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MALE CLINICAL PSYCHOLOGISTS: ROLE OF THE MALE GENDER IN THERAPY AND ON THE ROUTE TO QUALIFICATION

Section A: Effects of Therapist Sex and Gender on Client Experience and Therapeutic Alliance: A Systematic Literature Review
7998 (plus 88 additional words)

Section B: Male Trainee Clinical Psychologists on their Journey to Qualification: A Critical Narrative Analysis
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Summary

Section A reports a systematic and critical literature review on the effects of therapist sex and gender on client experiences and the therapeutic alliance within psychological therapies. Previous qualitative and quantitative research is summarised and critically evaluated with regards to quality and methodological approach. The effects of sex and gender of the therapist on the therapeutic process were found to be complex and highly dependent on context. Clinical implications of these findings were discussed and further research recommendations made.

Section B reports on an empirical study on the journeys of men pursuing a career in clinical psychology. Using Critical Narrative Analysis, male trainee clinical psychologists' accounts of their way into the clinical psychology career were analysed and then critically examined in the context of wider societal discourse. The main narratives were reported and positioned within the context of gender, power, minority and career research. Implications of the findings for the training of clinical psychologists were made and further areas for research were suggested.

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SECTION A

Effects of Therapist Sex and Gender on Client Experience and Therapeutic Alliance: A Systematic Literature Review

WORD COUNT: 7998 (plus 88 additional words)

Abstract

A systematic, critical literature review was carried out into the effects of therapist sex and gender on client experiences and the therapeutic alliance within individual psychological therapies. Studies were eligible for inclusion in this review if they were empirical investigations published in 1990 or later and followed either (a) a quantitative methodology with therapist sex or gender as an independent variable and a client-completed measure of the therapy process or therapeutic alliance as a dependent variable or (b) a qualitative methodology that included client experiences of the therapeutic process with regards to the sex and gender of the therapist. Fifteen studies met the inclusion criteria and were evaluated in terms of their findings and their quality. Results showed that therapist sex and gender had complex and idiosyncratic effects on the client experience of the therapeutic process. Implications of these findings for clinical practice were made, including a call for greater consideration and awareness of gender effects within therapy. Methodological issues and further research recommendations were discussed, including the importance of using more qualitative research methodologies.

Keywords: gender, psychological therapy, sex, therapeutic alliance, therapist

Effects of Therapist Sex and Gender on Client Experience and Therapeutic Alliance: A Systematic Literature Review

This review will focus on the effect of therapist gender on client experiences and on the therapeutic relationship in psychological therapies. The topic of the review will intersect with wider themes of sex and gender, power, diversity, career, the psychological therapy workforce and therapeutic processes and outcomes. However, it would be beyond the scope of this paper to give a comprehensive account of the current and historic academic and social debate in each of these areas. Therefore, only a brief overview of relevant psychological theory and empirical evidence will be given for each theme as it relates to the current review. The review will also be contextualised in relation to men as a minority among psychological therapists. In the discussion the above themes will be revisited and findings positioned in the context of these themes, including a discussion of narratives and discourses perpetuated by the state of the current research.

Gender in Society and within Mental Health

Sex and gender are one of the most visible interpersonal differences and gendered stereotypes appear to be ingrained in societal discourse. Efforts to dismantle and deconstruct traditional stereotypes, particularly by feminist writers who argued that traditional gender stereotypes maintained a power imbalance between men and women, may have been somewhat effective in introducing more legal equality between the sexes (such as equal voting rights and adding sex as a protective characteristic under the Equality Act, 2010). However, gendered stereotypes continue to operate and socialisation to these stereotypes often begins early (Tinsley, Howell, & Amanatullah, 2015). For example, boys and girls receive differential gendered socialisation even before they are born (Barnes, 2015) and this continues throughout their childhood (Mesman & Groeneveld, 2018). Gender stereotypes in relation to what constitutes an appropriate job for boys and girls are present by the age of

seven with four times as many boys as girls showing an interest in STEM-related professions (science, technology, engineering and mathematics) and two and a half times as many girls as boys wanting to become a doctor (Chambers, Kashefpakdel, Rehill, & Percy, 2018). It is not surprising, therefore, that there are vast differences in the proportion of male and female workers depending on career sector with posts in the care, leisure, administrative and sales sector mainly being held by women and posts in skilled labour, process, machine and plant operation and senior and management posts being dominated by men (Office for National Statistics, 2013).

Focusing on the mental health workforce, the sex ratio within frontline psychological care provision within the United Kingdom (e.g. therapists and nurses) consists of 20% men and 80% women (Morison, Trigeorgis, & John, 2014). Men make up 16% of counsellors, 24% of psychotherapists and 20% of clinical and counselling psychologists (Brown, 2017; Farndon, 2016). For clinical psychology the proportion of men on clinical psychology doctorates has been steady at about 15% for the past decade (Clearing House for Postgraduate Courses in Clinical Psychology, 2018). Within psychology undergraduate programmes between 2010 and 2015, men made up around 20% of the student population (Clearing House for Postgraduate Courses in Clinical Psychology, 2018).

Gender and sex also operate in the way emotional distress is seen to be manifesting (Hirshbein, 2010). There are fewer men than women reporting mental health difficulties, accessing mental health treatment and working in mental health services. In 2014, 19% of women, but only 12% of men self-reported as having a common mental health problem such as anxiety or depression (McManus, Bebbington, Jenkins, & Brugha, 2016). However, some argue that mental health problems are likely underdiagnosed in males and that emotional problems may often emerge in forms that would not attract conventional mental health diagnoses (e.g. crime, substance abuse, homelessness, school exclusions, suicide; Men's

Health Forum, 2017). Sixteen percent of women, but only 9.8% of men accessed any mental health treatment (including psychological therapy and psychotropic medication; McManus et al., 2016). Crucially, female gender remains a predictor of mental health treatment use (odds ratio of 1.58) even when gender differences in prevalence and severity are controlled for (McManus et al., 2016). For psychological therapy specifically, data reports from the Improving Access to Psychological Therapies (IAPT) programme show that only 35.6% of individuals accessing IAPT are male (NHS Digital, 2018). Additionally, for age groups 18 to 65 men are slightly less likely than women to enter and to finish psychological treatment. These numbers show that gender cannot be ignored as an important variable within mental health provision and service use and efforts made to research and understand how gender operates in this area are well placed.

General Gender Theory

In the literature a wide range of terms and conceptualisations of understanding differences between male and female are used. The two most common conceptualisations are that of "sex" and "gender". Sex refers to the underlying, innate, biological markers of sex and has historically been the predominant way of understanding differences between men and women. Gender refers to a social construction of how masculine or feminine an individual is in terms of, for example, their behaviour, attitudes, and appearance. Much of the later research (especially from feminist writers) focused on the deconstruction of the binary view of sex and introduced more fluid, dimensional concepts of gender that allowed more nuance, complexity and also set the foundation for the challenge of patriarchal power structures. For example, Eagly (2013) proposed gender role theory whereby men and women are seen to hold different social roles (e.g. women as housemakers and men as breadwinners) and to act outside of those roles is considered deviant and often a cause for discrimination. Bem (1981) postulated gender schema theory that defines that masculinity and femininity are separate

dimensions and that both men and women can express traits from each dimension to varying degrees. West and Zimmerman (1987) argued that gender is not innate but is a social construct that is continuously re-negotiated in everyday social transactions. They also referred to gender as one of the most visible individual characteristics, further emphasizing the significance and impact that gender beliefs have on a wide range of activities and interactions, and it is therefore not surprising that gender research also featured heavily within the domain of mental health.

Gender Theory and Mental Health Workforce

Gender theory is helpful in understanding gendered processes and phenomena within mental health contexts. For example, it is interesting to note that, historically, roles associated with more power, such as psychiatry and psychology, were largely occupied by men (in contrast to roles with less power such as nursing which were being predominantly occupied by women; Cynkar, 2007). It could be argued that psychiatry and psychology roles were more in line with male gender roles (e.g. authority and rationality) whilst nursing roles were more in line with female gender roles (e.g. caring and motherly; Dysvik & Sommerseth, 2010). However, in tandem with the advent of post-structuralist, feminist theorists the gender composition within the mental health workforce in most parts of the Western world underwent a change with half the psychiatrists and the majority of psychologists in the United Kingdom now being female (Morison et al., 2014). One explanation for this could be that as emancipation opened up the female gender role to incorporate roles traditionally monopolised by the male gender role, women were more able to move into positions of power and authority (Cynkar, 2007). This change was felt particularly rapidly within the mental health sector as many lower positions were already held by women and many parts of mental health care - psychotherapy in particular - already overlapped with the traditional female gender role (with its focus on the interpersonal domain, care, empathy and emotions). These

developments have led to some querying whether mental health services are "feminised" and whether men's mental health needs are not adequately catered for (Morison et al., 2014). The underrepresentation of men within the psychological therapies workforce has also been a focus of debate. Whilst men are in a numerical minority amongst those providing psychological therapies it is unclear whether this constitutes a problem or an inequality that needs addressing. One area that has received particular attention as a way of investigating this question is if and how sex and gender of the therapist matter in terms of psychological therapies outcomes.

Therapist Sex and Gender Effects on Psychotherapy Outcomes

Being a female clinician has been associated by both, male and female clinicians, with an orientation towards relationships and a caring aptitude, but also a tendency to take on too much work (Dysvik & Sommerseth, 2010). In contrast, being a male clinician has been associated by members of both genders with a lack of handling emotions, being too objective and distanced, but with the latter also being seen as a potential strength. These perspectives are largely in line with gender stereotypes and gender role theory may operate here which leads to individuals acting in line with their gender role and others perceiving and noticing those aspects of individuals that are in line with the gender role. How, then, do these perceptions of the differences between men and women affect the therapy process?

There has been long-standing interest in whether the combination of client and therapist sex has any effect on therapy process or therapy outcome and whether "gender matching" (the more commonly used term, although most studies actually investigate sex matching) leads to favourable treatment outcomes. It is often hypothesized that matching the client and therapist on gender will lead to better outcomes or be in some way preferable to gender mismatching. It is not always clear what assumptions this hypothesis rests on and in some ways it could be part of a wider historical gender stereotype that "men go better with

men and women go better with women". It is noteworthy that matching clients and therapists on variables has not been confined to gender, however, and this may suggest a wider belief that the greater the similarity between client and therapist, the better the clinical outcomes (e.g. Behn, Davanzo, & Errázuriz, 2018). Beyond gender matching, there has also been interest in whether male and female therapists bring different perspectives, attitudes, traits, behaviours to therapy and whether they may give rise to different feelings in clients (Felton, 1986). In short: Does therapist sex matter for therapy?

In a major meta-analysis in this area therapist sex has been found to be a poor predictor of therapy outcome for male and female clients (Bowman, Scogin, Floyd, & McKendree-Smith, 2001). However, other reviews have concluded that clients in therapy with female therapists gave higher ratings on therapeutic alliance, satisfaction with therapy and symptom improvement (Gehart & Lyle, 2001; Mirer, 2012). One possible explanation for this phenomenon may be the better "fit" between the role of the therapist and the stereotypical female gender role which may lead to less discomfort and gender role conflict in both clients and therapists. Furthermore, gender discourses were found to affect the preferences individuals had for hypothetical therapists with men and women preferring therapists with stereotypical sex-role traits of the gender opposite to theirs (DeGeorge, Constantino, Greenberg, Swift, & Smith-Hansen, 2013). This finding stands in direct contrast to the assumption of gender matching (i.e. that clients would prefer to see a therapist of their own sex). The variety of findings from these reviews point towards the complexity and subtlety in which gender appears to operate in and beyond the therapy room. However, the majority of empirical studies have employed research methodologies that have not captured this complexity adequately. Most are conducted on a positivist basis, often employing quantitative measures of variables and simply comparing outcomes between male and female therapists. Reviews have mostly mirrored this approach and have frequently neglected to

demonstrate a systematic search, not offered methodological critique of the papers reviewed, and were limited in their positioning of the findings in the wider societal and cultural context.

Aims of the Review

This review seeks to rectify some of the omissions of previous literature in the area of gender and therapy process. It also seeks to synthesize and critically evaluate this research in terms of methodology as well as in terms of the narratives and discourses that the research may perpetuate. The focus will be on the therapy process to understand how gender operates, not if it operates, and how it may affect the therapeutic alliance. The therapeutic alliance is often considered as one of the most significant predictors of therapeutic outcome and it refers to the multi-dimensional bond between therapist and client (Horvath & Luborsky, 1993).

The questions this review aims to address are:

1. What are the client experiences and perspectives in psychotherapy in regards to therapist sex and gender (and its interaction with client sex and gender)?
2. What effect does therapist sex and gender (and its interaction with client sex and gender) have on the therapeutic alliance in psychotherapy?

Method

Definitions and Inclusion Criteria

Literature was included in this review if:

- It reported original, empirical research employing any quantitative or a qualitative research methodology.
- It was published in English or German language (author speaks both)
- The sample consisted of actual psychotherapy clients (rather than analogue samples). "*Psychotherapy"* was defined as including any individual, couples or family therapy or assessment for therapy that was based on psychological

principles and delivered by a trained professional therapist (including clinical psychologists, counselling psychologists, psychotherapists and counsellors).

- Its main focus was the investigation of therapist sex or gender as a variable in relation to the therapy process. The term "*sex*" was used to refer to biological sex differences whereas the term "*gender*" differences in socially constructed variables such as gender and sex-role.
- It included either:
    - An account or investigation of client experiences and perspectives in relation to therapist gender. "*Client*" was defined as including any individual of any age who has or is due to receive psychotherapy of any kind. "*Client experiences and perspectives*" referred to the client's subjective experience of psychotherapy (e.g. captured through qualitative accounts or through quantitative measures that are completed by the client)
    - Or an account or quantitative measure of the therapeutic alliance as completed by the client (or both, client and therapist). As the definition and terminology of the therapeutic alliance differs as discussed by Horvath and Luborsky (1993), any reference to the therapeutic relationship in the widest sense was considered to be relevant to this review.
    - Or third party perspectives (e.g. observational measures) on the therapy process in relation to therapist gender, observed client and therapist behaviour or perceived therapeutic relationship.
- Its publication date was 1990 or later. Due to more recent societal changes in the conceptualisation of how sex and gender differences are understood (as discussed above), and to keep this review relevant to current practice only articles published in or after 1990 were included.

Articles were considered to be answering the second research question if they included some psychometric measure of the therapeutic alliance (e.g. Working Alliance Inventory) or a quantitative measure of the satisfaction with therapeutic alliance. Articles measuring any other variables relevant to the therapy process (such as perceived empathy or comfort with the therapist) or exploring the therapy process using a qualitative methodology were considered to be answering the first research question.

