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An Exploration of the Role Social Class has in Clinical Psychology Training and for Adults Engaging with Psychological Therapies in the UK.

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An Exploration of the Role Social Class has in Clinical Psychology Training and for Adults Engaging with Psychological Therapies in the UK.

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North Wales Clinical Psychology Programme

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Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

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'Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

Signed:

Katie Place

26th May 2023

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Thesis Summary

The thesis consists of three chapters focusing on social class, social class is an identity by which societies organise themselves hierarchically and can shape a person's life opportunities and experiences. Chapter one is a systematic review of UK studies researching if and how being working-class impacts engaging with psychological therapy for mental health difficulties. It found that being working-class was associated with difficulties engaging in psychological therapy for mental health difficulties. A possible reason was finding therapy unhelpful or aversive and one of the suggested changes to aid engagement was having a therapist with a similar social class status. However, there remains a significant gap in the literature regarding the underlying mechanisms resulting in engagement difficulties and evidence-base methods to address these. Chapter two is an exploration into the experiences of working-class trainee clinical psychologists and how they acculturated to UK Doctorate in Clinical Psychology (DClinPsy) training. Thematic analysis was used on semi-structured interviews and found a common trajectory of acculturation that was impacted by whether class was an invisible or visible social identity. Chapter three discusses pertinent topics of clinical and theoretic implications present in the systematic review and empirical research study. These topics consist of social identity being multifaceted and intersecting, with social class just one aspect of this. Also, exploring how social class is not currently a protected characteristic despite inequalities and discrimination, neither is there a consensus on how to conceptualise or measure it.

Chapter One

Systematic Review

Being a Working-Class Adult and Engaging with Psychological Therapies in the UK: A Systematic Review.

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Abstract

A systematic review of peer-reviewed UK studies concerning if and how being working-class impacts engaging with psychological therapy for mental health difficulties. PsycINFO, ASSIA and CINAHL were searched according to a registered study protocol (PROSPERO CRD42023403515). The search yielded 2,446 unique studies, of which 14 met the inclusion criteria for this review. There was considerable variance on how social class was measured across the studies as well as design, quality and outcome measured. Nevertheless, there was consistent evidence to suggest that being working-class was associated with difficulties engaging in psychological therapy for mental health difficulties. Some possible reasons contributing to difficulties engaging and suggested changes to aid engagement were both evidenced and theorised by the study's authors. There remains a significant gap in the literature regarding the underlying mechanisms resulting in engagement difficulties and evidence-base methods to address these. There is a need for engagement difficulties to be acknowledge and for national routine data collection methods to be established across all mental health services (not just IAPT) that would allow an exploration of engagement difficulties more widely. In addition, the development of robust and universal measures of social class would aid data collection, analysis, and comparisons across studies.

Keywords: social class, working class, psychological therapies, engagement

Being a Working-Class Adult and Engaging with Psychological Therapies in the UK: A Systematic Review

Introduction

It is widely accepted that there is a social gradient associated with health, the lower a person's social status the worse their mental and physical health (Health matters: reducing health inequalities in mental illness, 2018; Marmot, 2020; Schultz et al., 2018). For example, in the UK, women from the most deprived areas were living almost eight years less, men almost ten years less, than those from the least deprived areas (Office for National Statistics (ONS), 2021). Additionally, in the UK, people with a low socioeconomic status (SES) are 4.5 times more likely to experience mental health difficulties and twice as likely to die by suicide than those with high SES (Finegan et al., 2018; Gutman et al, 2015; ONS, 2021). Not only were people with a low SES more likely to experience ill health, but they were also more likely to experience co-morbidities and at an increased severity (ONS, 2021). This likelihood of experiencing physical and mental health difficulties is further increased when there is an intersection of other minoritised social identities such as ethnicity, disability and being LGBTQ+ (ONS, 2021; Ross et al., 2016; Alang, 2015).

Fundamentally, social conditions associated with having a low social status such as poor housing, poverty, poor diet, poor working conditions, and adverse childhood experiences, significantly increase the likelihood of physical and mental ill health (Fryers et al., 2003; Link et al., 1995; Lorant et al., 2003; Marmot, 2020; Silva et al., 2016; Walker & Druss, 2017; Wilkinson & Pickett, 2007). Living in poor and overcrowded housing has been associated with increasing the risk of cardiovascular and respiratory diseases, depression, and anxiety (ONS, 2020). Social conditions can influence a person engaging in unhealthy behaviours, such as more deprived areas have a significant increase in access to fast food and

limited access to affordable health food options. For people living in the poorest 10% household would have to spend 74% of their income to adhere to the UK government's guidance to a healthy diet. Thus, low income and living in deprived areas are associated with a poorer diet, and poor diets are associated with a plethora of physical and mental health issues (Frazão, 1999; McCulloch et al., 2006).

Research indicates that a low social status can also be associated with unmet healthcare needs despite the UK have a national healthcare service (Ojeda et al., 2008; Shi et al., 2005; Steele et al., 2007). Unmet needs may include difficulties accessing services (lack of provisions and/or less likely to be referred), the quality of services being poor and less likely to benefit or improve from services input (Delgadillo et al., 2016; Finegan et al., 2018; Grant et al., 2012; Saxon et al., 2007). For example, people living in the most deprived areas in the UK tend to have fewer General Practitioners (GPs) in relation to per head of the population and the quality of healthcare received is likely to be poorer than in less deprived areas (ONS, 2020). Although unmet healthcare needs span across physical and mental health services, the systematic review will focus on mental health services and specifically psychological therapies.

A recent systematic review of the literature up until 2021 found being working class was associated with reduced access to mental health services and poor outcomes following interventions. The review included a range of mental health interventions as well as but not limited to psychological therapies (Barnett et al. 2022). A systematic review of the literature focused specifically on psychological therapies between 2007 and 2017, found a low SES was associated with poor outcomes (Finegan et al., 2018). It may be that living in deprivation is associated with disengaging from psychological therapies which are impacting outcomes (O'Brien et al., 2009). Therefore, Firth et al., (2022) conducted a systematic review of the literature between 2010-2020 to explore whether poor psychological therapy outcomes were

related to an increased likelihood of dropping out of psychological therapy, however, the findings did not evidence this. Self et al., (2005) theorised that a low SES may reduce engaging in psychological therapies due to having less social support and resources (e.g., money or means to travel to appointments) and managing additional social, financial and health difficulties that are prioritised over accessing support for mental health difficulties. Although this is a theory, and it remains unclear what the mechanisms are (if any) that result in difficulties engaging in psychological therapies. The existing reviews included literature across contexts (e.g., Sweden, Finland, USA, Germany, and the UK: Barnett et al., 2022; Finegan et al., 2018; Firth et al., 2022). It was therefore difficult to discern if the existing review findings referenced were applicable to the UK.

Social class refers to a person's position within society, however it is important to be aware that there is not one universal and standardised way to conceptualise or measure social class. Bourdieu (1978) suggested a person's position is influenced by their economic, social, and cultural capital. To summarise, economic capital refers to money or assets, social capital refers to people you know and that surround you and cultural capital refers to symbolic resources that gives cues to class. Working-class people tend to have less, or different economic, social, and cultural capital compared to other recognised social classes in the UK (Clegg, 2011). Class identity has been difficult to measure due to its complexity and is often reduced to a person's economic capital (e.g., income). Literature on social class identity in mental health research commonly conceptualises it as a person's SES, which is based on a selection of capital; education level, occupation, and income (Galobardes et al, 2006; Krieger et al., 1997; Lynch & Kaplan, 2000). Some also measure community-level factors (also referred to as deprivation) to determine a person's SES such as living environments, type of housing and crime levels (Ministry of Housing, Communities & Local Government, 2019). More recently there has been a new method of measuring class (Great British Class Survey)

that was based on Bourdieu's theoretical framework (Savage et al., 2013). The differing and competing ways to conceptulise and measure social class will be accepted in this systematic review.

To summarise, there are stark differences between countries in terms of their societal structures that social class exists in and differences between mental health services, provisions, and systems, with the UK having a national health service (NHS). Since 2018, the UK government's agenda is to address inequalities by increasing access to psychological therapies through the *Health matters: reducing health inequalities in mental illness strategy*. To meet this strategy, it is imperative to understand if and how social identities, such as social class, impact engaging with psychological therapies, to ensure services can be designed and psychological therapies can be provided in ways that meet the needs of the population they serve. Therefore, this paper aims to systematically review the literature to address the following research question: Does being working-class impact engagement with psychological therapy for mental health difficulties in the UK and how?

Method

Protocol and registration

This systematic review was prepared and conducted following the Preferred Reporting Items for Systematic reviews and Meta-Analysis (PRISMA) guidelines and registered prospectively on the international prospective register of systematic review (PROSPERO, registration no: CRD42023403515).

