Exploring the trainees' view of a socio-political approach within UK clinical psychology

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Abstract

This paper aims to provide preliminary insights into the relationship between clinical psychology and a socio-political approach known as Critical Community Psychology (CCP). Methodologically it uses statements about CCP as stimulus material, and utilises both quantitative and qualitative exploratory techniques, to survey the opinions of 354 UK trainee clinical psychologists. Participants' ratings of the stimulus material and their qualitative comments reveal many positive endorsements of the socio-political approach. However, themes from the qualitative data raise questions about how socio-political ideas can be incorporated into clinical practice and highlight uncertainty over the relationship between clinical psychology and politics.

Orientation

Clinical Psychology in the UK developed during and the after the Second World War. Since that time its growth has been influenced by political movements in the country (Burton, 2004) and its relationship with psychiatry (Pilgrim & Treacher, 1992). The majority of UK clinical psychologists are employed within the publicly funded health care system known as the National Health Service (NHS), which is generally free at the point of access. There is an emphasis on treatments that are demonstrably effective and short in duration, and although the profession remains diverse in therapeutic orientation the majority practice remains cognitive behavioural therapy (Kuipers, 2001). Most clinical work takes place at an individual level; however it can also involve family, group, and systemic interventions.

To become a clinical psychologist one must first meet the British Psychological Society's (BPS) graduate basis for registration. This is done by completing a validated undergraduate degree, which majors in psychology, or by passing the societies own examinations. Potential trainees must then obtain relevant experience in clinical settings and / or undertake relevant post graduate

qualifications. Only then can one apply for clinical psychology training which takes a further three years and leads to a Doctorate in Clinical Psychology (Huey & Britton, 2002).

Introduction

Guidelines produced by the UK Committee for Training in Clinical Psychology (CTCP) highlight the need: "for clinical psychologists to incorporate awareness of the social and political context of people's lives into their understanding and clinical practice." (Attenborough, Hawkins, O'Driscoll, & Proctor, 2000, p.13). The CTCP add that: "Programmes should ensure that… the influences of society on the individual and their relevance to clinical practice are integrated into all aspects of teaching." (Division of Clinical Psychology, 1999, 8.12). Research evidence also demonstrates the relevance of socio-political factors to the practice of clinical psychology, particularly in the relationship between socio-economic status and mental health. Long established research correlates socio-economic status with mental health problems (e.g. Brown & Harris, 1978; Hare, 1956) and contemporary literature indicates similar findings (e.g. Bruce, Takeuchi & Leaf, 2001 [USA]; Weich & Lewis, 1998 [UK]). In their review of the area, Powell, Hoffman and Shahabi (2001) state: "studies consistently show that persons of lower socio-economic status fare poorly on a wide variety of indices of health and well-being" (p.722).

Despite this, writers continue to highlight the fact that clinical psychologists tend to ignore socio-political issues, putting consideration of them beyond their disciplinary boundary (e.g. Attenborough et al., 2000; Burton, 2004, p.124; Fleming & Burton, 2001; Nelson & Prilleltensky, 2004; Smail, 1993). This literature is exemplified by Patel (2003) who states that: "clinical psychologists have, with admittedly the best intentions, ignored the relationship between the individual and the historical, social and political contents which have shaped their lives and given rise to distress" (p.16). While some authors (e.g. McPherson & Sutton, 1981) have long called for a practice that moves beyond the individual the principle contention remains that within clinical psychology "the consideration of broader social factors is often absent" (Attenborough et al., 2000, p.13).

The most common explanation for clinical psychologists' tendency to ignore socio-political factors is the profession's implicit individualistic nature and treatment orientation (e.g. Attenborough et al., 2000; Nelson & Prilleltensky, 2004). Cox and Kelly (2000) claim that clinical psychology shares the same underlying individualistic basis as psychiatry and this results in the notion that individuals can be understood independent of their context, culture and history. A related literature that might help explain this situation concerns "professional socialisation". The term describes the processes by which an individual acquires the necessary knowledge, disposition and cultural skills to perform their professional role (Merton, 1963). Importantly it does not just imply the learning of technical skills, but can involve changing personal values and ways of thinking (Page, 2005). In this regard UK clinical psychology's dominant professional framework is the scientist-practitioner model, where clinicians personally conduct and/or draw on research to inform their practice (Kennedy & Lleweyen, 2001). Cox and Kelly (2000) argue that as psychology locates itself within this discourse it assumes that "the notion of the individual self is an objective truth rather than a cultural construction" (p.4). Accordingly, individuals trained in this tradition are perhaps socialised to think from an individualistic rather than a socio-political standpoint.

Recently, a number of more pragmatic articles have been published. A sub-committee of the Leeds Doctorate in Clinical Psychology described how courses could include teaching on socio-political issues in clinical training (Attenborough et al., 2000). Although their recommendations illustrate valuable steps towards meeting the CTCP criteria, the authors provide no evidence to illustrate the effectiveness of this teaching. Currently the only article that highlights reactions, of those within UK clinical psychology, to socio-political material is written by Fleming and Burton (2001). They delivered nine hours of teaching, to one trainee cohort, over three years. Though some trainees made positive comments, the balance was weighted more towards the negative. This included the suggestion that the teaching did not provide enough practical techniques, was not psychological enough, and was too conceptual. The authors concede that the teaching was in its first cycle and may have been too didactic. However, they also wonder whether the material "may not fit

with some trainees' experience or identity" and equally suggest that "there may be a lack of fit between the material being taught and the trainees' placement experience" (p.32). In this case, it is possible that trainees are simply reflecting the understanding and experience of the wider profession. If this is the case, Fleming and Burton (2001) acknowledge that limited teaching input alone will struggle to change the status of socio-political ideas within the profession.