Search Strategy

Previous reviews on this topic have failed to clearly describe their used search strategy. One possible explanation for this may be the relatively high prevalence in the literature of most key terms defined above (e.g. *client, therapist, gender, sex, experiences)* and the relative lack of search terms that would yield a well circumscribed body of literature. For this review a systematic database search was therefore combined with a cascading search strategy that involved using key literature as starting points to systematically identify further literature.

1. **Database search:** Databases PsycInfo and PsycArticles (via Ovid) were searched on the 20/01/2019 using the search phrase (*sex or gender AND therapeutic relationship or therapeutic alliance*). The search was limited to articles where these terms were present in title or abstract and those published from 1990 onwards. A total of 442 articles were identified this way. The title and abstracts of these articles were scanned for their relevance and 435 of those were excluded while seven were deemed relevant.
2. **Manual search:** An additional 10 relevant articles were identified as part of general, manual literature searching, mainly through Google Scholar, as part of general research for the background of this review. The majority of these

articles focus on client and therapist gender differences in relation to various aspects of psychological therapy and mental health.

3. **Cascading search:** A forward and backward citation search was carried out on all 17 articles identified in steps one and two as well as on any key review papers in this research area. Furthermore, the "related articles" search function on Google Scholar was applied to each of these articles. All further citations yielded from these processes were scanned in relation to their relevance to the research question. This process was then applied again to any new relevant citations and repeated until no further new relevant citations emerged. As part of this process a further 33 citations were identified.
4. Full text retrieval was attempted for a total of 50 articles identified through steps one to three. Full texts were then evaluated according to inclusion criteria. Fifteen articles met the inclusion criteria whereas 35 articles were excluded. Figure 1 includes details on reasons for exclusion. Most articles were excluded as they reported on studies that investigated related but distinct issues from those specified in the above review question. For example, studies examined the effects of client gender only (not therapist gender), focused on the effects of gender on therapy outcomes (rather than process) or focused on therapists' experiences and perspectives (rather than clients').

Quality Evaluation

Previous reviews have included limited description of any explicit evaluation of the quality of research they reviewed despite this being a recommendation for systematic reviews (Critical Appraisal Skills Programme, 2018; Moher, Liberati, Tetzlaff, & Altman, 2009). The Joanna Briggs Institute (JBI) published a range of critical appraisal tools to evaluate the quality of qualitative and quantitative research (Joanna Briggs Institute, 2017). In this review

the critical appraisal tools were used to evaluate the quality of each included study. The JBI critical appraisal tools were chosen over other appraisal tools in this instance as the JBI published tools for a wide range of methodologies, thereby offering a level of consistency in the evaluation of studies. Depending on the design of the reviewed study (e.g. qualitative or quantitative) the appropriate JBI critical appraisal tool was used. Where significant methodological limitations were identified these are discussed in text as well as summarised in Table 1. The validity of each study's conclusion and claims is then contextualised in light of any limitations.

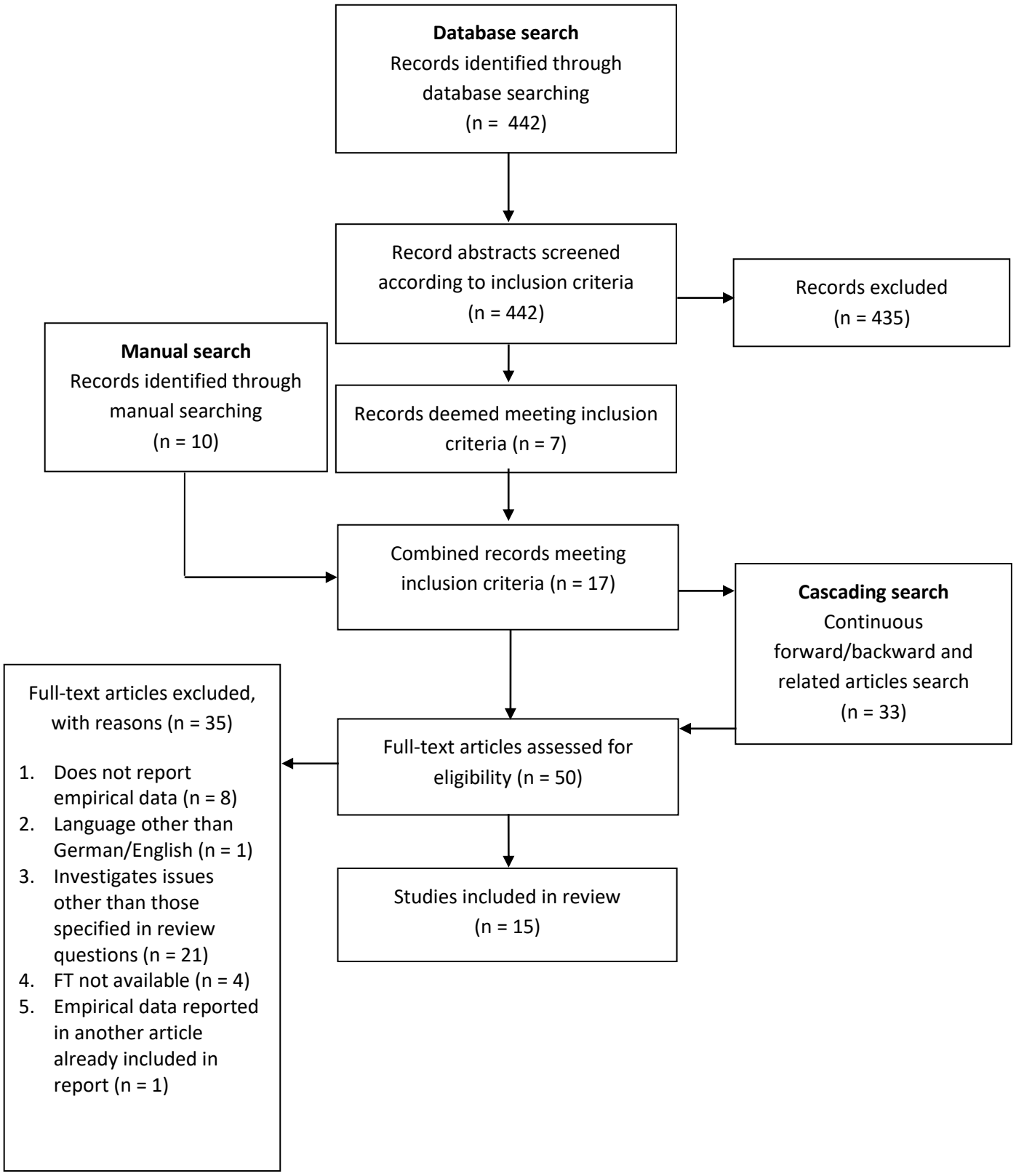

Figure 1. Article selection flow diagram.

Table 1

Summary of papers included in the review

Authors	**Year & Country**	**Study design and data collection**	**Participants** *(a) Therapists* *(b) Service users* *(c) Recruitment*	**Service setting and intervention(s)**	**Results related to RQ1**	**Results related to RQ2**	**Quality evaluation** *+ Strengths* *- Limitations*
Ametrano et al	1995 USA	- Quantitative - Quasi-experimental - Cross-sectional - Dependent variable measured through client self-report	(a) 65 Counsellor trainees (74% female; 26% male) (b) 65 Clients (c) Intake of new trainees at a counselling education centre (each trainee's first client)	Individual therapy in university and community counselling centre	- No effects of therapist sex and sex-role found for majority of measures (including client-rated therapist attractiveness, trustworthiness, feeling of being helped, willingness to return) - Male therapists categorised as undifferentiated (scored low on self-report sex-role measures of both, feminity and masculinity) were less likely to be referred to their clients' friends and family - For female therapists there was a negative correlation between their self-rated sex-role measure of femininity and their client-perceived expertness		+ Includes a socially constructed measure of gender (sex-role) + Standardised measures of sex-role and therapeutic alliance - Not peer reviewed - Small N in sample subgroups (no power calculation) - No statistical correction for amount of comparisons made - Lacks follow-up
Behn et al	2018 Chile	- Quantitative - Experimental - Longitudinal - Dependent variable measured through client self-report	(a) 28 Therapists with professional degree in psychology (mean age 37.8; 68% female) (b) 547 Clients (mean age 41.3; 74.4% female) (c) Outpatients	Individual therapy in general outpatient clinic		- No effect of gender match on first session client-rated therapeutic alliance - Male therapist/female client dyad associated with slowing of growth of client-rated therapeutic alliance compared to other dyads	+ No exclusion criteria + Large sample + Standardised measure of therapeutic alliance + Longitudinal analysis + Robust data analysis - No therapist-report measure of therapeutic alliance - Dichotomous biological definition of gender difference

Authors	**Year & Country**	**Study design and data collection**	**Participants** *(a) Therapists* *(b) Service users* *(c) Recruitment*	**Service setting and intervention(s)**	**Results related to RQ1**	**Results related to RQ2**	**Quality evaluation** *+ Strengths* *- Limitations*
Bhati et al	2014 USA	- Quantitative - Longitudinal - Dependent variable measured through client self-report	(a) 31 Therapists (qualified and trainee psychologists, psychiatrists and social workers; 75% were under 40 years of age; 64.5% female) (b) 92 Clients (mean age 40.3; 75% female) (c) Consecutive outpatients	Individual therapy (mainly Interpersonal Therapy and Cognitive-Behavioural Therapy) in outpatient clinic		- No evidence that gender-matching has any effect on the growth rate of the therapeutic alliance - Client-rated therapeutic alliance was higher in dyads with female therapist ("female effect")	+ Longitudinal analysis + Use of validated psychometric instrument - Small sample, especially for dyads with male clients - No randomisation of therapist allocation
Fowler et al	1992 USA	- Quantitative - Quasi-experimental - Cross-sectional - Dependent variable measured through client self-report	(a) Graduate students in counselling psychology (male and female) (b) 35 Clients (mean age 11.8; 100% female) (c) Consecutive outpatients	Individual assessment for therapy in service for girls who have experienced sexual abuse	- No effect of therapist sex on client-rated comfort in assessment - Clients prefer and anticipate feeling more comfortable with female therapist for treatment - Clients who had male therapist in assessment have less clear preference for female therapist for treatment		+ Specifically investigates experiences of children with sexual abuse - Data were collected by therapist in therapist presence (social desirability bias) - Data on therapist preference not collected before assessment (unclear whether contact with male/female therapist was cause for effect) - Lacks follow-up

Authors	**Year & Country**	**Study design and data collection**	**Participants** *(a) Therapists* *(b) Service users* *(c) Recruitment*	**Service setting and intervention(s)**	**Results related to RQ1**	**Results related to RQ2**	**Quality evaluation** *+ Strengths* *- Limitations*
Fowler et al	1993 USA	- Quantitative - Quasi-experimental - Cross-sectional - Dependent variable measured through client self-report	(a) 7 advanced -level doctorate students in counselling psychology (43% male; 57% female) (b) 20 Clients (mean age 11.4; 100% female) (c) Consecutive outpatients	Six session individual psychoeducational therapy in service for girls who have experienced sexual abuse	- All girls indicate preference for female counsellor pre-treatment - Those treated by a male rate score higher in anticipated comfort with and preference of male counsellors post-treatment compared to those treated by females - There was no difference in the rating of comfort in therapy sessions between those girls treated by males and those treated by females		+ Specifically investigates experiences of children with sexual abuse - Small sample size - No robust, standardised psychometric (e.g. of therapeutic alliance)
Gehart et al	2001 USA	- Qualitative-interpretive ethnography - Co-produced-data gathered through interviews	(a) 69% Marriage and Family Therapists, 12.5% Psychologists; 12.5% Psychiatrists; 6.5% Social workers (b) 15 Co-researchers (age range 13-53; 47% female) (c) Therapists were asked to identify suitable clients	Couples therapy, family therapy, individual therapy at two university clinics and one non-profit agency	- Six themes: client-therapist connection, male therapists, female therapists, topics discussed, effectiveness, counfounding factors		+ Strong emphasis on client perspectives + Robust methodology that ensures client perspectives and experiences are represented as accurately as possible (reducing risk of researcher bias) + All clients had experience of therapy with at least one male and one female counsellor + Rich discussion of data and clinical applicability - Small sample, focus on clients with extensive experience of therapy reduce generalisability of findings

Authors	**Year & Country**	**Study design and data collection**	**Participants** *(a) Therapists* *(b) Service users* *(c) Recruitment*	**Service setting and intervention(s)**	**Results related to RQ1**	**Results related to RQ2**	**Quality evaluation** *+ Strengths* *- Limitations*
Johnson et al	2011 USA	- Quantitative - Quasi-experimental - Cross-sectional - Dependent variable measured through client self-report	(a) 182 Masters and doctoral level Marriage and Family Therapists (86.3% female) (b) 233 Clients (58.8% female; 40.3% male; 0.9% other) (c) not specified	Individual, couples or family therapy at a university based outpatients clinic		- Clients in client-therapist gender matched dyads report higher satisfaction with the therapeutic relationship - When controlled for client-perceived therapist confidence there is no effect of gender match	+ Includes therapist rating of the satisfaction with the therapeutic relationship - Single, non-standardised rating scale as measure of the satisfaction with therapeutic alliance - No specification of recruitment route - Limited reported information about the gender and therapist dyads - No longitudinal follow-up - Limited critical discussion by the authors of the relevance of the findings to clinical practice
Kastrani et al	2014 Greece	- Qualitative - Interpretative Phenomenological Analysis (IPA) - Data gathered through interviews	(a) Seventeen clients worked with a female and ten with a male counsellor (b) 27 Clients (mean age 32; 100% female) (c) study advertised to potential participants through counselling centres and individual counsellors	Individual counselling and psychotherapy of at least 8 sessions (across a range of presenting problems and counsellor theoretical orientations)	Two super-ordinate themes: a) the counsellor's gender in the therapeutic relationship (including preference for and clients' experience of the counsellor's gender) b) the client's input to then gendered therapeutic relationship (including trust/self-disclosure and sexual attraction and the counsellor's gender)		+ Focus on the lived experience positioned in the social and cultural context - Methodology necessitates narrow sample (young, female, Greek adults) so generalising conclusions are limited - Limited discussion of the researcher's own cultural and theoretical position and its potential influence on the study process and outcome