Eligibility criteria

A PICO(SS) framework presented in Table 1 was used to determine eligibility criteria. To be eligible for inclusion in this systematic review, articles were required to report on social class and engaging in psychological therapy. Articles that explored other social identities (e.g.,

gender, ethnicity, and sexuality) alongside class were included. A broad range of psychological therapy modalities was included such as individual or group therapy. Articles were required to focus on the adult population. Both qualitative and quantitative peer-reviewed articles were included, available in English and conducted in the UK context in the last 10 years (2013-2023).

Table 1.

PISCO(SS) Framework

	Inclusion	**Exclusion**
Population	Working-class adults. Must explicitly investigate class (inc. SES), this can be alongside other social identities.	Studies that specifically focus on children (0-17 years old) or older adult (65+ years old) services. Studies that only focus on other factors and social identities unrelated to social class.
Intervention	Any psychological therapies across a range of modalities for a range of mental health difficulties.	Mental health services not specifically or including psychological therapies e.g., psychiatry appointments only.
Comparator	Within-group comparisons to other class identities (inc. SES).	
Outcomes	Engagement or non-engagement in psychological therapies.	The outcome of psychological therapies.

Setting	Outpatient settings across primary, secondary, charitable, or private psychological therapies in the UK.	Inpatient units. In countries outside of the UK.
Study	Qualitative and quantitative peer-reviewed studies including but not limited to RCTs, case studies, and surveys that are reported in English between 2013 and 2023.	Theoretical papers and literature reviews or papers not published through channels that are not peer-reviewed.

Information sources

Three databases were searched: PsycINFO, ASSIA and CINAHL with full text on 17th January 2023 and repeated on 10th May 2023 prior to final analyses to retrieve any additional studies for inclusion. The reference lists and citations of included papers and existing review articles were hand-searched for any additional articles.

Search strategy

The search terms were based on key terms identified in existing review articles and in collaboration with a local academic librarian. The search terms used were: (socioeconomic status OR SES OR economic status OR social class OR social status OR social rank OR social group OR social inequ* OR social depriv* OR economic depriv* OR education* depriv* OR low* wage OR low* income OR low* salar* OR un?employ* OR non?employ* OR working class OR lower class OR poverty) and (IAPT OR improving access to psychological therap* OR psychotherap* OR psychological therap* OR psychological treatment? OR talking therap* OR psychoeducat* OR psychological intervention? OR brief psychological intervention? OR adult mental health) and (engag* OR attend* OR attrition

OR drop out OR access* OR barrier? OR obstacle? OR hurdle? failure to attend OR premature termination).

Study selection

Search results were exported to ProQuest RefWorks and duplicates were removed. The titles and abstracts of the remaining studies were screened against the eligibility criteria. The full text of potential articles was screened to produce a final list of those that were included in the review.

Data extraction and synthesis

Due to the inclusion of studies that used a range of methodologies, a narrative synthesis was conducted to summarise the key findings, focusing on the impact being working-class had on engaging in psychological therapy. Narrative synthesis guidance from Ryan (2013) was drawn on and adapted to fit the review topic. A predefined data extraction framework was developed and applied which included the design, rationale, sample size, social class measure, type of psychological therapy, findings pertinent to this systematic review question on engagement, and main limitations using an appraisal tool. Tabulated summaries of the data extracted was developed followed by a descriptive synthesis of the relationship between the studies findings, highlighting any similarities and differences by grouping and clustering.

Assessment of risk of bias

Study quality was assessed using the Mixed Methods Appraisal Tool (MMAT: Hong et al., 2018). The MMAT has been specifically designed for systematic reviews containing empirical articles using a range of methodologies. The MMAT comprised of two screening questions followed by five questions dependent on the study's methodology. As advised by the MMAT, no articles were excluded from the systematic review due to poor quality

although this information was considered when synthesising the data with less weight given to the findings of poorer quality studies.

Results

Study selection

As demonstrated in Figure 1, the database search identified 3,123 and 6 additional papers through other sources. Once duplicates were removed, 2,446 articles were screened from their title and abstract resulting in 2,420 being excluded. Twenty-six articles were screened from their full text, and 12 of those were excluded for reasons outlined in figure 1. The remaining 14 articles met the eligibility criteria for inclusion in the data synthesis.

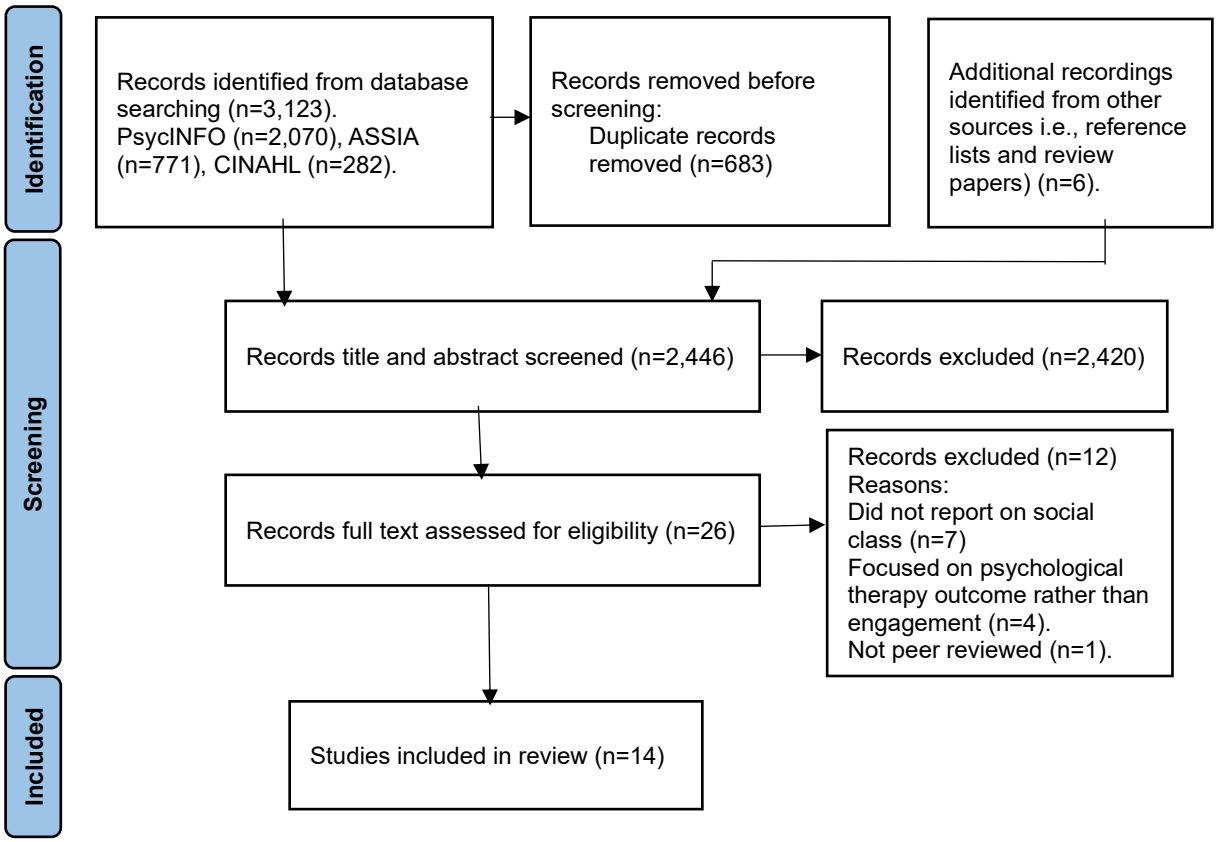

Figure 1. *PRISMA flow chart diagram of the systematic review process.*

Study characteristics

Data extracted from the 14 studies are presented in Table 2. The sample sizes ranged from 45 to 293,400, most included 1,700 or more participants (n=8). Across the studies, eight reported participants' ages, two included teenagers between 16 and 17 years old and six included older adults over the age of 65 within their sample of adults. Five articles did not specify participants' ages although these studies were conducted in adult settings or services which felt sufficient to confirm the participants met the age eligibility criteria. The measures used to define social class varied across the articles, most consistently the index of multiple deprivations (IMD) was used (n=8) which measures areas of poverty. Other measures of were employment status (n=3), occupation (n=1), education (n=3), income (n=1), self-identification (n=2) and ownership of a vehicle (n=1). Most consistently articles were based on primary care Improving Access to Psychological Therapies (IAPT) services (n=9), the remaining five articles did not differentiate between services providing psychological therapies. Most articles included a range or did not differentiate between the modalities of psychological therapies (n=10). The remaining three articles specifically studied a cognitive behavioural psychoeducation course called Stress Control (n=3) and cognitive behavioural therapy (CBT) (n=1).

Table 2.

Summary characteristics of included studies.

