you feel, just sitting at a predominantly Black college, the only White student on a nursing program...how would you feel...?'" (nurse student; Gardner, 2005). Feelings of isolation leading to a need for belonging or 'fitting in' were identified among many students across various disciplines with cultural incongruence negatively impacting on socialisation processes more so with increasing size of the White cohort (Amaro et al., 2006; Gardner, 2005; Jordan, 1996; Lempp & Seale, 2006; Odom et al., 2007; Schoonveld et al., 2007; Veal et al., 2004).

4.4.4 Theme 4: Balancing priorities

Students discussed a wide range of issues around balancing family obligations with academic responsibilities: *'I think the major thing is compromising my family life...which is my religion...you know, families are very important...clearly it is less in western cultures, but.....much more so in my culture a lot of the time I can't go home at the weekends although my parents are expecting me to....'* (medical student; Lempp &

Seale, 2006). For many students the importance given to their cultural role within the family meant there were high expectations of them. The expectation put pressure on the student to draw on personal resources and manage workload and time. For male students there were added pressures in terms of achieving independence and financial commitments (Amaro et al., 2006, Lempp & Seale, 2006). If the female was married there was an expectation to family commitments: *'Women just have to have great devotion to their family...That is number one even if they go to school [university]'* (nurse student; Snyder & Bunkers, 1994). Further pressure was felt if the career lacked status or if within the traditional family set up there was a lack of emphasis on education or educated role models (Dyson et al., 2008; Lempp & Seale, 2006; Odom et al., 2007).

4.4.5 Theme 5: Self-efficacy¹⁶

Common to a majority of the studies were themes relating to poor self-efficacy. Psychological responses consisted of becoming self conscious, feeling inferior, self doubting of one's academic ability and developing a fear of failure. (Maville & Huerta, 1997a; 1997b; Lempp & Seale, 2006; Odom et al., 2007; Rajan & Shaw, 2008). Woolf et al. (2008) found medical students' academic performance was negatively impacted by their perception of academic and nursing staff holding assumptions of them having a poorer academic ability compared to their White counterparts. The researchers suggested that students had 'internalised negative stereotypes.' A negative impact on learning was identified across all the studies either from the individuals' cultural difficulties exacerbated by a culturally insensitive pedagogy or as suggested by Woolf et al. (2008) from internalising negative stereotypes. There was also a common theme of ambivalence for many students from different disciplines and this appeared to be related

¹⁶ See Appendix 1 for researcher's use of this term

to the dissonance that existed in social/academic situations, students described feeling unsure whether to speak out, to challenge others or to behave the same or differently with peers.

4.4.6 Theme 6: Managing /coping

Many of the studies suggested that students were apprehensive of achieving success or completing the course and this had led to them feeling frustrated and angry (Amaro et al., 2006; Gardner, 2005; Lempp & Seale, 2006). Common themes relating to how students managed or coped with their feelings emerged across the studies. An increased persistence /resoluteness by students, as a means of coping, was described in many studies (Amaro, et al., 2006; Gardner, 2005; Jordan, 1996; Odom et al., 2007; Schoonveld et al., 2007; Veal et al., 2004). For some students, an increased sense of determination to achieve goals such as graduating was also described in some studies (Gardner, 2005; Jordan, 1996; Veal et al., 2004).

4.4.7 Theme 7: Support and needs

Consistent across the studies was the feeling that faculty staff lacked an awareness of how the minority ethnic student's culture had exacerbated their academic difficulties. Furthermore students felt that in attempt to understand an individual's difficulty faculty staff often made cultural misattributions. Students in many studies expressed the need for a mentor or tutor empathic to their cultural difficulties and needs (Amaro et al., 2006; Gardner, 2005; Rajan & Shaw, 2008; Snyder & Bunkers, 1994). Amaro et al. (2006) provide a good illustration of how this need was expressed: '*...that [an ethnic role model or mentor] was something I really wish I had because I never really had someone to look up to...but, there was never really a role mode or mentor. I really regret that....I just really feel like I got cheated.*' For some participants peer support

helped reduce feelings of isolation and cope with academic work (Schoonveld et al., 2007; Veal et al., 2004). Through seeking out other minority ethnic students, professional role models and/or a representative organisation, an increased perception of representation helped develop a sense of belonging (Dyson et al., 2008; Schoonveld et al., 2007; Veal et al., 2004).

5. DISCUSSION

Many themes were consistently found across the studies examined, for example the minority ethnic student/trainee was often wrongly perceived as the cultural expert in the teaching environment. This misconception has also been reported by the researchers Patel et al, (2000). The authors suggest that for clinical psychology training, Black trainees be involved in the learning processes and their experiences help inform training on issues of race and culture. Cultural competency training has also been suggested for improving culturally insensitive pedagogical practises (Papadopoulos, 2006; Tamkin et al., 2002).

Common to a majority of the studies were themes relating to minority ethnic students expressing poor self-efficacy. This was associated with feelings of being perceived by faculty staff as academically inferior to their White counterparts. A negative impact on student's learning was also suggested across the studies. Researchers have suggested that minority ethnic students in predominantly White academic institutions in America can have higher levels of stress than their White counter parts (Massey, 2001; Parker & Jones, 1999). Parker & Jones (1999) further suggest that being perceived as a minority ethnic student has a negative impact on the student's psychological and academic functioning. Cohen & Garcia (2005) proposed that the perception of minority ethnic students as having poorer academic ability fostered a negative stereotyping which when perceived by minority ethnic students led to their academic underperformance.

Difficulties in balancing academic priorities and family obligations were common difficulties identified within the studies. This was particularly evident in the female

students' experiences across all the ethnic groups, suggesting both cultural and gendered experiences.

Although the need for mentoring as a form of support was highlighted, unfortunately within the studies there was no suggestion if and how mentoring had actually been experienced. However, some studies suggested that having academic tutors of minority ethnic background helped students to feel better understood. The loss of confidence and motivation due to internalisation of negative stereotyping was also identified across the participants of all the studies but particularly highlighted for medical students in the UK study. However, it could be argued that this was highlighted because the study focused on using negative stereotype theory as the basis for their research. Issues of covert racial discrimination experiences were also identified mainly within nursing education in the US. This could be attributed however, to the age of some of the studies which were conducted more than a decade ago prior to the implementation of race relation national policies in the US. Similar issues have been suggested to still exist within certain health professions in the UK (Adetimole, Afaupe & Vara, 2005; Patel & Fatimilehin, 2005).

The systematic approach to searching and analysis of the data ensured reliability of the synthesis, whilst the presence of consistent themes across different health disciplines supports validity of the findings. According to the knowledge of the reviewer this review is the first to examine the challenges faced by minority ethnic students on training courses for health careers. However, it could be argued that the review was rather ambitious as it attempts to find commonalities amongst experiences across ethnic minority groups within different countries and that in essence it assumes 'essentialism'¹⁷ (Papadopoulos, 2006). The reviewer is however mindful of assuming

¹⁷ See Appendix 1 for the researcher's use of this term.

essential cultural differences between people and not giving importance to other aspects of being, such as the influence of socio-political and socio-economical factors. Such limitations were encountered by the researcher, as authors of many of the studies reviewed provided limited detail within the study on their participants' demographics. The studies lacked details on whether the student was UK or US born, the socio-economic status and details on family of origin. The review could also be critiqued on the fact that it includes a wide range of health disciplines with differing career routes and professional values. Cheshire & Pilgrim, (2004) suggested that the value given to a profession is complex and influenced by the interplay of factors within the wider context, such as the sociological value given to the profession. Thus whether conclusions can be made about a student's experiences in one profession e.g. clinical psychology by drawing on another profession e.g. medical or nursing could be regarded as questionable.

On the note of process issues, the study findings could be limited with regards to potential reviewer bias; the thematic analysis was only conducted by the researcher. To reduce further bias reflexivity is offered by the researcher through declaring her background as being South Asian and being a trainee in pursuit of a health profession.

6. CLINICAL IMPLICATIONS

This synthesis highlights the importance of socio-cultural challenges on the learning and interpersonal dynamics of the minority ethnic student. The findings support Greenhalgh et al.'s (2004) suggestion that the lack of academic ability or knowledge has been implicated for far too long as the reason for the unsuccessful academic pursuits of minority ethnic students. The findings also support suggestions that cultural misattributions made by academic staff and peers can lead to minority ethnic students suffering from stress and anxiety (Massey, 2001; Parker & Jones, 1999). Furthermore, that the internalisation of negative stereotypes held by academic staff and peers can negatively impact on students' academic performance and social experiences (Cohen & Garcia, 2005). As suggested by Cohen & Steel (2002), specific strategies aimed at challenging negative stereotypes of minority ethnic students will help to acquire a culturally sensitive pedagogy. Academic institutions and health organisations also need to consider what more can be done at the institutional level, and aim to combat what seems to be prejudice leading to discriminatory practise, deep rooted in historical racial intolerance (Tinsley-Jones, 2001).

There is a growing body of evidence that suggests the need for minority ethnic students to be supported by mentoring. Interventions that use 'mentoring' in training courses (Fox & Broome, 2001; Hill, Castillo & Ngu, 1999; Melynk, 2007) recognise the importance of personalised support. However, a closer examination of the literature to support mentoring interventions suggest the use of either a) quantitative research, that can be challenged on methodology and conceptual grounds or b) the use of anecdotal evidence, based on personal reflections of current minority ethnic practitioners (Nugent,

2004; Williams, 2001). Consideration of the findings of this review could help provide effective mentoring. The review highlights the need for mentors to be trained to deliver culturally sensitive support but also suggests that the question of 'who' is giving the mentoring needs to be considered. Atkinson (1994) identified that minority ethnic students were best mentored by minority ethnic psychologists. Within certain health professions supervision and reflective practice are key support strategies for personal and professional development (Dean, 1977; Golding & Gray, 2006; Hughes & Youngson, 2009; McNeill, Horn & Perez, 1995; Patel et al., 2000; Wong, 2006). The review findings suggest that facilitators of these forms of support should consider how to make their support culturally appropriate and specific to the students' cultural and ethnic needs.

Critiques of a cultural competency model would argue that it is the lack of visibility and positioning of minority ethnic groups within certain health professions that is implicated for the lack of cultural change. The review suggests that increasing representation of minority ethnic students could improve upon 'a sense of belonging' through more role models and mentors. For academic and health organisations the indirect impact of improved interpersonal relations and positive academic and social experiences, could mean the creation of champions, providing their expertise to address the concerns of recruitment and retention of minority ethnic students.

7. RECOMMENDATIONS FOR FUTURE RESEARCH

Although male perspectives were included in a few of the reviewed studies, a detailed exploration was overlooked in comparison to the female peers. Further dedicated exploration of how males experience choosing a health career and training experience in female dominated health professions would be of benefit. Specific exploration of minority ethnic male experiences would further the understanding of gendered roles and socio-cultural expectations on career trajectories.

Qualitative studies generate rich in-depth data (Ashworth, 2003; Barbour, Cohen, Chinnock, Peiperl & Yardley, 2007; Fossey, Harvey, McDermott & Davidson, 2002) and this review highlights the need for further qualitative studies to be conducted by specific health disciplines such as clinical psychology, in which anomalies in their representation exist. Within this profession, an increasing number of South Asian students are suggested to consider pursuing psychology at undergraduate level (Turpin & Fensom, 2004) and yet their representation within the profession is relatively lacking. Furthermore, there is evidence to suggest that Black and minority ethnic students that apply for the doctoral training show lower academic performance than their White counterparts (Scior et al., 2007). Given the findings of the review there is a danger that these students may become negatively stereotyped, if further insight is not offered as to what might be other influences, such as socio-cultural factors; remedial interventions may be inappropriately placed. This review further highlights the need to be culturally and ethnically specific with sampling if subtle nuances reflecting the wider socio-cultural economic and political context are to be explored.

8. CONCLUSION

The conclusions of this review are limited by the design and robustness of the methodology used by the studies. However, synthesis of the findings revealed across the studies commonality of themes related to social and academic experiences of minority ethnic students/trainees in pursuit of health careers. This review identified that many challenges are faced by the minority ethnic student; cultured, gendered and racial experiences are encountered. Culturally sensitive pedagogy that responds to their specific needs will ensure their retention and success. Culturally competency training may help provide appropriate mentoring support.

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SECTION C

THE RESEARCH REPORT

**‘How I came to be a Clinical Psychologist: An Explorative Study into the
Experiences of Becoming a Clinical Psychologist when from a South Asian
Background**

1. Abstract

Purpose: The aim of this study was to explore the experience of becoming a clinical psychologist when from a South Asian background.

Design: A qualitative interview-based study was used.

Method: Nine South Asian clinical psychologists were interviewed about their experiences of choosing clinical psychology as a career, their experiences of the doctoral training and their current practice. The interviews were transcribed and analysed using Interpretive Phenomenological Analysis (IPA).

Results: Over the career trajectory six themes common to all of the participants emerged. Themes regarding choosing a career in clinical psychology were: *Intrinsic motivational factors for choice*; *Socio-cultural influences challenging choice*; and *Supportive contexts to maintain choice*. Two themes emerged in relation to the doctoral training experience, which were: *Cohort/classroom experiences*; and *Personal impact*. The final theme: *Being a practitioner from a South Asian background* contained descriptions related to the individual's cultural and ethnic identity on their practice.

Conclusion: An early assessment of both personal interests and ability suggested a psychological career was a good match. However, pursuing 'clinical psychology' required persistence and defiance with a recognition of 'being different' to their South Asian peers. Issues of development and maintenance of self-identity were suggested. Lack of awareness of clinical psychology, its status and the long career route were seen as problematic in relation to the 'stronghold' of a model of education focused on traditional careers, within the individual's community. All of the participants were the only South Asian student in their cohort. Eight were the only minority ethnic student and participants gave descriptions of isolation in relation to this. Being seen as the cultural expert related to their cultural identity and minority ethnic status. Once qualified, being a South Asian clinical psychologist had the potential to induce subtle tensions when professional practice and responsibilities challenged cultural roles within the participants' own family and community.

Word Count: 295

2. Introduction

The minority ethnic population in the UK stands at 9 per cent (Office of National Statistics (ONS), 2003) but in certain geographical regions (for example, in the East Midlands and in particular Leicester) the figure is as high as 29.9 per cent (ONS, 2004). Clinical psychologists from a minority ethnic background make up 7.5 per cent of the profession nationally (Department of Health (DoH), 2004a); therefore within certain geographical regions the underrepresentation of minority ethnic clinical psychologists would pose concerns with respect to meeting national health targets (*Organising and Delivering Psychological Therapies* (DoH), 2004b). Meeting the specific mental health needs of a growing culturally diverse population has been a concern highlighted by previous researchers (Bender & Richardson, 1990; Boyle, Baker, Bennet & Charmann, 1993). Williams, Turpin & Hardy (2006) have reviewed the state of clinical psychology services and highlight the dichotomy between the minority ethnic professional representation and inadequate service provision. The reviewers urged the British Psychological Society (BPS) to address the concern of recruitment of minority ethnic students into the profession.

2.1 Research into Barriers for Choosing Clinical Psychology

The lack of awareness of the profession and the lack of role models have been repeatedly reported as possible factors for negative perceptions of the profession (Fatimilehin & Coleman, 1998; 1999; Helm, 2002; Nadirshaw, 1993; 1999; Sashidharan, 2003; Williams, 2006). A lack of family and community support, a negative belief of success in application for training, financial constraints and the lengthy route into clinical psychology have all been implicated as barriers for minority ethnic undergraduate students (Craig, 2007; Williams, 2002; Wong, 2007). Williams

(2002) explains how psychosocial factors such as low self-perception of ability deter minority ethnic undergraduate students from applying for clinical psychology.

However, due to methodological limitations the above studies have not explored 'how' family and community perceptions are inter-related and what influences exist within the wider socio-cultural context. Through seeking to compare minority ethnic students' perceptions to their White¹⁸ counterparts and with limited numbers of available minority ethnic participants to recruit from, researchers have been inevitably collective in their approach. Therefore, possible salient differences in perceptions to clinical psychology, in terms of race, culture and ethnicity have not been identified.

Patel & Fatimilehin (2005) suggested that the profession's attempts to understand the recruitment issues are to 'locate responsibility on the Black and Minority Ethnic (BME) student' and to suggest that they are 'not really attracted to the profession' (p. 20). As far back as 1998, research into the exploration of minority ethnic clinical psychologist's perspective has been recommended (Patel, 1998).

2.2 Research into Training Experiences

To date a few studies and personal reflections have been offered to further an understanding of the experience of clinical psychology trainees (Baker, 2002; Bender, 1995; Caswell & Baker, 2007; Cheshire, 2000; Cushway, 1992; Cushaway & Jay, 2000). However, the researcher identified only two papers to date specifically addressing minority ethnic trainees' experiences; a personal reflection by the researchers Adetimole, Afuape & Vara (2005) and a qualitative study by Rajan & Shaw (2008). The training experiences reported for minority ethnic clinical psychology trainees bear similarities to minority ethnic students pursuing other health professions. Feelings of isolation exacerbated by a lack of ability to share cultural difficulties were

¹⁸ The author uses 'white' to mean a sample that consists of Caucasians and white minority groups.

common difficulties faced by the minority ethnic student of other health disciplines such as nursing (Gardner, 2005; Jordan, 1996; Snyder & Bunkers, 1994).