This present study aims to investigate the relationship between socio-political ideas and the practice of clinical psychology. It will do this by inviting participants to consider the relevance of a field related to clinical psychology that takes a more socio-political approach. This material will act as a stimulus, prompting participants to consider the relevance of socio-political ways of working. Because of its particular emphasis on socio-political issues this research will focus on Critical Community Psychology (CCP; Nelson & Prilleltensky, 2004). Although it is not possible to describe all of the concepts, values and ideas present within CCP key concepts would include; social justice, social change, praxis, powerlessness, politics, diversity, oppression, liberation, and social action (Burton & Kagan, 2001; Prilleltensky & Nelson, 2002). While there has been some attempt to define the concepts, values and ideas of CCP (e.g. Angelique & Kyle 2002; Prilleltensky, 2001) there is no clear agreement on what they are. Consequently the first stage of this research involves compiling a list of statements that describe CCP.

Method

Procedure

The methodology is modelled on two studies: Haste, Hogan and Zachariou (2001), and Kennedy and Llewelyn (2001). The research began by collecting statements about CCP. Snowball sampling produced the names of 56 potential participants who came from different geographical locations (including Australasia, Europe, North and South America) and different professional backgrounds (e.g. academic psychology, clinical psychology and health psychology). They were contacted by e-mail and asked to generate statements about the concepts, values and ideas of CCP. One reminder e-mail was sent a fortnight later. Twenty-five people responded (44% response rate).

Responses varied from a short list of key words to complete papers or books. The researcher employed simple theme analysis to reduce the material to 44 representative statements. These statements were sent back to the 56 potential participants for their comments, responses and revisions. Again, reminder e-mails were sent after 2 weeks. Eighteen replies were received (32% response rate) and this material was used to produce a final list of 43 statements (see Table 1 [this process is described more fully in Thompson, 2005]).

Initially, the research planned to get participants to rate statements in terms of both personal importance and perceived relevance to future clinical psychology practice. However, a pilot study suggested that asking 86 (as opposed to 43) questions resulted in participant fatigue. As a result, the two questions were combined into one which asked participants to rate each statement in terms of how relevant it was to the future of clinical psychology as they understood it (1. very relevant, 3. neither relevant or irrelevant / unsure, 5. very irrelevant). Each participant was also invited to contribute qualitative comments about the statements they had just rated.

Participants

The CTCP criterion emphasising the relevance of socio-political ideas is written in the context of training clinical psychologists (DCP, 1999). It is also the trainee population at whom the more pragmatic attempts to raise awareness of socio-political material have been aimed (Fleming & Burton, 2001). Accordingly, this research identified all trainee clinical psychologists on the 26 UK postgraduate courses in clinical psychology as potential participants.

Participant recruitment began by gaining permission from course directors prior to contacting trainees. Of the 25 courses approached, 24 directors gave permission. (Trainees from the Bristol Doctorate in Clinical Psychology were not approached as they had completed a pilot version of this research). Trainees were approached via their course administration teams using e-mail. Trainees wishing to participate were able to do so online, by e-mail or by post. Reminder e-mails were sent 14 days after the initial mailing. Research that takes place within the NHS must ensure that participants are adequately informed and consent to take part. To this end both e-mails sent to

trainees stipulated that providing data assumed that the attached information sheet had been read and understood.

Of the 24 courses that gave permission for their trainees to be contacted, 22 forwarded the e-mail to their trainee body. Three hundred and fifty four trainees participated in the study. This represents 28.85% of the potential sample (1227). Participation, from course to course, ranged from 11 to 50%. One hundred and twelve participants (31.6% of sample) made qualitative comments about the stimulus material (a total of over 8,000 words with an average of 68 words per comment and including 28 comments of more than 100 words).

Of the 354 participants, 54 (15.3%) were male, 300 (84.7%) female (typical of the gender divide within UK clinical psychology). Ages ranged from 21-25 to 46+. The modal age was 26-30 (193 subjects, 54.5 % of the sample). Participants were evenly distributed from the three years of training. Of the three ways of submitting data, 282 (79.7%) responded online, 58 (16.4%) by e-mail and 14 (4%) by post.

Reflexivity

The researcher was drawn to this particular area as a result of an interest in socio-political issues and their apparent absence from UK clinical psychology. The researcher's personal belief is that socio-political approaches (along with many other perspectives) are important to the future development of the profession. The researcher's perspective can be encapsulated by this quote:

> "for any psychologist committed to the humanitarian values embedded within psychology, the challenge is, first, to engage in critical reflection of their own profession and personal biases, which serve the social order and which contribute to the perpetration of abuses of power and the maintenance of social inequalities; and, second to seek more just alternatives" (Patel, 2003, p. 16)

This research was carried out as part of a doctoral qualification in clinical psychology. Accordingly its methodology is constrained by the demands of this process. The researchers' training was based around the framework of the reflective scientist practitioner which encourages "a

constructively questioning approach to all aspects of theory and practice" (Stedmon, Mitchell, Johnstone, & Staite, 2003, p.31).