First author (Year)	Design	Data source	Service	Sample No.	Age range (years)	Social Class Measurement	Psychological Therapy
Avishai (2018)	Quantitative Randomised Control Trial		Mental Health Service	82	M= 42.11 (SD = 12.63)	Employment status, education level and ownership of a vehicle	Stress Control
Binnie (2016)	Mixed Methods	Admin	IAPT	201	18-89	IMD	CBT
Brown (2014)	Quantitative Non-Randomised	Admin	IAPT	4,988	16+ (M=42.1 and 40.8)	Employment status and benefits	All therapies provided by IAPT
Bu (2021)	Quantitative Descriptive	Survey	Not specified	26,720	18+	Education level and household income	Not specified

Delgadillo (2016)	Qualitative Descriptive	Admin	IAPT	293,400	Not specified	IMD	All therapies provided by IAPT
Delgadillo (2018)	Quantitative Descriptive	Survey	IAPT	144	Not specified	IMD	All therapies provided by IAPT
Firth (2020)	Quantitative descriptive	Admin	IAPT	2,071	M=42.8, SD=13.6	IMD	Stress Control
Giebel (2020)	Quantitative Descriptive	Survey	Not specified	6,860	18+	IMD	Not specified
Mills (2016)	Mixed Methods	Admin and interviews	IAPT	170	18+	MDM	Stress Control
Poots (2014)	Quantitative Non-Randomised	Admin	IAPT	6,062	Not specified	IMD	All therapies provided by IAPT

Potts (2020)	Quantitative Descriptive	Survey	Not specified	1,700	16+ (M=46, SD=19.7)	Occupation	Not specified
Sweetman (2022)	Quantitative Descriptive	Admin	IAPT	97,020	Service A (M=39, SD=14), service B (M=42, SD=15), service C (M=38, SD14), service D (M=40, SD=14), service E (M=44,	IMD and employment status	All therapies provided by IAPT

				SD=15).			
Thomas (2020)	Qualitative	Interviews	IAPT	116	Not specified	Self-identified	All therapies provided by IAPT
Trott (2018)	Qualitative	Interviews	Not specified	45 (15 working class)	Not specified	Self-identified	Not specified

Study quality and risk of bias

A range of study designs was used with the majority utilising pre-existing data sources including service administrative data (n=7) and surveys (n=4). Most studies were quantitative descriptive (n= 7) with the rest being qualitative studies (n=2), quantitative non-randomised studies (n=2), mixed method studies (n=2) and a quantitative randomised control trial study (n=1). The outcome of the quality appraisal is displayed in Table 3, with 1 indicative of the study adhering to MMAT criteria. It is important to note that MMAT is not intended to be used to provide a final quality score. Therefore, an overview of the MMAT scores is provided. The studies that did not state clear research questions and were scored 0 on the first screen question (n=9) did however state their research aims and/or hypotheses. The second screening question was determined whether the data collected enabled the research question, aim or hypotheses to be explored or answered, all the studies achieved this (n=14).

The two qualitative studies were deemed to be an appropriate methodology with findings and interpretations derived from the data. The study by Trott et al., (2018) aimed to seek perceptions and experiences of social class from clients accessing therapy however, chose trainee counselling psychologists accessing personal therapy as their population which was not a representative or a usual client group, resulting in a score of 0 on question 1.2. There was only one randomised control trial included, the randomisation was deemed appropriate as it utilised an unbiased tool and was double-blinded across a sample of people with similar demographics. An intention to treat analysis was employed resulting in a sore of 1 on question 2.3 and 2.5, however it is important to note that only 45.1% of the participants responded to the survey that included the intervention thus it was unclear whether all those in the intervention group adhered to the intervention on the survey. There was only one non-randomised quantitative study, and it was deemed to be representative of the target population

of a specific IAPT service and used appropriate validated measures (inc. demographic data, psychometrics, and attendance data) available to them to meet their aims. It was deemed to have complete data and acknowledged and accounted for confounding variables in the data available and other possible contextual changes.

Most of the studies were categorised by the MMAT as quantitative descriptive studies (n=8) and were deemed an appropriate method to address the research aims, appropriate analysis suitable for qualitative research and were representative of their target population. The study by Bu (2021) included 51% of participants and those that were excluded were based on non-complete data resulting in a score of 0 on question 4.4. The measures used in quantitative descriptive studies were appropriate and if required, validated. It could be argued that some measures capturing being working-class were sometimes reductionist such as reducing employment status to a binary yes or no category, household income as a binary above or below £30,000, being in receipt of benefits was reduced from 11 categories to a binary yes or no and IMD categories 1-4 was combined and compared against IMD 5 (Bu Mak, 2021; Brown, 2014; Giebel, 2020). However, the rationale for this was given and considered in the interpretation of the data and acknowledged as a limitation in the studies.

There were two mixed-method studies, and they explicitly gave a clear rationale for the use of a mixed-methods approach. However, the study by Binnie (2016) had limited integration of the qualitative and quantitative components with interpretations of the data in the discussion that was not clearly displayed in the results, resulting in a score of 0 on question 5.2, 5.3 and 5.5. The qualitative methodology was felt to be inadequate to address the research question, as it consisted of two brief self-reported open-ended questions with a 16% response rate, resulting in a score of 0 on question 5.5. It may be that attempting to include multiple components such as addressing and evaluating service processes and policies whilst also examining observational administrative data and analysing close and

open survey data at once impacted the integration and thus interpretation of the data in this article.

Table 3.

MMAT scores

	Avishai (2018)	Binne (2016)	Brown (2014)	Bu (2020)	Delgadillo (2016)	Delgadillo (2018)	Firth (2020)	Giebel (2020)	Mills (2016)	Poots (2014)	Potts (2020)	Sweetman (2022)	Thomas (2020)	Trott (2018)
S1: Clear research question?	0	0	1	0	0	0	0	1	0	0	1	0	1	1
S2: Data collected addresses the research question?	1	1	1	1	1	1	1	1	1	1	1	1	1	1
1.1: Appropriate method?													1	1
1.2: Appropriate data collection?													1	0

1.3: Finding derived from the data?			1	1
1.4: Findings substantiated by the data?			1	1
1.5: Coherence between method and analysis?			1	1
2.1: Appropriate randomisation?	1			
2.2: Groups comparable at baseline?	1			
2.3: Complete outcome data?	1			

2.4: Assessor's blinded?	1	
2.5: Participant adherence to intervention?	1	
3.1: Representative sample?		1
3.2: Appropriate outcome measures?		1
3.3: Complete data?		1
3.4: Confounders accounted for?		1

3.5: Intervention as intended?							1			
4.1: Appropriate sampling method?		1	1	1	1	1	1		1	1
4.2: Representative sample?		1	1	1	1	1	1		1	1
4.3: Appropriate measures?		1	1	1	1	1	1		1	1
4.4: low non-response bias?		1	0	1	1	1	1		1	1
4.5: Appropriate statistical analysis?		1	1	1	1	1	1		1	1
5.1: Rationale for mixed methods?	1							1		

5.2: Effectively integrated?	0	1
5.3: Integrated findings?	0	1
5.4: Inconsistencies in findings addressed?	1	1
5.5: Adherence to each methods quality criterions?	0	1

S = screening questions, 1 = qualitative methodological questions, 2= randomised controlled trial questions, 3 = non-randomised quantitative methodological questions, 4 = quantitative descriptive methodological questions and 5 = mixed methodological questions.

Synthesis of results

The main findings across the fourteen studies the main themes were: difficulties engaging, possible reasons contributing to difficulties engaging and suggested changes to aid engagement. All 14 studies found an association between being working-class and difficulties engaging with psychological therapies. Difficulties engaging were captured by being less likely to utilise therapy services (n=4), less likely to attend therapy appointments (n=1) and more likely to drop out of therapy (n=3) than others from a different social class. There was a range of suggestions as to why this was the case, such as difficulties accessing services providing psychological therapies (n=4), holding beliefs about their difficulties and psychological therapies that deterred them from engaging (n=3), contending with multiple difficulties (n=4) and psychological therapy being unhelpful or aversive (n=5). The suggested changes considered the location of therapy (n=1), the therapy group or therapist having a similar social class background (n=2), utilising social marketing or psychological tools (n=2), additional support (n=4) and social rather than health interventions (n=1).

The studies concluded working-class people were less likely to engage in therapy despite being more likely to experience mental health difficulties and experience more severe symptoms. Delgadillo (2016) noted that the number of referrals to mental health services corresponded to the increased prevalence of mental health difficulties in working-class people, however, this was not reflected in the number that engaged with the service (attended appointments and were on a staff members' caseload) following a referral. The discrepancy between the number of referrals of working-class people and those engaging was not due to a lack of provisions in these services (Delgadillo, 2018). The discrepancy may be explained by working-class people being less likely to attend appointments and more likely to drop out of therapy. Poots (2014) and Binnie (2016) found that those who dropped out also had more severe symptoms of anxiety and depression. Interestingly, rather than working-class people

engaging in therapy, they were more likely to use medication for their mental health difficulties. Giebel (2020) found that their use of medication was significantly above other IMD scores and above the national average. Similarly, when defining being working-class by having a low household income, unemployed and/or lower education also found that they were more likely to use medication (Bu Mak, 2021).