Authors	**Year & Country**	**Study design and data collection**	**Participants** *(a) Therapists* *(b) Service users* *(c) Recruitment*	**Service setting and intervention(s)**	**Results related to RQ1**	**Results related to RQ2**	**Quality evaluation** *+ Strengths* *- Limitations*
Mirer	2012 Switzerland	- Quantitative - Quasi-experimental - Cross-sectional - Dependent variable measured through observation	(a) 12 Therapists with professional degrees in psychology or medicine (mean age 51; 50% female) (b) 28 Clients (mean age 40.8; 60% female) (c) Outpatients	Individual therapy (50% Integrated Body Therapy; 50% Process-orientated Psychotherapy) in outpatients clinic	- More similarities than differences between male and female dyads in terms of the observed client stance/attitudes, behaviours and experiences - Little difference in observed stance/attitude of therapists towards clients between male and female dyads, but more difference in therapist behaviour - More talk about relationships in female dyads, more silences in male dyads		+ Observational measures + Comprehensive Q-sort method including therapist-factors, client-factors and interaction-factors - No measures of client and/or therapist experiences in the dyads - Focus solely on same-sex dyads
Pattee et al	2008 USA	- Quantitative - Quasi-experimental - Cross-sectional - Dependent variable measured through self-report	(a) 223 Therapists with backgrounds in psychology, psychiatry, social work, and counselling (mean age 45.7; 43% female) (b) 223 Clients (mean age 35.2; 67% female) (c) Outpatients	Individual therapy (32% Cognitive-Behavioural Therapy, 22% Psychoanalytic Therapy; 11% Ecletic; 28% not reported) across a range of settings (university health care centre, psychology and social work departments)	- Clients rated distress of self-disclosure higher in female client/therapist dyads - No effect of therapist gender or gender match on client-rated openness to disclosure		+ Uses standardised psychometric measure - Mean treatment length of clients is relatively long, possibly not representative of majority of clients in therapy and creates bias towards therapy dyads with relatively good therapeutic relationship - Does not appear to discuss the extent to which statistically significant results are clinically significant - No random allocation of clients to therapists

Authors	**Year & Country**	**Study design and data collection**	**Participants** *(a) Therapists* *(b) Service users* *(c) Recruitment*	**Service setting and intervention(s)**	**Results related to RQ1**	**Results related to RQ2**	**Quality evaluation** *+ Strengths* *- Limitations*
Pikus et al	1996 USA	- Mixed methods - Quasi-experimental - Cross-sectional - Dependent variable measured through self-report	(a) n/a(b) 116 Clients (mean age 27.9; 65% female)(c) Outpatients	Individual therapy in student and community outpatient setting	- Female clients more likely to have a preference for therapist gender than male clients- Where clients have a preference this is more likely to be for a female therapist than a male therapist- Thematic analysis for reasons of preference		+ Incorporates qualitative data collection on reasons for therapist gender preference- Sample is relatively young- No follow-up for how preference may have changed or affected therapeutic process- No data on clients' previous therapy experience
Staczan et al	2017 Switzerland	- Quantitative - Quasi-experimental - Cross-sectional - Dependent variable measured through client and therapist self-report	(a) 68 Therapists (mean age not reported for entire sample but around 50-60; 71% female) (b) 237 Clients (mean age 39.8; 68% female) (c) Outpatients	Individual therapy from a wide range of therapeutic orientations (mostly relational/psychodynamic/existential; no cognitive-behavioural or systemic approaches) in outpatient settings		- Clients rate therapeutic alliance higher in dyads with female therapists - Clients rate therapeutic alliance and satisfaction with therapeutic alliance higher in female/female dyads compared to male/male dyads	+ Large sample size + Incorporates analysis of significant number of other variables and potential confounds in order to contextualise the effect and significance of gender - Focus is on outcomes rather than process and data reported for process and therapeutic alliance appear incomplete making critical evaluation of full results difficult

Authors	**Year & Country**	**Study design and data collection**	**Participants** *(a) Therapists* *(b) Service users* *(c) Recruitment*	**Service setting and intervention(s)**	**Results related to RQ1**	**Results related to RQ2**	**Quality evaluation** *+ Strengths* *- Limitations*
Werner-Wilson et al	2003 USA	- Quantitative - Quasi-experimental/correlational - Data gathered through observational coding	(a) 42 Therapists (doctoral student family therapists and "master" family therapists; 32% female) (b) 106 Clients (50% female) (c) video recordings from marriage and family therapy clinic (doctoral student trainees) and video recordings from Master Series video collection	Initial couples therapy consultation session (one therapist, one adult couple) in a) non-profit family therapy clinic, b) part of the Master Series video collection		- Female therapists and female clients were rated higher on bond, but not goal or task subscales of the therapeutic alliance - Challenging and advice giving therapist behaviours associated with greater bond for male and female clients	+ Incorporates observational rating of therapeutic alliance using a standardised observational tool + Incorporates consideration of therapist behaviour - Behaviour rating codes are very limited and ambiguous - Observation completed by undergraduate students, not qualified clinicians - No self-report measures of therapeutic alliance - Possible sampling bias (trainee and master class therapists may not be representative of majority of therapy sessions) - No randomised time sampling of observations - No follow-up - Cause/effect conclusions are made based on correlations

Authors	**Year & Country**	**Study design and data collection**	**Participants** *(a) Therapists* *(b) Service users* *(c) Recruitment*	**Service setting and intervention(s)**	**Results related to RQ1**	**Results related to RQ2**	**Quality evaluation** *+ Strengths* *- Limitations*
Winterste en et al	2005 USA	- Quantitative - Experimental - Cross-sectional - Dependent variable measured through client and therapist self-report	(a) 14 Therapists ranging from bachelor to doctoral degree level (mean age 39.3; 64% female) (b) 600 Clients (mean age 15.7; 19% female) (c) Consecutive outpatients	Individual (83% of clients) and family (17% of clients) therapy in service for youth with substance abuse issues		- Therapeutic alliance rated higher in dyads with female clients and in dyads where gender was matched - Client-rated therapeutic alliance for female therapists higher for female clients than for male clients - In male therapist-female client dyads male therapists rate the therapeutic relationship lower than female clients	+ Large sample + Client and therapist rated standardised measure of therapeutic alliance + Specifically investigates experiences of young people with substance abuse problems - Large proportion of screened sample excluded - Dichotomous biological definition of gender difference
Zlotnick et al	1998 USA	- Quantitative - Experimental - Longitudinal - Dependent variable measured through client self-report	(a) 27 Therapists (not all delivering psychotherapy - see in-text; 74% female) (b) 203 Clients (70% female) with depression as presenting pro blem (c) Subanalysis of a medical trial	Individual pharmacotherapy, interpersonal therapy or cognitive-behavioural therapy in outpatient clinic	- No effect of therapist gender, therapist-client gender match, or match of patient expectation of therapist gender on client-rated empathy of the therapist		+ Uses standardised psychometric measure + Part of a robust randomised controlled trial - Male therapists have significantly more years of general clinical experience (confounding variable) - Main analyses also includes pharmacotherapy and majority of therapists are psychiatrists - Limited psychotherapy-only analyses due to lack of power - Low ecological validity due to tightly controlled randomised controlled trial

Results

The data published in all included studies relevant to either research question were reported here separately depending on the research methodology used. Further detail on each study is summarised in Table 1.

Cross-sectional Self-report Studies

Pikus and Heavey (1996) asked individuals before their first therapy session about their preference for the sex of the therapist and reasons for this preference. They found that women (68%) were more likely to indicate a preference than men (42%) but that where a preference was indicated both, men and women, were more likely to prefer a female over a male therapist. Most women preferring a female therapist said they would feel more comfortable with and better understood by another woman, whereas most women preferring a male therapist said they wanted to gain a different perspective. Most men preferring a female therapist said they would feel more comfortable with women or had a previous negative experience with a male therapist. Unfortunately, this study did not include any follow-up to see how preferences may have affected the following therapy process or how the therapy process may have affected initial therapist sex preferences. Additionally, with a mean age of 28 years the sample in this study was relatively young.

Zlotnick, Elkin, and Shea (1998) found no effect of therapist sex, therapist-client sex matching and client preference for therapist sex on how empathetic clients in various treatments for depression perceived their therapist to be. This study was part of a robust medical trial with a reasonable sample size (N = 203) and utilised a standardised psychometric measure of empathy (empathy subscale of the Barrett-Lennard Relationship Inventory). However, a third of the sample were allocated to the pharmacotherapy condition (as opposed to the two psychotherapy conditions) with over half the therapist sample being

psychiatrists. Although the authors re-analysed the psychotherapy only sample and were able duplicate the results, some analyses were not able to be repeated due to insufficient power.

Ametrano and Pappas (1995) analysed the effects of sex as well as sex-role (masculine, feminine, androgynous, undifferentiated) on the perceived effectiveness of counsellors. They found no effects of sex or sex-role alone on how clients perceived their counsellor. Undifferentiated male counsellors were less likely to be referred by their clients to friends and family whilst for female counsellors higher ratings on the feminine sex-role dimension were associated with lower ratings on perceived expertness. However, this study was not peer reviewed and had a number of significant methodological flaws. All therapists were new trainees and all clients were each trainee's first client. The sample size was very small for some of the categories that were compared (e.g. there were only seven undifferentiated therapists) and there was no evidence of power calculations or statistical corrections to reduce Type 1 errors given the number of comparisons made.

Staczan et al. (2017) investigated the effects of therapist sex, client sex and its interaction on the quality of the client-rated therapeutic alliance. Therapeutic alliance was generally rated higher for female therapists and in dyads with a female therapist and female client (in contrast with dyads with a male therapist and male client). This study had a relatively large sample size that was drawn from a large outpatient psychotherapy trial across multiple locations and therapy orientations (although notably excluding cognitive-behavioural therapy). The analysis controlled for a number of other variables, but not all data in regards to therapy process that were reported to have been collected were reported in the results making a complete critical evaluation of the full results difficult.

Johnson and Caldwell (2011) found that clients who were matched with their therapist on sex reported more satisfaction with the therapeutic relationship than those in mismatched dyads after the fourth session but this effect disappeared once therapist confidence was

controlled for. There was no effect of client-therapist sex match on the therapist-rated satisfaction with the therapeutic alliance. This study included individual as well as couples and family therapy but no separate analysis was conducted on the effect of the therapy format. There were a range of methodological issues that compromised the quality of this study. The satisfaction with the therapeutic alliance was measured on a single Likert scale (ranging from 0 to 10). No effect size or standard deviation was reported but a difference in the means of 0.3, although reported to be statistically significant, may be of limited clinical significance.

Pattee and Farber (2008) explored the role of therapist sex and its interaction with client sex on clients' experiences of self-disclosure in therapy. They found that female clients disclosing to female therapists reported more distress in self-disclosing on a range of personal topics than male clients and female clients with male therapists (small effect size). They found that neither therapist sex nor the interaction of therapist and client sex had any effect on client-rated openness to disclosure. This study benefits from its examination of self-disclosure by using the standardised psychometric Disclosure-to-Therapist Inventory-IV. However, the participants in this study were reported to be in long-term therapy for a median length of 1.2 years (mean of 2.46 years) which is likely significantly longer than average. Furthermore, mean ratings on distress to disclosure were low and openness to disclosure high and the authors acknowledged that those experiencing high distress would likely have discontinued therapy.

Cross-sectional Observational studies

Werner-Wilson, Michaels, Thomas, and Thiesen (2003) used observational coding to investigate the effects of therapist sex on the therapeutic alliance and therapist behaviours in couples therapy. This study benefited from its use of a standardised, robust observational tool of the therapeutic alliance (Working Alliance Inventory – Observer version). The Working

Alliance Inventory measures three dimensions of the therapeutic alliance: the emotional bond between therapist and patient, and the working alliances on the goals and tasks of the therapeutic interaction. Female therapists and female clients were rated higher on the emotional bond subscale (but not the goal or task subscale) than male therapists and male clients. However, the therapy sessions analysed were either part of a Masters video collection of reputable couples therapists or video recordings of trainee sessions and therefore perhaps not representative of the majority of couples therapy sessions by qualified clinicians. Further issues with the observational methodology include a lack of randomised time sampling and the use of undergraduate students (as opposed to qualified clinicians or researchers) as coders.

Mirer (2012) also used an observational methodology in the form of Q-sort ratings of client and therapist stance, behaviour and experiences and client-therapist interaction to compare male client/male therapist dyads with female client/female therapist dyads. There was little difference between the male and female dyads in terms of observed client stance, behaviour and experience. Furthermore, there was little difference between the male and female dyads in terms of observed general therapist stance, but there was some difference in therapist behaviour. In terms of interaction, there was more talk about relationships in female dyads and more silences in male dyads. A strength of this study is its use of the Q-sort methodology with 100 items covering wide range of factors. However, no correction was made for the elevated risk of Type 1 errors given that a separate comparison was made for each item. There was also no analysis of mixed sex dyads, making it difficult to attribute observed differences to either therapist or client related factors. Both observational studies (Mirer, 2012; Werner-Wilson et al., 2003) did not corroborate their findings with any client or therapist self-report measures of the therapeutic relationship making it unclear whether the

observed differences or similarities between the sexes translate into a “felt” difference by clients and/or therapists.

Longitudinal Studies

Bhati (2014) investigated the effects of therapist-client sex match on the development of the therapeutic alliance over time as reported by the client. It was hypothesised that therapist-client sex matching would positively affect the early therapeutic alliance but would lose significance later in therapy. However, therapist-client sex match did not have any effect on the growth of the therapeutic alliance. Across all stages of therapy, dyads with a female therapist achieved higher ratings of therapeutic alliance. A validated psychometric instrument was used for the measurement of the therapeutic alliance but the sample was relatively small, especially for dyads including male clients.

Behn et al. (2018) carried out a similar study and found no effect of therapist-client sex match on the client-rated therapeutic alliance in the first session. However, they found that the growth of the therapeutic alliance slowed down in male therapist/female client dyads. This study benefits from a large sample of over 500 clients, the use of a validated psychometric instrument (Working Alliance Inventory) and a robust data analysis. Behn’s and Bhati’s studies add a valuable longitudinal perspective to the research on therapist sex effects on the therapy process.

Studies with Child Populations

Fowler and colleagues (Fowler & Wagner, 1993; Fowler, Wagner, Iachini, & Johnson, 1992) investigated the effects of therapist sex on the preferences and comfort in therapy of girls who have been sexually abused. Girls in both studies indicated a strong preference for female therapists, but those treated by a male therapist had a less strong preference for female therapists post-therapy with some indicating no preference or preference for a male therapist. This shift was not observed in girls who saw a female

therapist. Girls seen by a male therapist also rated their anticipated comfort with male therapists higher post-therapy than pre-therapy and higher than girls treated by a female therapist. There was no difference in actual comfort as rated by the girls between those who saw male and those who saw female therapists. This study explored the role of therapist gender in a highly vulnerable client group that has been neglected by the studies discussed so far. However, research in this area requires particular sensitivity and brings its own challenges and as such the instruments used consist of mostly single Likert-scales and samples are relatively small. This client group may also have been particularly prone to social desirability bias especially as some of the measures about comfort within the session have been collected by the therapists themselves.

