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What attracts people with disabilities to pursue a career in clinical psychology?

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Abstract

Although exact numbers are not known, it is clear that the proportion of people with a disability within the UK clinical psychology workforce remains significantly less than within the UK population generally. The aim of this study was to investigate the attractiveness of clinical psychology to people living with a disability who are or are studying to become eligible to apply for professional psychology training. Q methodology was used to analyse patterns in the Q sorts of statements about recruitment incentives and disincentives of thirty three participants. From an exploratory factor analysis of ratings, four narrative interpretations are presented, one for each of four factors identified. Based upon high- and low-rated statements, each narrative demonstrates broad attraction to clinical psychology held in tension with various disincentives. The tensions generated by each narrative probably demand differing degrees of tolerance from potential recruits to apply for training. We conclude critically, wondering whether the profession's disincentives outweigh its attractors for recruiting staff with a disability.

Key Practitioner Message:

- Appreciating how potential applicants with a disability may construe clinical psychology, is a step further towards realising a more representative workforce
- Self-examination by the UK clinical psychology profession is required to raise awareness of barriers, inadvertent or otherwise, to recruiting staff with a disability

Keywords: Staff with a disability, Clinical psychology, Career attractors

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Introduction

Compared to the proportion of working age people with a disability within the UK (20%; Papworth Trust, 2011), UK clinical psychology certainly has a long way to go to achieve a representative workforce. No one knows exactly: in a British Psychological Society (BPS) (2005) report of qualified psychologists, disability was omitted from the workforce demographics surveyed. But data are available at pre-qualification level. In 2011, the proportion of new trainees for UK clinical psychology who declared a disability was 40 out of 547 – seven per cent (Clearing House for Postgraduate Courses in Clinical Psychology, 2012), a statistic that has risen by only two per cent since 2004. And it was in 2004 that the BPS (Turpin & Fensom, 2004) formally stated the national need to recruit more staff with disabilities to train as clinical psychologists. This need is therefore not being met in any substantial way. From an advertising perspective, the Clearing House did specifically include trainees with a disability in its recruitment DVD (CHPCCP/DCP, 2005). But Helm's (2002, p.20) understatement, 'there is little information about being a disabled psychologist', remains the case. Specifically, as far as this study was concerned, no one knows what potential recruits (i.e., psychology undergraduates and graduates who have a disability) may think about joining the profession. We were sceptical of the notion of a one-size-fits-all account, and wanted the clinical psychology attractors and disincentives of potential applicants with a disability to be expressed as multiple accounts. We chose to employ Q-methodology as a means of generating and giving expression to several narratives[1] of the subject-matter.

Method

Stephenson (1935) pioneered factor analysis of a data matrix by 'rows' rather than 'columns', so that persons rather than tests are treated as variables. This typically identifies

[1] The Introduction and Discussion sections are deliberately brief in order to present a longer Results section, keeping the narratives 'centre stage'.

several factors comprising uniquely and significantly loading individuals, who form a group whose data may be scrutinised for narrative interpretation. Watts and Stenner (2012) argue clearly that Q-sort data capture individual subjectivity, and they demonstrate how analysis provides a set of holistic social accounts. The ways in which individuals sort a set of statements about the phenomenon focused upon – in this case, professional clinical psychology, its recruitment processes, and their relevance to potential applicants with a disability – are entered into an exploratory factor analysis. Sorts that load significantly and uniquely onto each factor are merged to provide an exemplar sort. The interpretation of the way in which the statements are sorted within an exemplar is regarded in Q-methodology as a specific and social narrative of the phenomenon concerned.

Development of Q-sort concourse

In this study, the 44 statements used (Table 1) were derived partly from a review of relevant literature, partly from previous work (Meredith & Baker, 2007; Baker & Caswell, 2010), and principally from the analysis of individual interviews conducted by the first author with five psychologists with experience of living with a physical or mental health problem, each at different stages in their professional career. Nine key themes were encompassed in the concourse: role of the clinical psychologist; advantages/disadvantages of clinical psychology as a career; practicalities of undergoing the training process; accessibility of clinical psychology to individuals with disabilities; ease/difficulty associated with entering the profession; accessibility of training for individuals with disabilities; colleague attitudes about the recruitment of clinical psychologists with disabilities; benefits/challenges as a result of personal experiences; possible difficulties of being a trainee/professional with a disability in clinical psychology.