The reasons that may be underlying engagement difficulties both emerged from the data collected by the studies and were theories/suggestions following the authors' interpretation of their results. The data collected by two studies indicated that there may be difficulties accessing therapy services, one study found that GPs were less likely to refer people with mental health difficulties to IAPT if they were in receipt of benefits (Brown, 2014). Another study specifically exploring GP referrals to IAPT reported on practical issues that working-class people may experience (e.g., no access to the internet or no credit on their phone) which became a barrier to self-referring to IAPT (Thomas, 2020). The two theories suggested that working-class people may not know how or where to access therapy or may experience practical issues such as getting to appointments (Bu Mak, 2021; Binnie, 2016).

The data collected by Thomas (2020) highlighted beliefs that working-class people held became a barrier for them engaging with therapy. Working-class people thought that they were undeserving of help or that their difficulties were not legitimate or severe enough to warrant help thus they believed they would be wasting services time and resources. Further possible beliefs that could have been a barrier in engaging with therapy were theorised by other studies; a belief that they should resolve their mental health difficulties independently, a view that therapy will not be helpful, with beliefs being associated with fear of asking for or seeking help due to possible judgements, stigma or dismissive reactions from their community or professionals (Binnie, 2016; Brown, 2014). Thomas (2020) found evidence of

professionals holding judgemental beliefs about working-class people, for example, they did not self-refer because they could not be bothered to.

Another theory suggested by authors in four studies was that working-class people were contending with multiple difficulties which acted as a barrier for them engaging with therapy. These multiple difficulties may be co-morbidities (e.g., other mental or physical health difficulties) and/or social, contextual, and financial difficulties (e.g., antisocial behaviour in their neighbourhood, financial debt, and classism) which may be resistant to therapy and result in prioritising their basic needs over their mental health (e.g., gaining secure housing). Contending with multi-difficulties being a barrier would support Bu's (2021) theory that working-class people may choose to engage with medication over therapy for mental health difficulties as they sought temporary and fast relief from feeling overwhelmed by the situation/s they find themselves in.

The final reasons from the data collected in three studies indicated that working-class people have difficulties engaging in therapy as it was an aversive experience for them. In particular, the data collected suggested that working with a therapist or being in a group setting where they were from a different social class background was aversive (e.g., exacerbated existing feelings of shame and inferiority and felt disconnected from the therapist and feared being judged by others of a different social class) resulting in therapy being less effective and people dropping out (Firth, 2020; Thomas, 2020; Trott, 2018). Thomas (2020) found that working-class people experienced some professionals as rejecting or dismissive. Data collected by Delgadillo (2016), Potts (2020) and Thomas (2020) found that working-class people may have difficulties engaging with therapy due to experiencing therapeutic pessimism as when they did engage, they experienced poor outcomes (e.g., did not address underlying difficulties).

There were various suggestions on how to increase working class engagement with psychological therapies. Some of the suggestions were evidenced by the data studies collected and others were possible suggestions following the authors' interpretation of their results. The data collected by Mills (2016) highlighted the importance of the location therapy offered, when a group was facilitated in an area of deprivation this significantly increased its accessibility and thus engagement of people with low MDM scores. Additionally, when a therapy group or therapist was of a similar social class they were more likely to attend (Firth; 2020; Trott, 2018). Two studies explored strategies that may improve engagement such as social marketing and utilising a psychological tool referred to as an 'if-then plan' both finding promising results (Avushai 2018; Poots, 2014). Other studies that theorised possible solutions to aid engagement included providing additional support to access and attend therapy, especially for those that may find self-referring difficult (e.g., assertive outreach: Brown, 2014; Delgadillo, 2018; Sweetman, 2022; Thomas, 2020). Potts (2020) also suggested a possible solution may be to focus on social responses to support working-class people who experience mental health difficulties independent of health care.

Discussion

The review found that working-class people were less likely to engage in psychological therapy despite being more likely to experience mental health difficulties. This was in line with other review findings that found those with low SES were 4.5 times more likely to experience mental health difficulties compared with those with high SES (Finegan et al., 2018; Gutman et al, 2015). The studies in this review reported that there were barriers for working-class people in engaging at the point of accessing therapy services and attending and maintaining therapy appointments. This review's findings based in the UK supported existing review findings across a range of countries that accessing mental health services was difficult for people with low SES (Barnett et al. 2022; Finegan et al., 2018). The reasoning behind

engagement difficulties and potential solutions to address these were less clear and sometimes entirely theorised by the authors. The suggestions as to why engaging in therapy was difficult were; difficulties accessing services providing psychological therapies, holding beliefs about their difficulties and psychological therapies that deterred them from engaging, contending with multiple difficulties and psychological therapy being unhelpful or aversive. It was apparent that the processes underlying engagement difficulties were complex, interconnected, and difficult to capture in existing studies. Similarly, the suggested changes were unclear and sometimes entirely theorised by the authors. The suggested changes or interventions to aid engagement were the location of therapy, the therapy group or therapist having a similar social class background, utilising social marketing or psychological tools, additional support and social rather than health interventions. Therefore, applying these to clinical practice should be done cautiously.

There is no universally agreed conceptualisation of social class nor methods to measure it, meaning understanding inequalities can be a challenge. Studies aiming to measure social class are doing the best they can with the resources currently available to them. However, it resulted in studies in this review using eight different ways to conceptualise and measure social class. There are issues with assuming or categorising the working-class as people that are uneducated, unemployed, and in receipt of benefits as this may inadvertently exclude working-class people that have an education, are employed and are not in receipt of benefits. An example of an issue in using current measures of social class: a person may have a high income, or low educational attainment and view themselves as working-class yet if categorised based on their income alone they would be categorised as a higher social class. The most used measure for social class in this review was IMD however Clelland & Hill (2019) argued this measure has inaccuracies and is often over-relied on in research.

Limitations

This review has some limitations, including not extracting data on other social characteristics such as racially minoritised groups, sex, and age that may be intersecting with social class regarding engaging with psychological therapies. Most of the studies also focused on English IAPT services which may mean the findings are not generalisable to other mental health services offering psychological therapies such as private practice, charitable organisations, NHS secondary and tertiary care. It may also not be generalisable to Wales, Scotland, or Northern Ireland.

Conclusion

In conclusion, being working-class was associated with difficulties engaging in psychological therapy for mental health difficulties in the UK. There is a need for health services to acknowledge these difficulties and establish national routine data collection methods across all mental health services (not just IAPT) that would allow an exploration of engagement difficulties more widely. Clarity on the underlying mechanisms resulting in engagement difficulties is essential to ensure the design and delivery of therapy in the UK is accessible, equitable and effective across social class groups. In addition, the development of robust and universal measures of social class would aid data collection, analysis, and comparisons across studies.

Declarations

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Chapter Two

Empirical Research Study

Bridging the Social Class Gap: Experiences of Working-Class Trainee Clinical Psychologists.

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Abstract

The higher one's social class status the more likely one is to gain a place on the UK Doctorate in Clinical Psychology (DClinPsy). Working-class trainees are a minority group in DClinPsy training and there are known detrimental impacts associated with being part of a minority group. The aim of this project was to capture the experiences of working-class trainee clinical psychologists when acculturating to UK DClinPsy training. Thematic analysis was used on the data collected from semi-structured interviews. A Bourdieusian and Yossosian framework and social constructionist theoretic stance were adopted. There was a common trajectory that trainees described when acculturating to the profession, the trajectory was impacted by whether they felt that class was an invisible or visible social identity during DClinPsy training.

Keywords: social class, working class, trainee clinical psychologists, acculturation, doctorate in clinical psychology

Introduction

A fundamental sociological concept describes the patterns in which societies organise themselves, often referred to as social structures (Barkan, 2013). Social structures are imperative to humans being able to live together, these structures are often implicit and covert. They are designed to position people within their society by their status, their roles, and groups they belong, which contribute to the development of a person's identity. Social structures position people within a hierarchy by (but not limited to) their gender, ethnicity, and social class. Where a person sits within the social hierarchy can influence the resources, they have which can shape their lives, such as the opportunities they have and how they behave (Macionis, 2005; Webber 1958). Therefore, a person's position can provide advantages and disadvantages in the social structure of societies. Additionally, social structures also determine boundaries of hierarchical groups, thus determining where people belong (Barkan, 2013). These boundaries are maintained to uphold social structures, not only to keep people in, but to also keep people out.