The literature on training experiences of minority ethnic students in pursuit of health professions suggests that challenges faced by the minority ethnic student relate to issues concerned with their cultural identity¹⁹. In the medical profession in the UK where there is an overriding presence of South Asian students, negative stereotyping by faculty nursing staff was found to have a negative impact on the academic performance of Asian students (Woolf, Cave, Greenhalgh & Dacre, 2008). Furthermore, a systematic review of studies that compared the academic performance of minority ethnic medical students, in particular of Asian students to their White counterparts identified a reduced academic performance (Ferguson, James & Madeley, 2002). Greenhalgh, Seyan, and Boynton (2004) have strongly urged that before further assumptions about the minority ethnic student's educational attainments are made, further investigation is required to understand the influences within the socio-cultural context that may be present as barriers to learning. Family obligations linked to gendered roles have been suggested to present as challenges to minority ethnic female students' when pursuing nursing (Gardner, 2005; Jordan, 1996; Snyder & Bunkers, 1994). Furthermore for South Asian female students pursuing health professions such as nursing and medicine family expectations have been strongly suggested to pose unique difficulties (Dyson, Culley, Norrie & Genders, 2008; Woolf et al., 2008).

The issue of negative stereotyping of minority ethnic students' academic difficulties is of particular interest to clinical psychology; Scior, Gray, Halsey and Roth (2007) have identified that in the UK, Asian applicants to the doctoral training have lower academic abilities. If determinants possibly within socio-cultural context of the applicants are not further investigated, this finding could lead to a development of a

¹⁹ See Appendix 1 for researcher's use of this term

negative stereotype of the minority ethnic student wishing to embark upon a career in clinical psychology. Turpin & Fensom's (2004) comprehensive report into undergraduate psychology education also highlights the importance of understanding influences within the socio-cultural context on minority ethnic students' choice to pursue psychology careers. The report specifically highlighted that Asian Indians²⁰ are most represented at undergraduate level and this may reflect the national trends in education for this group (National Statistics Online, 2002, cited in Turpin & Fensom, 2004). The increase in representation by this ethnic group would suggest that South Asians are interested in psychology careers. However, the English Survey of Applied Psychologists (DoH, 2004c) indicated that of the 5.8 per cent of staff from a minority ethnic background in the UK, only 2.3 per cent are Asians²¹. At present the Division of Clinical Psychology (DCP) lack specific figures on the current number of its South Asian practitioners; however their lack of presence within clinical psychology profession is suggested to be of concern.

A strong preference by Asians in the UK for traditional careers (e.g. medicine, dentistry, law, pharmacy) (Modood & Shiner, 2002) could account for their apparent disinterest in pursuing clinical psychology. Turpin & Fensom (2004) have suggested further research into the influences on the diversity of the profession. The authors suggest that the visibility of psychology, parental influence and status of the career to be of importance. Such influences could be of particular relevance to the recruitment of South Asian psychology undergraduate students into clinical psychology.

The literature highlights the need for research into recruitment and experiences of minority ethnic clinical psychologists and specifically of minority ethnic groups such as South Asians. Below follows a brief review of literature that suggests that a changing

²⁰ This term is often used synonymously with the term South Asian; however, used as categorization as it is in this report, the authors are referring to persons of Indian origin, but specifically exclude people that identify themselves as Pakistani and Bangladeshi.

²¹ See Appendix 1 for researcher's use of this term

socio-cultural economic climate can have powerful influences on South Asian students' career choices.

2.3 South Asians and the Changing Socio-cultural Economical Climate

The 2001 census identifies just over half of the UK minority ethnic population as of South Asian origin. Before discussing the socio-cultural and economical changes that influence South Asians in Britain, it is important to bring into context a brief overview of their migration history. Initial South Asian migration to the UK was for the purpose of boosting the UK labour force in the late 1950's and 1960's. The majority of the South Asians were mainly from two large geographical areas of India, Gujarat and Punjab. A much larger proportion of South Asians then migrated to Britain from East Africa as a result of being forced to leave the country in the early 1970's. Many people from Sri Lanka also came as a result of the civil disturbances in the early 1970's. However, with changes in immigration laws, Pakistani young men also migrated to Britain, followed by a higher proportion of Bangladeshi men in the 1980's. The majority of Indian origin South Asians have therefore migrated twice (originally migrating to East Africa from India as indentured laborers) and mainly consist of successful business men coming from a heritage of trade and associated self employment (South Asian Development Partnership (SADP), 1991).

Robinson (2005) suggests that a difference in attitudes to acculturation and proficiency can exist between sub-cultures of South Asians (e.g. between Indians and Pakistanis), which may influence self-identity²² and therefore influence choice of career. Ram, Abbas, Sanghera, Barlow and Jones (2001) suggest that traditional careers (such as pharmacy, dentistry and accountancy) amongst South Asians, are taken up by those

²² See Appendix 1 for researcher's use of this term

individuals from families that still wish to use inherited business skills, remain self-employed and view a ‘business model’ as a way of achieving success.

However, as a result of competition and labour market changes in the UK there is now a documented retreat in the number of South Asian businesses (Jones & Ram, 2003; Targetjobs.co.uk, n.d). The impact of this socio-cultural economical influence on South Asian students’ educational choice has yet to be fully explored. Furthermore there has been very little research that has looked specifically at how through ‘family influence’ the socio-political salience of race and culture are translated into the individual’s career trajectory (Brown, 2004).

2.4 Gaps in the Literature

Studies conducted within clinical psychology to understand minority ethnic career pursuits into the profession have mainly focused on the psychology undergraduate and have used collective and comparative methodology to understand minority ethnic students’ experiences. Rajan and Shaw’s (2008) experiential study offers initial insight into understanding the ‘meaning’ of being a minority ethnic student and specifically being a clinical psychology trainee. Further exploration into the experiences of minority ethnic psychology students and clinical psychology trainees may help address the issue of underrepresentation within the profession. An experiential account of how minority ethnic students come to choose clinical psychology, train and how their experience affects practice, may offer an understanding into the ‘totality of the experience’ of becoming a clinical psychologist. Exploring the retrospective accounts of current minority ethnic clinical psychologists is warranted. Given the current literature on South Asians career choices, a focus on the career trajectories of clinical psychologists from a South Asian background as a basis for preliminary research into the given topic is suggested.

2.5 Aims and Objectives

Through the retrospective accounts of South Asian clinical psychologists' the principal aim of the proposed study was to explore the career trajectories of the participants' into the profession.

The research addressed two main questions:

- 1) What has been the participant's experience of the career route into clinical psychology; in particular what attracted them to the profession and what challenges within their socio-cultural context were experienced during their career pursuits.
- 2) How does their cultural background of the participants impact on their clinical practice and how do their family and community perceive their career route and profession.

3. Methodology

3.1 *The Research Design*²³

The research aims of this study are exploratory and concerned with the lived experiences of South Asian clinical psychologists and therefore a qualitative approach was chosen. As the area under enquiry is currently under researched, it was decided that the method of enquiry should remain focused on a phenomenological approach rather than developing an inductive theory. For this reason, Interpretative Phenomenological Analysis (IPA) (Smith, 2004) was chosen in preference to Grounded Theory²⁴.

3.1.1 *Interpretive phenomenological analysis.*

Ashworth (2003) suggests that IPA permits those interested in the lived experiences of the participants, to identify “elements of the ‘life world’ in participants accounts; selfhood, sociality, embodiment, temporality, spirituality, discourse” (Smith & Eatough, 2006, p.325). IPA is also a method of enquiry that adopts both a phenomenological and hermeneutic approach to the research (Moustakas, 1994), regarding interpretation and sense-making by *both* the participant *and* the researcher as important. The research is seen as a dynamic process with an ‘active role’ for the researcher in the process (Smith & Eatough, 2006). This method therefore not only aims to gain a description of the participants’ experiences but to develop with them an understanding of their “lived experience” (Haverkamp & Young, 2007, p.276), taking into consideration the researcher’s position and interpretations.

²³ The time scales for this study are presented in Appendix IV

²⁴ Development of the argument for IPA verses Grounded Theory is presented in Appendix IV, within the researcher’s epistemological statement.

3.2 *Researcher's Background*

The researcher was aware that the participants' descriptions would be shaped by their cultural background, their own personality and the context in which their account was given, but what was said held some objective reality beyond the bounds of the interview process. The researcher therefore held a critical realist ontological and epistemological position.²⁵ She was also aware that her own cultural background, experiences and current trainee position may have sensitized the participants to particular aspects of their narration. To enable the reader to judge the extent to which the researcher's background and biases may have influenced the research it is important to be explicit about this (Morrow, 2007).

The researcher is a 41 year old middle class female and is herself from a South Asian background. Her parents migrated to the UK from India in early 1970's. Her father was an architect and her mother worked in a mail order factory. Upon having to care for a younger brother with learning disabilities the researcher developed an interest in becoming a clinical psychologist. In 1986, however following peer pressure she gave up the psychology degree to study pharmacology and went on to complete an MPhil in Gastroenterology. Following further postgraduate study (MSc in Health Promotion and a PGCE) she eventually returned to her original ambition and completed a Psychology degree through the Open University in 2004. Given her convoluted career trajectory the researcher became interested in exploring how other South Asians have become clinical psychologists.

3.3 *Ethical Considerations*

3.3.1 *Informed consent.*

²⁵ Further details on the researcher's ontological and epistemological position are presented within the statement in Appendix V.

Information on the study ²⁶ inclusive of a reply slip was sent to each participant prior to their enrolment into the study. Prior to starting the interview, after having ensured that the participant had understood the information, the researcher obtained written consent.

3.3.2 *Participant distress.*

Although it was anticipated that the interview content or process would not cause any psychological distress, participants were made aware of the process of seeking support through the Participant Information Sheet and prior to starting the interview. The participants were also made aware that they had the right to withdraw from the interview process at any time and to ask for their data to be removed at any time.

3.3.3 *Confidentiality.*

All information gathered as a part of the research was anonymised and pseudonyms were used to protect participants and others to whom they may have referred. The information was stored securely in keeping with the NHS Trust and University data protection guidelines.

3.3.4 *Ethical and research governance approval²⁷.*

Although the participants were not from the clinical population within the National Health Service (NHS), ethical approval for the study was obtained from appropriate NHS Local Research Ethics Committee in September 2008, and the University of Leicester Ethics Committee.

²⁶ Information sheets, reply slip, consent form, demographic questionnaire are included in Appendix VI

²⁷ Copies of ethical and research governance approval documents are presented in Appendix VII

3.4 *Participants*

Recruitment strategy - Given the small pool of South Asian clinical psychologists across the UK, the recruitment strategy included a two pronged process: ‘snowballing’ and highlighting the study in late September 2008 to the Race and Culture Specialist Interest Group (SIG), a subsidiary group of the British Psychological Society (BPS). Snowballing entailed identifying potential South Asian psychologists that were known to the researcher, to the research supervisor, and known to the potential recruits.

Inclusion and exclusion criteria- The inclusion criteria specified that participants should identify themselves as being from a South Asian background (Marshall & Yazdani, 2000). Male and female, newly qualified and experienced psychologists were included. It was the intention of the researcher that clinical psychologists who had undertaken their DClinPsy doctoral training in the UK and currently practised in the UK would form a homogenous sample (Ashworth, 1986; Smith, Jarman & Osborne, 1999). Clinical psychologists who had completed the in-service training route were therefore excluded.

3.4.1 Sample.

Ten South Asian clinical psychologists were recruited into the study and interviewed. However, as one participant did not give written consent to use their data in the study, only the data from *nine* participants that gave consent formed the sample. The data obtained from the participant who did not give consent was destroyed according to the ethical research guidelines. Table C1 provides demographic information regarding the nine participants.

Table C1: Participants' demographics

²⁸ Participant identifiers	Age Band	Family origin & year of arrival into the UK	Religion	Number of years in profession
CP A-m	30's	Punjab Mid 1960's	Hindu	6-10yr
CP B- f	30's	Punjab 1950-60	Hindu	< 5 yr
CP C-f	late 20's	East Africa 1970's	Hindu	< 5 yr
CP D-f	30's	East Africa 1970's	Hindu	< 5 yr
CP E-f	30's	Kashmir 1978	Muslim	< 5 yr
CP F-f	late 20's	East Africa 1980	Hindu	< 5 yr
CP G-m	40's	East Africa 1968	Muslim	11 -20 yr
CP H-m	30's	Punjab 1972	Hindu	6-10yr
CP I- m	30's	Maharashrtra-India 1967	Muslim	< 5 yr

3.5 Data Collection

A demographic questionnaire was incorporated into the study (Appendix VI). Given the small pool of South Asian clinical psychologists and the recruitment strategy involving a snowballing process, the questionnaire helped to ensure the formation of a homogenous sample and that the participants met the inclusion criteria. Smith (1995) recommends that the qualitative researcher adopt a flexible approach to interviewing but that an interview guide can help to focus exploration in a semi-structured interview. The qualitative researcher should also seek data that provides a wider narrative and context, with further descriptions of the sample to aid transparency and the use of the data. To achieve this, the demographic questionnaire included questions on the cultural and family background of the participants. The questions served a practical advantage of

²⁸ CPA-*m*, CPB-*m* and so forth have been used as participant identifiers; *m* and *f* refers to their gender. The descriptors maintain participant confidentiality and anonymity, and reflect the order in which they were interviewed.

providing insight and a preliminary guide for further exploration in the interview. In line with the researcher's epistemology (i.e. critical realism), rather than imposing constructs into the study, questions were open ended and participants were asked to self-describe aspects of their cultural identity. A reflection and critique of collecting demographic data in the context of a critical realist stance is provided in the critical appraisal.

Due to the very small number of potential participants the schedule was piloted on a current South Asian clinical psychology trainee and a South Asian clinical psychologist that had been through the in-service training route. The pilot interviews suggested that the type of probe used by the researcher in the interview depended on the participant's style of answering. Furthermore that through the researchers' frequent reflection and clarification, less probes were required to facilitate exploration, the interview guide was therefore revised.²⁹

Participants chose the place and time of the interview. Four interviews took place at the participants' home address and one interview took place at the researcher's home address, the remaining took place at the participant's work place. The audio-recorded interviews varied from 75– 145 minutes per participant. Following the interview debriefing took place as a part of a conversation.

3.6 Data Analysis

Interviews were transcribed verbatim by the researcher (see Addendum for transcripts). The researcher approached the analysis of the interview as suggested by Smith and Osborn (2003) and the process began with the first interview transcript. This was read and re-read several times to facilitate the intimacy between the researcher and the data. The left hand margin was used to make a note of interpretations of the

²⁹ The initial guide and revised guide are presented in Appendix VIII.

descriptions taken line by line initially. With each reading words and phrases were developed describing the accounts; the notes were called the ‘left hand margin code’ and formed the first stage of analysis (Table C2 provides an example). Following repeated analysing of both the text and the left hand codes, the emergent themes were written in the right hand margin, and involved for some left hand codes transformation into phrases or metaphors. This transformed the data into a higher level of abstraction whilst still remaining grounded in the data, as can be seen from Table C2 below:

Table C2: An example of the first stage of data analysis

Left hand margin code	Text	Right hand code
Main driver interest and being that way inclined , not the studious medicine type, interested in woolly discussions	<i>If I'm honest, I guess I had a number of drivers but the core one... which has still remained with me, was just a real interest in that areaI was also just that way inclined. I didn't see myself as the studious medicine or law type so this fitted in with my way of thinking [...] even at that time, when it used to come into some of the sort of general studies discussions I found myself interested in those what some people might cynically say, woolly discussions (CP G-m 136-142)</i>	Recognition of personal ability, personality type different- psychology subject matching to different personality and ability

This process was repeated for a further five transcripts. All the themes/right hand margin codes from the six transcripts were typed into a word processor and cut and paste functions used to cluster the themes according to common features in terms of meaning, each of these clusters was given a summarised coding/metaphor. This formed the second level of analysis and the subsequent compilation of a list of master themes.

These themes were used to analyse the remaining three transcripts, adding to the coding and theme creation when new data emerged. Once all the transcripts had been analysed a further clustering of all the themes resulted in subordinate clustering to create superordinate themes³⁰. Development of these themes allowed for the description of experiences that were shared between the individual members of the sample.

3.7 Quality Checks

To improve validity of the research, the researcher used measures suggested by Elliot, Fischer and Rennie (1999):

- The researcher presented selected texts and the coding to the qualitative peer support group, to the research supervisor and to a participant of the study. This process of triangulation of sources provided checking of the validity of the process of analysis and to ensure the themes emerged from the data.
- The researcher provided detail of her own background and ontological position.
- Transparency and reflexivity by the researcher was afforded by keeping a field diary of the researcher's thoughts and processes, thereby providing clarity about links made between the researcher and participant accounts and, ensuring that the emerging data remained grounded in the participants' experiences.. Figure C1 is an excerpt from the researcher's diary.

³⁰ An example of the second level of analysis is provided in Appendix IX.

Figure C1: Excerpt from researcher's field diary

dd.10.08

She gives descriptions of her upbringing - her parents were quite disciplined. Her emphasis was on being different to others. She described the pressures she has with family routines and demands of profession now that she is married; she describes not getting respect for her professional status (tone of voice changes-tired/seems weighted/tied down by family life?). I wondered what else was going on for her at home, and how issues related to family dynamics may be interplaying with the topics being talked of. Interview lasted approx.2 hours- but it did not seem that long. She said she did not find it long but said that she had covered what she wanted (own agenda??) It felt like we had 'chatted' and more about her change in lifestyle and roles (self-identity?) At times, aspects of the interview felt like I was giving her space to reflect and share her feelings about her change in role, there was a focus on loss or a change in her own/self-identity. With me being married that seemed key in her being able to talk about her husband's family. She had to juggle her duty/demands as a wife with her professional

4. Results

4.1 Overview

A total of six superordinate themes were identified and were found in the majority of interviews (Appendix X). Three superordinate with six subordinate themes were identified in relation to choosing psychology. The remaining three superordinate themes relate to the postdoctoral training and current practice issues. See Table C3.