Wintersteen, Mensinger, and Diamond (2005) explored the role of client-therapist sex match on the therapeutic alliance in young people accessing support for substance misuse. They found that female clients rated alliance higher than male clients regardless of therapist gender. Dyads that matched on therapist and client sex also obtained higher client ratings on therapeutic alliance. Male client/female therapist dyads stood out in particular with clients rating the therapeutic alliance significantly lower in those dyads. There was no significant effect of therapist-client sex match on the therapist ratings of the therapeutic alliance, although the authors noted a discrepancy in female client/male therapist dyads. Female clients in these dyads perceived the therapeutic alliance as stronger than the male therapist. Strengths of this study were its relatively large sample (although more than 80% of clients were male), its inclusion of both therapist and client ratings of the therapeutic alliance and its focus on a younger population. However, a large proportion of young people (44%) screened for inclusion in the study were deemed ineligible potentially limiting the generalisability of the results.

Qualitative Studies

Kastrani, Deliyanni-Kouimtzi, and Athanasiades (2015) explored the experiences of Greek female clients of the gendered therapeutic relationship using Interpretative Phenomenological Analysis. They identified two superordinate themes: a) the counsellor's gender and b) the client's input to the gendered therapeutic relationship. They found that whilst some clients felt the sex of their therapist was not particularly significant to their experience of therapy, most felt the sex of the therapist affected the therapeutic relationship. Clients who preferred female counsellors often cited a sense of being better understood due to similar backgrounds and socialisation, whereas those preferring a male counsellor often reported wanting a different perspective. Some also mentioned that their experience of a male counsellor was different to their experience of men in general. Clients also reported that they generally felt more at ease disclosing to a female counsellor but acknowledged that they themselves also brought experiences and beliefs about gender that would have affected the therapeutic relationship. Some clients said that sexual attraction had gotten in the way of their therapeutic process and were therefore seeking out female therapists whereas others said that some erotic attraction towards the therapist facilitated the therapy process for them and was associated with trust. A strength of Kastrani's study was its in-depth exploration of the experiences of gender in the therapeutic relationship of a particular population, although these findings may not be applicable to other populations. Furthermore, there was limited discussion on the researchers' reflections on their social and cultural positions.

Gehart and Lyle (2001) carried out an Interpretive Ethnography recruiting male and female clients as co-researchers in their study on client experiences of gender in the therapeutic relationship. They identified six themes: client-therapist connection, male therapists, female therapists, topics discussed, effectiveness, confounding factors. Male therapists were associated with certain characteristics (e.g. goal-focused, firm, less tolerance

of feelings) as were female therapists (e.g. non-judgmental, emphasis on feelings, "soft"). They found that gender was an important factor for clients but that it operated in complex and often idiosyncratic ways in the therapeutic relationship. For example, some clients preferred a therapist of a particular gender for certain characteristics associated with that gender whilst other clients cited the same characteristics as reasons for why they would not want to see a therapist of that particular gender. The authors discussed the role of gender-stereotyped behaviour and in how far this is being co-created by client and therapist. Strengths of this study are its choice of methodology in emphasizing on client perspectives and its inclusion of researchers' reflections on their own position. Furthermore, including clients that had at least one male and one female therapist meant that there was sufficient experience of therapy with both sexes that enriched the data. However, this also meant that the sample possibly had more experience of therapy than the average client. Both of these qualitative studies add a valuable phenomenological perspective to the research on the role of therapist gender in the therapy process.

Discussion

First, each research question is addressed separately, before a more general discussion places the findings in the wider context.

Discussion of Research Questions

Research question 1: What are the client experiences and perspectives in psychotherapy in regards to therapist sex and gender (and its interaction with client sex and gender)?

The results of the quantitative studies suggested that there were a considerable number of occasions where therapist sex or therapist-client gender matching did not appear to have had any effect on the client's experience of the session or the therapist (including on client-rated empathy of the therapist, openness to self-disclosure, therapist attractiveness,

trustworthiness, feeling of being helped and wanting to return). Similarly, there were more similarities than differences in observed client stance/attitude, behaviour and experience between male therapist/male client and female therapist/female client dyads. Due to the low number of participants and the lack of reporting of power calculations, however, there was some risk that effects may have been failed to be detected. Some quantitative studies showed an effect of therapist sex on some variables but these were in studies that did not report statistical correction for the inflation of Type I errors. Given the larger number of non-significant results, it cannot be reliably concluded that these detected statistical differences are reflective of real effects of therapist sex on client experiences. Furthermore, even where statistical significance was reached, for some studies there appeared to be little clinical significance to the result (e.g. a difference of less than .3 points on a 5-point Likert scale). One exception to this trend was the investigation of client preferences for the sex of their therapist prior to therapy where female therapists were generally preferred over male therapists (further discussed below).

These quantitative studies may give the impression that therapist sex is perceived to be rather insignificant for clients, but qualitative studies show that this would be a false assumption to make. Qualitative studies have illustrated how differently and variably clients relate and make sense of their therapist's gender in relation to their own. Clients have ascribed different characteristics to their therapist based on whether they were male or female, they have voiced preferences for either gender (with a variety of underlying reasons) and have talked about how open they felt they could be as well as how the therapist's gender will affect what gets talked about in the session. Clients made links between their experiences of the therapist's gender and past experiences and encounters with persons of either gender in their wider environment and life history (e.g. comparing male therapists with other men in their life or reflections that their feelings about a female therapist may be rooted in their

experiences of their mother). These qualitative accounts suggest that therapist gender does matter to clients and does operate within the therapy process, but they do not necessarily allow generalisation about how male and female therapists are objectively different within the therapy process. This may be an explanation for why quantitative studies - built on the premise of using a small sample to make generalisable assumptions about a wider population – have failed to capture these effects.

Research question 2: What effect does therapist sex and gender (and its interaction with client sex and gender) have on the therapeutic alliance in psychotherapy?

Overall, there was not sufficient evidence that matching client and therapist on gender had any effect on the therapeutic alliance. There was some evidence that clients rated therapeutic alliances as stronger in dyads with female therapists and female clients (Bhati, 2014; Staczan et al., 2017; Werner-Wilson et al., 2003; Wintersteen et al., 2005). This phenomenon has been termed the "female effect" by Bhati (2014) but the mechanisms by which it occurs are unclear. Female therapists and clients may simply be more effective at building therapeutic alliances, possibly due to an emphasis on relationship building throughout gender role socialisation. However, it could also be that there is merely a perceived higher effectiveness at building a therapeutic alliance: Female therapists and clients may be subject to social desirability bias and an expectation due to the stereotypical female gender role to be good at relationship building and therefore give higher ratings to their perceived strength of the therapeutic relationship. This hypothesis would be supported by the gender role theory whereby rating the strength of a relationship as less strong may be seen as acting outside of the gender norm for women and therefore deviant (Eagly, 2013). In contrast, men may feel less pressure to give an overly favourable rating to therapeutic relationship. A further hypothesis could also be that clients feel more at ease with female therapists as the

stereotypical role of therapist fits better with the stereotypical female gender role than with the male gender role and therefore rate the alliance higher (Festinger, 1957). Additionally, clients are likely to have been exposed to more female than male health care professionals due to the disproportional representation of sex within the profession. It is also possible that the tendency for female therapists to be preferred over male therapists is explained by similar mechanisms. However, even though this "female effect" was statistically significant in several studies, it did not always seem to be clinically significant. Often, means on the self-report measures therapeutic alliance (especially Working Alliance Inventory) appeared to be close to the ceiling and differed in only a few points between male clients and therapists and female clients and therapists. Most studies failed to adequately consider the size of the effects and the implications of this on clinical practice with some not discussing clinical implications at all.

General Discussion

The reviewed studies raise a number of issues for how the role of sex and gender is understood within the therapy room as well as within society. Firstly, they highlight the potential power of gender stereotypes. Gehart and Lyle (2001) queried whether any perceived differences attributed to male and female therapists were reflective of actual (in a positivist sense) differences in the therapists behaviour, whether clients merely project gender norms onto the therapists or whether client and therapist co-create gender norms (in an interpretivist sense). They conclude that all three mechanisms are likely to be at play. The therapy space therefore could be seen as another environment in which participants enact and re-create stereotypical gender roles, i.e. are "doing gender" (West & Zimmerman, 1987). It is noteworthy that studies with observational measures generally found far fewer differences related to therapist and client gender than they hypothesised and although observers are not immune to the influence of gender stereotypes they may judge from a somewhat more neutral

position, not being as active a participant in the gender negotiation. The social construction of gender and what is projected onto male and female therapists and clients may therefore be just as important (or perhaps even more so) than any potential actual differences in male and female therapists and clients. Culture and gender stereotypes are closely interwoven and it is therefore important to acknowledge that the majority of included studies were carried out in the USA with Asian and African cultures not represented at all in the findings. This means that the findings discussed here may be specific to Western or North-American culture and constructions of gender.

Secondly, one must be aware of how much importance is placed onto sex and gender relative to other individual differences. Whilst sex is an important, socially ingrained and often very visible characteristic, it is also just one of many individual differences. On the surface, sex is a concept easily defined (through biology) and "measurable" which may make it an appealing characteristic to study and a variable commonly included in research studies and analyses even when they are not directly about the effects of sex. Gender, on the other hand, as many other socially constructed concepts (such as personality), is much harder to operationalise and measure making its study much more difficult. Of the studies reviewed few have included a measure of gender in addition to their measure of sex. Ametrano and Pappas (1995) - who had used Bem's sex role inventory to assess masculinity and femininity of therapists - found that the majority of their participants scored high on either femininity and masculinity or femininity only and only few scored high on masculinity only or neither of the two dimensions. This raises the question of whether the whole spectrum of sex and gender within the general population is represented amongst those who choose a career in the therapy profession. In particular, men with more stereotypically masculine personalities may be underrepresented within the therapy profession. This has implications for research as the extent of differences between men and women may perhaps be underwhelming partly

because men and women within the therapist population are more similar than men and women in the general population.

Thirdly, it is important not to overestimate the quantity and quality of sex differences through the relative saliency and preponderance of the variable in academic research. The relative number of quantitative studies in this review that failed to demonstrate any effect of sex or gender is significant, especially given that non-significant studies may be more likely to remain unpublished (file drawer problem; Rosenthal, 1979). Indeed, Rudolf (1991, 2002) has sought to examine the relative importance of therapist sex compared to other individual differences and created a cluster model to capture the differences in therapists' personalities and styles. Four clusters represented the therapists' general temperament, behaviour, personality, and interpersonal style. Even though the proportion of male and female therapists varied with cluster, all clusters contained both, male and female therapists. The academic debate around the research into gender differences in regards to mental health conditions has identified a similar issue: Hirshbein (2010) discussed the historic over-emphasis on biology in investigating sex differences and the neglect of gender but also power and cultural factors in creating what appear to be differences between men and women.

Clinical Implications

The findings of this review have implications for clinical practice. Gehart and Lyle (2001) caution against the assumption that gender is an unimportant variable in therapy and encourage clinicians to be gender-sensitive. They suggest a range of reflective questions that therapists and supervisors can use to consider the role of gender within therapy more fully. These include prompts for therapists to examine their relationship to their own biological sex and social gender role, their relationship with men and women and their attitude towards various forms of stereotypically gendered emotional expressions (e.g. anger and tears).

Jozefik and Janusz (2017) similarly point towards the importance of supervision in supporting clinicians in identifying their "inner voices" (p. 19) in regards to sex and gender.

According West and Zimmerman's (1987) "doing gender" theory therapy would also be expected to offer a space for therapist and client to re-negotiate gender roles and there is some evidence that this re-negotiation may be taking place. In the reviewed studies, some participants said they chose a therapist of a certain sex because they wanted to work through difficult experiences they had related to individuals of that sex (Gehart & Lyle, 2001). The studies of Fowler and colleagues (Fowler & Wagner, 1993; Fowler et al., 1992) of girls with a history of sexual abuse may be another example for how the therapy space can provide an opportunity to renegotiate beliefs around gender. Girls who saw a male therapist anticipated feeling more comfortable with a male therapist in the future and had less strong preferences for a female therapist compared to those who saw a female therapist. The sex and gender of the therapist may be more important for younger people as they may be more in need for good role models and therapists are likely to be representative of parental figures more so than for adults. Therapy could therefore provide a space in which contact with, for example, a male therapist could lead to re-negotiation of the client's relationship with men as well as masculinity and maleness. This process may be akin to that described within object relations therapy whereby the therapist uses the transference and the therapeutic relationship to help the patient strengthen their object relations (Segal, 2018).

Limitations

The fifteen articles included in this review reported on studies with widely variable methodologies, foci, results and conclusions. This gave rise to some epistemological, ontological as well as methodological issues. Both research questions (but particularly the first one) were rooted in an interpretivist perspective, enquiring about subjective experiences and idiosyncratic accounts. However, the majority of the articles reviewed had employed

quantitative methodology with focus on description rather than understanding which aligns best with a positivist ontology and epistemology. The value of these studies in contributing to the understanding of how clients understand gender (essentially a social construct) to be operating within the therapy process was therefore somewhat limited. These limitations were often reflected in some of the methodological shortcomings of these studies. In fact, the overwhelming use of positivist research paradigms to attempt to understand at least partly socially constructed phenomena, subject to constant change and re-negotiation, risks the drawing of misleading and limiting conclusions about the importance and role of gender in the therapy process.

Furthermore, the heterogeneous methodological and epistemological approaches of the studies placed limitations on the ability of making discrete and well-founded conclusions as each study investigated a slightly different area and there was little overlap and replication amongst the studies. However, this may reflect the great complexity of study in this field and the challenges in applying scientific method to the issue of gender which is so deeply interwoven with social and cultural history and is undergoing constant renegotiation.

Further Research

Further research on the role of therapist gender within the therapeutic process should include greater emphasis on studies that go beyond the investigation of the effects of sex as a dichotomous biological variable. These could include further studies using quantitative measurements of gender (e.g. the sex-role inventory). However, due to the greater lack of qualitative studies in this area, further studies of client's own personal accounts and experiences of gender and its dynamics within the therapy space are needed. In order to align with the understanding of gender as an essentially socially constructed variable, further research in this area should consider employing a qualitative and interpretivist research

paradigm. Additionally, further research should also consider cultural differences and more research is needed in non-American and non-Western countries.

Future studies should also include a study of the experience of therapists in relation to gender. This may focus on their experience of the role of gender in the therapeutic relationship. It would be particularly valuable to hear male therapists' perspectives and experiences of working in the profession given their numerical underrepresentation, queries around the feminisation of the mental health service (Morison et al., 2014) and some of the findings in this review that posited the "female effect" in therapy work.