Social class is one type of social structure that exists within societies and there are multiple competing ways to conceptualise it (Wright, 2005). Due to the comprehensive nature of Bourdieu's theoretical framework this conceptualisation of social class will be adopted (Bourdieu, 1986). Bourdieu conceptualises a person's assets (capital or power) into three types: economic, cultural, and social, with the more capital a person has the higher their position in society (Bourdieu, 1986). Economic capital referred to money or assets that can be easily transferred into money. Social capital referred to whom you know and their capital. Cultural capital referred to: accent, dress sense, skills, and tastes including the material belongings that have cultural significance such as certain brands like Apple or Jaguar. Social capital referred to whom you know and their capital. In addition, the historical and current capital a person has can be internalised to shape a person's norms, values, attitudes, and

behaviours which Bourdieu refers to as a person's habitus (Reay, 2004). Social fields refer to a collective context (e.g., religious, academic, or professional groups) which have their own collective habitus (Reay, 2004). If a person's individual habitus is aligned with the collective habitus or has a desirable habitus is likely to be privileged (hold more power). Yosso's (2005) 'community cultural wealth model' complements Bourdieu's framework of social class. The model conceptualises cultural capital of minoritised racialised groups, this can be adapted for other minoritised groups such as working-class. In the model, there are six strength-based categories of capital: aspirational, linguistic, familial, social, navigational, and resistant. Aspirational capital is having future hopes and preservation despite the barriers while linguistic capital is being able to use multiple communication styles. Familial capital refers to the sense of community that a minority group (working-class community) may provide. Social capital refers to the ability to find allies and 'homes' within a range of social fields. Navigational capital refers to successfully manoeuvring through social fields despite potential hostility. Resistant capital refers to an acute awareness of oppressive structures and the motivation to move towards social justice.

Social fields and their collective habitus referred to by Bourdieu (1986) act as ways to maintain and uphold boundaries of social structures. The social field that will be the focus of this study is higher education which has a collective habitus aligned with middle to upper social classes (Day et al., 2020). Undeniably higher education has been dominated by white middle-class people with working-class people being excluded (Archer et al., 2003; Crew, 2020; Day et al., 2020; Friedman et al., 2019; Littler, 2013; Sutton Trust, 2000; 2007). There are a range of social processes that maintain and uphold boundaries in higher education. One of them being specific cultural capital of middle-class individual being deemed as important and desirable (such as engagement in extra curriculum activities; Dumais et al., 2008). Another being the way higher education responds to people with middle-class cultural capital

(such as teachers giving them more attention and assistance and perceiving them as more intelligent; DiMaggio, 1982). This has been exacerbated by research, politics, and the media reinforcing boundaries of social structures by portraying working-class people as lacking intelligence, talent, abilities, and effort (Day et al., 2020; Friedman et al., 2019). There is a complex and interconnective process between individual and structural cultural capital within higher education that maintain and uphold its social structure. Merely addressing parts of individual cultural capital differences such as ensuring working-class people engage in extra-curriculum activities are unlikely to lead to equity in accessing higher education (Krarup et al., 2014). Similarly, merely addressing parts of structural cultural capital barriers are unlikely to lead to equity in accessing higher education. For example, in 2003, the 'widening participation' policy was introduced in the UK to increase under-representative (i.e., disabled, ethnically minoritised and working-class) groups in university (UK Government, 2003). Data from 2016, compared with 2006 indicated that there had been a 73% increase in working-class people in university, however overall, they remain less likely to attend university than people from other social class backgrounds (Davies et al., 2013; Friedman et al., 2019; Stich & Freie, 2016).

When part or parts of a person's social identity (i.e., social class) is minoritised within a social field (i.e., higher education) it can be experienced as emotionally and psychologically harmful and painful (i.e., feeling othered and a lack of belonging) (Crew, 2020; Day et al., 2020; Eisenberge et al., 2003; Williams, 2007). The experience of being minoritised can result in them hiding their authentic selves and withholding their ideas and perspective (Ragins et al., 2007; Volpone & Avery,2013). This process has been linked back to the inherent desires that humans want to socially belong (Baumeister & Leary, 1995). Research exploring the experiences working-class people have when acculturating to university found distinct types based on Bourdieu's theoretical framework; mismatched habitus, cleft habitus,

and preadapted habitus (Ivemark and Ambrose, 2021). The ‘mismatched habitus’ or being a ‘fish out of water’ person feels radically different from others at university (Bourdieu and Passeron, 1979; Ivemark and Ambrose, 2021). People in this category tended to remain ‘loyal’ to their working-class roots by distancing themselves from university (Abrahams & Ingram, 2013; Binns, 2019; Hurst, 2010). The ‘cleft habitus’ or being a ‘double agent’ person felt both similar and different to others at university and in their working-class roots (Hurst, 2019; Ivemark & Ambrose, 2021; Binns, 2019). This was described as a potentially painful process termed ‘habitus dislocation’ or a ’habitus tug’, whereby a person felt they did not belong in any social class and was pulled in different directions across contexts. Habitus tug resulted in hidden injuries such as the loss of relationships, and feelings of sadness and guilt (Hurst, 2010; Ingram, 2011). In contrast, being a double agent was also described as potentially beneficial because of being attuned to multiple contexts and thus able to navigate them effectively, which was specifically termed ‘chameleon habitus’ (Abrahams & Ingram, 2013). The ‘preadapted habitus’ person was aware of differences compared with university peers yet felt similar and had a sense of belonging to both university and their working-class roots (Ivemark & Ambros, 2021; Binns, 2019). Additionally, Hurst (2010) described another distinct category called ‘renegades’, when a person distanced themselves from their working-class roots to completely immerse themselves into the middle-class.

The social class difference in universities varies across subject areas, particularly those associated with medicine, law, architecture, and science, and is further pronounced in ‘elite Russell group’ universities and at postgraduate levels e.g., a doctorate (Godard & See, 2009; Henderson, L. & Carruthers, J. 2021; Steven et al., 2016). Working-class people make up 1.8 to 5.7% of those studying medicine in the UK with research emphasising the requirement for economic capital to pursue medicine (Steven et al., 2016). In 2021 there were 7% (as opposed to the expected 20%) of people from areas in the lowest quintile for

educational participants studying a doctorate in clinical psychology (DClinPsy; Leeds Clearing House, 2021). This was measured by POLAR quintiles, an area measurement of participation in higher education with quintile 5 being area of least participant in higher education (Office for Students, 2020). The DClinPsy is a particularly interesting higher education programme because it is a publicly funded postgraduate course (fees are paid by the government) and the NHS pay trainee clinical psychologist a wage. The programme results in qualifying to work in a high-status profession as a clinical psychologist. There are alternative higher education programmes to work as a psychologist although these are self-funded (counselling, educational, health and forensic psychologists). Despite this, there is evidence that the process of applying to the DClinPsy's disadvantage working class people which can perpetuate inequalities (Atayero et al., 2021; Goddard et al., 2020). Recently, there has been a spotlight on the inclusivity issues of the DClinPsy and lack of diversity within the profession with psychological organisations working towards addressing these (ACP, 2022; Cape et al., 2008). These stress the importance of the workforce representing the community it serves and for training and/or working environment to be supportive and nurturing for all (Turpin & Coleman, 2010). This project aims to understand specifically, the lived experiences of acculturating as a working-class trainee clinical psychologist, such as the challenges they may experience and the strengths that they might bring. In the hope that the results can contribute to ongoing discussions of widening the diversity of trainees and being an inclusive programme and thus a more diverse and inclusive profession that is representative of the people it serves (Turpin & Coleman, 2010).

Methodology

Recruitment

A purposive sample method was used to identify suitable participants. Twenty-nine DClinPsy programmes across the UK were contracted by email to distribute the recruitment poster seeking self-identified working-class trainee clinical psychologists Trainees were required to have been in post for at least a year and have no affiliations with the researcher. Expressions of interest were received from 56 trainee clinical psychologists across 16 DClinPsy courses. In 2022, over three months expressions of interest were categorised based on the course attended and the geographical regions. Twenty-six trainees were then randomly selected across these categories and invited to complete the consent form and social identities questionnaire (e.g., class, race, religion, sex; Burnham, 2018). Fifteen completed the forms, 13 were interviewed, and two were unable to be interviewed due to time limitations. On completion of the interview, the participants were awarded a £20 voucher for their time.

Data Collection

The data was collected by virtual semi-structured interviews using six open-ended questions and covered the main aspects of training such as placements, teaching, and assignments. Prior to the interviews the six questions were discussed within the Working-Class Clinical Psychology Collective (a group comprising of working-class people within the psychology profession in the UK) and revised to ensure that the questions were meaningful, sensitive, and appropriate. The first interview was used as a pilot and the questions were again adjusted based on the quality of information elicited. An example of a question was: “Thinking about being a working-class trainee, how have you experienced the placements?”. The interviews lasted between 51 to 61 minutes, with an average of 60 minutes, facilitated by one interviewer. To minimise researcher bias, the interviewer listened to the participants’ answers

in an open and accepting manner whilst asking appropriate follow-up questions to elicit more information (Murray, 2003). The semi-structured nature of the interviews allowed flexibility in the questioning and enabled the interviewer to follow issues which were most important to the participant (Murray, 2003). The interviews explored subjective experiences from participants' perceptions; thus, an interpretive constructionist approach was adopted. This approach attempts to understand the participants' world from their personal views, truths, and experiences (Schwandt, 1994). The interviews were audio recorded and then manually transcribed to aid the researcher to be immersed in the data. Transcripts were anonymised to remove potentially identifiable information including colloquialisms, names, and locations.