4.2 Structure of Results

Emergent themes have been organised into three sections and according to the enquiry. Section one, *Choosing to do Clinical Psychology*, contains descriptions³¹ of how career choice required the recognition of the individual ‘being different’ to their peers.

Furthermore, themes related to how the individual balanced and negotiated both subtle and overt pressures within their dynamic socio-cultural context that valued traditional careers. Section two, *Doctoral Training Experiences*, outlines themes reflecting the individual’s training experiences that related to their cultural identity and minority ethnic status within their cohort. Section three, relates to the experiences of *Practising as a South Asian Clinical Psychologist*, themes relate to how the individual’s cultural and ethnic identity impacted on practice and how professional practice impacted on cultural roles.

³¹ Quotations from the interview transcripts are provided in order to illustrate specific features of the themes. The following conventions have been applied: speech omitted for the purposes of increasing the coherence is denoted by [...], this may be repetitive speech or small amount of text felt not relevant to the reader’s understanding of the text. Three dots denote a pause in speech. The quote is accompanied by line numbers to aid location in the individual’s transcript.

Table C3: Details of the superordinate and subordinate themes

Line of Enquiry	Superordinate theme	Subordinate theme
<i>CHOOSING TO DO PSYCHOLOGY</i>	Intrinsic motivational factors for choice of career	Personality and academic ability
		Wanting to be different
	Socio-cultural challenges to choice of career	Pressure from an implicit socio-cultural model of education
		Lack of awareness of clinical psychology
	Supportive contexts that maintain choice	Individual family dynamics
		Doing a 'DOCTORate' – helping to negate family pressures
<i>DOCTORAL TRAINING EXPERIENCES</i>	Cohort/classroom experiences	Being in the minority
	Personal Impact	Balancing academic and cultural pressures
<i>PRACTISING AS A SOUTH ASIAN CLINICAL PSYCHOLOGIST</i>	Being a practitioner from a South Asian background	Bringing culture into practice
		Balancing professional roles with cultural roles

4.3 Section 1: Choosing to do Clinical Psychology

4.3.1 Intrinsic motivational factors for choice.

Two themes comprised this category: ‘*personality and academic ability*’ and ‘*wanting to be different.*’ As there appears to be interplay between these two categories the quotes that define both themes are given under one section:

Themes: Personality and academic ability and ‘wanting to be different’

For some participants practising psychology appealed to aspects of their personality. For others, pursuing traditional careers entailed academic stamina, not considered to be within their capacity. Therefore in a sense, participants were making assertions of their personality and academic ability with psychology perceived as a good match:

...I was also just that way inclined. I didn't see myself as the studious medicine or law type so this fitted in with my way of thinking [...] even at that time, when it used to come into some of the sort of general studies discussions I found myself interested in those what some people might cynically say, woolly discussions. (CPG-m; 138-142)

*I wanted to be different, find out what it was like [...] rather than just go into this kind of study type mode [...] so I felt like I really didn't connect with it all
(CPA-m; 498-501)*

I think I was in some ways kind of drawn to this idea of (.) of a different type [...] (.) working in a helping kind of profession. (CPB-f; 77-79)

In fact my decision to pursue psychology as an academic subject ... came from a Gujarathii lesson [...] I was one of these kids that I always wanted to do something slightly different and I was a bit of a ... busy-body to be honest. (CPD-f; 233-236)

Contained within the descriptions were explicit references to ‘being different’ to peers or doing differently to what was expected. The researcher felt that for some participants practising psychology somehow related to *wanting to be different*. There was a sense that choosing a career was not about a vocation but about maintaining or developing self-identity. At times this opposed gendered expectations:

But if you look at all the context [...] and the family I grew up and the culture [...] it's almost at odds [...] that you've got a male here who's interested in these touchy feely things. [...] (CPG-m; 258 -261)

4.3.2 Socio-cultural challenges to choice of career.

The themes represented in this category provide insight into an implicit model of education presented in discourses within South Asian families and their communities. The impact of migration and the subsequent socio-economical climate were identified as instrumental in the development of the model and its educational values. The presence of many traditional careered role models and absence of role models in clinical psychology reinforced the model's stronghold:

Theme: Pressure from the implicit socio-cultural model of education

The accounts below provide a sense of how migration to the UK led to an implicit socio-cultural model of education that was implicated in achieving a better quality of life:

I think that pressure was coming from their experiences of migration. [...]. They thought that you had to have a well paid job [...], an edge on your White counterparts. Educationally they didn't do well but what [...] they saw was other people who came over from Uganda with traditional professions doing really well and ... succeeding in this country so...they wanted me to have that... (CPD- f; 309-312; 325-327)

I think the mantra was very much that [...] parents and [...] families wanted their kids to do much better than what they had so they didn't want, [...] kids to end up working in mills and factories. (CPG-m; 80-83)

[...] that's what they knew from the community [...] as being something that (.) you aspired to [...] it's almost like you had to escape from the present state that you were in [...] and to do that the only gate way out was through academia.

(CPA- m; 355; 356-358)

The challenges from both the presence of traditional careered role models and absence of role models in clinical psychology were also highlighted:

My mum wanted me to be a pharmacist... my family are very much accountants, lawyers, pharmacists [...] nobody had even thought of psychology... (CPF-f; 96-99).

Participants often had to be persistent and defiant to maintain their choice:

I definitely didn't wanna be an accountant that was for sure and my mum was trying to persuade me that was a good idea... (CPD-f; 278-279)

Subtle pressures I think [...] and I'm sort of proud in a way that I stuck to my guns in terms of what I wanted to do rather than become swayed in terms of...parents and people saying, [...] don't you want to go for a proper sort of career like the others. So, this all sounded very different and woolly and people were uncomfortable with it. (CPG-m; 227-232)

The last two extracts identify possible differing processes of acculturation within South Asian communities:

What...happens in Asian families, people are interested in what the kids are doing and parents are very proud to say my son's doing medicine at Oxford or engineering in London. (CPG-m; 235-237)

I think there's nothing people have said...but I think there's a kind of competition [...].I think that there's a...kind of status that's [...] associated with ... being the most academic person, [...] like my brother got a first and everything and that was [...] from a top university. (CPB-f; 196-197; 200-202)

In the last extract, in the participant's community the educational model had progressed; value was placed on going to a traditional university and achieving the best. There was a sense that social cultural identity was associated to social status achieved through academia.

Theme: Lack of awareness of clinical psychology

'Parents and people saying, don't you want to go for a proper sort of career like the others? So, this all sounded very different and woolly and people were uncomfortable with it' (CPG-m; 227- 232). This excerpt, (taken from the participant's description presented earlier), highlights the stronghold of community values on traditional careers and the lack of awareness of professional status associated with clinical psychology. This theme highlighted how the lack of knowledge of psychological careers, lack of role models in clinical psychology, its professional status and route, all contributed to it being a weak contender to following a traditional career trajectory:

I think the South Asian population are very aware of medicine and [...] that whole career...path really...something like clinical psychology is just ...they don't even know what that means. (CPC-f; 85 -88)

But [...] they [meaning his parents] didn't have a template to say [...] well actually,[...] he's interested in psychology [...] and we had this very eminent priest visiting, and I remember my dad saying[...], I think it was just because he didn't know how to explain it. He says [...] if he asks you, just say you're doing engineering [...] and I would just go along with that. (CPG-m; 238-244)

The previous extract highlights the interplay between a lack of awareness of psychology, the traditional career being the cultural norm and the association of education and profession to social identity and status.

Six of the participants stated a lack of careers advice, but three provided explicit accounts of how the socio- cultural model of doing a traditional career was also being reinforced by school educators. There was a sense of stereotyping of South Asian's professional interests; the account below best illustrates this:

[...] the teachers were very discouraging [...] it was [...] some kind of moral obligation to kind of separate out people into different profession groups and [...] rope off all the Asians into medicine. (CPH- m; 127-130)

For many participants the unfamiliarity of the value of psychological careers and clinical psychology meant there was a lot of justification and explaining. The participants who had parents migrated from East Africa with business traditions, justified their choice by explaining how their psychology degree could be a useful application:

It was doing something really different ... [...] so I kind of convinced my parents that I could go into business [...], as I said my family are kind of lawyers and accountants. (CPF- f; 101-106)

I persuaded my parents that it was a good idea... because [...] a background in psychology is helpful...for any graduate scheme if you wanted to go into the business corporate world. (CPD- f; 273-274; 276)

Once having chosen clinical psychology and embarking upon the doctoral course, 'justifying became clarifying' in discussions:

[...] I was forever explaining how a clinical psychologist was different to being a doctor... (CPG-m; 449)

I remember when I was having a conversation with one of my aunts for example about, what I do, what does it mean, [...] I remember thinking I've explained this to you face to face before [...] on several occasions. (CPB-f; 463- 468)

For many of the participants the lack of knowledge of the career route led to getting relevant experience as an additional challenge in particular when they worked as support workers. The participants held negative attitudes that stemmed from the implicit expectations of what their degree should have led to i.e. that is a good paid job with professional and social status:

I was paid [...] but it was [...] very menial [...] and it wasn't a great deal either [...].I remember thinking that [...] some of the Asian pharmacy graduates were coming out at [...] seventeen, eighteen thousand. (CPH-m; 383-385)

I'd come home sort of saying oh guess what I've been cleaning up today [referring to excrement] and ...my parents were ...[...] I don't know if they were as much as extended family... were kind of thinking ooh is that what a graduate does! [...] it was such a low wage [...]and I spent a year kind of ... not being really happy. (CPE-f; 122-126)

However, in contrast for one participant the nature of the post obtained for relevant experience was respected for its altruistic value:

They could also see it [...] with the job I was doing something which was looking after other people. (CPI-m; 414-416)

4.3.3 Supportive contexts that maintain choice.

In this category the two themes that emerged highlighted how the expectations to pursue traditional careers varied according to individual family contexts and gender:

Theme: Individual family dynamics

With further exploration of the careers of other family members, interestingly a new theme emerged of a reduced family pressure in families where other siblings had followed traditional careers.

I think in a way, by the time I was going on ... people had already done other things [...] in the family that were sort of in their eyes acceptable [...], so there was less sort of pressure [...] to [...] kind of follow that road. (CPG-m; 248-252)

The next participant described how the pressures from extended family were felt indirectly:

It's really interesting cause it [the pressure] wasn't at all from my parents but it was me thinking about how my parents... would be talking about me to the extended family. (CPE-f; 145-146)

Later on in the interview whilst she talked about her sister she described how her own upbringing was different to her elder sister's:

[...] it is really interesting I don't know why she did that [became a solicitor] cause she was really good at English [...] for me I never felt I had to grow up and do medicine or be a solicitor or anything. (CPE-f; 387-387; 389-390)

An elder sibling in a traditional career reducing the pressure is echoed in the next extract, which created for her a sense of 'being lucky' and reinforced the presence of the pressure to pursue a traditional career:

I was very lucky [...] my parents were quite strict in a way but I was very lucky that my older sister had sort of paved the way for us... (CPC-f; 44-45)

Theme: Doing the DOCTORate –helping to negate family pressures

Four of the female participants expressed how the long career route of clinical psychology meant persisting with education beyond an expected age precipitated additional challenges and careful negotiating had to take place:

[...] so I kind of like said [...]they [her parents] had met me half way in terms of letting me do this, I should meet them half way, so I was like yeah,[...] I'll see people [referring to prospective partners] so I had that pressure as well as of ...trying to get onto the course, trying to get another assistant post, trying to[...].kind of work out whether I was ready for marriage at that time. (CPF f; 365-369)

The pressure to get married was often related to an implicit cultural developmental model present in the extended family and community. Contesting it posed personal conflict, which was explicitly expressed by two participants:

It meant three years more studying which ... you know what it's like personally culturally, while I was[...] just being newly married [...] so I think there's always been [...] this kind of personal conflict and [...] professional conflict and kind of trying to merge the two together[...], well you know, we've got kind of different pressures. (CPC-f; 301-306)

[...] and [...] at the wedding, [...] it was [...] my last year of training, I was twenty-eight ... I remember thinking oh god everyone's just gonna be asking me when I'm getting married you know what I mean. The marital expectations [...].some of the older people traditional kind of family friends [...] were coming up to me saying so [...] why aren't you married and were not interested in hearing anything to do with what I've been doing for the last three years. (CPB-f; 490-495; 498-501)

The knowledge that participants were pursuing a doctorate or the notion that they had become a 'doctor' reduced marital pressures. There was sense that this added to their personal status putting them on par with other traditional professions:

[...] having that kind of model in their mind and realising that I'd be three or four years delayed they were getting a bit anxious [...] but then it's funny because I was on the doctorate[...] and it almost overrode everything [...]I think it made me more marriageable (CPD-f; 505-508; 510)

[...] it's the highest educational qualification [...] my aunts who are doctors [...]...they do think my gosh! She's got a doctorate. They call me ...Dr [...] so I think it is given equal status to those who have medicine [...] in my family (CPE-f; 285 -286; 287-288; 291-292)

In this last extract the positive influence of having role models in clinical psychology is suggested:

Since I've done it ...my cousins who were actually encouraging me to do medicine... their kids have now actually gone into psychology which is interesting [...]. I think now it's approved of in the family [...] because I've become a doctor! (CPF-f; 157-160)

4.4 Section 2: Doctoral Training Experiences

The themes in this category related to the responses given by the participants when asked 'how was training for you in terms of cultural diversity?' All of the participants reported that they were the only South Asian in their cohort. For one participant there were two other minority ethnic students in her cohort from an African-Caribbean background. Balancing academic pressures with cultural led to additional pressures:

4.4.1 Cohort /classroom experiences.

The main themes to emerge were how being the only South Asian felt isolating and how within the classroom participants' cultural identity led to an assumption of expertise on regarding cultural diversity issues.

Theme: Being in the minority

Being the only ethnic minority trainee provided mixed emotions and thoughts; at times it was described positively and for two participants there was sense of a disappointment with feeling that they only got on the course only because of their minority ethnic status:

I mean it was obviously there I think I was quite aware on the course that... there is an under-representation because it was only me and yet at the same time it was quite good that there was me... there was a representative of the South Asian community. (CPC-f; 446-448)

Sometimes I kind of thought well have I got on because of my ethnicity and equal opportunities, is that the reason I got onto it? (CPF-f; 459-460)

When asked how having others from a similar cultural background may have helped, many participants referred to the importance of sharing experiences and the inability to do so effected the participants negatively, feeling lonely and with an inability to express their concerns:

I didn't want to become this to become a hot topic [...] there's the Asian guy [...] with the Asian issues [...] I actually was doing well [...] getting on and [...] I thought well it's easier for me to just ride it through (CPA-m; 792-796)

I think I felt isolated in terms of [...] how to actually take forward something [...] which I think I felt at the time that I worried was too provocative really [...] I think in some ways I think it was quite a lonely experience (CPI-m; 693-697)

The participant with other minority ethnic students in her cohort found reflective practice difficult for sharing as her minority ethnic colleagues were not in her group:

We did have reflective practice and opportunity to bring these things back but I guess [...] because I was the only one ... I think it was a little bit more difficult... because there wasn't that shared experience. (CPC-f; 483-485)

For two participants, the feeling of being a minority voice was not that alienating and it had been experienced before:

Yeah...it's in most circles I'm a minority... I'm really used to that. (CPE f; 453-454)

Additionally, being in a minority was expected after entering into the clinical psychology career trajectory:

But [...] maybe it's something to do with doing psychology [...] where you are in the minority, I've always been in cohort at university, or as an assistant...so then being in a cohort in where I was on my own again, it didn't feel different, it actually felt kind of the norm (CPB-f; 584-589; 591-592)

When cultural issues were brought up there was a sense that it may have not have had the same relevance or shared meaning:

I guess they didn't really have a frame of reference for it themselves. It remained more of a kind of [...] I guess [...] a mental exercise [...] for them but in terms [...] of it having any[...] importance to them [...] it didn't matter that much [...] really, it was perhaps an interesting idea that's about it really. (CPH-m; 423; 427-430)

Not having others to share and/or not being understood meant having to keep explaining cultural contexts behind difficulties to staff and peers:

There wasn't anyone else there that you could kind of... really discuss your experience with as much without having to...well explaining it all...I kind of almost felt a little bit disadvantaged really. (CPC-f; 486-488)

They did not understand...I said to them that [...] we mourn for thirteen days [...] they were really good with that and then the same thing happened [...] my grand-dad past away [...] ...but now they'd already experienced it with me [...] so they kind of knew what to expect this time, but... I did have to do a lot of explaining still. (CPF-f; 801-804)

The majority of the participants gave specific descriptions of their experiences in their teaching sessions with their cohort:

Being the only one in the room...I almost felt this real kind of expectation from me to [...] be putting my views across [...] but actually I am not an expert.

(CPC-f; 495-496; 497-498)

But I know that when there were lecturers coming in and if there was an ethnic minority issue it was almost [...] like assumed that I will [...] step in and talk about it.