Conclusion

In conclusion, this review demonstrates that the sex and gender of the therapist affect and play a role in the therapeutic process. However, these effects are very idiosyncratic and are closely interwoven with the social and cultural context and with the personal experiences of therapists and clients. The review has found no support for any universal differences in the way the gender or sex of the therapist affects the therapist process. Methodological and philosophical issues that affect the research process were discussed. Suggestions were made for implications for further research and clinical practice surrounding the issue of gender within therapy. In particular, it was recommended that researchers and clinicians pay more attention to the subtle ways in which gender may present within the therapy process.

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SECTION B

Male Trainee Clinical Psychologists on their Journey to Qualification: A Critical Narrative Analysis

For submission to Narrative Inquiry

WORD COUNT: 7990 (plus 513 additional words)

Abstract

Men are numerically underrepresented within the profession of clinical psychology but little is known about the experiences of the minority of men who do enter the profession. The present study aimed to explore the accounts of male clinical psychology trainees of their journey into training, in particular focus on their encounter and negotiation of issues around gender stereotypes, minority and power. Ten male clinical psychology trainees from course centres around the United Kingdom were recruited took part in individual interviews which were then analysed using Critical Narrative Analysis. Results yielded five narratives: psychology as a meaningful career, psychology as a deeply personal matter, gender in a side role, minority and power, minority as a discomfort. Narratives were then critically examined in the context of wider societal discourses, particularly in regards to careerist, feminist and gender discourse. Similarities were identified between the narratives of men within clinical psychology and men working in other female-dominated environments. Implications of the findings for clinical psychology training programmes and the clinical psychology workforce were discussed. Future research recommendations were made.

Keywords: clinical psychology, gender, men, minority, workforce

Male Trainee Clinical Psychologists on their Journey to Qualification: A Critical Narrative Analysis

Whilst the proportion of men and women in any type of work in the United Kingdom is roughly equal (with 53% of workers male and 47% female), there is wide variation in the numerical representation of men and women by employment sector and occupation (Office for National Statistics, 2018). For example, some roles mostly filled by men include those in the managerial sector, engineering, and skilled manual trades whereas roles in secretarial, administrative, caring and leisure occupations were mostly filled by women. Occupations where the proportion of men and women is more equal include elementary occupations, natural and social sciences, legal, media and business professions. Within healthcare, there tends to be male underrepresentation (e.g. roughly one in ten nurses are male) or equal gender representation (e.g. medical or dental practitioners).

These statistics raise questions about the mechanisms and reasons for these wide variations in the proportion of men and women by occupation. The above variations for the United Kingdom are similar to those of other European countries but by no means universal suggesting the impact of significant social and cultural factors (United Nations, 2010). A number of psychological theories have been drawn on as an attempt to explain the gender disparity in occupational sectors. Firstly, gender role theory (Eagly, 2013) posits that men and women hold different social roles and that acting in line with those roles is rewarded whereas acting outside of them may be discouraged or even punished. For example, boys may be rewarded early on by parents and teachers for an interest in science, engineering and the world of work in general whilst they may be discouraged for an interest in caring professions, such as nursing (e.g. Chambers et al., 2018). Secondly, gender schema theory (Bem, 1981) explains the existence and maintenance of gender stereotypes and how individuals become gendered. Gender stereotypes may explain the apparent correlation between the gender

disparity in an occupation and the extent to which the individual attributes and characteristics required for this profession are associated with one gender or the other. For example, caring professions may require more interpersonal skills, such as empathy (stereotypically more associated with women), whilst managerial professions may rely more on rational thinking (stereotypically more associated with men; Reskin & Bielby, 2005). Thirdly, the theory of precluded interest hypothesises that individuals choose careers with significant attention to how similar they perceive themselves to be to those already working within a certain occupation (Cheryan & Plaut, 2010). This theory also implies the existence of a feedback loop whereby, for example, female dominated sectors will attract more women thereby continuing to be female dominated and this may contribute to continued gender disparity and stereotypes in certain occupation that have historically been difficult to shift.

Male Clinical Psychologists: A Numerical Minority

Men are underrepresented amongst qualified applied psychologists (12% of applied psychologists are men; Farndon, 2016), psychology undergraduates (20%) as well as specifically amongst clinical and counselling psychologists (20%; Office for National Statistics, 2018) and those in clinical psychology training (15%; Clearing House for Postgraduate Courses in Clinical Psychology, 2018). However, the underrepresentation of men in the mental health and psychology sectors is and has not been universal. Firstly, men have historically been overrepresented on psychology programmes in practice as well as research (for example, 80% of PhD recipients in the US in 1970 were male; Cynkar, 2007). Secondly, many well-known psychological theorists (such as Freud, Beck or Rogers) were male, providing valued role models. Thirdly, even today the proportion of male professionals increases with seniority: The proportion of men within management of mental health services is 35% and men outnumber women in professions that shape services with 85% of commissioners and cabinet members being male (Morison et al., 2014). Yet, Fairburn (2007)

argued that a greater representation of men in the psychology profession is important for three key reasons. Firstly, it can provide male and female clients with positive male role models. Secondly, it can challenge stereotyping and discrimination against male service users within services. Thirdly, it can provide more choice in allocating therapists to service users.

Some commonly cited barriers for men entering psychology careers are perceived lower status and pay than other careers, unhelpful career advice, anticipation of choosing a "feminine career" as a man, perceived lack of ability to cope with the emotional demands of the career, and a perceived emphasis on having to continuously represent and speak from the position of the masculine gender (Arnold et al., 2003; Cheryan & Plaut, 2010; Fairburn, 2007; Morris, Cheng, & Smith, 1992). Most of these barriers could be understood as effects of the gender role and gender schema theories at play (Bem, 1981; Eagly, 2013): Psychology may be seen as a "feminine career" requiring characteristics and skills commonly associated with femininity (e.g. a focus on emotional work) and not offering some of the benefits that may be stereotypically associated with male careers, such as social status and higher pay. Furthermore, the large proportion of female psychologists may further discourage men from considering the profession (theory of precluded interest; Cheryan & Plaut, 2010). Gender stereotyping has been considered as a framework to explain the minority of men in educational psychology (Murphy & Monsen, 2008).

These theories may explain why there has been little change in the proportion of men working within clinical psychology. They do not, however, account well for the historical overrepresentation of men working in psychology or for the significant minority of men who do choose psychology as a career. Caswell and Baker (2008) highlighted the complex interaction of gender, social identity and career choice that was involved in men deciding to pursue a career in clinical psychology. Crucially, their study showed that men within psychology were not a homogenous group but rather a diverse set of individuals that had

different and, at times, contrasting views about and motivations to enter psychology as a career (see also Rudolf, 2002). Some of the attractions of clinical psychology for men have been reported to be the potential doctoral status, an opportunity to challenge stereotypes, a more interesting career than traditional male careers, job security and a good salary (Fairburn, 2007). The apparent conflicting perceptions amongst men of clinical psychology as a career (e.g. low salary and low status as a barrier vs high salary and doctoral status as an attractor) further demonstrate the complexity of career decision making and the considerable heterogeneity amongst the minority of men who do enter this career.

Omissions of Previous Research

Most previous research in the area of gender and careers in general and men and clinical psychology in particular has been carried out under traditional, scientific and positivist paradigms. However, these paradigms position the individual as passive and subject to external forces and stimuli (Hiles, Čermák, & Chrz, 2017). Langdridge (2007) argued that attempting to understand human nature and human lives by only using an approach traditionally used in natural sciences limits our understanding. Little psychological research has adopted methodologies that view individuals as active agents. Narrative methodologies and approaches - one example of such a methodology – acknowledge that individuals hold some and agency over their lives in the form of meaning making and storytelling. Two concepts underlying narrative methodologies are positioning theory and identity positioning (Hiles et al., 2017; Langenhove & Harré, 1999). Both concepts refer to the ability of individuals to use language and storytelling to place themselves in relation to others and the world. Individuals may choose to reveal, conceal or emphasize different aspects of their story and thereby construct their identity in different ways. However, individuals are never free from the constraints and societal discourses that they operate in and as such individuals are

often involved in negotiating their individual narratives with wider societal narratives and discourses.

Whilst much research has been undertaken to examine the factors, barriers and theories involved in the creation and maintenance of the gender disparity in the clinical psychology profession, little attention has been paid to the men who do successfully enter the profession and who go “against the norm”. Much of the individual meaning making of men embarking on clinical psychology careers is undocumented. Given the presence and potential power of discourses around gender stereotypes and careers, it will be important to understand how those men that do enter the profession have encountered, experienced, negotiated and made sense of these discourses.

Aims of the Present Study

The present study aims to explore the accounts of male clinical psychology trainees of their journey into training using narrative inquiry. In particular, the following research questions were posed:

a) What are the main narratives (and their tone and function) that male trainee clinical psychologists employ to describe their journey towards clinical training? Are there common themes across participants or narratives?

b) How do male trainee clinical psychologists use those narratives to construct their own identity and position themselves within the context of clinical psychology training and gender?

c) How do male trainee clinical psychologists navigate socially-prevalent discourses in their narratives?

Methods

Design

As the research question addressed phenomenological issues and the individual meaning-making of a series of experiences, a qualitative and narrative-orientated research methodology was chosen. Critical Narrative Analysis (CNA) is a practical methodology devised by Langdridge (2007) and based on the work of Ricoeur (1970, 1981) who first sought to apply a "hermeneutic of suspicion" to the study of individual experiences (phenomenology). CNA goes beyond classic phenomenological research methods as it incorporates analysis of individual stories with the addition of a critical contextualisation of these stories in wider social and cultural context. This contextualisation or "hermeneutic of suspicion" aims to bring out additional meanings because it attempts to view the individual narratives through a number of lenses and positions them in the wider social discourse. The text that was subjected to CNA was gathered through individual interviews with male trainee clinical psychologists.

Participants

Ten male trainee clinical psychologists (ages ranging from 24 to 39) from six different course centres in the UK took part in the study. Two were in their first year of study, four in their second year and four in their final year.

Due to the narrative methodology no further information about participants was formally collected but throughout the interviews some participants revealed further details about themselves: Five participants were White British, four participants were from other White backgrounds and one participant was Black. One participant identified as gay and several others described a fluid sexuality. Most participants had completed their undergraduate degree and graduate jobs within the UK, although some had lived and studied in their non-UK home countries before coming to the UK for work and further study. The

majority of participants chose psychology as their first career path, but one participant had come to psychology from a social work profession. Prior to doctoral training, about two thirds of participants had mainly worked in health care practice and clinical work (e.g. Health Care Assistant & Assistant Psychologists) whilst one third mainly worked in research, although most participants had experience of both fields.

Data Analysis

The data were analysed using the six steps of CNA (Langdridge, 2006):

1. *Critique of the illusions of the subject*: The author examines their own beliefs and attitudes in regards to the topic of study and uses one or several hermeneutics of suspicion to reflect on their own position and role within the research.
2. *Identifying narratives, narrative tone and rhetorical function*: Main and sub-narratives are identified with a description of apparent tone and function of each narrative.
3. *Identities and identity work:* Narratives are analysed in regards to how they shape and contribute to the individual's portrayal of their identity.
4. *Thematic priorities and relationships:* The text is re-analysed to draw out the main themes and relationships of themes within the narratives using a process similar to that employed in classic thematic analysis.
5. *Destabilising the narrative:* One or several hermeneutics of suspicion are used to critically interrogate the data and to place the narratives in the context of wider societal discourse.
6. *A critical synthesis*: The results of previous steps are integrated into a coherent summary of findings.

Langdridge noted that the different steps of the analysis are not necessarily discreet stages and will inevitably overlap. He also noted that researchers may place more emphasis

on certain steps over others. Due to the emphasis of the present research on narratives and the limited space in relation to the size of data gathered stage four has therefore been incorporated into stages two and three. For stages one and five the related hermeneutics of gender, feminism and sexuality were deemed most relevant to the research topic.

Procedures

Ethical approval for the study was granted by the Salomons Institute for Applied Psychology, Canterbury Christ Church University Ethics Panel (Appendix E). Prior to recruitment the author was interviewed by their supervisor in a bracketing interview about the research topic and personal motivations as well as about their own narrative of their journey onto clinical training. Together with a reflective research diary kept throughout the study period, this aided the process of reflection and critique of the illusions of the subject (the first stage of CNA).

Participants were then recruited through email advertisement to a randomised sample of clinical psychology course centres in the United Kingdom. Interested participants were given the information sheet and asked to sign a consent form (Appendices G and H). The interview was carried out either in person at the participant's educational institution or over the phone/Skype and was of approximately one hour length. The interview was semi-structured with a general opening question and a number of loose follow-up questions that were employed as appropriate when the participant's account touched on any of these issues (see Appendix I for the interview schedule). The participants were purposefully given a lot of freedom in the interview to allow them to develop and enrich their individual narratives. Interviews were audio-recorded and transcribed either by the author or, with explicit consent of participants, by a professional transcriber who was required to sign a confidentiality form. Anonymised transcripts were annotated and analysed according to the six stage process detailed above (see Appendix J for a full example of an annotated transcript). The annotation

process involved the identification and labelling of narratives by giving them a brief title, describing their tone and rhetoric function (following recommendations set out by Langdridge, 2006). Narratives were distinguished from themes in that narratives had to tell a story, even if brief, that involved a beginning (setting the scene and introduction of characters), middle (the action) and an end (conclusion and integration of the story into the greater narrative; Labov & Waletsky, 1967). As further interviews were annotated, similar narratives were grouped together into sub-narratives. Where stories were similar in terms of the setting and action but differed substantially in terms of meaning-making, tone and function, these were grouped into separate sub-narratives (e.g. a number of participants referred to their own personal experience of mental health difficulties but related to this in different ways and subsequently used this story to make different points as part of their overall narrative). Eventually sub-narratives that supported each other in their rhetoric function were grouped together into the main narratives described in the results section. An overview of sub-narratives and main narratives can be viewed in Appendix L. Upon completion of the project, all audio and transcript files were submitted to the Assessments Officer of the Salomons Institute for Applied Psychology, Canterbury Christ Church University the on a password encrypted CD.

Results

In his methodological account of CNA Langdridge described a suggested structure for reporting results but also acknowledged that the nature of the methodology and its versatile applicability necessitated flexibility. Results are prefaced here by a brief synopsis of stage one (the author's self-examination of his beliefs and relationship to the research topic through the hermeneutics of gender and feminism). This section is then followed by a comprehensive breakdown of the common and main narratives that appeared across interviews as well as sub-narratives and narratives that were perhaps less often represented but nonetheless

appeared to add to the richness and diversity of the interviews. Tone, rhetorical functions and identity work of each narrative are also discussed at this point. The results section is concluded with stage five of CNA, an attempt to destabilise and view the narratives through the hermeneutics of gender, feminism and sexuality.