Data Analysis

Braun and Clarke (2006) thematic analysis and theoretical perspective were adopted to capture multiple trainees' experiences and voices. After reading and re-reading the anonymous transcripts, codes were assigned which were sorted into interconnecting themes. Semantic codes were used to summarise concepts in the data that answered the research question and aims. There were multiple ways to the interpret and group the identified codes into themes, in this case the development of the themes was influenced by Bourdieu and Yosso's frameworks. The transcripts and codes were referred to throughout the development of the interconnecting themes. The process in which decisions were made was documented to improve rigour and transparency and apply quality checks on the data.

Reflexive Stance. The interviewer acknowledged their own influence on the construction and interpretation of the participant's constructions of their world (Charmaz, 2008). The interviewer also identifies as a working-class trainee clinical psychologist, which can be an advantage to be able to empathise with the participant and can create a safe place to discuss social class (Cohen & Crabtree, 2006). It may also help to establish a rapport when

virtually interviewing participants to be able to obtain relevant data on this sensitive topic (Murray, 2003; Steubert and Carpenter, 1999). However, there may be a tendency for the researcher to overidentify with some participants or certain themes and overlook others. There has been evidence that suggested that when an interviewer also has a therapeutic role, they may be inclined to adopt therapeutic approaches when the participant talks about difficult experiences. Although there is not a lot of research on what to do about these, other than seeking supervision to maintain self-awareness and disclosing their therapeutic role to the participants, which was carried out (Schwartz *et al*., 1994).

Results

Demographics

Participants ranged from first-year to third-year trainees who self-identified as working-class and were from a variety of DClinPsy courses across the UK (except Scotland and Northern Ireland). Their geography of origin included locations across the UK and other countries. Unsurprisingly and in line with Leeds Clearing House (2021) data most participants were: cis-female, heterosexual, White British, not religious, had no lived experiences of mental health difficulties, able-bodied, and neurotypical, aged between 25 and 34. However, some participants held minoritised social identities within clinical psychology such as cis-male, bisexual or homosexual, European, Asian and Black, Christian, experienced mental health difficulties, were neurodivergent, lived experience of the care system or being a carer, and were above the age of 34.

Themes

The results identified three overarching themes: 1) Trajectory of acculturation, 2) Making class invisible, and 3) Making class visible, each with subthemes as summarised in table 1. The themes and subthemes were interconnected as demonstrated in figure 1, the trajectory of

acculturation (theme 1) and the four separate parts of this process (subthemes 1a – 1d) was impacted on whether social class was invisible (theme 2 and its subthemes a – c) or visible (theme 3 and its subthemes a and b). Social class being invisible (theme 2) can exacerbate and perpetuate shame and change (subtheme 1b) and social class visible (theme 3) can support pride and embrace and integration of selves (subthemes 1c and 1d).

Table 1.

Summary of the themes and subthemes.

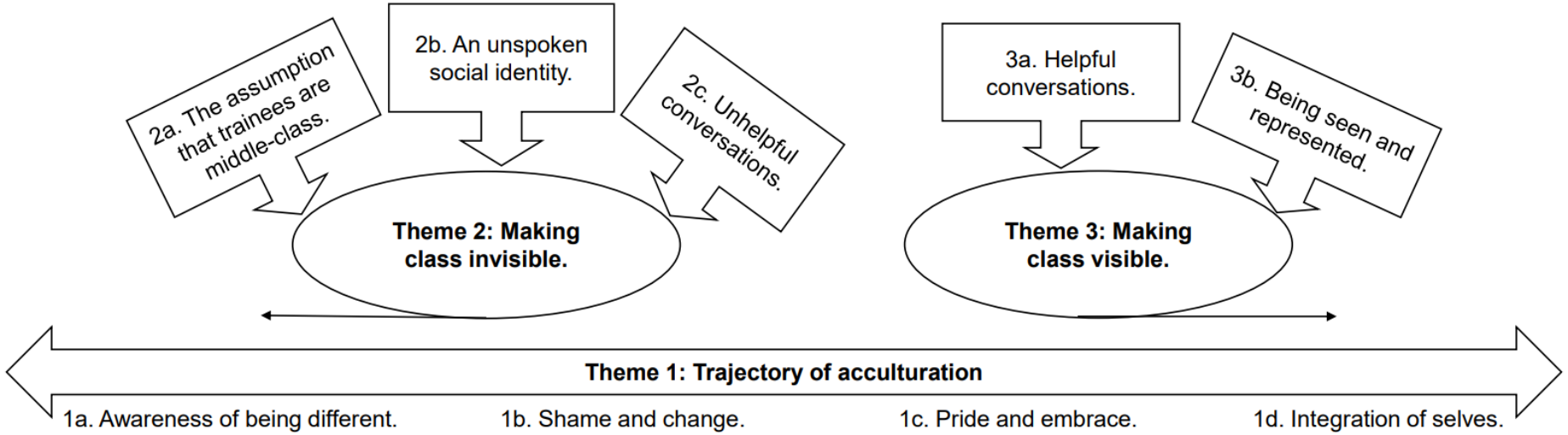
Themes	Subthemes	Description
Trajectory of acculturation	Awareness of being different	Developing an awareness that they were different from their peers and others in the profession due to being working-class.
	Shame and change	Feeling shame associated with their class identity and unintentionally and/or intentionally changing and/or hiding parts of themselves they attributed to being working-class.
	Pride and embrace	Feeling pride associated with their class identity, acknowledging strengths that come with being working-class and actively

		embracing these parts they attributed to being working-class.
	Integration of selves	Making room for changes in their capital and to nurture the working-class parts of themselves enabling them to be their authentic and genuine selves.
Making class invisible	Assumption that trainees are middle-class	Direct and indirect assumptions made about trainees' capital in conversations and the way courses are organised and structured.
	An unspoken social identity	A lack of opportunities to learn about, reflect on and discuss social class.
	Unhelpful conversations	Conversations about social class were experienced as aversive, dismissive, and hostile.

Making class visible	Helpful conversations	Conversations about social class were helpful when they those involved remained open, facilitated psychological safety, and were ring-fenced.
	Being seen and represented	Knowing that there are peers and others in the profession that are also working-class.

Figure 1.

Interconnecting themes and subthemes.



Trajectory of acculturation. Trainees described a process of acculturating to the clinical psychology profession. The processes included four subthemes: a) awareness of being different, b) shame and change, c) pride and embrace and d) integration of selves. Trainees at the time of their interview reported being at various points of the process. It did not appear that a trainee went through the entire process of acculturation, neither in a linear fashion nor was acculturation something everyone hoped to work towards. It was clear that the process of acculturating to the clinical psychology profession was an individual experience likely shaped by other social identities they held along with their unique life experiences. Despite this, the subthemes identified captured the commonalities among working-class trainees' experiences.

a. Awareness of being different.

Developing an awareness of being different in clinical training because of their working-class identity was a prominent commonality across trainees' experiences. This can be described as awareness that their habitus was not aligned with the collective habitus on clinical training (Bourdieu, 1986). Some trainees reported that this was the first time they had experienced feeling different from their peers because of their working-class identity, whereas others had experienced this before, from as early as primary school age. Those with previous experience with this described that clinical training led to a re-emergence of these old feelings. The quotes from Emma and Sarah are examples:

> I am different to other trainees […I am] surrounded by people that have had really different opportunities to me […] it was a real eye opener for me, kind of coming onto the course and kind of leaving home and realising that there was this whole different life that I have never really been aware of […] because I am working-class but in an area where everyone was pretty much working-class. (Emma)

> I felt that I did not fit in with psychology […] I mean even to the point that I did not eat my lunch with the psychology team but went to eat my lunch with the nurses instead […] it did take me a little while to cotton on that it was class. I just always saw psychologist as so stuck up […] I was like oh! It is a class thing, about people's backgrounds. (Sarah).

Trainees highlighted their differences because of their working-class identity not only amongst their peers in clinical training but also amongst qualified clinical psychologists and course staff. Some of the experiences were related to food or activities/hobbies they chose, their accent, word choice/vocabulary, kinds of humour as well as the topics of conversations. These experiences took place across formal and informal interactions (e.g., in lectures, on placements and socialising at break times), both face-to-face and virtually (e.g., in offices and on WhatsApp) and within and outside of the clinical training setting (e.g., during the week and weekends). Trainees also reported noticing middle-class assumptions about one's capital made by others (e.g., course staff, professionals delivering lectures and colleagues on placements) or existing structures and processes (e.g., expectations of knowledge or financial resources). The experiences described were best attributed to the influence that their economic and/or cultural capital had on their habitus and the mismatch this had with the collective field habitus (Bourdieu, 1986). This quote from Daniel and Sally are examples of the types of differences working-class trainees noticed:

> I noticed that I say things differently […] I will maybe say things without thinking them through fully, people seem a bit more eloquent than me or might have a different like view of things with more of a filtered lens. […] There are assumptions [from the course] that we have spare money, it just really pulls me back into, ah yes […], I do not have spare money *laughs*, I have never had spare money. I am using all my money on things and even helping other family members. (Daniel).