(CPF-f; 454-457)

It was like 'well you know what it means to be different.' I remember this person who was giving this talk, she kept asking me questions ...and so all of a sudden I'd become the cultural expert for the cohort, [...] I was like I don't ... and in the break I kind of said to her "I'm really sorry I'm not really answering your questions" and then she said "it's just I didn't want you to feel left out" Well... I said [...] just because I'm not White it doesn't mean that other people don't have a culture or don't have any kind of views on it.

(CPB- f; 547-554)

4.4.2 Personal impact.

The personal impact of pursuing the clinical psychology training course was expressed both implicitly and explicitly. From the above themes personal conflict, challenging and persistently explaining the profession and career route are implicit suggestions of the personal impact experienced whilst on the course. However, the

majority of the female participants explicitly described the pressure of balancing student life with family roles.

Theme: Balancing academic and cultural pressures

Three female participants explicitly described how cultural pressures from their home life impacted on their training experience; the extract below best illustrates their difficulties:

The career route, the pathway [...] the workload is a challenge because there are other expectations on you [...] I mean to the point where ...with my clinical training I [...] asked for one of my placements to be in elsewhere so I could live away for the week (CPD—f; 1111-1114;1115-1116)

4.5 Section 3: Practising as a South Asian Clinical Psychologist

4.5.1 Being a practitioner from a South Asian background.

Participants were asked how their cultural and ethnic identity impacted on work to which they described various scenarios and gave explanations. When asked how their professional identity impacted on their home life, female participants described how their family roles, positions in the community and priorities came first which at times made it harder to impart psychological insight:

Theme: Bringing culture into practice

Participants spoke about how their cultural identity provided an empathic perspective but not necessarily expertise. They recognised that they were now being perceived by their South Asian clients as different because of their professional identity:

Maybe I can sometimes relate to them a little bit better ... I'm not saying I'm an expert or anything but maybe I can kind of understand and appreciate a bit more because maybe it's similar to some of the kind of cultural and background issues I may have. (CPC-f; 503-506)

But I also wonder sometimes [...] when I'm working with someone who's an Asian teenager [...] what's it like meeting with an Asian therapist who's a doctor and maybe she's thinking 'How can she really understand what I'm going through? (CPB-f; 696-701; 702-704)

How this [their own culture] fits in. It helps me to understand... why certain [...] people of my own background cultural background don't like being part of their own cultural background [...] and they want to be something different. (CPA-m; 1005-1008)

For some participants the issue of a cultural identity was irrelevant and the focus was on individuality:

You don't need to know about that culture [...] it's respecting somebody's agency (CPE-f; 564)

I think also we've kind of got to cross the [...] collective [...] culture [...] as Asians we're brought up with and get to the individual... culture. (CPH-m; 481-483)

Theme: Balancing professional roles with cultural roles

Participants were asked how their profession impinged upon their cultural identity or roles, how it impacted on the family or others within the community. In answer to this participants provided descriptions of how their knowledge was used to eradicate misconceptions of mental health either at home and within the community:

[...] I personally try to push [...] people's understanding, especially this notion [...] and I think it's stronger in the Asian culture that you have to be completely mad to have benefit from psychological help.(CPG-m; 713-716)

Challenging misconceptions was not that easy especially when the professional role comes secondary to family roles:

My dad the other day like he was getting a bit cross with whatever he was trying to do and I said oh gosh dad you know just calm down what's wrong with you? And he said oh I'm so depressed [...] I was like no... no you're not depressed at all! And he was like fine I'm not and I was just like I really want you to understand this [...] but it's so difficult because you're apart from your professional roles.[...]. I'm always gonna be seen in the earlier roles...it's hard [...] then... cause you're never really respected as having that professional background. (CPE-f; 622-626; 628-630)

In an earlier theme, this participant had made sense of her family calling her 'Dr' as mark of respect for her new professional identity. From the contrast in feelings expressed here, the researcher got the impression of perhaps cultural roles/positions

within the family or the family had within the community, had a powerful influence on how the person was valued and could override the professional status:

I'm also aware that maybe some people don't wanna hear it from me. I don't know what that's about for them whether that's from jealousy or because I'm a psychologist and what it means or whether that's because they just they don't value it. (CPB-f; 743-743)

I don't think when you become an Indian wife your professional status matters [...] you don't have an identity there's no individuality, your status is about what you do for others. (CPD-f; 1186-1188)

5. Discussion

5.1 *Overview*

There are number of similarities in the experiences (represented as shared themes presented in the results) of the participants of this study. Across their career trajectory i.e. from being a psychology student, clinical psychology trainee and practitioner, the participants describe challenges and incentives to practising clinical psychology. The influences stemming from their socio-cultural contexts were most evident whilst choosing to do clinical psychology. Challenges faced were mainly in relation to maintaining career choice and developing a sense of ‘being different’ in terms of their self-identity. Challenges faced during training were related to specific pedagogical processes evoking issues of cultural identity and balancing academic responsibilities with cultural expectations. Within practice, challenges were in relation to being proactive in raising awareness of the profession within the individual’s social context; balancing professional roles with cultural roles created unique tensions.

There is a dearth of literature on the experiential accounts of minority ethnic educational experiences pursuing a health career. The literature on the experiences of minority ethnic psychologists is particularly sparse. The findings from this study will therefore be compared and contrasted to both empirical studies conducted in other health professions and personal reflections from minority ethnic psychologists found in the published literature. Theoretical explanations for the findings will be discussed in relation broader psychological theories.

5.2 Interpretations of Findings

The findings will be discussed according to the three main lines of enquiry; choosing to do a clinical psychology career, doctoral training experiences and being a South Asian practitioner.

5.2.1 *Choosing to pursue a clinical psychology career.*

Personal interests and the value of helping others were described as motivational factors when choosing psychology by some of the participants of this study. A desire to 'help others' and personality traits such as 'altruism' in American students' choice of psychological careers has been repeatedly reported (Byrne, 2008; Kobel, 1997; Leong, Zachar, Conant & Tolliver, 2007; Malhi et al., 2002; Paterson, 1956), and was specifically important for choosing genetic counseling by minority ethnic students (Schoonveld, Veatch & LeRoy, 2007).

Of particular interest in the findings of this study was that some of the participants were making assertions early in their career trajectories about their personality and academic stamina. Compared to pursuing a traditional career such as medicine or law, a career in psychology was perceived as a sensible match and perhaps an easier option. On the surface this may provide some support to Scior et al.'s (2007) finding that Black and minority ethnic applicants to clinical psychology show lower academic performance compared to their White counterparts. However, the results of this study also identified that participants had chosen clinical psychology as supporting their notion of 'being different' and 'wanting to do something different' to their peers. It further suggests that for these participants choosing psychology was perhaps also related to issues of developing self-identity.

The Social Cognitive Career Theory (SCCT) (Lent, Brown & Hackett, 1994) highlights how personal beliefs about one's own ability (self-efficacy) and beliefs about efforts of being successful (outcomes) can mediate career preference. Researchers interested in understanding the career development of minority ethnic students suggest that their career choice *and* subsequent career performance is based not only on the minority ethnic student's evaluation of one's academic ability (self-efficacy) but to their ethnic and cultural identity (Gushae & Whitson, 2006; Lent & Worthington, 2000). On the basis of this model, it is possible that for some of the participants the decision not to pursue a traditional career (for example, medicine) could be based on the perception that this was unachievable and therefore seen as unsuccessful outcome. Doing psychology however, was perceived as achievable. According to this model, the large number of South Asians doing medicine or other traditional careers (Modood & Shiner, 1994) provides for an ethnic and cultural identification leading to a collective positive self-efficacy for these careers. This, it could be further hypothesised that by 'not' wishing to follow these careers, the participants perceived themselves as somewhat 'different' to their peers. Lightbody, Nicholson, Siann and Walsh (1997) reported that within the UK in 1997, occupational choices by South Asian school pupils and undergraduates depended on shared beliefs about social position, achievable from working in a 'respected profession.' Considering that for some of the participants educational choices were being made at around this period, this empirical evidence may further support the finding of a notion of 'being different', in that the participants were perhaps challenging shared values of traditional careers.

Robb, Dunkley, Boynton and Greenhalgh (2007) suggest that peers provide shared inspirations whereas family inspirations are from a family regard for education as providing a social status suggest. The importance of family, friends and community on career decision making in minority ethnic school pupils has been identified by many

other researchers from other disciplines (Coombs et al., 2007; Daly, Swindlehurst & Johal, 2003; Darr, Atkin, Johnson & Archibong, 2008; Li, 2002; Van der Veen & Peetsma, 2003). The participants in this study described general discourses about children's educational aspirations amongst extended family and community. Where pressures from parents to do traditional careers were absent, the participants described themselves as 'lucky.' The findings therefore suggest an implicit socio-cultural model of education which reinforces the value of doing traditional careers.

Brown (2004) suggests that race, class and the socioeconomic status of the family is an important influence on career development. These factors were also suggested in this study as some of the participants described education for their parents as a means of getting a better and 'different life style.' However in addition, some participants associated parental and community pressures to personal losses incurred during migration and the racial discriminatory and oppressive socio-political context presented to their parents' communities in the 1970's and 1980's in Britain.

Jones and Ram (2003) suggest that extended family roles and gendered roles place an emphasis for South Asians to continue with family businesses. In this study, participants did not explicitly relate such influences as challenges to their career choice. However what was interesting was how the business application of a psychology undergraduate degree was put forward in convincing discussions by participants with parents that had migrated from East Africa.

Participants in the study described challenges to doing clinical psychology to be specifically due to a lack of awareness of the profession, its professional status, lengthy career route and lack of role models. These barriers have been identified by minority ethnic students and health professionals of other underrepresented health professions (Greenwood, Wright & Bithell, 2006; Oh & Lewis, 2005; Schoonveld et al., 2007). Researchers have used Social Learning Theory to explain how the presence of

professional role models impact on social identities and promotes self-efficacy in individuals (Greenhalgh et al., 2004; McHarg, Maltick & Knight, 2007). Participants in this study described the lack of role models in clinical psychology to also pose challenges but not to their self-efficacy. The absence of role models made it harder for them to justify the value or professional status of clinical psychology. Interestingly, for many participants in this study, the presence of traditional career role models in the extended family in fact placed ‘pressures’ to conform, whilst the presence of siblings (suggested to be elder siblings) in traditional careers reduced their family pressures. This finding supports the notion that family influences are multifaceted (Blunstein, Kenna, Murphy, DeVoy & DeWine, 2005).

A perceived negative attitude towards a career in clinical psychology in Black and minority ethnic communities has been suggested (Craig, 2007; Williams, 2002; Wong, 2007). Doing menial tasks and low paid jobs can contribute to negative perceptions of certain careers (Darr et al., 2008). Interestingly, for some of the participants in this study specific challenges were expressed whilst doing low paid support worker jobs that included menial tasks. Explicit comparisons to peers in traditional careers and feeling pressure from parents’ expectations of them to be in successful jobs after completing their degree were suggested. This finding suggests that getting relevant experience proved culturally challenging.

Wakeling (2009) identified that for minority ethnic groups, in particular for Indians and Chinese, there is greater importance given to attending prestigious and traditional universities as it is associated with positive outcomes in terms of getting into the labour market. This was also found in this study, some participants explicitly described how the importance of going to a traditional university was discussed by parents and family relations. Interestingly, for both the male and female participants, gaining a doctorate was perceived by their family and immediate community as similar

to becoming a ‘Doctor.’ Some participants also described their professional status to have become akin to a medical doctor. Wakeling (2005) suggested that there is a differential relationship between progression to higher degrees and social class in minority ethnic groups. This may explain how for many participants, the importance given to doing a doctorate altered their social status. Doing a doctorate also helped negate pressures from lengthy career route and the pressure of getting married.

5.2.2. Training experiences on the doctoral course.

Being a minority ethnic student was suggested to be a paradoxical position. For some participants the minority status on the course meant feeling privileged and a representative of their minority ethnic identity but for others it was perceived as an equal opportunities exercise. However, overall participants described being the only minority ethnic person in the cohort or being the only South Asian, as an isolating experience. Wanting to have other minority ethnic students/trainees within the cohort to share experiences was expressed by many participants. This could be formulated from socio-cultural identity theoretical position as ‘empathetic identification,’ whereby minority ethnic groups will seek to find commonality of experience and culture between themselves (Alexis & Vydelingum, 2005). Cohen and Garcia (2005) suggest that academic achievement of minority ethnic students can be greatly enhanced by improving their sense of ‘belonging’ and associating their ‘social identity to positive stereotypes’ in the educational environment. Although in this study there was no suggestion of a negative impact on academic ability through a lack of representation on the course, wanting ‘not be seen as different’ to their peers could also be hypothesised as wanting ‘to belong.’

Participants also described that colleagues and teaching staff assumed that their cultural identity meant they had expertise on cultural diversity issues. Accounts

contained descriptions of how this ‘cultural expert’ position and not sharing of issues of diversity exacerbated feelings of alienation and isolation. Descriptions also suggested that there was ambivalence in raising issues. Challenging negative perceptions by others was feared as it may exacerbate the ‘difference’ between themselves and the cohort.

Experiences of the participants in the study paralleled many accounts of student’s training experiences into health professions found in the literature. Feeling privileged because of holding a minority ethnic status but also being wrongly assumed the cultural expert, resonated with training experiences of minority ethnic clinical psychology trainees (Rajan & Shaw, 2008). It also resonated with training experiences of international students of a doctoral Marriage and Family Therapy course (Mittal & Wieling, 2006) and within the personal reflections of clinical and counselling psychologists (Davidson & Patel, 2009; Vasquez et al., 2006).

The study also highlighted how for some participants the experience of being the only minority ethnic was normalised by comparing it with previous experiences in their educational trajectory. Smith, Allen and Danley (2007) suggested that social conditioning occurs for minority ethnic students particularly if differential practises occur on a regular basis. The student develops an ability to continuously assess racial or culturally discriminatory situations and as a result a ‘downplaying’ of discriminatory situations occurs.

The process of applying for clinical psychology can be anxiety provoking (Malston & Logue, 2008). Clinical psychology training has also been suggested to have a profound impact on the trainees’ lives; acting as a catalyst facilitating personal development, self-identity and professional identity (Hughes & Youngson, 2009; Tan & Champion, 2007). Lempp and Seale (2004) suggest that ‘training courses’ present students with a ‘hidden curriculum’ inclusive of a set of implicit rules and customs and a process of enculturation to develop the student into both practitioners and members of

the profession. If the hidden curriculum is based on ethnocentric pedagogy, challenges to learning are inevitable. In this study, although the participants' descriptions did not contain a negative impact on their learning, female participants specifically described challenges with regards balancing cultural expectations with academic pressures. This type of personal impact of training has not been described within minority ethnic clinical psychology trainees (Rajan & Shaw, 2008). However, gender related pressures in relation to cultural values have been found for South Asian nurse students (Dyson et al., 2008) and reflected upon by female American professional psychologists (Rheingold, 1994; Vasquez, 1994).

5.2.3 Being a clinical psychologist from a South Asian background.

Menon, McKinlay, and Faragher (2001) identified that for minority ethnic health professionals in the UK, their 'background and experience' was regarded as important in delivering culturally appropriate services. Whilst participants in the study critically reflected on how within their social and academic experiences ethnocentric models and practises impacted on their development of self-identity (Goffman, 1959; Hare, 1997), they also described how a reflection on the development of their own cultural identity helped understand the experiences of minority ethnic clients. Iwamasa (1996) suggests that minority ethnic therapists, *because* of their ethnicity, are most apt at recognising how ethnic and cultural variables interact and influence therapy. However, the author further suggests that therapists should be warned against 'overdoing' the cultural basis to patient's difficulties. It was reassuring to find that this was not identified in any of the participants' accounts. On the contrary, participants recognised that their ethnic and cultural identity did not confer expertise; although they could be ethnically the same as their clients, there was a need to respect client's individuality.

The literature suggests that improving minority ethnic visibility in the profession will improve access (Williams et al., 2006) and the uptake of services (Khatib, 2001). The literature further suggests that minority ethnic therapists should and do become proactive in raising awareness of services in their respective communities (Bernal & Castro, 1994; Rajan & Shaw, 2008). The findings of this study suggest that many participants were proactive in eradicating family and community misconceptions about the use of psychology and challenging cultural attributions to mental health difficulties. However, the findings also suggest that for some participants the mission was somewhat harder as it depended on the individual's respected position in the family and/or in the community.

5.3 Limitations of the Study

The main limitation of the study is that the participants were asked to reflect on influences upon their career trajectory that had taken place a number of years ago and it is likely that this may not be as accurate as the actual events. Furthermore, it could be argued that as culture is dynamic, the influences described in their early trajectories may not reflect the experiences of current South Asian students.

IPA methodology advocates a homogenous sample, the researcher recruited clinical psychologists that had completed the DClinPsy training in the UK and were currently practising in the UK. It was hoped that clinical psychologists of all ages and various number of years experience would be recruited. However, with the opportunistic aspect of sampling (i.e. participants who were known to the researcher and supervisor) the majority of the participants had less than five years of experience. The sampling procedure also led to recruitment of a less ethnically diverse sample than hoped for. It could be argued that the sample recruited is not representative of the

population the profession seeks to serve i.e. the participants were not from South Asian communities that find it difficult to access the health services such as Bangladeshi women and Pakistani men (Papadopoulos, 2006). These groups of South Asians are affected the most by socio-economic barriers that impinge on access to education and employment (Clarke & Drinkwater, 2007; Commission for Racial Equality, 1998; Modood, 1997). In this sample there was a suggestion that the participants were from communities in which processes of acculturation had led to emphasis on education and obtaining professional status. However, considering that the researcher aimed at identifying socio-cultural and economic influences on career choices and as possible barriers for choosing clinical psychology, the study has achieved this aim.