Analysis

Quantitative

It is beyond the scope of this paper to provide detailed descriptive statistics for each of the 43 statements. It is, however, possible to characterise the results for different clusters of statements. To avoid undue researcher bias in selecting statements, factor analysis was employed. This "allows researchers to make broad generalisations from detailed sets of data" (Cooper, 1998, p.225). Factor analysis does this by examining the latent structure underlying a set of variables, revealing if and how they can be combined together (Tabachnick & Fidell, 2001).

Qualitative

Data was analysed using an abbreviated grounded theory framework that stopped after one cycle of data collection (Willig, 2001, p.38). It utilised techniques such as coding, memo-making, and constant comparison, but neither tested explicit hypotheses nor used methods such as theoretical sampling (Charmaz, 2003). Pidgeon and Henwood (1997) acknowledge that grounded theory projects rarely reach saturation and promote the validity of interim goals such as taxonomy development and local theoretical reflection.

Initially line by line coding took place and pertinent sections of text were labelled in order to organise the data thematically. Categories developed when existing codes were re-used or similar codes were combined under one heading. A fellow researcher reviewed the original data and the analysis in order to provide a check on its plausibility. Discrepancies were discussed and a consensus was reached as to the best way to describe the data. The only discrepancies that arose were around which quotes could best illustrate the main themes. Data was entered into a qualitative data analysis program (Kwalitan 5.0, www.kwalitan.net).

Results

Quantitative Data

Factor analysis was conducted on the correlations of the 43 items. The number of components to be extracted was determined following examination of eigenvalues and a scree plot. The initial principal components were rotated orthogonally (Varimax). Four factors, which together accounted for 52% of the variance, were obtained. Individual factors contributed 42.8, 10.8, 4.3 and 3.4% of variance respectively. Cut off points for factor loadings were set at 0.5 (Hair, Anderson, Tatham, & Black, 1998).

[INSERT TABLE 1 HERE]

Factor 1: Reflective practice

The 10 statements within this factor represent values shared by both CCP and many clinical psychologists (e.g. working at the micro or personal level). Though some statements would not necessarily represent the practice of the traditional clinical psychologist (e.g. recognising that professionals are not the only people who hold expertise) they all appeared indicative of the "reflective practitioner" position (Cushway & Gatherer, 2003; Schön, 1983). Mean values for statements in this factor range from 1.25-1.49 (SD range 0.64-0.82) suggesting that participants saw the statements as being very relevant to the future of clinical psychology (N.B. 1.0 = very relevant, 5.0 = very irrelevant). The popularity of items within this factor is supported by the fact that 6 of its statements have the lowest mean scores of any of the 43 statements.

Factor 2: Radical socio-political ideas

The 7 statements within Factor 2 contain radical socio-political ideas (e.g. challenging the purpose and prevalence of capitalism, globalisation and individualism). In terms of popularity this factor is different to Factor 1 with means ranging from 2.13-3.07 (SD range 0.90-1.11). Three statements within this factor have the highest mean score of any of the 43 statements (42=3.07, 41=3.02, 43=2.89). However, those same statements also have the highest standard deviations suggesting a wide variation in opinion (43=1.11, 42=1.09, 41=1.06). Although the means are high

relative to the other 43 statements, they only fall between being “relevant” and “neither relevant or irrelevant”. This suggests, at its strongest, that the average trainee was unsure or unconcerned about whether these statements had a place in the future of clinical psychology.

Factor 3: Acknowledging and understanding

The 5 statements within the third factor were all formed around the rubric “acknowledging and understanding the impact of ‘X’ on suffering” (‘X’ variously stood for economic, sociological, environmental, cultural and religious / spiritual factors). Mean scores for these statements ranged from 1.42-1.82 (SD range 0.69-0.87) suggesting that trainees tended to find these statements very relevant to the future of clinical psychology.

Factor 4: Core socio-political ideas

The 7 items in Factor 4 contain statements representing core socio-political ideas (e.g. working towards a just world; identifying and working against oppression in all its forms). The factor also contains two statements pertinent to psychology (acknowledging that psychology needs to do more to bring about a just world; acknowledging that psychology's current position perpetuates social injustice). Mean values for these statements ranged from 1.50-2.64 (SD range 0.83-1.02) suggesting that, on average, trainees found these statements to be relevant or very relevant to the future of clinical psychology.

Summary

The results of the factor analysis suggest that many ideas from CCP are considered to be relevant to the future of clinical psychology. Even the most politically radical statements were not, on average, seen as being irrelevant to clinical psychology’s future. This appears to be contrary to literature which suggests these ideas are ignored. It is hoped that the qualitative data will provide more insight into the relationship between these socio-political ideas and clinical psychology.

Qualitative Data

The major emergent themes are highlighted in the figure below. Participant quotes are edited for the sake of clarity and brevity.

[INSERT FIGURE 1 HERE]

1. Positive Endorsement

The dominant theme arising from the qualitative material was that of "positive endorsement" (44 comments). This implies that material from CCP was seen as being relevant to the future of clinical psychology. The sentiment of positive endorsement is epitomised by the extract below;

"I think these issues have a growing role in the field of clinical psychology i.e. attending to sociological / political / environmental / global domains." (Segment 23: Female, 21-25, 3rd Year.)