Participants

Following research ethics approval from University of East London, 32 heads of university departments hosting BPS-accredited undergraduate programmes (122 had been emailed) agreed to circulate details of the study to their students; advertisement to psychology graduates was via *The Psychologist*, the *ClinPsy.org.uk* website, and the Chairs of 25 UK assistant psychologist groups. Inclusion criteria were study on or graduation from a psychology programme giving BPS Graduate Basis for Chartership, and self-report as having a physical, mental health or learning difficulty. The first author, who had disclosed her own experience of living with a physical health difficulty, was the point of contact for recruitment. Thirty-three participants[2] volunteered, to whom research packs[3] were sent. All completed and returned the Q-sort data, and a brief demographics questionnaire. Thirty were women; 15 were undergraduates; average age was 29 years (range 19-41 years); the majority (N=27) was *interested* or *very interested* in clinical psychology as a career; eight described physical health problems, eight mental health difficulties (MHD), six specific learning difficulties (SLD), six a combination of these, and five reported unseen disability.

<u>Procedure</u>

Written instructions asked participants to rank the 44 statements on a scale from –5 (least) to +5 (most), within a fixed quasi-normal distribution (Figure 1), according to how much each one attracted them to clinical psychology. On completion, the statement numbers were transferred into their position on a copy of the distribution grid, which was returned to the first author. In addition, participants were invited to submit written comments about any statements, as they wished.

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[2] Q-methodology specifies that the numbers of concourse statements and of Q-sorts should ideally not be too discrepant (Watts & Stenner, 2005). The research timeframe entailed halting recruitment at 33, which yielded 33 completed sorts, compared to 44 statements.

[3] Packs comprised: information sheet, consent form, instructions for completing the task, 55 cards (44 statement cards, and eleven ranking cards numbered from -5 to +5), participant response form, feedback sheet, demographics questionnaire and freepost envelope. Helpful advice from the Psychology Network of the Higher Education Academy (HEA, 2012) about accessible presentation was followed, though time constraints and lack of financial support did not enable major modification, e.g., for full visual impairment.

- Figure 1 about here -

Analysis

The data were submitted to a dedicated factor analysis programme (Schmolck, 2002). Factors were extracted (eigenvalue>1) and rotated (varimax rotation). The social narrative is expressed within the exemplar Q-sort of at least two participants loading significantly and uniquely on it. Four factors[4] were identified (a full account may be found in Twena, 2008). The ratings for each statement of each exemplar's constituent Q-sorts are weighted by their loadings and merged to yield a z-score. Statements are then positioned from highest to lowest onto the quasi-normal distribution – a single Q-sort which serves as a 'best-estimate' of the item pattern characterising each factor. Pattern analysis is based on these merged arrays, the ratings of each factor exemplar (see the columns of Table 1, below) being interpreted[5] as a 'gestalt'. In the present study, the eight statements rated most positively, and the eight rated most negatively, formed the basis of each of the four narratives below, which are supplemented by participant comments.

Results

Cross-factor ratings

Inspection of the 'rows' of Table 1 shows the most frequently endorsed cross-factor issue to be personal experience consequent upon disability – items 1, 27, 28, 36, and 41. This may be unsurprising, though for two statements (items 1 and 27) Factor 4 'breaks rank', with negative rather than positive ratings. This observed, it is noticeable within the 44 statements – assuming higher ratings 3, 4 and 5 demonstrate greater item salience to participants than the lower 0, 1 and 2 – that only one item (36) received a set of uniformly high positive or high

[4] In fact, the fourth of these was exemplified by only one Q-sort; exceptionally, it was retained for narrative analysis for the reasons given below.

[5] Watts and Stenner (2012) have usefully pointed out that the process of generating each factor's narrative may be best understood as following the principles of abductive inference (Shank, 1998).

negative ratings, testifying to the main thrust of Q-methodology as emphasising multiple perspectives rather than an overall one.

- Table 1 about here -

Narrative interpretation of each merged Q-sort factor

Factor 1: Taking on a dual role

The Q-sorts of ten participants loaded significantly and uniquely onto Factor 1, which accounted for 30% variance (eigenvalue 9.90). Most were graduates (N=8), and over half had experience of mental health difficulties (N=6) (Table 2). Factor 1 presents a two-fold narrative of how these ten participants are drawn towards the profession.