Through three procedures, peer review, supervisor review and participants' validation, the researcher attempted to improve the validity of the analysis and emergent themes. However, the limited time scales of the project meant that only one participant validated the data. Pilot interviews conducted on two people (a trainee clinical psychologist and a clinical psychologist trained through the in-service route) helped to refine the semi-structured interview schedule. However, the researcher found that incorporating the three lines of enquiry (choosing to do psychology, training and current practice issues) meant the interview was often lengthy and extended over the original ninety minutes. For the researcher this resulted in an overwhelming amount of data, cautioned against by the IPA approach and many qualitative researchers (Barker, Pistrang & Elliott, 2002; Denzin & Lincoln, 2000; Smith & Osborne, 2003). However, this did not cause undue stress or difficulties for the participant; this was checked in the participant's debrief.

Breaches of confidentiality and anonymity are ethical considerations to be made in all research. However, in samples from minority populations (e.g. South Asian clinical psychologists) potential breaches of confidentiality may be more likely given

that there are relatively few in the UK. In this study, the demographic questionnaire had sought to obtain descriptions of the sample that could aid the use of the data and transferability of the findings. However, the researcher found that the collection and use of demographic data had the potential to compromise confidentiality. Therefore, the researcher had to limit the demographic data presented in the research report and ensure that procedures which protect participants' confidentiality were followed strictly and in accordance with ethical governance, university requirements and the British Psychological Society (BPS).

Difficulties with researching minority ethnic groups and improving validity of research have been reported by other researchers (Dickinson and Bhatt (1994) and is further highlighted by Kauffman, (1994). The researcher highlighted the potential bias to data collection because of researcher's ethnicity and suggested that the researcher ask the question as to how the findings would have differed if the interviewer's ethnicity had been different. Other researchers have suggested that being of a similar cultural background or having familiarity with the researched can lead to an in-depth exploration, specifically due to the assumption of the participant that the researcher has an 'insider's viewpoint' (Evans, 2006; Hanson, 1994). Such assumptions were evident by the recurring presence of the use of the expression '*you know what I mean*' in many of the participants interviews.

Given the above limitations the interpretation and generalisation of the findings should be taken with caution and the findings cannot be generalised to the broader population.

5.4 Implications of the Study

The clinical psychology profession is familiar with the fact that undergraduate minority ethnic students are not attracted to the profession and that South Asians in

particular prefer to follow traditional careers. The current findings demonstrate that socio-cultural factors relating to the South Asian family and community present as powerful influences on career choices and these were observed at early stages of their educational journey. The changing socio-cultural and economical context had an impact on collective aspirations. The study urges both the British Psychological Society (BPS) and policy developers within health and education settings to make concerted efforts to raise awareness of the *value of the profession* and its *professional status*. Early intervention should involve parents, schools, career services and traditional career role models, who by their sheer visibility, professional and social status could inadvertently act as ‘gate keepers.’ This study strongly suggests that school based initiatives (Martin, Newland & Shuttleworth, 2004) need to be reinvigorated on a national basis and that strategies should be directed to include raising awareness of the profession in communities.

Faster and shorter routes into a profession is perhaps a universal demand, however this study helps the profession to consider the presence of additional barriers such as duties and obligations felt by the South Asians linked to their gendered and cultural roles and therefore, suggests the applicability of alternative routes (Taylor & Mowbray, 2004). The study also suggested that the socio-political and economical history of South Asians has meant that education and professional status are perceived as improving social status. Therefore, with respect to the importance given to doing a doctorate highlighted in this study, this particular aspect of the career route into clinical psychology could be emphasised within careers information.

With respect to training issues the findings suggest that mentoring could help trainees through difficulties related to balancing their academic and cultural roles. However the profession needs to assess the needs of minority ethnic students before implementation and ensure that mentoring avoids the use of ethnocentric and

Eurocentric models (Hill, Castillo & Ngu, 1999; Nugent, Childs, Jones & Cook, 2004). The profession needs to consider the development of cultural competency of mentors (Atkinson, 1994) whereby ‘cultural competency’ should not be considered as static but considered as a part of continuing personal and professional development. The profession should also proactively encourage minority ethnic practitioners to take up mentoring and be involved in the development of culturally appropriate models mentoring. Given the expertise shown by the clinical psychologists in this study on understanding how their ethnicity has impacted on their career trajectories and the social and academic experiences whilst on route to becoming a clinical psychologist, the BPS should develop strategies that encourage minority ethnic psychologists to take leadership in addressing issues of recruitment into the profession.

Academic institutions have historically been reported to not meet the cultural needs of minority ethnic students (Dean, 1977). In terms of teaching within doctoral training programmes, the study highlights the need to support tutors, trainers and supervisors to develop culturally specific teaching-learning strategies (McNeill, Horn & Perez, 1995). Perhaps methods of teaching that involve patterns of bridging gaps between the majority and the minority learning styles could be considered (Yoder, 1996). Researchers have also suggested that students be helped to maintain their cultural and ethnic identity in predominantly White academic institutions (Jessop & William, 2009; McInnis, 2003). Literature also suggests that within the teaching practices ‘cultural complacency’ (Gallagher, 2006) can lead to generalisations and negative stereotyping. The study findings suggest that this may also lead to assumptions of the minority ethnic trainee as the expert on cultural issues. Patel et al. (2000) have suggested that for clinical psychology training Black trainees be involved in learning processes and training issues on race and culture. Kvaal & Myers (2003) provoke

thought on ‘who is teaching psychology?’ and highlight the issue of the lack of cultural and ethnic diversity amongst faculty staff.

From this study further research is warranted, below are suggestions based on the implications given above:

- To repeat this study to improve validity of the findings may be difficult given the small pool of South Asians, however the researcher identified a small pool of South Asian clinical psychologist that had trained through in-service training and had come through the ‘statement of equivalence’ route. Comparisons of their experiential accounts to the findings of this study may help to further understand the extent of the ‘stronghold’ of the model of education. This was suggested to be a product of the process of acculturation and the socio-cultural political climate faced by the participants’ parents and communities upon migration. This would be different for the aforementioned participants.
- Male experiences warrant further exploration and perhaps in comparison to Caucasian males given that in general males within the profession are a minority.
- Survey South Asian sixth form or Year 13 students and their parents attitudes to a career in clinical psychology.

6. Conclusion

This paper describes a qualitative study, using IPA methodology, which facilitated the exploration of the experiences of becoming a clinical psychologist when from a South Asian background. In terms of understanding the issue of underrepresentation of South Asians and barriers to choosing a career in clinical psychology, the study suggests the problem to be complex and the interplay of subtle nuances. Family influence and socio-cultural economical context are suggested as powerful influences on career choices of South Asian students. Furthermore pressures to maintain choice and pursue an ‘unknown’ career or one that is ‘less valued’ were from the ‘stronghold’ of a model of education that advocates pursuing traditional careers. These careers represent a higher professional and social status. Compared to these careers clinical psychology is simply the ‘weak contender.’ Its long career route exacerbates its perceived negative professional value.

In terms of clinical psychology training, experiences of being the only minority ethnic person on the course posed unique challenges within the pedagogical environment. Within the teaching environment students described feeling isolated and ambivalence over challenging the use of ethnocentric and Eurocentric models. Furthermore, the minority ethnic trainee was often wrongly assumed the ‘cultural expert.’ Family pressures and responsibilities related to the individual’s culture posed unique challenges that were often not recognised by faculty staff during training.

Having emerged as clinical psychologists, the study identified the participants to become proactive in raising awareness of the profession and removing cultural stigma associated to mental health. Although their cultural and ethnic identity was of value in relating to South Asian clients, the recognition of individuality and a need for self-identity from their own experiences created a unique way of practising.

7. References

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SECTION D

CRITICAL APPRAISAL³²

³² Written in the first person according to qualitative research guidelines.

Wilkinson (1988) suggested that personal reflexivity is important when evaluating research. This paper will reflect on how my experiences may have influenced the research study from inception to date and will consider my personal and professional development in relation to the research process.

1. Developing the Research Topic

When we were asked to think about our research topic during the first year of the course, I was initially keen to pursue research within the area of health psychology. After having done qualitative research in health psychology as a part of my Masters in Health Promotion, my intention was to research an area that interested me with an advantage of it being familiar. However, through my role as cohort representative on the BME diversity course committee, I became aware of the need for the faculty to be proactive regarding research into cultural diversity issues. In addition I wanted to support the new director's passion for the Leicester DClinPsy course to contribute to implementing change in relation to the profession's ethnocentric ideals. I decided to leave my 'calculated option' and focus on a topic related to cultural diversity issues.

Hughes and Youngson (2009) suggest that personal reflection is an essential aspect of becoming a clinical psychologist; the processes of personal reflection had already begun for me as soon as I had entered onto the course and I was mindful that I was the only minority ethnic student in my cohort. During cohort discussions of our career trajectories I soon realised that I had had a rather convoluted journey.³³ I had embarked on my journey of becoming a clinical psychologist in 1986. Unlike many of the younger peers in the cohort, clinical psychology was my 'third change' of personal direction (I had been a teacher and a Health promotion specialist previously). Given the issue of underrepresentation of minority ethnic clinicians within clinical psychology

³³ A synopsis of the journey is given in the researcher's background presented in section C of this thesis but further details are given in section 4.3 of the appraisal.

(Williams, Turpin & Hardy, 2006), I wondered how my experiences of entering the profession compared to other minority ethnic trainees, in particular South Asian clinical psychologists. In addition, I wondered why the two members of my family that were doing undergraduate psychology were not even considering clinical psychology.

Having been a health promotion specialist I had become primed at noting the importance of social context on human behaviour. For instance over the last few years in general discourses within the South Asian community that I belong to, I noticed changes in parental ambitions of their children's careers, in particular there was less emphasis on pursuing traditional careers. There also appeared less emphasis on carrying on the family business and I wondered if this could explain the increase in South Asians pursuing undergraduate psychology (Turpin & Fensom, 2004). Current literature also suggested that changes in the socio-economic contexts were powerful influences on this particular ethnic minority group's career preferences (Jones & Ram, 2003). It therefore seemed timely to conduct research into understanding the socio-cultural influences on the career choices and trajectories of this ethnic minority group. I had already conducted a small scale study using qualitative methodology to research into South Asian perspectives on breast cancer as part of my MSc in health promotion. I was keen to consider its use for exploring the lived experiences of current South Asian practitioners and what journeys they had undertaken to become clinical psychologists.

2. Conducting the Research

2.1 Recruitment of participants.

Obtaining ethical approval was fairly straight forward due to the participants being clinicians and not patients. The initial anxiety linked to being able to recruit sufficient participants was also alleviated when through snowballing potential participants were recruited into the study. Recruitment was also supported through the

Race and Culture Specialist Interest Group (SIG) meeting/conference in September 2008. Although identification of potential participants appeared to progress quickly, I soon realised that recruiting senior clinicians was going to be difficult as I learnt from a few I spoke to that they had become practitioners via a 'statement of equivalence' (one of the study's exclusion criteria). The senior clinicians had been trained and for some educated mainly outside of the UK. I also found through the conference that many of the senior South Asian clinicians suggested as potential recruits had also become practitioners through the in-service route.

At the Race & Culture SIG meeting I particularly remember the narrations of two Indian senior clinicians that had pursued the statement of equivalence route. Their narrations included feelings of disappointment for not receiving recognition for their credentials upon entering the UK. Furthermore, they had experienced discrimination and described an internalization of the minority ethnic status. Their enthusiasm to contribute to the study but my inability to provide them with a forum created mutual disappointment. We discussed a possibility of further research focused on clinicians from abroad. Following the conference I was eager to get onto interviewing as there was a sense that the participants that had come through the DClinPsy would also have interesting accounts and the study would provide them with an opportunity to tell their stories.

The informal discussions were noted in my reflective field diary and I shared the notes with a colleague that had experience of IPA. The researcher advised me to write a reflection of my own career trajectory and to ensure this was referred to when conducting the data analysis. This would help to ground the findings in the participants' data and identify any possible source of contamination by my own experience.

I also found it difficult to recruit male clinicians. Those that had been identified through snowballing were slow to return their reply slips and it was not as easy to

arrange their interviews as it was for the female participants. The interview with the first male participant shed some light on this situation; during the debrief he raised concerns of being identified because of the small pool of South Asian male clinicians. He requested that I only use his data after recruiting further male participants. This was also echoed by the two other male participants that were eventually recruited into the study. The concerns of being identifiable through the demographic data were discussed further with my supervisor and what was placed into the report was limited. It was recognized that this placed limitations on the study in terms of providing more explicit details of the participants to enable the reader to gauge the transferability of the data.

2.2 Interviewing.

Taking part in the interview included participants agreeing to being tape recorded and transcribed. As a rule consent for this was obtained prior to starting the interview and highlighted in the consent form. In one interview although the participant was keen to take part in the study, she was not keen to sign the consent form and was reluctant on having the interview tape recorded. For this participant my respect for her seniority and her expectation of it meant that I conducted the interview with verbal consent. I found this interview challenging as there was a real sense of professional power dynamics at play mixed with South Asian cultural etiquettes. However, by my answering the participant's questions about my ethnic and family background she gained confidence in me. It also seemed that after she had realised that I was married with children, the information about me helped reduce the power dynamics in the interviewing process. There was a sense in this interview that generational differences were also at play, I therefore ensured that throughout the interview, my tone of voice remained subordinate and respectful. Interestingly, the participant did suggest midway of the interview that I could start recording her narration if I still wished, which I did. At

the end of the interview due to the fragility of the interview process, it remained difficult for me to ask for her to sign the consent form. Instead I requested the participant to forward it to me. As it was never returned, the participant's data was not used in the study and was destroyed according to ethical and research guidelines.

I found the pilot interviews invaluable. They enabled me to quickly recognize that I could actually use less prompts if need be. I found in general participants preferred to follow their focus of interest, which provided an in-depth exploration and an evolving enquiry to take place. My skills of reflection and summarizing that I had learnt in my clinical practice were useful to keep the interview within the parameters of the enquiry. All of the participants were very forthcoming with their narrations.

In general the interviews lasted longer than I had anticipated and one participant who's interview went on for just over two hours found the interviewing enjoyable and stated: *'You should know that psychologists do not get an opportunity or space to talk about themselves, no wonder we go on forever when given half the chance.'* (CPD-f; 1189-1190)³⁴. Extension of the time allocated only occurred if the participant wished to expand on certain aspects and in debriefing none of the participants described feeling uncomfortable with the length of the interview. Three of the male participants stated prior to starting the interview that they had allocated only the time suggested in the invitation letter. It was interesting to find that despite my reminding them of the time in the interview, they continued with their narrations over their allocated time limit. When I mentioned this to a participant in debriefing, he commented that the interview had given him opportunity to *'really sit down and reflect'* (CP-G-m, see footnote below).

Already having information regarding aspects of the participant's family and cultural background via the demographic questionnaire, helped to focus the interview. A good example of this is how the question: *'Tell me about your family background,*

³⁴ The quote is taken from a participant's transcript- 'CPD-f; is the participant's unique identifier, the numbers 1189-1190 are line to identify where this quote is positioned in the transcript.

starting perhaps when your parents first came into the country’ was rephrased for one participant to: “*Can you tell me a little more of how your family came to leave Punjab in 1950*’ based on the information about their family or origin. Further examples are ‘*With respect to being a Muslim- Indian, how large was the community your family belonged to in Britain?*’ and ‘*With your father being an imminent Muslim priest, how did your family feel when you said that about your career?*’ The latter question took into consideration the religious and cultural identity as construed by the participant and enabled a person-centred exploration into cultural influences on education.

On reflection however, the use the demographic questionnaire to collate specific data such as that related to the individual’s cultural identity (e.g. religious identity), may have appeared essentialist. I was mindful of this and ensured questions were open-ended, asking participants to self describe, providing their own constructions and interpretations. The questions in the demographic questionnaire served a practical advantage of focussing the interview and facilitating further exploration into the individuals constructs, in keeping with the IPA methodology. In keeping with my epistemological stance and critical realist ideas of psychological theories, in the interview I consistently explored how social, political, ethnic, gender and religious values defined participants’ experiences and their perception of their cultural identity.

2.3 *Ethnicity issues.*

Interviewing people from the same ethnic minority background can have its advantages and disadvantages (Gonzalez, 1995; Kauffman, 1994). Certain participants and in particular the females when trying to describe specific cultural influences frequently used the phrase ‘*you know what I mean*’. This suggested that my ethnicity was providing some commonality between us and may have helped to improve rapport and facilitate a deeper level of exploration. However, the drawback was an implicit

assumption by the participant of my understanding of their cultural perspective. I realised that if I did not seek to clarify their meaning of the experience I risked contaminating the research with my own cultural beliefs and experiences. To avoid this occurring in the interview through using more directive questioning I explored the issues further, giving the participant opportunity to clarify and expand so that I could avoid making assumptions when analyzing the data. When at times this felt difficult as it meant interrupting the flow of the narration I used debriefing to explore the matter further making notes into my field diary.