There was a parallel theme expressing negative endorsement towards the socio-political approach. However this material was much less sizeable than that which positively endorsed the statements.

2. Yes But…

Though many trainees made positive endorsements, their comments often came with caveats. These qualifiers form a number of distinct but interrelated themes, grouped under the title "Yes But…" (28 comments).

2.1. Yes But… – How (generally)?

Despite positive endorsements, trainees were unclear about how socio-political issues could practically be addressed. The material raised concerns as to how ideas from CCP can be incorporated into clinical practice.

"I always have a sense that these ideas are often difficult to put into practice." (Segment 17: Female, 26-30, 2nd Year.)

2.2. Yes But… – How within the system?

Whilst some trainees commented on general difficulties they saw in bringing ideas from CCP into clinical psychology, others were clearer about the barriers that stood in the way.

"I feel passionately towards the ideals of some of these statements... However, I struggle on a practical level when confronted with NHS systems, waiting lists and the very here and now of problems people present with. Sometimes it feels hard to hold onto, work towards and find a way to put into practice these ideals and beliefs." (Segment 3: Female, 21-25, 2nd Year.)

The qualitative comments appear to suggest that the way clinical psychology functions within the UK actually hinders the implementation of socio-political ideas. More specifically, this theme breaks down into two sub areas. Firstly, some saw barriers formed by the structures within which most UK clinical psychologists work (i.e. the NHS);

"I think it is naive to think that we can actively challenge the systems we work within, due to the constraints and dependence of our employment. To what extent can we really be critical of the NHS, the Government and social policy?" (Segment 48: Female, 26-30, 3rd Year.)

The suggestion here is that the practicalities of working within the NHS system restrict the clinical psychologist's role such that it would be difficult for them to incorporate socio-political ideas into their practice. The second barrier to taking a more socio-political approach comes from pressures present in the day to day work of the clinical psychologist. For example, the pressure of waiting lists suggest that there is already too much to be done within conventional clinical psychology before broadening horizons to look at meso and macro levels.

"However, I also see long waiting lists of people who need relief NOW on an individual/couple/family level too and am not sure how resources can be balanced to meet all the possible areas that Clinical Psychology could have an impact." (Segment 109, [Capitalization in

original]: Female, 26-30, 3rd Year.)

2.3. Yes But… – Is this just idealism?

Some trainees questioned whether ideas from the CCP approach were simply too idealistic. Though they may have liked clinical psychology to pay more attention to socio-political issues they wondered whether this could only happen in an ideal world.

"I also found the decision as to whether something IS relevant or SHOULD BE relevant, a problem. I do feel that Psychology should challenge the spread of individualism and global capitalism, however, I do not feel this will ever actually be a subject that Psychologists really deal with or have any influence over." (Segment 46, [Capitalization in original]: Male, 26-30, 3rd Year.)

3. Personal and Professional

A significant theme that emerged parallel to "Yes But…" was the distinction between personal and professional opinions (11 comments). A number of trainees made positive endorsements of CCP but raised concerns as to the legitimacy of applying these personal endorsements in a professional context.

"In answering this questionnaire it is difficult to separate 'I' the psychologist and 'I' the person. As a person I think all the statements are extremely important and should be the goals of humanity. However as a psychologist I must accept that there is only so much I can achieve and that it is better to use my resources in fields in which I am an expert i.e. mental health rather than fields where I had little knowledge or power e.g. politics." (Segment 19: Female, 21-25, 1st Year.)

4. Politics

Discussion of clinical psychology's involvement with politics represented a diverse but significant amount of material within the qualitative data (16 comments). Participants voiced a range of opinions about the extent to which clinical psychologists can or should be involved with

politics. A spectrum of opinion was collected; broadly it fell into one of three camps: Pro, Anti and Unsure.

4.1. Politics – Pro

Though participants were not necessarily clear about how this should happen, some unambiguously stated that clinical psychologists should take on more of a political role.

"The questionnaire tapped into some of my concerns about clinical psychology not adopting as political a stance as it should do." (Segment 66: Male, 26-30, 3rd Year.)

4.2. Politics – Anti

Some views reflect the idea that if clinical psychology were to become involved in politics it would damage the integrity of the profession. Specifically, this would happen because it would challenge the objective stance and professional neutrality the profession currently enjoys.

"I have grave concerns about clinical psychologists becoming heavily involved in political agendas and discussions. These are necessarily loaded, steeped in history, economic and 'power' struggles and it is not our role to become involved and/or contribute to these discussions. If we do this, we risk alienating clients and compromising the skills and purpose of our training to help alleviate distress." (Segment 55: Female, 26-30, 1st Year.)

4.3. Politics – Unsure

Finally, though some people identified politics as an issue, they expressed uncertainty about clinical psychology's relationship to it. Participants appear to be suggesting that they do not know how, or in what way, clinical psychology and politics should co-exist.

"We need to be debating and exploring these issues so that we as practitioners can make choices about our own political positions as psychologists." (Segment 88: Female, 26-30, 2nd Year.)