- Table 2 about here -

Firstly, the diversity of approaches that clinical psychology can employ to help relieve psychological distress is a great attractor (13, +5)[6]. But this is only half the story. Repeated emphasis is given to a deeply-felt further attraction: the added therapeutic value for clients' problems consequent upon working with professionals who have had personal experience of them (41, +5), who have been mental health service users themselves (23, +4), and wish to practise in order to give the fuller provision that they themselves did not receive (27, +3). Indeed, clinical psychology is endorsed as a vehicle for such personal experience to be effective (1, +4) and to provide a practical solution-focused approach (36, +3). The Factor 1 narrative thus portrays a dual role – the expert in psychology, who also has expertise in disability.

> Being good at something 'in theory' is not enough when it comes to practising…unless you actually have experience of what it's like to 'feel' or 'live' with a disability it is almost impossible to fully relate to the feelings of someone that does! (P17[7])

[6] Statement number, and rating
[7] Participant number

Becoming a clinical psychologist is therefore both an end in itself, and for purpose: to 'right the wrong' of construing clients as problematised, and psychologists as problem-free (6, +3) – and to do so from within the NHS (15, +3) rather than as outsiders.

However, 'doing so from within' means becoming a clinical psychologist, and this is beset by substantial discouragement. It is highly competitive (7, -5), and by and large prioritises academic prowess of applicants over their personal experience (20, -3). It also demands prior work in relevant employment that is really hard to obtain (4, -4). These in themselves would be bad enough, but for people living with disability, difficulties are multiplied. Very few training programmes overtly welcome applications from those with mental health difficulties (42, -3), and year after year, the profile of successful entrants is characterised by the same normative demographics, disclusive of disability (43, -3). Alluding to the way (above) that Factor 1 portrays applicants with disability as so highly 'fit for purpose', Participant 9 reflected on this lack of diversity:

> It should be about survival of the fittest, not survival of the norms (P9)

The attitude of some colleagues is that disclosure of personal experience of psychological distress – the quality that makes the psychologists of this narrative so effective – is unprofessional (30, -4); and, doubt may be cast on one's suitability to do the job anyway (26, -5). The narrative therefore comes head on with such attitudes and assumptions (33, -3), which are ironically the sort of thing that disability legislation is designed to combat. In addition to being potential clinical psychologists, in several ways the profession thrusts upon the participants characterising Factor 1 a second role: that of disability rights advocates.

Factor 2: So much to offer, but with limited physical resources and an inflexible system

The Q-sorts of eight participants loaded significantly and uniquely onto Factor 2, which accounted for 24% variance (eigenvalue 7.92). Their profile was somewhat different

from that constituting Factor 1; most were still undergraduates (N=5) and most reported some aspect of physical health difficulty (N=6) (Table 3).

- Table 3 about here -

The attraction of clinical psychology in Factor 2 includes the goal of increasing the diversity of the workforce (18, +3), with psychologists with disabilities increasing service credibility and accessibility (3, +3), and being accorded 'expert' status by colleagues (8, +4). At a more individual level, living with a disability is a really positive job asset (28, +4): the narrative values such personal experience very highly, as facilitating both empathic understandings (41, +5) and practical interventions (36, +5). Indeed, one of its attractive features is that clinical psychology is construed as an opportunity to convert the experience of disability into the provision of support to engage and enable service users (1, +3; 11, +3).

> The client wants to talk to someone calm, and with life experience…rather than a well meaning but walking text book (P3)

Similarly to Factor 1, however much the experience of living with a disability would enhance the practice of the profession, entering it requires qualification. But whereas Factor 1 focused upon the selection process for gaining admission to training, much of the narrative of this factor is about structural aspects of the training itself. Factor 2 emphasises how unfriendly professional training courses can be to the trainee with a disability – and the disability of the Factor 2 participants was mainly around physical, rather than mental, health. The sheer practicality of several of the disincentives that are emphasised is consistent with this. The difficulty of negotiating flexible hours (19, -5), or working part-time (2, -3), in order to manage the physical exertion involved (40, -4), are rated as clear barriers to training, as is the lack of appropriate support available (38, -3).

With support needs being more obvious/visible for several of the physical health problems of Factor 2 participants, the potential for stigma may be that much greater (16, -3).