A Critique of the Illusion of the Subject

As a male trainee clinical psychologist my interest in this research area is inevitably embedded in my own meaning making and narrative of how I came to pursue a career in clinical psychology. As a White European and as a man I found myself in a double minority on a clinical psychology training course in the United Kingdom and that stimulated my own reflections on "what had happened" for me to be doing this course "against the statistical odds". Whilst I see gender as more of a spectrum than a discrete binary concept, I identify as a man and cannot escape the deeply ingrained, often gender binary, societal discourses about sex and gender. Furthermore, I see myself as largely subscribing to many of the views and perspectives associated with feminism and greater gender equality, but nonetheless cannot deny the power and privileges that my white and male identity bestows upon me in current society. My own journey onto training was one that repeatedly made me face the way I expressed my own gender and in how far I was willing to go against the male stereotype of pursuing a career where men are consistently underrepresented at most levels. My journey was also marked by the internal, perceived tension between the power and privilege I had as a result of being male and White European on one hand but the double minority status I had in the context of the clinical training course demographic on the other hand. As part of my own reflections on these issues I became interested in whether and how other individuals faced and made sense of these issues. However, my beliefs have also undergone a change as this research progressed. Whilst I initially believed that most other male trainees would have in some ways faced disadvantage and tension between their identity and gender role

expectations, I shifted towards a more curious and open position as I read more literature and had more conversations with men in the field. Undoubtedly, as the person interviewing and analysing the data my own beliefs and experiences will influence the interviews, transcripts and results at times and it is important to highlight that narrative research (possibly, in fact, any type of research) can never be fully separate from the subjectivity of the researcher and author.

Narratives, Identity Work and Themes

Narrative 1: Psychology as a meaningful career.

The majority of participants started their narrative by detailing how they came to first choose psychology as an A-level or undergraduate subject. Psychology was often positioned as an "interesting" subject and, in some ways, as an extension of an already established tendency to be curious and interested in the human world around them. A-level and undergraduate degree choices often confronted participants with a choice between following their inherent interests (continuing a sort of childhood curiosity and playfulness in the form of psychology) and the start of the world of work and the more "traditional" and "career-focused" subjects.

> "So initially I kind of took psychology on a whim, you know, having very vague notions of, 'oh that would be interesting to see how people tick', that sort of thing, and 'I'll probably end up dropping that because it's unlikely that you'll be able to get much in the way of careers'. So I did physics, biology, history and psychology, and I thought, well, I'd probably go down the biology route. Because sciences I guess were generally better thought of, or at least in my own worldview at that time." (Participant 7)

Narrative tone was often marked by an absence of emotion and, instead, rather rational and deliberate. The rhetorical function of this narrative appeared to be to give an impression of psychology as a carefully considered career choice taking into account a number of factors and constraints including interest, personal abilities and values. By using this narrative participants appeared to position themselves as subjects within a wider discourse around the importance of having a career that is sustainable, pays well and has good social status. Although an interest in psychology was present in all participants' narratives, this alone did not appear to be sufficient to justify the choice of psychology as a career. The progression of the narrative, at times, involved episodes of conflict – a time in the narrative where it appeared challenging for the participant to follow their interest in psychology whilst also meeting perceived expectations of obtaining a career that pays well and is highly regarded by society. Narrative tone during these episodes was often marked by anxiety and hardship. Conversely, the narrative also contained moments where individuals appeared able to integrate their interest with the demands of a career. These parts of the narrative were often accompanied by a joyful, optimistic and hopeful tone. They occurred later in the narratives and, in some ways, could be understood as participants finding a resolution to the earlier conflicts.

> "I suppose that interest wasn't quite enough to pay your bills and things like that, so I needed to get out and do a job. So at that time the improving access to psychological therapies had started - the IAPT programme. I got wind of that and thought, well, I mean I've got a psychology degree, I've got some relevant experience in working with people, personally I had some experience with family and friends who had been sort of battling with depression. And I just sort of, well- actually, this is just an

> opportunity to do a meaningful job, get a bit of money and, who knows, it might lead to something.“ (Participant 2)

For some participants this narrative also included other characters that were cast into the roles of allies, role models and guides and who aided the participant. Common figures included those that the participant had direct contact with, such as parents, teachers, managers and supervisors as well as more distant figures, such as past and current famous psychologists. Parents often indirectly sanctioned the participant's choice, for example by already having established a career in the area of healthcare. Teachers often guided and encouraged the participant to follow an interest in psychology. Later in the narrative, supervisors and managers opened up opportunities for the participant and supplied the participant with the relevant skills and abilities to make psychology into a career. Famous psychologists (in particular, male psychologists) often served as role models and as evidence that psychology is not incompatible with the traditional markers of a career (such as status). These parts of the narrative often had a tone of warmth and gratefulness to them suggesting that the help was often welcome by the participant and that, perhaps, without these guiding figures, some may have changed path or not arrived on clinical psychology training.

> “ […] I had a really helpful and, eh, supportive form tutor who said to me, at one point, ‘had you ever thought about doing psychology?’ I think partly because he saw that, you know, behind the occasional bravado of the classroom, he saw a little bit of kindness there and he thought learning more about how people ticked and how I was quite good with young kids as a mentor.“ (Participant 2)

Narrative 2: Psychology as a deeply personal matter.

Whilst many participants made reference to personal experiences (such as personal or familial experience of mental health difficulties or emotional trauma) that they deemed relevant to journey into clinical psychology training, these narratives were often much thinner and less central than the main career narrative. There was much more variation in terms of how many of these narratives were elaborated on and how participants positioned themselves in regards to their personal experiences and their role in their journey. Some participants' narratives actively minimised the extent to which personal experiences were seen to be playing a role in their narrative. Within their narrative they appeared to safeguard their choices as results of a logical and reasoned thought process in which psychology is viewed primarily as a career rather than a personal endeavour.

> "And there seemed to be some sort of insistence that I thought that could be misplaced but then I felt from the […] interview panels, well there has to be something related to your family. I mean, you know, going through training now, there's like small pockets where maybe I could sort of pick up things. Obviously the way I was brought up has maybe influenced the way I talk to people now or the way that I can empathise or maybe sometimes not empathise with them. And that may inadvertently have occasionally influenced certain decisions along the way. Ehm, that's certainly possible. Whether that's the primary thing…" (Participant 4)

However, for a few participants personal experiences and motivations were central to their choices.

> "And strangely, I don't know why but I chose to study psychology at A-Level, and to them [friends] it was quite random. I mean it seems quite random, so I did sociology, history and psychology. But I think part of it was that I was just interested in my own psychology. But you know, just as a way to understand it by studying the subject. But I don't think that was a conscious thing, I just think I thought 'oh that's interesting, psychology'. But there's something about that that would have been interesting to me. And I think that, looking back, is me wanting to understand my own self, without knowing that at the time." (Participant 6)

> "I guess maybe part of the reason, and a more cynical thing, could be because actually there were some difficult parts of having a mum with bipolar disorder and her going away to hospital for certain periods and maybe cannabis was a kind of way of not thinking about that or not dealing with that. […] Taking drugs actually became quite a large part of my identity when I was an adolescent and psychology, I guess, addressed some of those experiences you might have on drugs. To a small degree at A-level, then certainly later on I thought that psychology was a subject best equipped to kind of explore and explain that world." (Participant 1)

For these participants it appeared as though they had initially made sense of their choice of psychology because they considered it to be an interesting subject, but more recently re-evaluated and understood their journey in a different way, namely as an attempt to understand themselves and their own experiences, rather than only those of others. The tone of these narratives was often marked by tragedy and sadness, but also courage, bravery, honesty and a kind of hope or commitment to come to terms with and explore their own experiences. The way in and extent to which participants positioned themselves to this

narrative may have had to do with how able they felt to get in touch with perhaps a more emotional side – and therefore perhaps a stereotypically more feminine side – to their life choices.

Narrative 3: Gender in a side role.

Almost all participants told their story in what may best be described as a "curriculum vitae form": a chronological series of events, with a lot of focus on school subjects, university subjects, jobs, roles, and responsibilities (Narrative 1) with occasional reference to personal experience (Narrative 2). This way of telling their story appeared to fit within the career discourse. Very few participants made unprompted reference to gender or their maleness in the initial narrative despite supposedly being aware that only men were being interviewed and that the research would look to examine participants' relationship to and experiences around gender. Where reference was made, some appeared to dissolve the significance and importance of gender in their narrative.

> "I think I see gender much less. As in like I see it as much less of an important thing, which is quite good movement I think in my development, in my cohort especially, because I have friends- I have ones that are more acquaintances but obviously the more we all have like a group identity it being, you know, our cohort. And yeah, I don't see the guys- There are some of the guys that we talk to more in my friendship group and there are some we talk to less. Yeah, I see them, I see that less as a defining feature now or a defining difference. Particularly now being much more involved in thinking about gender spectrum and sexuality spectrum and stuff and that way my thinking has shifted a bit anyway." (Participant 3)

In their rhetoric they emphasized other individual differences (such as race and sexuality) by which they may have wanted to protect their individualism. Participants also appeared to be responding to the binary concept of gender and gender stereotypes that were put towards them by the interviewer by acknowledging their existence in principle but often queried or dissolved their importance in their own lives. Participants achieved this in their narrative by telling the stories of others, rather than their own, who they perceived to have encountered gender as an issue or barrier in their lives.

> "I've got a friend, she's a woman, she's a mathematician. She's involved in kind of specialist groups that are kind of encouraged to provide a degree of support to women in maths and science type careers where they might be a minority. And you know, I've read bits and pieces in the news and whatnot, and I have an understanding that you can feel like a bit of an outsider as a woman in, say, STEM [science, technology, engineering, mathematic] careers. But to be honest I've not felt that so much with psychology, and I wondered why that was. And I think part of it is, well, there's still a fair proportion of men in positions of authority, and there's also, if you look at the most famous psychologists, you've got Jung, Freud, Rogers, there's a lot of role models to pull from almost. So I can understand a woman sort of asking the question, 'should women be mathematicians?' and being a bit unsure about that, but if you're a guy and you say, 'should guys be psychologists?', and then you look at the most famous psychologists, you're like 'oh yeah, of course, you can be'." (Participant 7)

Other participants expressed ongoing uncertainty in regards to gender as concept and how significant it was. Narrative tone was often reflective, doubtful and unsure. The rhetoric

function of this may have been to portray thoughtfulness but also not risk committing to a seemingly fixed opinion on gender which may have been vulnerable to challenge.

> *Interviewer:* ”And so is there a sense that being a male psychologist is different from being a female psychologist? ”
>
> *Participant:* ”Again, I’m not sure. I suppose there are, I suppose there are differences but yeah, I don’t know, let me think. This is what’s interesting to me, are there any differences? I suppose there are, because, well every person is different anyway, outside of gender identities and stuff. But I guess the way you are in the room with somebody, all your mannerisms and the way you go about things might be different. Not necessarily I guess the way you connect with people, although that depends also with the client you have and the connection you have with them. Yeah. It’s a good question, is there any difference for me? I haven’t really figured it out yet. ”
>
> (Participant 5)

The dissolving of the binary gender concept also contributed to the participants’ identity work. Some optimistically talked about the opportunities that positioning themselves outside of the traditional male identity had given them. But there was also some reference that perhaps it would be challenging to hold on to a male identity whilst pursuing a career in clinical psychology.

> “Yeah, that’s very interesting. I think if I was holding onto the typical male identity I would find it very hard to be in this profession. But I think I wasn’t holding onto that, even before I stepped into this profession. So I think in a way this profession helped me to explore different parts of my identity more freely, if you like, without having to

fit into the specific box of how a man behaves and all the masculinity that goes with it." (Participant 5)

Narrative 4: Minority and power.

In regards to their gender minority status, participants often positioned themselves as being comfortable in this minority. The narratives around casting gender into a side role (Narrative 3) appeared to help set up a dissolving of boundaries between male and female and therefore also lowered the contrast between male and female trainees. Nonetheless, many participants acknowledged holding power in the minority. Power was either construed to be a result of being in a numerical minority, or power was construed as a result of being male and having male privilege. Participants generally appeared to have a positive and comfortable relationship with power that they held as a result of being part of a numerical minority. In their narratives they often responded to the interviewer's supposition that they might have faced discrimination by pointing out that being in a minority had its benefits. This was often accompanied by comments that the participant had been working in female-dominated environments for a long time in their career. It seems that identity work takes place which paints participants as sensitive individuals who have adapted to their environments and found ways of being influential from a minority position. There was also some acknowledgement that minorities may be valued more within psychology than others domains of society. However, some participants also acknowledged power held as a result of their male gender (male privilege). Individuals generally appeared more uncomfortable with this type of power and the narrative tone was often hesitant, somewhat anxious and, at times, defensive. Some individuals construed their narrative in such a way that they positioned their own experiences and researched data in contrast to the male privilege narrative. The rhetoric function here may

have been an attempt to limit the reach of male privilege and protect individual achievements from being dismantled.

> "In terms of the uniqueness. Like I've been exposed to contexts where people were saying, 'yeah, we need more male perspectives', or 'we need more minority background perspectives' […] Yeah, it's a welcoming attribute I think. Whereas in other areas of society it's not. And it's a difficult thing because it's that intersectionality, because as a male, you've got power. So yes, you're a minority, but at the same time you've got power. So it's really tricky, this one." (Participant 5)

> "And there was lots of people saying to me, when I was applying, like, 'oh, you'll probably get a bit of positive discrimination being a guy because they need more guys in psychology', or what have you. But then I looked at the data about the proportion of men that apply versus that get on, because I found that published somewhere, and that doesn't seem to be true, so. The ratio of men to women that apply versus that got on the course in the last couple of years, when I looked, I can't remember exactly when it was, but a smaller proportion of men got on than those that applied. And I'm not saying that that's discriminating against men, it could just be that the men that applied were a bit rubbish. But it didn't seem at that time that there was a lot of positive discrimination." (Participant 7)

Narrative 5: Minority as discomfort.

Whilst the majority of participants appeared to feel comfortable in the gender minority, a few also reported stories where they felt more uncomfortable. One narrative

concerned the ability to voice divergent opinions as a man in an environment where the majority are female, in particular about topics to do with gender, power and feminism.