Discussion

The main objective of this study was to provide initial insights into the status of, and attitudes towards, a socio-political approach within clinical psychology. Pre-existing literature suggested that these ideas were ignored by clinical psychologists (e.g. Attenborough et al., 2000). The literature also proposed that individualism was a key factor within this relationship (e.g. Cox & Kelly, 2000). While the results of this study do not refute this literature, they do suggest that if socio-political ideas are ignored it is not because they are seen as irrelevant. The exploratory findings of the study suggest there are more tangible barriers stopping ideas from socio-political approaches being brought into practice.

The factor analysis revealed four factors. Factor 1 contained statements common to CCP and clinical psychology. The other three factors contained different groupings of socio-political material. The content of these factors suggest why they appear independent of each other. Factor 2 is made up of active, challenging statements orientated towards the radical end of the spectrum. Factor 3 takes a more passive stance, whereas Factor 4 contains core socio-political ideas, which lie between the active and passive positions. Because of the differences in emphasis, it is understandable that the factors' relevance to clinical psychology may be viewed differently. It may be useful for those wishing to integrate socio-political ideas into clinical psychology to consider which variety of socio-political practice they are hoping to import.

It is also important to consider how relevant participants thought each of the factors were to the future of clinical psychology. Obviously, trainees had a range of feelings towards the ideas from CCP, but on the whole Factor 2 (radical socio-political ideas) was considered least relevant. Despite this, the average participant still rated statements pertaining to this factor as relevant or neither relevant or irrelevant to the future of clinical psychology. The mean statement values for the other two socio-political factors suggested that the average trainee found them either very relevant or relevant. If these results are accurate, it seems odd that such ideas are ignored within the practice of clinical psychology. However, preliminary insights into the complexities of this relationship were

found in the qualitative data.

The most frequently mentioned qualitative theme was positive endorsement (1.0). Like the results of the factor analysis, this supports the idea that socio-political factors are seen by UK trainees as relevant to the future of clinical psychology. However, the "yes but…" themes (2.0) suggest the presence of a number of barriers and anxieties which prevent positive endorsements being turned into practice. "How generally" (2.1) expresses a broad concern as to how socio-political approaches can be integrated into the discipline. Interestingly, even the current CCP literature rarely explicitly addresses how it is possible to work at the macro level.

The content of trainee concerns become more specific in 2.2 (how within the system). Here, trainees express doubts as to how socio-political factors can be put into practice alongside the structures and pressures present within contemporary clinical psychology. First, there is a very pragmatic concern as to how socio-political factors can be applied within the NHS, and how managers and the Government would view this work. Secondly, there is a suggestion that the work of a clinical psychologist is already too pressured to be able to afford the luxury of working socio-politically. Practitioners within CCP and the prevention field (e.g. Albee, 1990) would argue that transformative (as opposed to current ameliorative) ways of working may also help reduce the waiting lists. However, this does not remove the reality of the anxiety, or provide a pathway to move from the current situation to a new one. So perhaps understandably when faced with the demands of the system (2.2) participants expressed concern that applying a socio-political approach within clinical psychology was too idealistic (2.3) and consequently impractical. Similarly, the content of theme 3 (personal and professional) presents doubt as to whether examples of personal positive endorsement are valid within the professional role. Though there is evidence that socio-political areas do impact on mental health (e.g. poverty [Weich & Lewis, 1998]), this position of doubt is understandable because of the presence of the structures and pressures described in theme 2.2.

Whilst the existing literature suggests that individualism is the reason socio-political

approaches are ignored (e.g. Cox and Kelly, 2000) the findings of this study actually suggest that uncertainty over means of practical application (2.1) and inhibitions caused by the structures and pressures of the system (2.2) may be just as significant. In turn, these barriers make those who positively endorse socio-political ideas question whether their views are either legitimate (2.3) or realistic (3) views for a clinical psychologist to possess.

This preliminary data also raises questions about clinical psychology and the process of professional socialisation. Specifically, how can trainee clinical psychologists favour socio-political approaches and yet at the same time be in the process of being socialised into an individualistic profession such as clinical psychology? Although the traditional professional socialisation literature describes a deterministic process which actively moulds passive recipients, other interpretations allows for individuals to exercise their own personal agency (e.g. Becker, Geer, Hughes, & Strauss, 1961). Clouder (2003) suggests that individuals maybe differently or only partially moulded by their professional socialisation experiences. In the case of UK clinical psychology Pilgrim and Treacher (1992) suggest that the professional framework of the scientist-practitioner fails to provide a coherent description of the discipline and that the adoption of this model has more to do with maintaining professional status than real-world practice. Indeed, Pilgrim (1997) demonstrates that the majority of clinical psychologists do not actually carry out publishable research. Accordingly, as the integrity of the model itself is questioned, it seems possible for trainee clinical psychologists to favour socio-political approaches and yet still manage to adhere to the individualistic training requirements of UK clinical psychology.

Significantly, the qualitative data also highlighted ambiguity in the relationship between clinical psychologists and politics. Of the two terms within "socio-political", it is interesting that it was the "political" component that was repeatedly mentioned. This is possibly because the "socio-" aspect is already integrated within areas of the profession (e.g. community psychology (Orford, 1992), systemic family therapy (Dallos & Draper, 2000), and narrative therapy (Speedy, 2004)). Whilst clinical psychology may have taken a position in relation to social context, the same cannot

be said of politics. Some felt that clinical psychologists should be more involved (4.1), some not involved at all (4.2), whilst others felt that they needed more understanding of the issues (4.3). It is perhaps because being "socio-political" involves, by definition, being "political" that some participants worried that this was an inappropriate professional position to take. It is beyond the scope of this paper to define the current position of clinical psychology and politics (or to map out a new one). However, the presence of three divergent voices, suggest the need for more thinking, teaching and guidance on the relationship between politics and clinical psychology.