Being regarded as 'not up to it' may be really difficult to bear (26, -3), giving rise to pressure to excel simply in order to be viewed as a viable trainee (10, -4). Facing negative perceptions of disability from others is rated overall as the highest disincentive (33, -5), felt as much as or more severely than the practical matter of 'reasonable adjustments'.

> [Negative attitudes from others have been] the biggest barrier without a doubt; there is the feeling from staff that I am lazy/incompetent/unable to manage time, because it physically takes me a longer time to complete the task (P14)

Factor 3: Am I being set up?

The Q-sorts of three participants loaded significantly and uniquely onto Factor 3, which accounted for 10% variance (eigenvalue 3.30). All were undergraduates and all reported moderate to severe physical health problems (Table 4).

- Table 4 about here -

The highest positive ratings tend to be for somewhat generic statements about clinical psychology. Even at a training grade, it offers a stable reasonably well-paid job (9, +5), which is not overly mechanistic in that it tackles psychological distress with varied approaches, as appropriate (13, +4). However, this does not involve settling for the status quo: more highly rated than in Factor 1, one role for which there is strong attraction (15, +5) to joining the profession is as an agent of change in how services are provided.

This vision is embodied in staff diversity (18, +3) of which, the experience of living with a disability is an important part (28, +4). Two specific positives are given – but each is counteracted by negatives. Firstly, psychologists with disability highlight for their colleagues (and have expertise in) disability issues (8, +3); but they may then be expected to act as an 'ambassador' for people with disability generally (24, -4) and their expertise may not be well received by their colleagues (39, -4). Participant 22 – although recognising the general relevance of disability (she rated statement 8 as +3, for instance) – at this juncture made a pointed comment about her desire to practise in her own right as a psychologist:

> I don't want to represent *any* group; I don't want my disability to be of relevance to the work I do! (P22, emphasis added)

Secondly, their life experience brings substantial familiarity with coping strategies and practical solutions that 'work' for clients (36, +3); but they often find the profession placing greater importance upon academia than it does upon this life experience (20, -3). The narrative here distances itself from Factor 1 by stating clearly that the 'life experience' attractor is in no way linked with having been a mental health service user oneself – this is assigned the highest possible disincentive (23, -5).

Clinical psychology training courses are encouraging disabled students to apply: this statement is rated as attractive (32, +3) but it begs the question, how welcome will they be when they get there? Will they feel they have to attain higher standards than their non-disabled fellows, to offset unspoken discriminative attitudes (10, -3)? And there is the off-putting lengthy duration of training itself (12, -3) – which, if part-time attendance were needed as part of reasonable adjustments, could go on for even longer. Resolving uncertainty about applying for training would be greatly helped if already-qualified psychologists living with a disability were easily available as role models/mentors; but they are not (25, -3). Even better if relevant pre-training posts were easily available; but they too are not, *especially* when you have a disability (22, -5).

Key elements of the narrative of Factor 3 struck us as positioning attraction to clinical psychology as a 'Catch-22'. As the profession currently stands, the intersection of getting attracted to it *and* living with a disability resembles something of a set-up. Small wonder the Interest rating of one of the three participants involved (see Table 4) was *Unsure*.

Factor 4: Disability 'in perspective' – a more balanced view?

The Q-sort of one participant loaded significantly and uniquely onto Factor 4. The factor accounted for 6% variance (eigenvalue 1.98). Although less arguably representing a

social narrative, the Q-sort involved was from the sole participant using British Sign Language, whose 'interest in clinical psychology' remained high, despite having graduated about ten years before, at the time of data collection (Table 5).

- Table 5 about here -

The narrative of Factor 4 is very appreciative of clinical psychology's flexibility in meeting client needs (13, +5), and its status in terms of career and salary (9, +3). Unlike Factor 1, the challenge of competition to enter the profession is welcomed (7, +3).

> I personally think that having to excel shows greater achievement, and sets a good example against negative stereotypes of disability (P9)

On the whole, the contribution of a clinical psychologist living with a disability is regarded as more *systemic* than personal. The very presence of such a psychologist on staff would enhance service credibility and accessibility (3, +4).