> I noticed psychologists were really well spoken or did not have an accent and I am common with quite a common vocabulary and accent, and I felt like I did not belong […]. Teaching can feel quite inaccessible at times in terms of all the jargon and what feels to me, unnecessary wording […] it feels really connected to my working-class background that has not been lavished in education and my vocabulary that feels quite limited […] I am so aware of seeming different or less well-spoken or less academic and less intelligent. (Sally)

b. Shame and change

There were various stigmatising external narratives (e.g., media, politics, and the news) within the UK context that trainees described internalising (e.g., feeling less than, reduced confidence and self-esteem) and resulted in them feeling shame about their working-class identity. A common narrative that trainees referenced was that working-class people do not go to university because they are unintelligent and lack personal attributes, this narrative was also reflected in various class-based literature (Crew, 2020; Day et al., 2020; Friedman et al., 2019; Littler, 2013). This narrative depicted an idea that being working-class was bad, a weakness and something to be ashamed of. This resulted in some trainees actively hiding or masking parts of their working-class identity that reflected their cultural capital, such as accent and dress sense (often used to determine a person's class and thus intelligence; Bourdieu, 1986), out of fear of being deemed unintelligent, unprofessional, or incompetent. Hiding or masking may make the trainee speak less or become skilful at mimicking others that matched the collective habitus to fit in, and may make them appear more reserved and aloof. The process of masking or hiding working-class parts of themselves created a dissonance between whom they appeared to be on the surface and whom they felt they were internally (habitus dislocation; Bourdieu, 1986). Some of these changes filtered into trainees' personal life and resulted in hidden injuries such as impacting their relationships within their

working-class communities (Hurst, 2010; Ingram, 2011). The quotes from Carrie and Mia are examples:

> You want to come across as good and you can't have certain parts of your working-class identity on show and still portray as a competent and skilled professional psychologist. […] I have had to sort of learn and change is the language, I would not be viewed as professional otherwise, so I have had to tone that down. […] I am not able to bring my working-class part of me because I feel that they would look negatively at me and assume I am not good or I will never move into leadership positions. […] There is a lot of fear of judgement when you come from a working-class background, fear that you are viewed as lesser, less educated, less skilled, not in the same league as someone middle-class. (Carrie).

> I have very consciously hidden [my class identity] and not wanted to tell people […] the language that I use and how I express myself changes a lot just from starting on the course […] it changes really quickly, you just pick it up quickly from watching other people and trying to mimic their behaviour and it just comes from knowing from quite a young age that there is something shameful about being working-class […] I have internalised that shame from quite a young age, so you become really observant of knowing that the way that I am is not acceptable. (Mia).

c. Pride and embrace

Some trainees described a narrative of moving from shame to pride about their working-class identity, by acknowledging that they have successfully gained a place in clinical training through their personal attributes, such as persistence and determination (aspirational capital) and have and are successfully navigating higher education (navigational capital) (Yosso, 2005). A particular strength of being working-class was to be able to effectively

communicate and connect with people from different and similar social class backgrounds (linguistic capital; Yosso, 2005). Trainees reported that they would often 'code-switch' depending on who they were speaking with, which would determine their accent, topics of conversation, vocabulary, humour, tone of voice, and body language. Although, code-switching can be exhausting and contribute to a sense of not belonging with either, when it was recognised as a strength it helped trainees to embrace the skill. In addition, trainees reported that another strength was being acutely aware of oppressive structures from their lived experiences of being in a position of less power and passion for equity and social justice (resistant capital; Yosso, 2005). Trainees reported that this shaped their perspectives and clinical practice (e.g., how they formulated a person's difficulties). The quotes from Sally and Lily are examples:

> I just see the beauty in having those characteristics that I have and being grateful that I have got those life experiences to bring to the things that I do. […] I offer a different perspective shaped by being working-class in a space where those perspectives are less, it affords me a really different stance in my profession. […] Those who are working-class can be marginalised and unheard, there is a real sense of wanting to eliminate that that drives my practice and values in terms of things being fair and honest and everybody being accepted. (Sally).

> I am proud of being working class actually, I feel more embedded, or I can understand the kind of difficulties people go through because it happened in my family. […] I have a switch when I talk with people who are psychologists […] the minute I work with someone mostly from a working-class background it just kind of switches back […] it is the rhythm of speech […] the language […] gestures […] body language […] boundaries, very kind of colloquial and informal. […] it is a strength being able to do that and adapt. (Lilly).

d. Integration of selves

Being a trainee brought into question their class identity as they no longer felt they could be working-class or they felt like parts of them were no longer aligned with being working-class due to the increase in their economic and social capital (e.g., wages, career, and social connections). This process of questioning their class identity was described as a difficult and uncomfortable adjustment process (habitus dislocation; Hurst, 2010; Ingram, 2011). Although trainees acknowledged the changes in their capital and life opportunities, they reported that parts of them still felt working-class. It was difficult for trainees to conceptualise parts of them that they felt remained working-class but described it as something that was a core part of who they were. Some trainees described those parts of themselves that remained working-class as their beliefs, life experiences and ways they related to the world (cultural capital and habitus; Bourdieu, 1986). The process of integrating these parts of themselves allowed them to make room for changes in their capital and to nurture the working-class parts of themselves enabling them to be their authentic and genuine selves. This process supported trainees' personal growth and the development of their professional identity. The quotes from Emma and Chris are examples:

> I do feel like I am straddling two identities and two classes and that feels really weird and uncomfortable but that is just something that I roll with and I do not think I will ever drop my working-class identity because that is many, many years of my life, that is kind of all of the early parts of my education, my family and friends, it is never going to disappear. […] I would personally internally always be working class in terms of how I feel and how I relate to the world […] but equally, there is something about, you know, I cannot deny my academic achievement, my income, where I live now, suggests that that is not the case anymore. (Emma)

> I am always mindful that moving through that process I have stepped out of that working class sort of community and moved into I guess what I perceive as more middle class, and educated, academic community and its, it was initially hard to bring [working-class] parts of myself into this sort of arena […but I have learnt that] I do not have to lose those [working-class] parts of what I think are core in my identity. […] I feel quite emotional about it […] the process has been me going back and getting those parts of myself the bringing them forward with me. (Chris)

Making class invisible. Trainees reported experiences which kept class an invisible and hidden social identity within clinical training. There were three sub-themes: a) the assumption that trainees are middle-class, b) an unspoken social identity and c) unhelpful conversations. Making class invisible was present in the subtheme b) shame and change, in the theme identified as trajectory of acculturation.

a. The assumption that trainees are middle-class

Trainees described that the way the courses are organised and structured are aligned with being middle-class such as assuming trainees have learnt to drive and own a car, have had a condensed period in higher education with minimal gaps, and have financial resources readily available (economic capital e.g., to buy houses). Middle-class assumptions were also communicated to trainees in the way that others spoke to them, for example assuming that they had childhoods aligned with being middle-class (e.g., experienced high-quality education or went on family holidays abroad). The quotes from Daniel and Kelly are examples:

> There is an assumption that trainees are a homogenous group where class does not play into people's identities. […] It took 3 months to get [expenses] back and I complained and someone from the course said, oh well can your parents not have helped you out […] there

> was an assumption that I came from a family where my parents would have spare money […] it made me quite angry, […also] where lecturers have said things, well we all go on lovely abroad holidays, and I was like did we? […] to assume that I had these extravagant holidays, and I came from a wealthy family has come up a few times. (Daniel)

> The expectation is that we pay for everything up front and claim in back and you have to wait months for that and some people have paid thousands and that just would not be possible [for me…] there was just an expectation that I would have a good enough computer to access all the teaching on. […] I think, sometimes there is the assumption that everyone, not just me, everyone can afford those things. (Kelly)

b. An unspoken social identity

Trainees reported that some social identities were explicitly and overtly discussed in teaching and used by lecturers and clinical psychologists to reflexively position themself however, class identity, along with some others were not mentioned. Trainees reported that conversations lacked space for taking a reflective intersectional lens when discussing social identities which meant it felt like there was tension about which social identity will be recognised. For the trainees who related to these unspoken social identities were left feeling invalidated and dismissed and felt this part of their identity was unimportant or not a priority. Some trainees found that not speaking about social class and a lack of intersectionality created further divides within the trainee cohorts and was experienced as unhelpful and frustrating which negatively impacted opportunities for learning. Trainees attempted to make sense of the lack of focus on social class identity, and one of their theories was because there are few people in the clinical psychology profession were from a working-class background thus it was not on their 'radar'. Another theory was that the current topics of conversations in society and in the media which at the time of the interviews were centred around race, ethnicity, gender identity and sexuality influenced which social identities were focused on.