It is worth noting that the debate about psychology's involvement in politics is not just taking place within clinical psychology, but psychology more generally (e.g. Brown, 2005). Moreover, psychological history suggests there are dangers in claiming the discipline has no political role. For example, Geuter (1992) describes how psychology was complicit with the army and ruling regime in Nazi Germany. Louw (1997) also explains how psychology allied itself with racism and sexism within apartheid South Africa. As Kidner (2001) says "whether we like it or not, psychology, like any other discipline, contains an implicit political ideology; and silence or denial of our involvement is no less a political act than an explicit political action" (p.178). Clearly more discussion needs to take place about the legitimacy of clinical psychology having a political role, and how this would dovetail with more traditional practice. Such debates would necessarily need to consider the fact that most clinical psychologists work within the NHS which, on the one hand is an organisation that offers free health care to all, but is also a "political football" and as such is influenced by political priorities and agendas (Burton, 2004).

Overall, many within the UK trainee clinical psychology population seem to feel positively towards practice that is influenced by a socio-political approach. However there are perceived to be practical and political issues preventing this from becoming a reality. Though it seems important to include information about socio-political issues and approaches in the teaching of trainee clinical psychologists, it is first necessary for clinical psychology as a whole to examine how it relates to the political side of the socio-political. Then, if the profession decides it can enter the political arena it

needs to find practical and applied ways in which socio-political approaches can influence its ways of working. If these processes do not take place at a wider level first it is difficult to see how simply providing more teaching to trainees is going to be helpful.

Methodological issues and future research

The statements contained within factor two were all prefaced by the rubric "acknowledging and understanding". Accordingly, it is unclear whether they clustered together because of the rubric itself or the factors that followed (e.g. economic, sociological and environmental factors). However, even if the clustering occurred because of the statements rubric this is still interesting because of the passive and intellectual stance that is implied by phraseology of the statements. Future research in this area could attempt to tease apart the interactions between the rubric and the factors.

Although this study attempted to survey the entire population of trainee clinical psychologists in the UK, one course director refused permission and two other courses failed to distribute the statements. This reduces the extent to which its findings can be generalised. That said, the participation figures were commensurate with other research that has recruited from the UK trainee population (Hannan, 2004 [18.8%]).

It is also important to consider whether the data gives a representative picture of trainee clinical psychologists or if there was a self-selection bias in those who submitted data. Though both qualitative and quantitative datasets contained participants who considered socio-political factors to be irrelevant, it is possible that these feelings were under-represented. This may be because participants who were less interested in socio-political approaches were less likely to participate. Further studies could attempt to assess whether these opinions are being adequately accessed. Equally, as the study only surveyed the opinions of trainee clinical psychologists, it is impossible to generalise the results of this study to the entire clinical psychology profession. Clinical psychologists who have been acculturated over many years within the structures and pressures of the NHS may perceive socio-political approaches differently to trainees. Future research may, for example, attempt to examine changes in the perceived relevancy of socio-political issues in

professionals who have been working for differing periods of time.

References

Albee, G. (1990). The futility of psychotherapy. *The Journal of Mind and Behavior. 11,* 3/4, 369-384.

Angelique, H. & Kyle, K. (2002). Monterey declaration of critical community psychology. *The Community Psychologist, 35,* 35-36.

Attenborough, L., Hawkins, J., O'Driscoll, D., & Proctor, G. (2000). Clinical psychology in context. The impact of the sociopolitical environment. *Clinical Psychology Forum*, *142,* 13-17.

Becker, H., Geer, B., Hughes, E. & Strauss, A. (1961). *Boys in white*. Chicago: University of Chicago.

Brown, G., & Harris, T. (1978). *Social origins of depression.* London: Tavistock.

Brown, K. (2005). President's column. *The Psychologist, 18,* 2.

Bruce, M., Takeuchi, D., & Leaf, P. (1991). Poverty and psychiatric status: longitudinal evidence from the New Haven epidemiological catchments area study. *Archives of General Psychiatry, 48,* 470-474.

Burton, M. (2004). Radical psychology networks: a review and guide. *Journal of Community and Applied Social Psychology, 14*, 119-130.

Burton, M., & Kagan, C. (2001). *Community psychology: Why this gap in Britain?* Retrieved 6th April, 2004, from http://homepages.poptel.org.uk/mark.burton/index.htm

Charmaz, K. (2003). Grounded theory. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 81-110). London: Sage.

Clouder, L. (2003). Becoming professional: exploring the complexities of professional socialization in health and social care. *Learning in Health and Social Care, 2(*4), 213-222.

Cooper, C. (1998). *Individual differences*. London: Arnold.

Cox, R., & Kelly, P (2000). From anti-psychiatry to critical psychology. *The Journal of Critical Psychology, Counselling and Psychotherapy, 2*, 3-5.

Cushway, D. & Gatherer, A. (2003). Reflecting on reflection. *Clinical Psychology, 27,* 6-10.

Dallos, R., & Draper, R. (2000). *An introduction to family therapy: Systemic theory and practice.* Buckingham: Open University Press.