> Deaf patients feel that a hearing psychologist does not understand the impact of deafness or the importance of the deaf culture. Therefore having a deaf psychologist...would break down a lot of the barriers (P12)

However, the role model potential of a psychologist living with a disability is greatly diminished because so few are open about it (25, -4), possibly because of the stereotype that someone with the title 'doctor' shouldn't be disabled (29, -3); or, as hinted at by P9 above, that the very competence of such a person is subject to suspicion (26, -5).

The *personal* experience of disability is given only a limited role in this narrative. It is positively rated as an adjunct to mainstream clinical psychology, like empathy (41, +3) and a solution-focused approach (36, +5). But – unlike Factors 1 and 2 – what is definitely *not* positively rated is the idea that this experience might be directly drawn upon as a main resource for providing psychological help (1, -4). And the thought that training might be a route to caring that is motivated by 'projective identification' is even more firmly dismissed (27, -5).

The narrative also includes several statements about support for training, which taken overall show a realistic mixture of incentive and disincentive. There are high physical demands on trainees (40, -3). Admittedly there is support available for disabled applicants who get on a course (5, +3). Arranging the support may be slow, but at least it is sure (14, +3).

> When I went through the DSA and access to work [schemes], it took longer, but I was able to keep them for the duration of the [undergraduate] course and it was often a higher quality of support [than I had received previously] (P12)

However, it is patently off-putting if information about accessing the support – which in itself is appreciated – is not user-friendly, in the sense of being difficult to find out about (35, -3); and particularly so if in the end the support falls short of what is needed to meet the demands of the training programme itself (38, -3).

We felt the narrative of Factor 4 to be less strident than the others. Current views of what constitutes professional clinical psychology are challenged, but not swept aside, by the Q-sort ratings of the participant concerned.

Discussion

The relatively neglected intersection between disability and the UK clinical psychology workforce and its training (e.g., it was ignored in a recent special issue of *Clinical Psychology Forum* (2012) on Diversity and Training) was a driving force behind this study. Attending to what potential recruits with a disability think about entering the profession was only one way of addressing this; but it was a start. While the study carefully followed the procedural steps of Q-methodology, the status of its findings is clearly exploratory – they would be greatly enhanced if triangulated by further investigation less constrained by the timeframe of professional doctorate studies, and employing an alternative methodology. For example, the pros and cons identified in the analysis of participants' data could be disregarded as predictable products of the rating and interpretation methods

employed, given that using a graded dimension and focusing upon its extremes may be viewed as necessarily dichotomising; other methodologies could avoid this critique.

Taking the present findings at face value, though, the study's aim – to delineate multiple accounts of the job attraction of clinical psychology to potential recruits living with a disability – was clearly fulfilled in the four narratives above. Our inclination is to view them as a standalone end-product. Below, however, we add two further considerations, about strands of the narratives that were reflected within each of the factors. This could on the surface be evidence for a single over-arching account. But Shemmings (2006) cautions against assuming uniformity on such grounds, contending that the factor analysis of Q-sort ratings identifies "the presence of robust, non-overlapping, conceptually distinct clusters of attitudinal patterns' (p. 153). The two further considerations concern the role of personal experience, and that of barriers to access. Neither had a single story to tell.

The significance given to personal experience was noticeable. There were several indications that this was more than an across-the-board endorsement of the significant discourse about legitimating service provision through personal experience (as can be seen from Table 1, for instance, in the variation in ratings on items such as 1, and 28). The narrative of Factor 4 was especially distinctive in attributing high *dis*incentive value to some statements concerning personal experience as career motivation, or as resource for clients. And those who indicated support for the relevance of personal experience were by no means strident – several added reflective notes on the experience of living with a disability, and their current work:

> On the one hand this is an asset, but I've also found it difficult to work with clients who have a similar diagnosis to me – with my issues of over-identification – especially if it is a symptom that is causing them distress and currently resonates with me (P6)

But, aware of the limitations, participants were not going to be silenced about the benefits. Ratings for items mentioning personal experience were indeed often highly positive,

especially for matters like empathy, coping, and solution focus – matters which for many areas of clinical psychological work, represent ‘added value’ not as a top-up or optional extra, but as solid and substantial.