2.4 Data analysis.

I had attended a workshop on IPA run by Dr Sheila Bonas (health psychologist) and had read papers and textbooks by qualitative researchers (Moustakas, 1994; Smith, Jarman & Osborn, 1999). However, I found this aspect of the research process the most challenging, perhaps reflecting the fact that I was a novice at IPA. When using IPA it is important to read and re-read the transcripts to create intimacy between the researcher and the data and by doing so researchers become immersed in the data. In the first instance I found this process difficult and I was overwhelmed by the magnitude of the data and how I could produce a set of overall themes that would capture the accounts of all the participants. However, once the analysis began and the first transcript had been analysed and the analysis progressed I began to enjoy the creative process. When I presented the initial version of my themes to the Qualitative Support Group, I was surprised how they felt that my initial attempt at theme formation had led to a concrete form of coding. This may have reflected my conscious effort not to influence the data by my own experiences and cultural background. In the second attempt at theme generation my research supervisor felt that in my attempt to stay grounded in the data, I had used metaphors that were too descriptive and not interpretive. It was only by the

third attempt that both the support group and my supervisor were contented with the semantics used to label the themes.

3. Supervision

I found research supervision and the Qualitative Research Support group invaluable in helping me to reflect on the impact of the research process. Both supervisor and the Qualitative Research Support group were also invaluable in helping me manage my anxieties related to processing the data and completing the project.

4. Personal Impact

4.1 Making new friends.

I found each interview interesting and varied in style and dependent on the extent of rapport with the participant. I was curious to find that with the female participants my gender, ethnicity and personal attributes (such as being married) were instrumental in gaining rapport. In the interviews with many of the female participants there was a sense of a new relationship, a friendship that had been created by the process. All of the female participants interviewed suggested we meet up after the end of the project and many offered additional support and advice. With the male participants the interviewing process was just as relaxed but perhaps both gender differences and cultural etiquettes meant that they did not make suggestions of continuing the acquaintance further. The interviews that were conducted in the participants' home and my home were found to aid the relaxed atmosphere of the interviewing process and may have accounted for the increased time of interviewing for some of the participants.

4.2 Emotive interviewing.

I found one interview particularly emotive. The narration of racial abuse whilst growing up in the 1970's resonated with my own personal experiences of racial discrimination. During the description the participant signaled for the tape recording to be stopped. After discussing this aspect of the narration the interview recording was restarted. In debriefing the tape recording was listened to and edited. The participant assured me that the process had not been distressful but instead had found sharing the experiences beneficial. The participant did stress however, that these issues were not to be expressed within the main findings but was happy for me to bring up the issue as part of my reflection so long as anonymity was ensured. After leaving this interview, I found myself ruminating over the account and in particular linking it with my own experiences of explicit racial attacks whilst at school. I reflected on how these events had been downplayed by me, but as this participant had pointed out, for many ethnic minorities these situations are instrumental in their personal and professional development.

5. Personal Reflection on one's own Career Trajectory

5.1 Choosing to do clinical psychology.

Unlike the participants of this study I became aware of the subject of psychology at early age and mainly through the presence of a brother with profound learning disabilities. His presence also had a profound impact on family dynamics and parental expectations. Being the eldest of the family, my parent's expectations were that I share the responsibilities of my brother's welfare and that I should become highly educated and perhaps choose a profession in mental health. Being a small nuclear family without an extended family to support us my family became quite isolated from the predominant Gujarathi community. Brought up generally without South Asian friends I feel I had little influence on my career intentions by the community. I am also not aware of any

pressure felt by my parents' social network (possibly because this was very limited) to pursue a traditional career. Although my father was a professional, he was an architect; his family were also educated and were architects. Although my mother was relatively uneducated due to her getting married at early age she too had members of her family that were professionals. For my parents education was important for gaining independence and not as a means to change our social status as was suggested from the findings of the study. Unlike many of the participants in this study my father came to England in 1970 on the basis that it would provide him professional fulfilment. He regarded himself as a victim of the British Raj and felt that he had left India because of the subsequent oppression he felt due to the injustice of the caste system. When we came to England he immediately worked as an architect and we quickly moved into an area that was affluent but was predominantly White.

I remember that my decision to pursue clinical psychology was made in 1986 and during the last year of my 'A' levels. This decision reflected many factors; my responsibilities as an eldest child to be educationally successful, my duty and love for my brother and the subsequent developing interest in Psychology. Unlike the majority of the participants in this study, the decision also reflected my parents' ambition for me to enter a caring profession. I feel that through the presence of my brother my parents and I valued the mental health profession. A lack of awareness and role models was identified as a barrier in the study. I had gained an early awareness of the profession and through significant role models; the psychiatrist linked to the care of my brother and an English friend that was doing an MSc in clinical psychology.

I began studying undergraduate psychology in 1986 at Portsmouth University. After going to a predominant White middle class school I was pleased to enter an educational institution that had a high proportion of South Asians (predominantly from Gujarath and Punjab). I found that a majority of the students were studying pharmacy

and it was interesting to observe that the majority were those that had not got into medicine. Many had come from family business background and explicitly expressed an interest in being self-employed, perceiving retail pharmacy as business opportunity.

As I made many South Asian friends I began to develop a better sense of my cultural identity and the values given to education and careers in the South Asian culture. Although I had been used to being the only minority ethnic student throughout my educational experience so far, I found that being the only minority ethnic person on my undergraduate psychology course isolating. The themes of ‘feeling isolated by being the only minority ethnic student’ and ‘perceiving the situation as the norm’ were presented in the study’s findings.

I remember my values and subsequent altruistic career intentions were contested by my peers’ values on achieving success through financial security. Succumbing to the peer pressure to do a traditional or at least a science based career, I gave up my undergraduate psychology after eight months and replaced it with pharmacology. My parents were grossly disappointed with my decision to be a research scientist. My father then insisted I do a PhD and therefore after completing my degree I completed an MPhil and then worked as research associate within the blood transfusion centre pursuing a PhD. My father valued doing further education and in particular doing a PhD, it was regarded by my parents as a sign of marked intelligence! I do feel that my encouragement of the exploration of what ‘value a doctorate’ held in the participant’s family was born out of my own experience. However, I think that this example describes a benefit of how my own experiences and insider’s perspective have helped provide richer data. Both the Qualitative Support Group and my supervisor have been shown my field noted and relevant aspects of the transcripts to ensure transparency.

The birth of my son and the simultaneous loss of my mother from cancer had an impact on my career intentions. My interests in helping others or for an interpersonal

career were revived at this point. However, my responsibilities as a mother, daughter-in-law and wife meant I also required a career that enabled me to perform my family duties. I chose teaching and pursued a PGCE. I feel that my genderised roles and cultural expectations had the most impact on my self-identity and career trajectory at this point. The pressures felt to balance family duties particularly post marriage were similar to those reported in the female participants of the study, although not in relation to pursuing clinical psychology.

Having found teaching a frustrating profession for various reasons and after working as a science teacher I returned to my career interests in health and completed an MSc in Health Promotion. For the years leading up to getting my first assistant psychology post I worked as a health promotion specialist working with South Asian communities raising awareness of breast cancer. However my work with cancer patients and research in health psychology in particular re-invoked my interest in pursuing clinical psychology. Subsequently whilst working as a project manager in health promotion I completed the Open University undergraduate psychology course over three and a half years.

Once I had gained this new degree I was encouraged by fellow professionals to pursue clinical psychology and was fortunate enough to quickly obtain assistant posts. Unlike the majority of the participants of this study I did not have to work as a support worker prior to getting the assistant post. I do believe that like the participants of this study I would have struggled to have undertaken support work or similar positions. However, unlike some of the participants in the study it would not have been due to conducting menial tasks involved with daily patient care (I was used to this through caring for my brother) but because I had previously held senior posts that were highly regarded by my family. Being a support worker or similar would not have fared well with my in-laws or my husband's values of careers and the meaning of working.

Therefore, I would have met with resistance to pursue clinical psychology as a direct result of this.

5.2 Training experiences.

With the participants of the study I share the experience of being positioned as the cultural spokesperson in teaching sessions. Often in lectures I found that cultural issues were not encouraged to be shared amongst the cohort. Unlike the participants of the study overall I have not had isolating experience. However I can remember two interesting situations in which similarly to the participants in the study I lacked the ability to share my feelings and experiences. I remember in my first year there was media focus on cultural diversity and racial discrimination issues due to the T.V programme Big Brother and the scenario involving the late Jade Goody and a Bollywood actress. I felt at the time it would have been useful for us to reflect on the general discourses but my attempts to initiate discussions were met with silence from my cohort. Another example of wanting to share my feelings was upon the election of President Obama and the significance of this on the description of minority ethnic. I found that there was no forum to discuss these events or their wider implications and it was at these times I believe I felt socially isolated. However, I have been supported by the university staff and have had mentoring by a senior South Asian clinician. Within this have found a forum to share my experiences and in particular gaining support for understanding how personal family matters have at times challenged me to successfully complete my academic work.

6. Conclusion

The research process has been challenging in particular with the amount of data created and the subsequent analysis of it. However through this process there is a

development of a new competency; to use and evaluate qualitative methodologies in researching minority ethnic populations. The study's findings provide a basis for further qualitative research, exploring the association of a sociocultural value for traditional professions and the lack of awareness and/or value for clinical psychology, possibly though grounded theory. Through IPA the lived experiences of a minority ethnic group within the profession have been voiced.

Gonzalez (1995) suggests that the journey for becoming an ethnic researcher can be challenging and coping strategies need to be in place. Having supervision and the Qualitative Support Group has been a part of my coping strategy for the research process. However, IPA itself has helped me to establish labels for the influences felt in my own career journey and understand their significance. The research process of interviewing other South Asian clinical psychologists has also provided a sense of belonging in a profession that is predominantly White. Thus I feel that the research subject and its process of enquiry have aided my personal and professional development

7. References

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SECTION E

APPENDICES

APPENDIX I:

RESEACHER'S USE OF TERMINOLOGY IN THE THESIS

APPENDIX I: RESEACHER'S USE OF TERMINOLOGY IN THE THESIS

Below are explanations of how specific terms have been used by the researcher in the thesis. The list is presented in alphabetical order:

Asian This term applies to anyone originating from the Asian subcontinent. However, in the UK it usually used synonymously with the term South Asian (see below) and therefore refers to persons with origins in the Indian subcontinent. In the US, the term has a broader meaning and includes persons of Far Eastern origin, e.g. Chinese, Japanese and Phillipinos.

Black One of the problems with using this term is its varying acceptability in different communities. Some researchers (Patel et al. 2000) intend the term to be self-labelling, 'a political term for stating allegiance with all those that have experienced oppression because of their colour' (p 16). For some researchers (Williams, Turpin & Hardy, 2006), it is regarded as a collective term, used to identify and unite large groupings of people in terms of their 'common experiences of discrimination, racism, marginalisation and oppression' (p 325). As the use of this term can be historically problematic (because of its use as a generic and politicized description), it used in the thesis when cited in the published literature. Where the author of the literature provides the meaning of the term, reference is made to it in the text; otherwise the term 'Black' holds the above definitions.

Cultural identity This term relates to the identity of a group, country, society or an individual as far one is influenced by one's belonging to the group or culture. 'Culture' is regarded by the researcher as not something the individual or group posses but a social process or practises that reflect the context, changed by history, race, ethnicity,

gender, sexuality, language and religious beliefs. In relation to self-identity, cultural identity is seen as a matter of ‘becoming’ as well as ‘being’ considered as a fluid construct and a dynamic positioning of ourselves within narratives of the past.

Essentialism This term refers to a viewpoint that seeks generalization, and assumes that characteristics or properties possessed by a group (e.g., people) are universal and not dependent on context. In an essentialist position, characteristics such as gender, sexuality, race and ethnicity would be considered to be fixed traits.

Minority ethnic Williams, Turpin & Hardy (2006) suggest that this term includes people of African, African Caribbean and South Asian origin. The authors state that the term excludes white minorities (e.g. of Irish origin) and persons with East Asian origin’ (p 325). In this thesis this term has been used according to this description.

South Asian As per Marshall & Yazdani’s (2000) suggestion, this term has been used to refer to people mainly from South East Asia and the Indian subcontinent. It therefore includes people of Indian, Pakistani, Bangladeshi, Sri Lanka and East African origin (with Indian origins).

Self-efficacy This term refers to the individual’s perception or belief of their ability to reach a goal or succeed in specific situations. In the thesis the term is used in relation to the individual’s evaluation of their academic ability and pursuing certain careers.

Self-identity This term refers to the perspective we have of ourselves as ‘becoming’ or ‘being’ a separate entity. However, the researcher is of the opinion that our identities are simply names we give to the different ways we are positioned and position ourselves

within discourses and narratives of the past. Furthermore that our identities are always in production and never complete, thereby self-identity is not regarded as a fixed essence, lying unchanged by our context.

White The term is often used to describe persons of European ancestral origins who have or are identified as White. The term is also used in literature to distinguish these groups from those groups of skin colour. In the thesis it used to refer to an assumed White majority group.

APPENDIX II:

**NOTES FOR CONTRIBUTORS TO INTERNET JOURNAL OF ALLIED
HEALTH SCIENCES AND PRACTICE**

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An international journal dedicated to allied health professional practice and education

<http://ijahsp.nova.edu>

ISSN 1540-580X

A Peer Reviewed Publication of the College of Allied Health & Nursing at Nova Southeastern University

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The The Internet Journal of Allied Health Sciences and Practice publishes scholarly papers, descriptive and timely reports, and continuing information and findings related to research and development in the practice and education of allied health professionals. The Editorial Board of the Internet Journal of Allied Health Sciences and Practice encourages the submission of articles, letters to the editor, research abstracts, case studies and book reviews as well as original research and evidence based practice. Of special interest are articles with a broad allied health practice, education and research emphasis. Submissions with appeal to segments of our audience are also very welcome. The journal follows closely the Uniform Requirements at this link: <http://www.icmje.org/>

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2. Relevance to Audience. Is it relevant to health professionals in diverse fields of allied health?
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Manuscript. Authors should use only 10-point font size, Arial Narrow, preferably in Microsoft Word or OpenOffice format. Do not use proportional spacing; use left-justified (ragged) right margins and letter-quality printing.

Preparation of Copy. The manuscript should be submitted to the link located at the end of this guide (including references) and should have single line spacing using 10 pitch Arial Narrow font. **Page size should be set to "LETTER" not "A4."** Do not use line numbers. A separate cover letter must be inserted into the manuscript system using cut and paste or typed in the box provided and must indicate the title of the article. The letter shall list the names, credentials, and affiliations of the authors in the order of authorship. This letter must also state the contributions made by each author.

All files must be zipped as one file prior to submission to the manuscript system.

Length of Manuscript

Although the information presented in the article will determine

It may also be faxed toll free or mailed to the journal office.

Fax: 1-866-613-2402, Attn. Dr. Guy Nehrenz

Postal Address:

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Authors may acknowledge persons who have made substantial contributions to the development of the study or manuscript, but must obtain permission from all persons named in an

the appropriate length, it is recommended that the length not exceed approximately 15 single-spaced pages, including references, tables, and figures. Longer manuscripts must be accompanied by justification of length.

Style, Citations, and References

Manuscripts and citations should be prepared in accordance with standard style (American Medical Manual of Style, Chicago, and AMA preferred). The Internet Journal of Allied Health Sciences and Practice follows standard guidelines for nonsexist use of language. References should be listed as they appear in the text, not alphabetically. Include year, volume number, and inclusive page numbers in the reference. Do not put page numbers in the text citation. Text citations should be a superscript number with no brackets on parenthesis, such as.¹ Do not put citation numbers within the sentence, only place them at the end of the sentence. See the following link for reference style. There should be no more than 40 references in the standard article. Do not use automatic referencing systems or endnotes as the reference may renumber or disappear altogether during formatting.

http://www.nlm.nih.gov/bsd/uniform_requirements.html

Manuscripts under *Student Perspectives* at times may be in APA at the discretion of the editorial board.

Paragraphs

Do not indent the first line of a new paragraph. Just separate each new paragraph with a line space. Much like this guide to authors.

Tables and Figures

Authors are encouraged to submit tables and figures. All diagrams, photos or drawings must be converted to jpeg or gif images prior to submission for review and attached in jpeg or gif form as separate items in the zip file during submission.

Tables must be developed using the TABLE FUNCTION of Microsoft Word. Do not make a table with Tabs. Separate text with cells in the table. Do not use a text box or Excel to create a table. Use NO graphics in a table. All tables must fit on a portrait page, not landscape. Landscape tables will be placed as Appendixes.

A text marker should dictate the placement of photographs or diagrams; "Place Figure 1 here." Tables are to be placed in their appropriate spot by the author.

Abstract

An abstract of no more than 350 words is required for all submissions. It should be written as a single paragraph. It must also be included on the manuscript and pasted into the window of the manuscript submission page. It should include the following components as appropriate.

- Purpose
- Method
- Results
- Conclusions and possibly recommendations.

Abstracts do not contain references.

Informed Consent

Patients have a right to privacy that should not be infringed upon without informed consent. Identifying information, including patients' names, initials, or hospital numbers, should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Informed consent for this purpose requires that a patient who is identifiable be shown the manuscript to be

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- *International Committee of Medical Journal Editors ("Uniform Requirements for Manuscripts Submitted to Biomedical Journals")*
-- February 2006

All research manuscripts where human subjects were used, must have the IRB approval letter included with the submission.