Division of Clinical Psychology. (1999). *Criteria for the accreditation of postgraduate training programmes in clinical psychology.* Leicester: British Psychological Society.

Fleming, I., & Burton, M. (2001). Teaching about the individual and society links on the Manchester clinical psychology training course. *Clinical Psychology, 6,* 28-33.

Fox, D., & Prilleltensky, I. (Eds.). (1997). *Critical psychology: An introduction.* London: Sage.

Geuter, U. (1992). *The professionalization of psychology in Nazi Germany.* Cambridge: Cambridge University Press.

Hair, J., Anderson, R., Tatham, R., & Black, W. (1998). *Multivariate Data Analysis* (5th ed.). Englewood Cliffs, NJ: Prentice-Hall.

Hannan, R. (2004). *Trainee clinical psychologists' intention to disclose personal clinical mistakes in supervision.* Unpublished Doctoral Thesis, University of Sheffield.

Hare, E. (1956). Mental illness and social conditions in Bristol. *Journal of Mental Science, 102,* 349-357.

Haste, H., Hogan. A., & Zachariou, Y. (2001). Back (again) to the future. *The Psychologist, 14*(1), 30–33.

Huey, D. & Britton, P. (2002). A portrait of clinical psychology. *Journal of Interprofessional Care, 16*(1), 69-78.

Kennedy, P., & Llewelyn, S. (2001). Does the future belong to the scientist practitioner. *The Psychologist, 14*(2), 74-78.

Kidner, D. (2001). Silence is a political act. *The Psychologist, 14*, 178.

Kuipers, E. (2001). The present and the future of clinical psychology in the UK. *Epidemiologia e Psichiatria Sociale, 10*(3), 135-138.

Louw, J. (1997). Social context and psychological testing in South Africa: 1918-1939. *Theory and Psychology, 7,* 235-256.

McPherson, I. & Sutton, A. (Eds.). (1981). *Reconstructing psychological practice.* London: Croom Helm.

Merton, R. (1963). *Social theory and social structure*. New York: Free Press.

Nelson, G., & Prilleltensky, I. (Eds.). (2004). *Community psychology: In pursuit of well-being and liberation.* New York: Palgrave Macmillan.

Orford, J. (1992). *Community psychology: Theory and practice.* Chichester: Wiley.

Page, G. (2005). Professional socialisation of valuers: What the literature and professional bodies offers. *International Education Journal, 5*(5), 105-116.

Patel, N. (2003). Clinical psychology: reinforcing inequalities or facilitating empowerment? *The International Journal of Human Rights, 7,* 16-39.

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 245-273). Hove: Psychology Press Ltd.

Pilgrim, D. (1997). Clinical psychology observed. *Clinical Psychology Forum*, *107*, 3-6.

Pilgrim, D. & Treacher, A. (1992). *Clinical psychology observed.* London: Routledge.

Powell, L., Hoffman, A., & Shahabi, L. (2001). Socioeconomic differential in health and disease: Let's take the next step. *Psychosomatic Medicine, 63,* 722-723.

Prilleltensky, I. (2001). Value-based praxis in community psychology: Moving toward social justice and social action. *American Journal of Community Psychology, 29,* 747-778.

Prilleltensky, I., & Nelson, G. (2002). *Doing psychology critically: Making a difference in diverse settings*. London: Palgrave/MacMillan.

Schön, D. (1983). *The reflective practitioner.* New York: Basic Books.

Smail, D. (1993). *The origins of unhappiness*. London: Harper Collins.

Speedy, J. (2004). The contribution of narrative ideas and writing practices in therapy. In G. Bolton, S. Howlett, C. Lago, & J. Wright (Eds.), *Writing cures. An introductory handbook of writing in counselling and therapy.* Hove: Brunner Routledge.

Stedmon, J., Mitchell, A., Johnstone, L. & Staite, S. (2003). Making reflective practice real: problems and solutions in the South West. *Clinical Psychology, 27, 30*-33.

Tabachnick, B., & Fidell, L. (2001). *Using multivariate statistics* (4th ed.). Boston, MA: Allyn & Bacon.

Thompson, M. (2005). *The concepts, values and ideas of critical community psychology.* Retrieved 10th June, 2005, from http://www.did.stu.mmu.ac.uk/cwf/cd/full-papers/Miles-Thompson.pdf

Weich, S., & Lewis, G. (1998). *Poverty, unemployment, and common mental disorders: population based cohort study. British Medical Journal, 317,* 115-119.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Maidenhead: Open University Press.

Table 1. Statements describing CCP, Mean Scores, Standard Deviations, Factors and Loadings