Secondly, ratings indicating clear de-motivation were found in externally imposed barriers to being a clinical psychology trainee with a disability. Pope’s (2005) typology distinguishes ‘physical’/‘structural’ from ‘attitudinal’ barriers to access, and these were a contrast reflected in the narrative accounts of the first two factors in particular. With a majority of significant Q-sort loadings from participants with a physical disability, Factor 2 emphasised the former: the intransigence of physical and administrative features of clinical psychology training was especially unappreciated. With a majority of significant loadings from participants with mental health difficulties, Factor 1 highlighted non-material disincentives such as professional disapproval over disclosure of personal experience. While the two accounts were noticeably distinct, the difference was not completely watertight: Factor 2 also gave high negative rating to a non-material barrier (item 33), and Factor 1 to structural barriers (item 4, and also item 7 – an issue paradoxically welcomed in the narrative of Factor 4).

Both these issues – personal experience and barriers to access – expose broad tensions. How much weight does personal experience hold in the evidence-based presentation of the profession that it often claims, and in the competency and skills framework frequently used to define its activities? How long does institutional inertia hold out against the dismantling of physical and attitudinal paraphernalia prejudicial to access, while needing to adopt the spirit and the letter of UK disability legislation? Taken together, these seem to us to embody major dilemmas.

We concluded that the view embedded in all four narratives of the present study (although more muted in the fourth one) was that behind the public face of the profession’s

welcome for psychologists with disabilities as part of the workforce, lies strong and barely concealed resistance. This is demonstrated by barriers at an attitudinal, physical, and organisational level. We stress that not one of the participants' comments mentioned words like hypocrisy or discrimination – but it was difficult not to think them. However the participants were keen to emphasise that they did not wish to receive special treatment, but simply requested fair treatment for all applicants. The participants in the study clearly felt that, rather than being viewed as a problem, they have a useful and valid contribution to make to the profession. We hope that this study goes some way towards giving voice to the motivations, needs and concerns of this group of people who are an as yet untapped resource for the future.

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Table 1: Factor arrays for the four narratives

	Concourse statements	*Factor 1*	*Factor 2*	*Factor 3*	*Factor 4*
1	Clinical psychology offers the opportunity to use personal experiences to help others.	+4	+3	+2	-4
2	The clinical psychology programme is not widely available as a part-time option.	0	-3	-2	0
3	The presence of disabled psychology professionals makes a service more credible and accessible to disabled clients.	+2	+3	+1	+4
4	It is very difficult to get paid relevant clinical experience pre-training.	-4	-2	+1	0
5	A wide range of practical and financial support is available for disabled applicants.	+1	+1	+2	+3
6	Recruitment of disabled trainees would help to move away from the ‘them and us’ culture in clinical psychology.	+3	+2	+1	-2
7	There is a great deal of competition for places on post graduate courses in clinical psychology.	-5	-1	0	+4
8	Having colleagues with a disability can act to highlight and inform upon the issues faced by disabled people.	+2	+4	+3	+1
9	Training as a clinical psychologist offers you a stable career and financial security.	+1	+2	+5	+3
10	Students with a disability have to excel in order to be accepted as credible.	-1	-4	-3	0
11	Client’s awareness of a therapist’s disability can break down unhelpful barriers, and enable them to be more open about their own difficulties.	+2	+3	+1	-1
12	It takes a long time to qualify as a clinical psychologist.	+2	0	-3	0
13	Clinical psychology offers a range of approaches to understand and manage psychological distress.	+5	+2	+4	+5
14	It often takes considerable time for required support and equipment to be put in place.	0	-2	-2	+3
15	Clinical psychologists have the ability to change services from the inside.	+3	+1	+5	+1
16	Being in a minority group on a training course can be an isolating experience.	-1	-3	0	-1
17	The clinical psychology training course is emotionally demanding.	+1	+1	+1	0
18	The profession would benefit from a more diverse workforce.	+1	+3	+3	+2
19	It can be difficult to negotiate flexible working arrangements.	0	-5	-1	-1
20	Clinical psychology places more emphasis on academic excellence than life experience.	+3	-2	-3	-2
21	Familiarity with NHS systems and procedures can make you a more effective clinical psychologist.	+1	+2	0	-2
22	Assistant psychology posts are rarely given to disabled psychology graduates.	-1	-2	-5	-1
23	The value of receiving psychological treatment interested me in pursuing a career in clinical psychology.	+4	+1	-5	+1
24	Disabled psychologists can be expected to be a representative of this group.	-1	0	-4	+2
25	Very few clinical psychologists disclose a disability and can therefore act as role models or mentors.	-2	0	-3	-4