Research Articles

This feature presents original research that addresses an important issue in allied health. Manuscripts should report recent, original work that expands the body of knowledge in one or more allied health disciplines. The research should either have implications for the improvement of practice, provide a better understanding of contemporary issues, present a program evaluation, or advance a theoretical framework. Both quantitative and qualitative approaches are encouraged. Manuscripts submitted for this must be methodologically sound and supported by data. Manuscripts reporting original research customarily include: a structured abstract, an introduction stating the purpose and relevance of the study, a clear and full description of materials and methods, including criteria for subject selection, a report of the results, a discussion of the findings and a bibliography.

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This feature will be used for the presentation of scholarly discussion of an issue of interest to allied health professionals. Commentaries or editorials can focus on such topics as discussions of applications of theory to practice, a critique of certain practices, recommendations for change, or contemporary controversial issues. Commentary and editorials are at the invitation of the Editor only. Letters to the Editor may be submitted at anytime without invitation.

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This feature identifies and abstracts key articles that deal with current thinking in allied health education and practice. Appropriate articles may be found in the professional journals of the individual allied health disciplines and in journals with a wider spectrum of interest. Topics might include, but not be limited to, research and development in allied health education and practice, current trends and history in allied health, health care policy and planning, legal and political issues in allied health, interpersonal skills development, simulation, and unique audiovisual approaches. Abstracts should be limited to 200-250 words and should include title, author, journal name, volume and number, and

published. Authors should identify Individuals who provide writing assistance and disclose the funding source for this assistance.

Identifying details should be omitted if they are not essential. Complete anonymity is difficult to achieve, however, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of patients is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic pedigrees, authors should provide assurance that alterations do not distort scientific meaning and editors should so note.

The requirement for informed consent should be included in the journal's instructions for authors. When informed consent has been obtained it should be indicated in the published article.

- International Committee of Medical Journal Editors ("Uniform Requirements for Manuscripts Submitted to Biomedical Journals")
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A good reference book for grammar, syntax and punctuation is,

Hacker, D. (2003). *A Writer's Reference*, 5th ed. Bedford/St. Martin's: Boston. ISBN 0-312-41262-2.

All submitted manuscripts must be free of editorial comments, change tracking code, end notes, running headers or footers and anything other than the manuscript text and tables. It is the AUTHORS responsibility to submit a clean copy. Manuscripts submitted for consideration will be immediately rejected if such code or comments exist in the text. Manuscripts will also be rejected if all guidelines above are not met.

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Book Reviews

The Internet Journal of Allied Health Sciences and Practice invites readers to review current books, monographs, or audiovisual materials of general or specific interest to the allied health community. This material may be appropriate from a single discipline or be of interdisciplinary interest. Reviews should contain the following information: title, author, publisher, city and state of publication, year of publication number of pages, and price. The review should include a description of the central theme of the work, a brief objective summary of the content and a critical analysis by the reviewer regarding the potential value of the material to allied health education and/or practice. The review should not exceed two double-spaced pages.

Features

This section is reserved for special topics of potential interest to the allied health community, chosen at the discretion of the Editor. Features may include such things as summaries of proceedings of conferences, abstracts of submitted papers, speeches, executive summaries of government reports and summaries of special studies related to important issues in allied health. It is used primarily to communicate significant matters to the allied health community.

Any other concepts for consideration should be directed to the editor for evaluation and possible inclusion. The journal reserves the right to refuse and and all submissions.

Educational Perspectives

All manuscripts related to teaching and educational methods will be considered for this category.

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Manuscripts written by students on topics of interest to the allied health community will be considered for publication in this section. The only exception will be systematic reviews. These will be published in the Evidence-Based practice section.

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This section covers case reviews, case studies, procedural descriptions and clinical policy. Other areas of clinical medicine and healthcare related to the delivery of competent care will be considered for this section.

Evidence-Based Practice

All systematic reviews, or specific evidence-based practice research studies will be considered for publication in this section.

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APPENDIX III:

LITERATURE REVIEW: SEARCH STRATEGY PROCESS

AND DATA EXTRACTION TOOL

APPENDIX III: Literature review: search strategy process and data extraction

Table E1: Key search terms and categories

<u>MeSH Key Search Term and categories (combined with ‘AND’ syntax)</u>	
1	South Asian* or Pakistani or Bangladeshi or Indian or Black Minority Ethnic or BME or ethnic minority or under-represent* or Black
2	race or rac* or ethnicity or culture* or marginal* or diversity or discrimination
3	career pathway or career or trainee or train* or education*
4	recruitment or retention
5	nurse student or medical student or dental student or speech and language or occupational therap* or psycholog* or undergraduate or student or clinical psychology* or counsel* or physiother* or dietician or ophthalmol*
6	Health profession* or mental health or allied health*

MeSH key words and synonyms were collated from potential articles in a preliminary scoping exercise. Search limitations: English language, exclude dissertations and books; search terms set as ‘keywords’

Table E2: Database returns and duplicate exclusions

<u>Database</u>	<u>Total number of articles returned</u>
PsycINFO	78
Web of Science	169
CINAHL	111
Medline	81
BNI	143
Cochrane	4
EMBASE	98
Social Science citations	34
Total number of articles	718
Total number of articles after including complementary searches (hand search, web based resources, consultations) (n=19)	737

APPENDIX III: Literature review: search strategy process and data extraction

Table E3: Qualitative assessment and data Extraction Tool

Author (s) and Year	
Aim	
Study Location	
Coherent epistemology/epistemological integrity- ontology, methodology	
Theoretical perspective	
Sample/participants: Size Gender Age Ethnicity/race/cultural description	
Data collection	
Data Analysis	
Reflexivity	
Quality Issues	
Transferability	
Researchers conclusions /interpretations found paper's discussion/ conclusion section	
Findings/themes from results section	verbatim illustrations given in result section for theme

APPENDIX IV:

CHRONOLOGY OF RESEARCH PROCESS

APPENDIX IV: Chronology of Research Process

Peer review of research proposal	June 2008
Appointment of academic supervisors	June 2008
Submission of Research Ethics Committee application form for approval	July 2008
Approval received from LREC and Leicester University	September 2008
Recruitment process/data collection	September-December 2008
Data Analysis	December 2008 -March 2009
Writing	January – May 2009
Submission to University of Leicester	May 2009
Dissemination	September – July 2009/2010

APPENDIX V:

RESEARCHER'S STATEMENT OF EPISTEMOLOGICAL POSITION

APPENDIX V: RESEARCHER'S STATEMENT OF EPISTEMOLOGICAL POSITION

According to Groenewald (2004) a researcher's paradigm is 'literally her theory of knowledge which serves to decide how the social phenomena will be studied' (p2). Two concepts define a research paradigm; first an ontological position. This is a description of how reality is perceived and the positioning of the researcher on the nature of reality. The second is an epistemological position; this defines the relationship between the researcher and the researched. Guba & Lincoln (1994) have described four research paradigms from which psychological research can be conducted; Positivism, Postpositivism, Critical theory and Constructivism. With respect to the ontological position held within these paradigms, Positivism considers only one reality to exist. Post-positivism also suggests this but suggests that our acknowledgement of it is inexact and imperfectly accessed. Critical Theory states that reality is defined by our social, political, cultural, economic, and ethnic and gender values. The final position is constructivism which argues that reality is a fluid concept which changes through social interaction, therefore is subjective and socially constructed. With respect to the epistemological position held within each paradigm, this is also on a continuum. The researcher is considered independent and objective by positivists whereas within constructivism there is interdependency between the researcher and the phenomena under question, which renders the findings totally subjective.

Groenewald (2004) suggests that how the researcher's paradigm was formulated from their epistemological and ontological positions should be made explicit. The researcher's position was formulated as follows:

- 1) The data to the questions posed by this study were considered to be contained within perspectives of current South Asian clinical psychologists. The researcher

believed that the descriptions of the phenomena under enquiry within the retrospective accounts of the participants hold significance. Furthermore, that objective truth/reality exists beyond the interview and as part of the individual's ongoing self-narration (Smith, 1995). Willig (2008) aptly puts forward the argument: 'the world is not orderly,' (as realists would posit) and that 'there are a diversity of interpretations' of the phenomenon (p.13). Sharing this position, the researcher's ontological position was therefore to be that of a 'critical realist' (Madill, Jordan & Shirley, 2000) within the Critical Theory paradigm.

- 2) In terms of the epistemological position, similarly to Hycner (p, 144, 1999), the researcher was 'reluctant to use methodology with prescriptive techniques and specific steps.' The researcher believed that through making assumptions about the world, injustice is done to the integrity of the phenomenon under study (Willig, 2008). In contrast to positivists, the researcher does not pretend to be detached from the data (Hammersley, 2000) but considers to be 'engaged' in data collection, thereby considering the importance of presuppositions, (based on the researcher's own cultural background and experiences which have been made explicit³⁵), on the data. The researcher holds a reflexive and hermeneutic position, believing that the interpretation of the data and sense-making is by both the participant and the researcher; a process that is dynamic with an active role for the researcher (Smith & Eatough, 2006).

³⁵ The researcher background has been provided in the methodology of this thesis

Both Grounded theory and IPA are two methodologies that reflect both the critical realist perspective i.e. that the data contained the phenomenon, whilst considering that its interpretation is multiple and co-constructed i.e. during the engagement between the participant and the interviewer. Grounded Theory (Charmaz, 2006) was considered initially by the researcher. The researcher was aware that the phenomena under the research question was under researched and may therefore make the development of an inductive theory easier with regards to approaching the research with a blank canvas. However, being of a South Asian background, the researcher was concerned about remaining objective; she was aware that her interpretations may be prone to bias from her own experiences and career trajectory into the profession.

The Charmaz (2006) approach to using Grounded Theory, does however suggest that the researchers' preconceptions to be used as guided interests and as 'points of departure.' The emerging theory should be seen as a combination of *and* grounded in the participants' accounts as well as the researcher's interpretation of the accounts. Grounded Theory relies on data saturation and identification of outliers and therefore requires more data to improve the validity of findings. The researcher was conscious of the fact that the sample in the study would be too small to achieve saturation and validity. Furthermore, given that the phenomena currently was under researched, the researcher was not primarily seeking to use the study findings to develop theoretical explanations but to provide a voice for the participants' experiences. The researcher wished to understand participants' 'meanings' of becoming a clinical psychologist through their 'lived' experiences. Based on the considerations, the researcher felt that IPA would be more appropriate than Grounded Theory at this current stage of investigation of the phenomena.

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APPENDIX VI:

INFORMATION SHEETS, CONSENT FORM & DEMOGRAPHIC

QUESTIONNAIRE



Letter of Invitation to the Participant

Dear [PARTICIPANT]

Research Title: An Explorative Study into the Experience of becoming a Clinical Psychologist when from South Asian background.

As part of my training at Leicester University to become a clinical psychologist, I am planning to conduct research with Clinical Psychologists of a **South Asian background***, practising across the UK.

I am interested in hearing the experience of becoming a clinical psychologist with regards to peer, family, societal and cultural influences with respect to your South Asian background, on individual career trajectory and current practise.

The findings from the research will help to address the current challenges posed to the profession such as the under-representation of clinical psychologists from minority ethnic communities and in particular from a South Asian background, which within the UK are the largest Asian group. The research will help to increase our understanding of how cultural psycho-social and economical factors influence career decisions, present difficulties for choosing and pursuing training in clinical psychology for South Asian students, for which, undergraduate psychology, has gained rapid popularity but is not subsequently perceived as choice of career.

I am writing to you to invite you to take part in this research. Enclosed is an Information Sheet, which describes what the research would involve. I would be extremely grateful if you could read the information and consider taking part.

Participation is entirely voluntary. If you would like to speak further about the research then please contact me on the telephone numbers below or by email. Or if you feel you have enough information and would like to take part, then please complete and return the reply slip enclosed. I also enclose a pre- paid envelope if you are returning the slip by post and request you return the reply slip *two weeks from the date/receipt of this the letter*.

*(If you or your family are from the Indian subcontinent and/or describe your self to be of Indian, Bangladeshi, Pakistani, East African (migrated from the Indian subcontinent originally) Sri Lankan or are of mixed South Asian background).

Thank you for your time, I look forward to your participation.

Yours sincerely,

Dipti Thakker
Trainee Clinical Psychologist
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LE1 7LT

Leicester University, Clinical Psychology Dept:
Tel No: 0116 223 1639
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Information Sheet

1. Research Title: An Explorative Study into the Experience of becoming a Clinical Psychologist when from a South Asian Background.

2. You are being invited to take part in a research study. This Information Sheet explains the nature of the research, and what it will involve. Please read through the following information, which will help you to decide whether you would like to take part in the study. If you would like more information then please do not hesitate to contact me using the details below.

If you would like to take part after reading the information sheet, then please complete the reply slip and return this to me. If you are returning by post, I enclose a pre- paid envelope.

Thank you for reading the Information Sheet.

3. What is the purpose of the study?

Research suggests that the number of psychology undergraduate students from certain South Asian backgrounds is increasing and yet there is distinct under representation of these cultural groups within the clinical psychology profession. Research to date has not explored the career experiences of current South Asian clinical psychologists. This study aims to explore the influences of psycho-social cultural influences on career trajectories and current practise of South Asian clinical psychologists

Why am I being asked to take part?

You have been chosen because you are Clinical Psychologist from a South Asian background. Your educational experience and your views on what psycho socio-cultural pressures you have experienced and believe exist will be relevant information for this study.

Do I have to take part?

Taking part in this study is entirely voluntary. If you decide to take part I will contact you and arrange an interview time and venue that are convenient to you. You will be asked to sign a consent form before being interviewed.

If you decide to take part you can still withdraw from the study at any point without giving a reason.

If you do not want to take part then do not return the reply slip. I will not contact you again.

What will be involved if I take part in the study?

The study will involve Mrs. Dipti Thakker, a trainee Clinical Psychologist interviewing you, which will last up to ninety minutes. The interview can take place at a time and venue to suit you. Before the interview you will be asked to sign a consent form and asked for some basic demographic information.

The interviews will involve me asking a set of questions and recording your answers using a Dictaphone. The questions will ask you about how your education, your family background and in particular the influence of this and your culture on your career, and finally your perspectives on your current practice. You do not need to answer questions that you do not want to. There will also be scope within the interview for you to bring up things you would like to say that are not in my set of questions. We can build in breaks during the interview, if these are needed.

Following the interview, I will add your comments to the comments from other psychologists who will be interviewed. Taking the comments together, I will identify themes and interesting subjects raised in the interviews, which I will write up. All of your comments will be made anonymous.

The transcripts of the interview will be forwarded to you to verify for authenticity if you so wish. The findings of the study in the form of an executive summary will then be forwarded to all participants and if possible will be presented at relevant meetings e.g. Race & Culture SIG. I will also aim to get the results published in an academic journal and identify conferences where the results could be presented.

Will information obtained in the study be confidential?

Throughout the research process, your identity will remain anonymous. The interview will be recorded using a Dictaphone, and the recording will be saved onto compact disc (CD) and labelled in numerical order of the interview (e.g. interview one). Each interview will be transcribed and saved in a computer file labelled with the same identifier (e.g. interview one). Files will be password protected and encrypted. The CDs, consent forms and printed transcripts will be stored at the University of Leicester in a locked cupboard when not in use.

During the transcription process, each participant will be labelled numerically and the name of the participant will not appear in the report, but will be labelled as participant one, and so forth. In the transcript and report, if another person's name is mentioned, this will be given a pseudonym to protect the identity of the person talked about. In the report, it may be useful to use a direct quote from the interview transcript. Where this occurs, the participant will not be named, and the quote will be labelled for example as *Participant 1* or *CPI*.

My Research Supervisor, and fellow Trainee Clinical Psychologists (part of a Qualitative Research support group) may want to look over the transcript from the

interviews, to help me with analysis and writing the report. By this point, all transcripts will be anonymous and will have been labelled numerically, with pseudonyms given to names mentioned in the transcript when this occurs. The transcripts, consent forms, and CDs will all be destroyed by fire seven years after the research is completed.

If, during the interview, I am concerned about anyone's safety e.g. if there is a concern of harm to you or to others by you, I will have a duty to act on this and may need to disclose your identity to my Research Supervisor. I will be able to let you know if I need to do this.

What are the possible disadvantages and risks of taking part?

We do not feel you will be harmed by taking part in this study but talking about family influences or certain experiences may be sensitive. You will always be given the option to stop the interview and withdraw if you wish. I will discuss the matter and any other concerns further in a short debrief with you following the interview. We will discuss how you have found the interview, your concerns and how support can be obtained for your concerns either through your own supervision, the Race & Culture SIG or through contacting my research supervisor.

What happens if something goes wrong?

If you have concerns about any aspect of the way you have been approached or treated in this study or have reason to complain about any aspect of the study, the NHS complaints mechanisms are available to you. You may also contact my Research Supervisor, Dr Steve Melluish, at the University on 0116 223 1639.

What are the possible benefits from taking part?

There are no direct benefits to taking part in this study. The study aims to uncover influences on career trajectories of South Asian clinical psychologists.

What will happen to the results of this study?

The results will be written up and submitted as a thesis for the Doctorate in Clinical Psychology. A copy of the thesis will be stored at the University of Leicester.

The results will be written up as an executive summary, and circulated to those who took part in the research and also to the BPS and Race & Culture SIG.

The research will also be submitted to a relevant journal, and presented at conferences.

Who is organising and funding the research?

The research is organised and funded by the University of Leicester and Leicestershire NHS Partnership Trust.