Factor	Factor 1	Factor 2	Factor 3	Factor 4	Statement	Mean Score (1.0-5.0)	Standard Deviation
1	**0.82**	-0.06	0.18	-0.02	30. Understanding problems from an individual perspective	1.31	0.73
	0.78	-0.07	0.22	-0.02	27. Working at the micro or personal level (i.e. with individuals)	1.39	0.78
	0.73	0.05	0.28	0.10	25. Awareness, monitoring and management of the uses and abuses of power within therapeutic settings	1.33	0.68
	0.73	0.19	0.23	0.22	14. Recognising that professionals are not the only people who hold expertise	1.25	0.66
	0.66	0.07	0.20	0.18	22. Promoting empowerment (i.e. a process by which people gain increasing control over their lives and circumstance)	1.26	0.64
	0.61	0.25	0.25	0.10	12. Drawing on the skills, knowledge and expertise held by people and communities	1.35	0.69
	0.59	0.04	0.17	0.19	11. Working collaboratively and forming partnerships with others (i.e. working 'alongside of ' not just 'on behalf of')	1.34	0.71
	0.57	0.02	0.24	0.25	28. Working at the meso or relational level (i.e. with families, schools, workplaces)	1.25	0.65
	0.57	0.31	0.13	0.27	31. Understanding problems from a community perspective	1.43	0.70
	0.56	0.09	0.35	0.14	24. Challenging the dominance of medical / psychiatric conceptualisations of distress	1.49	0.82
2	-0.02	**0.89**	0.15	0.24	42. Challenging the purpose and prevalence of capitalism in contemporary society	3.07	1.09
	0.01	**0.87**	0.10	0.24	41. Challenging the purpose and prevalence of globalisation in contemporary society	3.02	1.06
	0.02	**0.83**	0.15	0.30	43. Challenging the purpose and prevalence of individualism in contemporary society	2.89	1.11
	0.11	**0.63**	0.25	0.34	40. Challenging governments and other institutions that perpetuate social injustice	2.38	1.01
	0.11	**0.51**	0.22	0.12	23. Working outside of the accommodationist paradigm (i.e. accommodationist practice accepts injustice believing change is outside of its remit of legitimate work)	2.18	0.96
	0.09	**0.50**	0.16	0.30	21. Promoting social justice (i.e. the fair and equitable allocation of bargaining power, resources, and burdens in society)	2.17	0.93
	0.15	**0.50**	0.10	0.46	18. Aiding conscientization (1) (i.e. where the oppressed develop an awareness and understanding of the nature of their oppressing circumstances)	2.13	0.90
3	0.30	0.14	**0.80**	0.21	36. Acknowledging and understanding the impact of economic factors on suffering	1.57	0.72
	0.35	0.17	**0.76**	0.19	35. Acknowledging and understanding the impact of sociological factors on suffering	1.52	0.72
	0.41	0.18	**0.73**	0.13	38. Acknowledging and understanding the impact of environmental factors on suffering	1.53	0.74
	0.44	0.19	**0.73**	0.16	37. Acknowledging and understanding the impact of cultural factors on suffering	1.42	0.69
	0.38	0.14	**0.73**	0.11	39. Acknowledging and understanding the impact of religious / spiritual factors on suffering	1.54	0.73
	0.18	0.28	**0.66**	0.23	34. Acknowledging and understanding the impact of political factors on suffering	1.82	0.87
4	0.17	0.37	0.02	**0.67**	01. Working towards a just world	2.24	0.97

	0.18	0.34	0.08	**0.64**	02. Collaborating with other social movements who are working towards a just world	2.25	0.97
	0.06	0.43	0.19	**0.61**	03. Identifying and working against oppression in all its forms	1.95	0.91
	0.24	0.35	0.11	**0.61**	04. Acknowledging that much human suffering is a result of social injustice	1.95	0.95
	0.11	0.23	0.36	**0.63**	08. Acknowledging that psychology needs to do more to bring about a just world	2.25	0.92
	-0.06	0.33	0.30	**0.60**	09. Acknowledging that psychology's current position perpetuates social injustice	2.64	1.02
	0.40	0.05	0.23	**0.54**	05. Working with the poor, marginalised, oppressed and disadvantaged	1.50	0.83
	0.41	0.00	0.29	0.30	06. Reflecting on and responding to criticisms of psychology (in all its forms)	1.49	0.82
	0.39	0.30	0.22	0.46	07. Bringing a sense of social responsibility to psychology’s work	1.63	0.82
	0.05	0.34	0.29	0.45	10. Recognising the explicitly political nature of psychological work	2.33	1.00
	0.41	0.03	0.09	0.31	13. “Giving psychology away” by sharing psychological knowledge with others	1.55	0.87
	0.38	0.02	0.19	0.16	15. Promoting individual and collective resilience	1.50	0.78
	0.24	0.26	0.14	0.16	16. A focus on social and collective action as opposed to purely academic or philosophical discussion	1.86	0.86
	0.02	0.30	0.03	0.17	17. Working towards transformation as opposed to amelioration (i.e. trying to achieve more permanent and fundamental change than can be achieved by working with one person or one problem at a time)	1.97	0.91
	0.16	0.45	0.18	0.16	19. Aiding conscientization (2) (i.e. where oppressors develop an awareness and understanding of how they contribute towards oppression)	2.07	0.87
	0.43	0.14	0.29	0.06	20. Promoting praxis (i.e. the integration of critical research, reflection and action (the combination of all three elements – not just researching without acting, or acting without reflecting))	1.47	0.78
	0.31	0.50	0.10	0.11	26. Awareness, monitoring and management of the uses and abuses of power outside of therapeutic settings	1.94	0.87
	0.38	0.29	0.13	0.18	29. Working at the macro or collective level (i.e. with communities and society)	1.65	0.82
	0.29	0.15	0.37	0.18	32. Understanding problems from a national perspective	1.82	0.84
	0.17	0.24	0.36	0.17	33. Understanding problems from a global perspective	2.11	0.95

Figure 1. Overview of the main themes from the qualitative material