26	Disclosing a disability may lead to concerns over your ability to do the job.	-5	-3	-2	-5
27	Personal experience of the lack of provision of psychological treatment, in wide sections of the NHS encouraged me to train to become a clinical psychologist.	+3	+1	+1	-5
28	Having experience of living with a disability is an asset as a clinical psychologist.	+2	+4	+4	0
29	People with a disability are often not expected to be doctors.	0	0	-2	-3
30	Some psychologists may feel that it is unprofessional to disclose/ talk about having experience of mental health difficulties.	-4	0	-1	-1
31	There is no requirement to undergo personal therapy as part of the clinical psychology training.	-2	0	0	+1
32	Courses are increasingly encouraging disabled students to apply.	+1	+1	+3	+1
33	Other peoples' attitudes and assumptions of disability can act as a barrier to entering the profession.	-3	-5	-1	-1
34	Declaring a disability leads to additional administrative procedures.	0	-1	0	+2
35	Information on the support available for disabled students is hard to find.	-1	-1	-1	-3
36	Disabled people bring substantial personal experience of coping strategies and practical solutions to problems.	+3	+5	+3	+5
37	It can be necessary to take on characteristics of the dominant group in order to get through training.	-2	-1	-2	0
38	There are not enough effective support structures for trainees with disabilities.	-1	-3	-1	-3
39	Other psychologists can feel threatened by the expertise of their disabled colleagues.	0	0	-4	+2
40	The training course is very physically demanding.	0	-4	0	-3
41	Having personal experience of managing difficult emotions can enable you to empathise and help others to work through these.	+5	+5	+2	+3
42	Two out of 30 universities have a clear statement saying that they welcome applications from people who have had experience of mental health difficulties.	-3	0	0	0
43	Clinical psychology courses select for white, middle-class, normally functioning individuals.	-3	-1	0	-2
44	Recent legislation has improved the accessibility of hospital buildings.	0	+1	+2	+1

Table 2: Details of participants loading significantly and uniquely onto Factor 1

Participant no.	Age Range	Gender	Disability	UG /year of Graduation	Interest in Clinical Psychology
2	25-29	F	MHD, sleep disorder	2003	*Very*
6	25-29	F	Lupus	2004	*Interested*
7	18-24	F	MHD	2006	*Very*
9	35-39	F	SLD, MHD	3rd P/T	*Interested*
10	35-39	F	MHD	2004	Missing data
11	25-29	F	Chronic Fatigue Syndrome	2002	*Very*
13	18-24	F	SLD	2005	*Very*
16	25-29	F	SLD	2006	*Interested*
31	18-24	F	MHD	2005	*Very*
33	18-24	F	MHD	3rd F/T	*Very*

Table 3: Details of participants loading significantly and uniquely onto Factor 2

Participant no.	Age Range	Gender	Disability	UG /year of Graduation	Interest in Clinical Psychology
3	30-34	F	Chronic arthritis/ use of wheelchair	2001	*Interested*
15	18-24	F	Diffuse RSI	2005	*Very*
20	18-24	F	MHD	1st	*Interested*
23	25-29	F	Chronic pain, hypermobility syndrome	3rd	*Interested*
27	35-39	F	Rheumatism, MHD	3rd	*Interested*
28	40-44	F	SLD, Crohn’s, Fibromyalgia	4th	*Interested*
29	40-44	M	MHD	2nd	*Very*
32	25-29	F	Rheumatism	2003	*Very*

Table 4: Details of participants whose Q sorts loaded uniquely and significantly on Factor 3

Participant no.	Age Range	Gender	Disability	UG / year of Graduation	Interest in Clinical Psychology
18	35-39	F	Ankylosing spondilitis	4th (Hons)	*Very*
22	30-34	F	Distal spinal muscular atrophy	1st	*Very*
30	18-24	F	Spinal muscular atrophy, wheelchair user	1st	*Unsure*

Table 5: Details of the participant whose Q sort loaded uniquely and significantly onto Factor 4

Participant no.	Age Range	Gender	Disability	UG/year of graduation	Interest in Clinical Psychology
12	30-34	F	Deafness	1998	*Very*

Figure 1: Example of a grid used in Q sort