> "There is a moment that I recall, I think it was in the first year, first or second year, where there was a discussion about, it was broadly about rape or sexual assault and victim blaming and the messages that are sent by the police or authorities. And I felt like I wanted to put a certain view forward and found it really difficult, being in a very strongly female environment, that is not just female but there's sometimes a sense that there's a certain position that is held by the group. And to, I felt like, there was a genuine, not even as strong as counter-argument, but there was nuances and things that could be raised in objection to a certain position and yeah, I just felt very uncomfortable, it was kind of dismissed. And yeah, I was kind of, I felt that I couldn't say anything else. So that was challenging." (Participant 10)

> "So I think sometimes I feel that the feminist sort of viewpoint is quite popular in psychology and that's good in a sense because those ideas are important and it does help people who are struggling and who are experiencing difficulties with the dynamics in society. But sometimes I feel like the need to defend the kind of typical bloke type character who sort of just maybe gets laid off as, 'oh your problem is toxic masculinity, you need to sort that out'." (Participant 7)

The tone of these narratives was often more tense and animated, suggesting that this was an important issue to participants. Some later commented that they perhaps would not have mentioned their views on feeling uncomfortable being in the male minority at times if the interviewer had not also been a male trainee. Some also commented on a lack of spaces

within their training to think about gender issues and others commented on how they had made efforts to bond with and create support structures for other men pursuing a career within clinical psychology. All these aspects of the narrative suggest that despite gender often being cast into a side role (Narrative 3) or the male minority being a comfortable place (Narrative 4), being a man remains an important part of some participants' identity that can, at times, be threatened in female majority environments.

Destabilising the Narrative

The above narratives have been critically interrogated here using the hermeneutics of gender in particular. It is significant to note the relative side role that gender played in participants' narratives and there is a question whether it would have featured at all if the interviewer had not directly confronted participants with questions about their gender identity and experiences. However, the participants' narratives are peppered with references to stereotypically male and patriarchal concepts and concerns, such as the centrality of "getting a career", the issue of whether clinical psychology meets the hallmarks of a "career", and the motivation to portray values such as hard work and commitment and to reject claims of positive discrimination. It is possible that this constitutes an instance of blindness to male privilege, i.e. men not consciously considering their gender of much importance as it has largely not been a hindrance (and could, indeed, have been a beneficial characteristic) in their pursuit of clinical psychology as a career (Ferber, 2012). This hypothesis may be further supported by participants whose identity contained membership of groups commonly associated with holding less power in current British society, such as the queer community and the international and black and minority ethnic communities. These participants often highlighted these parts of their identity over their maleness which led to participants speaking from a position of oppression rather than privilege.

It may also be important to consider the context that participants were relaying their narratives in. As burgeoning clinical psychologists with many years of experience in the field most will have had significant experience of participating in academic debate, being sensitive to difference and relaying their own beliefs and opinions in a considered and nuanced way. Participants may have, to varying degrees, approached the interview also as a professional, intellectual and academic exercise with a motivation to demonstrate skills in critical thinking and reflection. This in itself, it could be argued, may be a gendered phenomenon with men potentially more likely to highlight professional aptitude and skill rather than emotional and personal developments. The presence of a male interviewer may have led to a sense of unconscious competitiveness where participants may have felt they needed to prove their worth and were less able to be vulnerable. These factors may have led to narratives becoming less flexible and certain nuances or aspects of participants' journeys onto clinical training may not have been heard.

Discussion

The narratives of ten male trainee clinical psychologists' journeys on to the clinical psychology doctorate programme have been illuminated using Critical Narrative Analysis with a particular focus on issues around gender and the numerical minority of men within the profession. Five prominent narratives were identified and subsequently scrutinised using Riceour's (1981) hermeneutic phenomenology. Male trainees put Western, middle-class career discourses at the centre of their narratives with gender only featuring in a side role. Where gender did feature, the significance of being part of a male minority was often minimised with participants stating they felt generally comfortable in the minority or positioning themselves as part of an environment where gender mattered less than, perhaps, other characteristics. The relative gender neutrality of these narratives raise the possibility that these narratives may be more universal and not specific to the male gender and that

female trainees, for example, would have drawn on similar stories were they included in this study. They stand in contrast to other narratives that appeared to specifically describe experiences of trainees related to their male gender: When men did position themselves as members of the male minority they often told stories of when being in a minority gave them status and power or they talked about others ascribing them status and power based on their maleness. The latter was often met with discomfort by participants who, at times, positioned themselves as having to navigate prevalent feminist discourses of male privilege, positive discrimination and toxic masculinity.

It is important to put the findings of this research in context of the environment that the research was carried out in and in context of the wider literature and research in this area. Men pursuing a career in clinical psychology may well differ from men in the general population, for example by expressing more androgynous or feminine traits (Ametrano & Pappas, 1995). Participants in this study have often positioned themselves in contrast to the stereotypical male, suggesting a degree of self-differentiation. Men taking part in this study may less strongly identify with traditional masculine values which may have been one key reason they have been able to pursue and go against stereotypes when it came to pursuing a career in a female-dominated field. However, it may also explain why participants identified less strongly with being male and named gender as less of an important characteristic compared to other variables, such as race, nationality or sexuality.

Research investigating the experiences of men in other female-dominated professions has reached similar conclusions to the findings of the present study (Simpson, 2004): Men who worked as librarians, cabin crew, nurses or primary school teachers appeared to be associated with a more careerist attitude to work (similar to Narrative 1 in the present study). They further appeared to gain advantages from being part of a minority, such as assumed authority and differential treatment (similar to Narrative 3 in regards to power in the

minority). Further, Simpson (2004) made reference to men feeling comfortable in the female environment but also to men distancing and re-establishing their masculinity at times (similar to Narratives 4 and 5 respectively). These similarities may suggest that the processes and narratives the men pursuing a career in clinical psychology draw on may not be limited to the field of psychology but extend to other occupations where men are in the minority.

Lastly, the findings of the present study also further emphasize some of the previously discussed limitations of positivist research paradigms and underline the added value of qualitative methodologies. Gender theories such as gender role (Eagly, 2013) and gender schema theory (Bem, 1981) are limited in their utility to explain phenomena where individuals will not act in line with their role or stereotype (such as men pursuing careers in stereotypical female environments). Other theories have been developed that posit a more fluid process when it comes to career choice and development. For example, Krumboltz (2009) proposed a theory that incorporates life events and "happenstance" as random factors that may outweigh more stable and predictable factors, such as personality traits and gender stereotypes, in explaining why men choose non-typical careers such as clinical psychology seemingly "against the odds". However, the present research demonstrates a third layer, beyond stable and fluid factors, that is important in career decision making. This third layer is that of individual meaning-making through the medium of stories and narratives and it is perhaps more elusive than the other two layers and harder to capture or research. This is because it is idiosyncratic and subject to constant change and renegotiation and because it is impossible to consider others' stories and meaning-making without it being coloured by our own experiences, beliefs, and perspectives.

Limitations

Firstly, due to the number of participants, lengths of interviews and richness of the data, there were limitations on the level of detail that could be reported. A compromise had to

be made between giving enough life and detail to individual stories on one hand and being able to draw out common narratives and themes across stories on the other hand. Undoubtedly, there will be further sub-narratives and nuances in the data that have not been adequately reported here and further re-analysis of either the entire sample or even individual stories may yield further results.

Secondly, a limitation of perhaps every research methodology, but particularly applicable to qualitative and narrative methodologies, is the difficulty in extrapolating from the sample to the general population. Although this study has demonstrated that certain canonical narratives were drawn on by a number of participants, it has also shown that participants have positioned themselves in a number of sometimes contrasting ways in relation to these narratives. It is therefore difficult to make conclusions about the population of male clinical psychologists in general based on these data alone.

Thirdly, the exclusion of female trainees as participants in this study meant that it cannot be concluded that all narratives identified in this study are exclusively related the male gender of trainees. For example, it may be possible that female trainees' narratives could similarly draw more heavily on career rather than personal discourses. Despite the rigorous methodology, it is important to acknowledge again the authors own identity as a male trainee clinical psychologist and the potential bias this may have introduced on the interview process as well as analysis.

Clinical Implications

The findings of the present study have important implications for the commissioning of clinical psychology training programmes and the promotion of diversity within applied psychology in general. The research shows that male trainees pursue clinical psychology as a career and there has been a general absence of "barrier" or "negative discrimination" narratives. This may suggest that, contrary to other underrepresented minorities within the

profession, such as individuals from black and minority ethnic communities or individuals with disabilities, men may not face the same type of disadvantages when it comes to entering the profession. There is no evidence that men have less than equal opportunity to enter the profession, in fact several men mentioned that they faced claims of positive discrimination or advantage as a result of being in part of an underrepresented group within the profession. Men have opportunities to study psychology at A-level or at undergraduate level but the minority are choosing to do so, suggesting that the uneven gender split within clinical psychology can be traced back all the way to young adulthood or earlier. In order to increase the proportion of men in the profession efforts may need to be directed at changing and modernising the discourse in regards to the role of boys and men in society in general, but also in regards to emotional intelligence and mental wellbeing in men in particular. The narratives in this study have pointed towards a less prominent but no less significant narrative around the role of personal experience of mental health difficulties in men pursuing clinical psychology training. An increased awareness and acceptance of mental health and emotional wellbeing as well as a consequential increased uptake of mental health service use amongst men may also lead to an increased number of men showing an interest in psychology and, eventually, in a career in clinical psychology. There is no pretence that this is an easy task which clearly intersects with a number of other fields outside of clinical psychology, such as gender studies, sociology, education, health and politics and further research is clearly needed.

Further Research

Further research could expand on the findings of the present study in a number of ways. For more robust conclusions about the potential barriers that men face when entering the profession, future research could investigate the experiences and narratives of men who may still be in the process of gaining a place on a clinical psychology doctorate (for example

those currently studying for a Masters degree) or indeed those who have changed paths and are pursuing alternative careers. A further recommendation would be to interview young men who are having to choose A-level or undergraduate courses around their experiences and relationship to psychology as a career. To test hypotheses that men may in some way differ from other minorities in clinical psychology, further critical narrative analyses may investigate the experiences and meaning making of individuals from, for example, black and ethnic minorities or those with disabilities.

Conclusion

The present study makes a unique and novel contribution to the field of gender and careers research in general and the field of men as professionals within clinical psychology in particular. Using Critical Narrative Analysis the stories and meaning making of male trainee clinical psychologists has been explored and positioned in the context of wider societal discourse. The findings will help further the understanding of what draws a minority of men into the profession and how they negotiate their career in a female-dominated environment. It was demonstrated that career decision making is complex and longstanding positivist paradigms centred on gender stereotypes and social roles are not enough to explain the diversity and heterogeneity of men within the clinical psychology profession.

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SECTION C

Appendices of Supporting Material

Appendix A

Abridged Research Diary

27/03/2018

I have completed my first pilot interview of my MRP and I am pretty satisfied with how it went. I felt honoured to be allowed in to what appeared to be a very personal story and even though we had less time to talk than I would have in the actual interview. Even though I will not be able to use the pilot interview as part of the data, it has already given me quite a bit to think about and I was already able to identify a few narratives that came through around masculinity and clinical psychology as a career choice. But I also noticed that when talking to male trainees about their career choices a lot more is part of their decision, journey and story than gender discourses. It seems that even by the time people apply or undergraduate psychology courses, so much has happened already in their lives that leads them to take that particular choice. I am now looking forward to getting started properly and recruit trainees for the actual interviews.

03/07/2018

I was surprised by the response I had to my first batch of emails. I have had about ten replies and have booked in a number of trainees and interviewed one. The interview went quite well and I really enjoyed the conversation. I realise how privileged I am to talk to men about their experience of getting into training which often is attached to very personal experiences. I noticed that I am shifting further away from the very initial idea of doing something around widening access and getting more men into the profession. I notice I am much more open to be challenged on the idea that we need more men and I am much more interested to hear what others think about this idea.

10/08/2018

I have done five interviews now. I feel very privileged to be let into the lives of these trainees and I am often humbled by their accounts. I have noticed, however, that it is sometimes difficult to leave behind my own beliefs and experiences that I am holding through my own story. On re-listening to some of the recordings I notice that what I am choosing to enquire more about or the way I ask my questions could sometimes be more objective. But then again, the research methodology I am following criticises the assumption that there is something like "objectivity" within qualitative methodologies. I am trying to find a balance between acknowledging and accepting my assumptions and judgements but also privileging the individual experiences of those I am interviewing.

20/10/2018

I have done eight interviews now, so only two to go until I get to my aim or ten. I have been positively surprised by the diversity that I seem to have in my sample. I am not collecting demographic information in a systematic or quantitative way, which leaves the judgement of how diverse my sample is to myself, in some ways. However, I have had participants from a range of ethnicities, nationalities and sexualities. There has also been a good range of course centres represented. Qualitatively, participants have some quite varied stories of their journey onto training, but it is interesting to start noticing certain parallels or narratives that seem to pop up again and again.

11/11/2018

I noticed that I have changed my personal position quite a bit since starting this research. The initial idea for the research project was definitely born out of a motivation to increase the proportion of men in the profession. But over time I have had many discussions with others

about my project, I realised that I made quite a few assumptions that a) we would need more men in the profession and b) that there was something holding them back. I guess this is why Part A changed so many times and I am now posing the question whether maleness actually adds anything to clinical psychology. Which is a fairly big question!

15/01/2019

I have now finished recruiting and started transcribing and analysing. There is a huge amount of data with about ten hours' worth of conversation. I am finding it quite challenging to think about putting all this into a concise MRP. It feels like I could write a whole MRP for each single narrative. It makes me a bit sad to think that some of the richness of the data will be "lost" as there is just so much in the narratives – more than I can fit into my writeup.

18/03/2019

I have almost finished my analysis and it has actually raised so many questions for me (possibly more than it answered), not just about my research topic but about the practice of research in general. I have become quite disillusioned with research. It seems simply impossible for research to ever be objective, even within quantitative research. It raises so many questions of bias which, in turn, raises so many questions about evidence based practice and whether it's really based on impartial evidence or by evidence that is pushing an agenda or trying to make some kind of point. It seems there is fairly little recognition of that outside of full-time research circles. It has certainly not helped me with my own research and holding on to the value and importance of it. Lately I have questioned a lot whether what I am doing is actually based on anything or whether it's just my own subjective perspective sold as "research".

Appendix B

Joanna Briggs Institute Quality Appraisal Tool: Quasi-Experimental Studies

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Appendix C

Joanna Briggs Institute Quality Appraisal Tool: Qualitative Studies

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Appendix D

Author Guidelines for Journal: Narrative Inquiry

1. Narrative Inquiry publishes exclusively in English.

2. Authors should submit their article online via Editorial Manager. The manuscript should be double-spaced (12pt), prepared according to the *Publication Manual of the American Psychological Association* (6th edition), and in Microsoft Word format (.doc). The manuscript should further include an abstract (with up to six keywords), a covering letter stating the format of the contribution (e.g., article, commentary or book review), and the preference whether the author prefers the manuscript to be reviewed anonymously or openly.

3. The journal publishes target articles along with invited commentaries, articles, research notes, un-solicited commentaries, review articles, book reviews and occasional announcements. Articles should preferably not exceed 7000 words (incl. endnotes and references). Notes and commentaries should not exceed 2000 words.