Has the study been approved?

Yes. This study has been approved by the initial research panel organised by the University of Leicester, the Research Supervisor, has been formally peer reviewed and has passed ethical approval from the Leicestershire, Northamptonshire and Rutland Research Ethics Committee 2.



Reply Slip

**Research Title: An explorative study into the experience of becoming a Clinical
Psychologist when from a South Asian background.**

- I am interested in taking part in the above research.

☐

- I give my permission for Dipti Thakker (Trainee Clinical Psychologist)
to contact me to arrange an interview.

☐

- I understand that taking part in the study is voluntary.

☐

Name.....

Daytime telephone number.....

Work telephone number (if different).....

Date.....



Consent Form

Research Title: An Explorative Study into the Experience of becoming a Clinical Psychologist when from a South Asian background.

Interviewer: Dipti. P. Thakker (Trainee Clinical Psychologist)
School of Psychology- Clinical Section, University of Leicester, 109 Regent Road,
Leicester, LE1 7LT

Please read this consent form and feel free to ask any questions about the research. If you are happy to proceed with taking part, please sign the form.

Consent:

- I have read the Information Sheet and have had opportunity to ask questions. ☐
- I understand that I am volunteering to take part and am able to withdraw from the study and any point, without giving a reason. Any data that I have provided will be destroyed. ☐
- I understand that the interview will be recorded using a Dictaphone, and will be transcribed. ☐
- I understand that my identity will remain anonymous throughout the study and that if quotes are used from my interview, my identity and the identities of others I may mention will remain anonymous. ☐
- I understand that if the interviewer is concerned about anyone's safety or practice during the interview, that the interviewer has a duty to break confidentiality. ☐

- I understand that data from the interview will be kept securely at the university, and destroyed after seven years by fire. ☐
- I understand that to ensure validity and reliability within the study, the researcher will; forward my transcript for me to verify all data presented, engage in supervision, keep researcher's diaries. The diaries and coding may be discussed with others, however, my data will be kept anonymous and confidentiality maintained. ☐
- I understand that my interview will be written up as part of a thesis, and the results will be published in academic journals, and fed back to participants and other relevant professional bodies. ☐
- **I agree to take part in this study.** ☐

I have had the nature of this study explained to me and have understood what is involved in my participation.

.....

Participant's signature	Name of participant	Date
--------------------------------	----------------------------	-------------

Thank you for agreeing to take part in my research.

I confirm that I have explained the nature of this study, as detailed in the Information Sheet, and that the above participant has understood what is involved in participation.

.....

Researcher's signature	Name of researcher	Date
-------------------------------	---------------------------	-------------



Research Title: An Explorative Study into the Experience of becoming a Clinical Psychologist when from a South Asian background.

Demographic Information Sheet

Before commencing with the interview, please answer the following questions. The purpose of asking these questions is so that in the introduction to the research report, a summary of the demographics of those who took part in the research can be given.

1. Into which age band do you fall?

- Twenties ☐
- Thirties ☐
- Forties ☐
- Fifties ☐
- Sixties ☐

2. Place of birth.....

3. Please state your religious identity.....

4. Please describe your South Asian cultural identity?

.....

5. When did you and/or your family come to the UK?

.....

6. Place of education (school to DClinPsy., training)

.....

.....

.....

.....

.....

.....

7. Where did you do your DClinPsy., training?

.....

8. How many years in the profession since training?

- Under five years ☐
- Between six and ten years ☐
- Between eleven and twenty years ☐
- Between twenty- one and thirty years ☐
- Over thirty years ☐

9. Previous places of work.....

.....

.....

.....

.....

.....

.....

.....

10. Current Place of work

.....

11. What other contexts have you worked in other than your current post?

.....

.....

.....

APPENDIX VII:

ETHICAL AND RESEARCH GOVERNANCE APPROVAL DOCUMENTS

National Research Ethics Service

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 2

1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 0115 9123344 ext. 39428

Facsimile: 0115 9123300

19 September 2008

Mrs Dipti.P. Thakker
Trainee Clinical Psychologist
Leicestershire Partnership NHS Trust
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Mrs Thakker,

Full title of study: 'How I came to be a Clinical Psychologist': An explorative study into the experiences of becoming a Clinical Psychologist when from a South Asian background.

REC reference number: 08/H0402/83

Thank you for your letter of 16 September 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	3636/5077/1/435	24 July 2008
Investigator CV	Supervisor	
Investigator CV		24 July 2008
Protocol	5	24 July 2008
Covering Letter		24 July 2008
Peer Review		22 February 2008
Interview Schedules/Topic Guides	5	24 July 2008
Letter of invitation to participant	6	16 September 2008
Participant Information Sheet: Demographic	6	16 September 2008
Participant Information Sheet	6	16 September 2008
Participant Consent Form	6	17 September 2008
Response to Request for Further Information		16 September 2008
Reply Slip	6	16 September 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

With the Committee's best wishes for the success of this project

Yours sincerely,

PP / Renato Silva

Mr Ken Willis/Miss Jeannie McKie
Chair/Committee Coordinator

Email: jeannie.mckie@nottspct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Sponsor/R&D office for NHS care organisation at lead site - LPT

Research & Development Office
Daisy Peake Building
Gipsy Lane
Leicester
LE5 0TD
Tel: 0116 225 3743
david.clarke@leicspart.nhs.uk

Mrs Dipti P Thakker
c/o School of Psychology (Clinical Section)
University of Leicester
104 Regent Road
Leicester
LE1 7LT

29th October 2008

Dear Dipti

Re: How I came to be a clinical psychologist: An explorative study into the experiences of becoming a clinical psychologist from a South Asian background
Ethics Ref: 08/H0402/83 Trust Ref: PSYC0507

Thank you for applying for NHS Permission to Conduct Research for the above-named project. This study has now been validated and reviewed according to the Standard Operating Procedure for research appraisal. The study therefore has been granted the following level of approval:

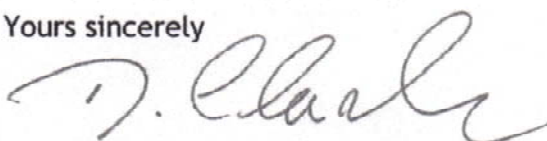
Full Approval	<input checked="checked" type="checkbox"/>	Approval in Principle	<input type="checkbox"/>	Approval refused	<input type="checkbox"/>
---------------	--	-----------------------	--------------------------	------------------	--------------------------

Under the Research Governance policy of the Trust, confirmation of appropriate ethical approval is a necessary prerequisite for Trust Approval. This office is now in receipt of confirmation of a favourable ethical opinion (NRES: LNR Research Ethics Committee Two) dated 19th September 2008, following your amendments submitted on the 16th September. I can also confirm that this study has Trust Research Governance Approval, and you will be covered by Trust research indemnity. This approval is conditional upon:

- A complete set of the amended paperwork approved by the ethics committee being received.
- Adherence to the agreed protocol
- Presentation of final report/summary findings to the Trust/Participants at the conclusion of the study.
- Confirmation of local management approval from, or notification to relevant host organisations.
- Any changes in the protocol, timescale etc. are notified to the research office.
- A copy of any subsequent publication is lodged with the Trust.

Please sign and return the agreement on the next page. With best wishes on the success of your study.

Yours sincerely



Dr. Dave Clarke
(Associate Director, R&D)

Leicestershire Partnership NHS Trust will act as a sponsor for the project named below provided the Chief Investigator adheres to the following conditions:

1. The investigator and all members of the research team shall comply with all the regulations applicable to the performance of the project, including, but not limited to, the NHS Research Governance Framework for Health and Social Care (April 2005), the World Medical Association Declaration of Helsinki (2000), the UK Medicines for Human Use (Clinical Trials) Regulations (2004), ICH Good Clinical Practice Guidelines (1997), the Human Tissue Act (2004) and the Data Protection Act (1998), Mental Capacity Act (2005).
2. The project must not start until:
 - Favourable ethical opinion from an appropriately constituted LREC or MREC and MRA approval (if applicable) has been obtained, or evidence has been provided that such approval is not necessary.
 - Final indemnity has been confirmed from either the R&D Office or other appropriate organisation.
 - Non-LPT employees having direct contact with patients and/or direct bearing of the quality of their care should ensure they have honorary contracts (see Trust policy).
 - If the project is externally funded, financial arrangements must be covered by a suitable agreement approved and signed by the R&D Office. For any project which uses Trust resources, the R&D Office must have assessed the associated costs and made arrangements for their recovery.
3. During the project, the Chief Investigator must ensure:
 - Participants are consented to the project, using the version of the consent form and patient information sheet which has received a favourable opinion by the ethics committee.
 - Amendments to the protocol or project documents are approved by the ethics committee MRA where applicable (see NRES website for guidance on substantial and minor amendments). The R&D Office needs to be notified of any changes to the project and copies of the updated documentation and approval letters forwarded to the R&D Office.
 - The R&D Office is notified of the actual start and end date of the project and any extension or early termination of the project, and of any major staff changes to the research team.
 - All near misses and incidents stemming from the research are notified to the Trust Clinic Risk Department using the Trust incident form.
 - All project documentation, medical notes and staff involved in the research project are available for audit if requested by regulatory bodies or by the R&D Office.
 - At the end of the project, documents relating to the project are appropriately archived within the Trust's and/or the University's archiving facilities, and a final report is submitted as appropriate.
 - Any potential intellectual property stemming from the research must be disclosed to the Trust, University and/or East Midlands Innovations Hub.
 - The R&D Office is notified of any outputs of the research such as guidelines, publications, changes in service delivery etc.
 - For research governance purposes, any requests from the R&D Office for further information on the project are responded to at the earliest convenience.

I have read the above and agree to adhere to these responsibilities for the project stated below.

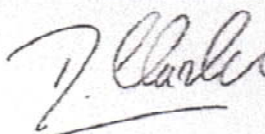
Project title: How I came to be a clinical psychologist: An explorative study into the experiences of becoming a clinical psychologist from a South Asian background

Chief/ Principal Investigator: Mrs Dipti P Thakker

Signature: 

Date: 6th November 2008

For the Sponsor Organisation:
Dr. David Clarke (Associate
Director (R&D))



Date:
29th October 2008

APPENDIX VIII:

INTERVIEW GUIDELINES

APPENDIX VIII: Interview guidelines

Interview schedule (Initial/pilot)

Introduction to participants:

“I am interested in understanding your experience of becoming a Clinical Psychologist; what cultural, psycho-social influences have been important in shaping your educational pathway and of choice of career. I also would like to explore what it means to you to be a practising clinical psychologist. If and how, your cultural values influence your professional practise and how your professional identity may impact upon your family life, and perhaps your role in the community.”

Topic guide for a semi-structured interview:

These topics will be used as a guide in the interview.

- Introductory: The individual’s cultural family background
- The individual’s educational pathway inclusive of school to training
- Possible motivations and barriers for pursuing a career in Clinical Psychology
- Current perspective on the professional role
- The impact/influence of the professional role on self-identity, family life and wider community

Themes to follow up:

- How did the individual’s educational experience in terms of knowledge/peers/role models shape choosing psychology at A level and /or degree level
- How was the family cultural background/life history important in making career choices
- How did peers/role models/knowledge influence subsequent career choices
- What difficulties were perceived/experienced in do clinical psychology
- What does being a clinical psychologist mean for the individual, individual’s family and society they belong to?
- In what way is the individual’s professional role acknowledged in the community they belong to.

Examples of questions to be used as prompts:

Cultural background:

1. Could you tell me about your family and cultural background?

Prompts:

- When and why did the family come to in England?
- Parent’s education/vocation
- Extended family

Choosing clinical psychology

Educational Pathway:

2. What was school education like?

Prompts:

- Motivation?

- Expectations/aspirations of self
 - Expectations/aspirations did of parents?
 - Expectations linked to gender?
3. When did you consider doing clinical psychology and why?
 - Role models?
 4. What difficulties did you perceive in doing the training?
 5. How easy or difficult has it been getting relevant experience?
 6. What influenced your choice of training course?

Training Experience

7. What was your training experience like?

Prompts:

- Any others from a minority ethnic background?
- Impact of cultural identity?
- Family perception of training? Supportive?

Being a clinical psychologist- Practice issues

- a. How the individual's culture influences practise.
8. How does your culture influence your practise and perception of the profession?

Prompts:

 - Working with other minority ethnic clients
 - Diversity of department
 - b. How the professional/ role impacts on own culture; the individual's family and community/society.
9. What impact does your professional role have on how you perceive your cultural values, your expectations of family?
 10. How does your professional role impact upon the wider community?
 - Removing mental health stigma
 - Raising awareness of the profession

APPENDIX VIII *continued*

Interview schedule- revised version

Cultural background:

1. Could you tell me about your family and cultural background?

Prompts:

- What was it like in England when they came, the community your family belonged to?
- Parent's education/vocation- prior to coming to the UK
- Extended family-influence on own family
-

Choosing clinical psychology

2. Tell me about your education, when you first started to think about psychology moving through to doing the DClinPsy training.

Prompts:

- Motivation
- Expectations/aspirations of self, other friends
- Expectations/aspirations did of parents? Siblings doing what?
- Expectations linked to gender
- Thinking of clinical psychology
- Role models
- Jobs/assistant posts- where? near home ?
- Training course?

Training Experience

3. What was your training experience like?

Prompts:

- Any others from minority ethnic background?
- Impact of cultural?
- Family perception of training? Supportive?

Being a clinical psychologist- Practice issues

a. How the individual's culture influences practice.

4. How does your culture influence your practice and perception of the profession?

Prompts:

- Working with other minority ethnic clients
- Diversity of department

b. How the professional/ role impacts on own culture; the individual's family and community/society.

5. How does being a clinical psychologist influence cultural values/roles?

6. Do many people know what you do now? / What do they think you do? Is it important? Do they ask you for advice? /Help?

APPENDIX IX:
THE STAGES OF DATA ANALYSIS

APPENDIX IX: The stages of data analysis

Table E4: Example of first stage of data analysis

Left hand margin code	Text	Right hand code
Main driver interest and being that way inclined , not the studious medicine type, interested in woolly discussions	If I'm honest, I guess I had a number of drivers but the core one... which has still remained with me, was just a real interest in that area ... and I was also just that way inclined. I didn't see myself as the studious medicine or law type so this fitted in with my way of thinking even at that time, when it used to come into some of the sort of general studies discussions I found myself interested in those what some people might cynically say, woolly discussions (CPG-m;137-143)	Recognition of personal ability, personality type different- psychology subject matching to different personality and ability
Being someone who always wants something different, to do something different to other South Asian friends, being a busy body	[...] so I guess in fact my decision to pursue psychology as an academic subject (.) came from a Gujarati lesson on Saturday school because I was one of these kids that I always wanted to do something slightly different I was a bit of a (.) busy-body to be honest I just wanted to (.) be a little bit different to other people (CPD-f;233-237)	Recognizing wanting to be and to do different career to South Asian peers , being nosey in others matched to psychology
Had an emotional experience at school (led to being different ?) to looking at profession to help others , seeing how interest in helping others may be useful	I think I had a quite difficult emotional time in sixth form as well ...and so I think unlike others I was in some ways kind of drawn to this idea of... type of...erm...working in a helping kind of profession and working and seeing how it could be useful. (CPB-f;77-79)	Reflection on personal experience leads to being different , sees herself as wanting to emotionally help others seeking this type of profession

APPENDIX IX: The stages of data analysis

Table E5: Example of collapsing codes to create themes

Right hand code	Metaphor/higher level coding	Theme
Recognition of personal ability, personality type different- psychology subject matching to different personality and ability	Personal ability and personality different to others –soft nature related to doing something different	Being different
Recognizing wanting to be and to do different career to South Asian peers , being nose in others matched to psychology	Wanting to do and be different from peers, interest in others matched to psychology career	
Reflection on personal experience leads to being different , sees herself as wanting to emotionally help others seeking this type of profession	Being different by seeing one as wanting to help others emotionally type seeking	

N. B This table is not a comprehensive summary of the data contributing to the theme but shows some examples of data at each stage level of analysis

APPENDIX X:

REPRESENTATION OF THEMES IN EACH INTERVIEW

APPENDIX X: Representation of themes in each interview

Table E6: Summary of themes within the interviews

Line of Enquiry	Superordinate theme	Subordinate theme	Interview								
			CP A-m	CP B-f	CP C-f	CP D-f	CP E-f	CP F-f	CP G-m	CP H-m	CP I-m
Choosing to do psychology	Intrinsic motivational factors for choice	Personality and academic ability	√	√	√	√	√		√	√	
		Wanting to be different	√	√		√	√	√	√	√	√
	Socio-cultural influences challenging choice	Pressure from implicit socio-cultural model of education	√	√		√	√	√	√	√	
		Lack of awareness of clinical psychology	√	√	√	√	√	√	√	√	
	Supportive contexts for maintaining choice	Individual family dynamics	√	√	√	√	√		√	√	√
		Doing a ‘DOCTORate’ –helping to negate pressures	√	√	√	√	√	√	√	√	
Doctoral Training Experiences	Cohort/classroom experiences	Being the minority	√	√	√			√	√	√	√
	Personal Impact	Balancing academic and cultural pressures		√	√	√		√	√		
Practicing as a South Asian clinical psychologist	Being the South Asian practitioner	Bringing culture into the practise	√	√	√	√		√	√		√
		Balancing professional roles with cultural roles	√	√	√	√	√		√	√	