4. Upon acceptance the author will be requested to send the final version in electronic form accompanied by one hard copy of the text.

5. FIGURES and TABLES should be numbered, with appropriate captions, and be placed following the reference section. Reference to any Figures and Tables should be made in the text and their desired position should be indicated on the hard copy.

6. QUOTATIONS should be given in double quotation marks. Quotations longer than 4 lines should be indented with one line space above and below the indented passage.

7. FOOTNOTES should be kept to a minimum; be numbered consecutively throughout the text; and follow the main text in a section ‘Notes’, starting on a new page. The notes should not contain reference material if this can be absorbed in the text and References section.

8. To facilitate quick review of manuscripts, authors should submit a list of three possible reviewers. The addresses and telephone numbers of potential reviewers should be included. All submissions are screened first by the editors for an initial acceptance decision. Those papers considered to fit the scope of the journal are further reviewed by three independent reviewers. Submitted manuscripts will not be returned to the authors if rejected. If the manuscript is accepted, substantive commentaries upon the paper may be published simultaneously.

9. Manuscripts are received by the explicit understanding that they are original pieces of work and not under simultaneous consideration by any other publication. Submission of an article for publication implies the transfer of the copyright from the author to publisher upon acceptance. Accepted papers may not be reproduced by any means, in whole or in part, without the written consent of the publisher. It is the author's responsibility to obtain permission to reproduce illustrations, tables, etc. from other publications.

10. Authors will receive electronic proofs sent per email for final corrections. These must be returned to the editor by the dates determined by the publication schedule. Authors receive one copy of the journal upon publication.

11. Please submit articles online via Editorial Manager. For editorial correspondence, please contact the editors: mbamberg@clarku.edu and dorien.vandemieroop@kuleuven.be

Source: https://benjamins.com/catalog/ni

Appendix E

Ethics Approval Letter and Approval of Ethics Amendments

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Appendix F

Recruitment Email to Clinical Psychology Course Centres

Dear [name of contact person],

I am a Trainee Clinical Psychologist at Salomons Centre for Applied Psychology, Canterbury Christ Church University and I am emailing to ask if you could forward a study invitation to your male clinical psychology trainees.

I am conducting my doctoral research project on the experiences and narratives of male trainees of choosing clinical psychology as a career and would like to invite male trainees to take part in a one hour individual interview. The research is being conducted with the aim of understanding more about men as a minority in the profession and the relationship between gender, identity and profession. The research may also inform initiatives to recruit more men to clinical psychology training. To make it as convenient as possible for potential interviewees I am conducting the interviews via Skype or phone.

I am attaching an information sheet and consent form for further information. The study has received ethical approval by the Salomons Centre for Applied Psychology Ethics Review Panel.

Interested trainees can contact me on j.himmerich990@canterbury.ac.uk

Kind regards,

Julian Himmerich

Trainee Clinical Psychology

Salomons Centre for Applied Psychology

1 Meadow Road

Tunbridge Wells

TN1 2YG

Appendix G

Participant Information Sheet

INFORMATION ABOUT THE RESEARCH

Project: Male trainee clinical psychologists: narratives of the journeys into clinical training

Researcher: Julian Himmerich, Trainee Clinical Psychologist

Hello. My name is Julian Himmerich and I am a trainee clinical psychologist at the Salomons Centre for Applied Psychology, Canterbury Christ Church University. I would like to invite you to take part in a research study that I am conducting as part of my clinical psychology doctorate course. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

Part 1

What is the purpose of the study?
The purpose of the study is to find out more about the stories/narratives that male clinical trainee clinical psychologists tell of their way into clinical training. We are wanting to know how, looking back, you make sense of what led you to take an interest in clinical psychology, how you pursued that interest and how you came to be on a clinical psychology course. We are also interested in how societal views and ideas about gender, careers and clinical psychology may or may not have played a role in your story in how you came to be a trainee clinical psychologist.

We are hoping that understanding more about your story and how you tell it will help us learn more about the experiences of men embarking on a career in clinical psychology and will, in the long–term, contribute to us finding ways of increasing the proportion of men delivering psychological services.

Why have I been invited?
You have been invited because you are studying for a doctorate in clinical psychology on a UK course and because you identify as a man.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?
If you agree to take part, I will invite you for a one-off interview lasting up to 60 minutes. In the interview you will be asked to tell your story of how you came to be on a UK clinical psychology course. What you include in this story is up to you, although I may prompt or ask for elaboration at times. The interview will take place either in person at your educational institution (if practical for me to get to), via Skype or over the phone. I will ask you to agree that I can audio-record our interview for later analysis.

Expenses and payments
Unfortunately we are not able to reimburse you for the time you give to participate in this study. You should not incur any travel expenses as interviews will be held over Skype/phone or at your educational institution at a time that suits you.

What are the possible disadvantages and risks of taking part?
We do not foresee any major risks associated with taking part in this study. However, some people might find that thinking and talking about previous or current experiences brings up difficult feelings. You are asked to only share what you feel comfortable sharing and there is an opportunity to debrief “off tape” following the interview.

What are the possible benefits of taking part?
The interview will give you a chance to reflect on and talk about your own journey towards clinical training so far. You may not have had a chance to do this in such an explicit way and you may welcome an opportunity to talk about and share how you experienced this journey and what sense you make of it looking back. We find that many people enjoy putting their experiences into a story and telling it to someone else. Your participation in this study may also, on a wider scale, contribute to initiatives that aim to increase the proportion of men in clinical psychology.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You can decide you do not want to carry on with the study at any time.

If you change your mind before our interview, then we will simply cancel the interview and you will not need to do anything else.

If you change your mind during the interview, then we will stop the interview immediately. You will have an opportunity to discuss any concerns or distress "off tape" if you wish. You will be given the choice about what should happen with the part of the interview already recorded. You may choose that it is fine for me to use this as part of my analysis or you may choose that it should be destroyed and not used any further.

If you change your mind after the interview has been completed but before I completed my analysis, we will destroy your audio recording as well as any transcripts and your data will not be included in the study.

What if there is a problem or if I have a complaint?
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by email (j.himmerich990@canterbury.ac.uk) or by calling the Salomons Centre: 01227 92 7070.

If you remain unhappy and wish to complain formally, you can do this by contacting Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology – paul.camic@canterbury.ac.uk, tel: 01227 92 7070.

Will information from or about me from taking part in the study be kept confidential?
The interview will be carried out in a private setting (e.g. a room at your university). Where the interview is conducted over the phone or by Skype I will take your call in a place where it cannot be overheard by others and will ask that you do the same. The interview will be audio-recorded using a dictaphone (if in person or over phone) or via recording software (if over Skype). The recording and transcripts will be stored in a secure way for up to five years post completion of the project or five years post publication (whichever is later). A copy of the recordings and transcripts will also be stored securely at the Salomons Centre for Applied Psychology, Canterbury Christ Church University, for up to five years post completion of the project.

The recording will be transcribed by myself and this transcript will be anonymous and any identifying information will be changed. The content of your interview will be confidential and where I am using excerpts or quotes from your interview these will be anonymised.

Your interview will only be used for analysis in this study (and potential publications arising out of it) and for no other purpose.

What will happen to the results of the research study?
This research forms part of my dissertation for the clinical psychology doctorate course I am studying. The results will be written up and submitted to the university for examination and a copy of my dissertation, including the results of this study, will be available to view online. The results may also be published in an academic journal. The dissertation and the journal publication may include anonymised quotes from your interview if you have consented to this.

I will write a shorter summary of the results that is intended specifically for those that have participated in the study. I will ask whether you would like to receive this summary which I can send to you via email. You may also be interested in receiving a notification should the findings be published in an academic journal.

Who is organising and funding the research?
The research is organised and funded by Canterbury Christ Church University.

Who has reviewed the study?
This study has been reviewed and given favourable opinion by The Salomons Ethics Panel, Salomons Centre for Applied Psychology, Canterbury Christ Church University.

Contact details
If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01227 92 7070 or email me at j.himmerich990@canterbury.ac.uk. Please say that the message is for me (Julian Himmerich) and leave a contact number so that I can get back to you.

Finally… if you would like to take part..
I am glad to hear that you are considering participation in the study. Please read and complete the attached consent form and contact me using the contact details above so we can arrange a suitable time and date for the interview. If possible, please send the consent form (scanned or a photograph of) to j.himmerich990@canterbury.ac.uk. If this is not possible we can discuss how you will be able to return the form to me before the interview.

Appendix H

Consent Form

CONSENT FORM

Project: Male trainee clinical psychologists: narratives of the journeys into clinical training

Researcher: Julian Himmerich, Trainee Clinical Psychologist

Please initial box

1. I confirm that I have read and understand the information sheet dated 07/02/18 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	☐
3. I agree for my interview to be audio-recorded and the recording to be stored in encrypted form.	☐
4. I agree that anonymous quotes from my interview may be used in published reports of the study findings.	☐
5. I agree to take part in the above study.	☐

Name of Participant_____
Date_____

Signature _____

Name of Person taking consent _____
Date_____

Signature _____

Appendix I

Interview schedule

Project: Male trainee clinical psychologists: narratives of the journeys into clinical training

Researcher: Julian Himmerich, Trainee Clinical Psychologist

Introductory questions/topics:

Check consent, any questions/concerns prior to starting

Some general getting to know the person an gathering of demographics (e.g. where they study, what year of study, how old they are)

Opening question:

Could you tell me your story of how you came to be on a clinical psychology doctorate course. I would like you to give as much detail as possible, but ensure that your story arrives at the present day by the end of this 60 minute interview. You can choose what to include in this story, but I might ask you to elaborate on or clarify aspects at times.

Elaboration prompts:

I will try to ask for elaboration and clarification if and when the narrative appears to address the following themes:

- gender identity and roles (particular male identity and role)

- views/attitudes/perspectives of others/society in relation to participant's choices (e.g. conflict between self-fulfilment and societal norms)

- discussions of minority/majority

- power, choice and agency

- (re)solutions (of conflict/barriers/problems)

These interjections may take the form of questions, such as:

- *Could you tell me a little bit more about…*
- *Could you provide more detail about what happened when/after…*
- *Could you tell me how you managed/coped with/dealt with….*

Closing questions/topics:

What is it like to be a part of the minority gender group in the helping profession?

How has the experience of being in a gender minority affected your gender identity?

Reflecting on the interview and taking part (including prompt to think about how the narrative may have been "edited" in light of the research context and what parts may have been highlighted and which may have been omitted)

What might you may have wanted to be different throughout your journey (e.g. something you would do differently, or something you would have wished others would have done differently)?

From reflecting on your own experiences, do you think there should be more men in the clinical psychology profession? And if so, what do you think needs to change to recruit more men into the profession?

Appendix J

Annotated Transcript

This has been removed from the electronic copy

Appendix K

End of Study Report to Salomons Ethics Panel and Participants

Male Trainee Clinical Psychologists on their Journey to Qualification: A Critical Narrative Analysis

Summary Report

What was the background to this study?

Men are numerically underrepresented within health care, helping professions and the profession of clinical psychology specifically (around 15-20% of the workforce). Numerous theories cite gender role development and gender stereotyping as reasons for this underrepresentation as caring and nurturing roles are more associated with stereotypically feminine attributes. Nonetheless, a significant minority of men do enter the profession but little is known about the experiences of this minority in terms of how they made sense of their choices and their journey within the career so far

What were the aims of the study?

The aims of the study were to illuminate how male trainee clinical psychologists made sense of their journey into the career. We were interested in whether they encountered issues around gender stereotypes, minority status, power, privilege, positive or negative discrimination and how they negotiated these issues. We were also interested how they told their story and how they positioned themselves in relation to the above issues.

How was the study conducted?

Ten male trainee clinical psychologists took part in individual interviews which were then analysed using the principles of Critical Narrative Analysis by Langdridge (2008). Critical Narrative Analysis was chosen as it involves critically examining the individual

stories and positioning narratives in the wider social discourse, e.g. taking into account current discourses around gender and feminism.

What were the findings?

Five narratives were identified as common to several participants' accounts:

1. Psychology as a meaningful career: Most participants told their story in "curriculum vitae" form, often starting with an account of choosing psychology as at A-level or undergraduate degree. The narrative was characterised by participants' struggle to combine psychology (an "interesting" subject) with the hallmarks of a traditional career (e.g. status and pay).
2. Psychology as a deeply personal matter: Several participants referred to personal or familial experience of mental health difficulties as relevant to their career choices but for most this appeared to be a side narrative whilst the career narrative took centre stage (although very few understood their personal experiences as the most significant factor in their career choice).
3. Gender in a side role: Very few participants made spontaneous reference to gender in the initial narrative. The significance of gender appeared somewhat "dissolved" in the narrative with participants generally highlighting other individual differences and minimising the role that their male gender played in terms of their choice of psychology and progression within the career.
4. Minority and power: Some participants had come across narratives of others who claimed that being male bestowed upon them a certain advantage in the profession (male privilege) but participants generally felt uncomfortable with this power. However, participants also said they felt they had power because they were in a minority and felt that minority views are particularly valued within clinical

psychology – participants appeared to feel more comfortable with this type of power.

5. Minority as a discomfort: Some participants made references to feeling uncomfortable in the minority at times. They felt that it was difficult at times to voice a difference opinion as a male at times, e.g. particular around feminist issues. There were also some narratives of male bonding and having to stick up for the male gender.

What were the conclusions?

The results were contextualised in previous research and wider societal discourses. A focus on a career perspective and perhaps gender as a relative side issue may be seen to be characteristic of male privilege and blindness to privilege. Findings of the present study share significant similarities with other studies that investigated the experiences of men in female dominated professions. It was also argued that more qualitative research should be carried out in order to take account how individuals make sense of and attribute meaning to their experiences.

Appendix L

Narrative Development and Subnarratives

Narrative 1: Psychology as a meaningful career

Subnarratives:

- A-level choices: psycholoy as an interest and other subjects as careers
- Rational choices: pro's and con's of psychology as a career
- Making it work: creating the psychology CV, rising through the ranks
- Conflict and integration: Continue or stop?
- The help of others: influence and role models

Narrative 2: Psychology as a deeply personal matter

Subnarratives:

- Parents and loved ones: early familial exposure to ill mental health
- Understanding one's own mind: psychology as a tool for self-discovery

Narrative 3: Gender in a side role.

Subnarratives:

- Genderblindness: the minimisation of the importance of own maleness
- Intersectionality: the highlighting of other difference
- The experiences of other men and women in psychology in relation to their gender

Narrative 4: Minority and power.

Subnarratives:

- Minority status as a source of power
- Male power and privilege
- Protecting the individual identity within the group identity

Narrative 5: Minority as discomfort.

Subnarratives:

- Disagreeing in female majority environments
- Sources of support for men