Another theory that social class was an uncomfortable topic as it may highlight others' privileges which may evoke shame. Lastly, trainees also theorised that it may be related to a person's class being an invisible part of a person's identity meaning it can be easily overlooked. The quotes from Talia and Julia are examples:

> It feels that there is only space for one social grace. […] We do not speak about disabilities, class, age […] I do not feel that there is any space to talk about faith whatsoever and that it will not be welcomed. […] When there is a focus on just one or two social identities it can make people feel frustrated when their group is not in the focus, it kind of further divides when actually there are probably far more commonalities across minoritised social identity groups. [There is] no space to talk about class […which] is not helpful. (Talia)

> We talk about race, gender, culture, we have never spoken about or had any kind of sessions on class.[…] It's frustrating, it is a big unspoken thing but we see it, especially with the people we work with, a lot of clients come from a working-class background and to be almost blind to it, it is unethical and wrong. We are uncomfortable with having conversations around class. […] If you are not directly impacted by class you do not tend to think about it, and the people typically in clinical psychology are not working-class. (Julia)

c. Unhelpful conversations

When conversations have included class identity, trainees reported experiencing these as adverse, such as othering, hostile, stigmatising, shut down, dismissive or tokenistic. Especially when there was inadequate time allocated for class identities in teaching or when feedback from working-class trainees around class inclusivity goes unactioned. When trainees openly identified as working-class in lectures, on placement with peers or staff they

experienced some unhelpful responses such as others being shocked, met with defensiveness, and invalidating or minimising responses. These experiences consequently meant that trainees were less likely to talk about social class in future conversations which perpetuated class being an unspoken social identity. The quotes from Hannah and Sarah are examples:

> I have experienced a bit of defensiveness, that sense of well it is not my fault that I am not working-class. […] I do not feel there is space to talk about class […but the course staff] say identity stuff is important, it is tokenistic […because] they are not really practising what they preach. […] We have given feedback to the course [about class inclusion] the change is not implemented, and it feels tokenistic. (Hannah).

> It kind of feels like a really morbid fascination of like, wow, I cannot believe that, that is what it was like and […] you talk about being working class and they will say well you know my family had it really difficult and will just like counter back with something else […] people feel the need to justify their own, I guess struggles. I am not insinuating that your family have not had any hard times in anyway [by talking about being working-class]" (Sarah)

Making class visible. Trainees reported experiences which helped to make class visible within clinical training. There are two sub-themes: a) helpful conversations and b) being seen and heard. Making class visible crossed over with the subthemes c) pride and embrace and d) integration of selves, in the theme titled trajectory of acculturation.

a. Helpful conversations

Trainees described that the helpful conversations about class identity were when differences were acknowledged with open curiosity (including others acknowledging if they had a privileged social class position). However, to have helpful conversations there needed to be clear structures and protected, psychologically safe spaces to reflect and learn about a range

of social identities, including class. A structure along with protected, psychologically safe spaces ultimately gave trainees permission to talk about class. When social class was spoken about trainees found that it offered opportunities to enrich learning which contributed towards their personal and professional development. For working-class trainees, having helpful conversations was experienced as reassuring, validating, nurturing, and supporting. These conversations were also reported to play a pivotal role in supporting working-class trainees to move from shame to pride about their identity. The quotes from Chris and Hannah are examples:

> We did a lot of self-reflection on different parts of my identity and really got me to a place of being able to confidently talk about them and not feeling it was something that I had to be ashamed of […] seeing them as assets and owning them. We have monthly sessions that sort of move through the social graces and how we can bring those pieces of ourselves together and into training, so it is those forums that are really helpful […it supported my] personal growth […because] the course has been quite open to us exploring our individual identities and bringing them into the course […so] having those conversations about class […] gives me a bit of confidence. (Chris)

> Just listening and being willing to be open to understanding and stand alongside people who have different identities rather than defending themselves is much more helpful [when talking about social class]. […Conversations about class] nurture this quality in people and help people to own it. […] Owning it helps me to be a bit more comfortable with my sense of self in the role and own it to the sense that I was able to be a bit more of my authentic, genuine self and use that positively. (Hannah)

b. Being seen and represented

Some trainees reported the significance of working-class identities in the profession, such as having accents, and similar childhood experiences. Being seen and represented in the profession helped trainees feel a sense of belonging. The quotes from Julia and Lucy are examples:

> I met this member of staff, and she explicitly said she grew up on a council estate and that is the first time I have ever heard a psychologist say that I emailed her after saying that I really appreciated it […] it was the most validating thing to hear […] it was such a huge moment (Julia).

> I always notice if a psychologist has a regional accent because I feel that especially at the beginning of my career, I did not hear very many accents, regional accents at all and feeling quite alienated by that, but then, sort of moving through my different roles and meeting people I can still remember meeting the first psychologists with an accent, it was quite significant for me. (Lucy)

Discussion

Interestingly, the results from this study suggested that working-class trainees' experiences were aligned to a 'cleft habitus' or being a 'double agent'. This was when a person felt both similar and different to others in training and the profession, and in their working-class roots (Hurst, 2019; Ivemark & Ambros, 2021; Binns, 2019). The study demonstrated that working-class trainees' clinical psychologists often felt different from their peers and others in their profession where a middle-class field habitus was the norm. There were various external and internal narratives that trainees experienced linked with feeling shame about their working-class identity resulting in them hiding, masking, and changing parts of them that they associated with being working-class. Working-class trainees also described experiences aligned with 'habitus dislocation' or a 'habitus tug', whereby they felt

that they did not belong in any social class and were pulled in different directions across contexts (e.g., DClinPsy and home). Habitus dislocation may result in hidden injuries such as the loss of relationships, and feelings of sadness and guilt (Hurst, 2010; Ingram, 2011). The study demonstrated habitus dislocation may occur when the course assumed that trainees were middle-class or did not speak about class identity or conversations about social class were unhelpful perpetuating feelings of being different and ashamed of their working-class identity.

Working-class trainees also reported experiences that aligned with the strengths of being a 'double agent' such as being attuned to multiple contexts and thus able to navigate them effectively, which was specifically termed 'chameleon habitus' (Abrahams & Ingram, 2013). The process of having helpful conversations about class identity and working-class identities being represented within the profession supported trainees to acknowledge and embrace these strengths. The study demonstrated the importance of trainees' moving from shame to pride about being working-class to embrace these strengths. It was clear that simply having conversations about social class was not always helpful and may unintentionally be harmful or unhelpful and perpetuate existing difficulties working-class trainees experience. Thus, it was about how these conversations took place, psychological safety was essential for people to benefit from conversations about social class which can be summarised as talking about social class without the risk of being humiliated (Clark, 2020). The study highlighted that those involved in conversations must be open and curious about their own social class identity and others, with differences respectfully acknowledged. The DClinPsy courses must have clear structures that protect time to reflect and learn about social class (alongside other social identities). Clear structures validated the importance of all social identities and their interconnectedness, but to also gave trainees permission to talk about them, especially stigmatised or minoritised identities such as being working-class.

Furthermore, it is important that courses acknowledge that being working-class may pose additional challenges that may impact their learning experiences. Some existing DClinPsy processes or experiences may be unintentionally unhelpful or harmful including but not limited to their teaching content, expense policies and supervisory experiences. Therefore, it is imperative there are structures in place that enable working-class trainees to feedback to the course and/or seek additional support. Feedback is only helpful when processes promote psychological safety, and the course actively appreciates and transparently responds to said feedback (Winstone & Carless, 2019). Similarly, additional support must also suit the trainees' needs and where they are on their personal and professional development journey (e.g., shame or pride and anywhere in between). It may be that working-class trainees would benefit from a private space to explore their personal and professional identity, this may be a trainee group or one on one support, this may be affiliated with the course or separate. It may that existing support networks already offered by DClinPsy courses are reviewed, with the idea of upskilling those supporting trainees to be able to have supportive conversations regarding social identities.

In doing the suggestions above would likely enrich trainees' personal and professional identity development and help them to bring strengths associated with being working-class along with them into their clinical practice (Yosso, 2005). It may also help working-class trainees through the process of reshaping and conceptualising their identity given the social, capital, and cultural changes that came with being a trainee clinical psychologist (Ivemark & Ambrose, 2021). In turn, supporting working-class trainees to be proud of their identity and showcase this within the profession could help change the face of clinical psychology away from being seen as an exclusively middle-class profession. In turn, this may encourage people to pursue a career that may not have considered it or may have previously been deterred from due to a lack of belonging.

The above suggestions were derived from the data and any implementations DClinPsy courses make should be developed alongside working-class trainees and regularly monitored and evaluated for their effectiveness. Despite this research and its finding, DClinPsy courses are not obliged to address any class inequalities or class-based issues as it is not a protected characteristic, unlike other social identities such as race, gender and age (Equality Act, 2010). However, a lot is to be said about the courses that do choose to actively address class-based issues highlighted in this report. I would urge any DClinPsy course to be transparent about their actions and/or aims as this may support trainees to select courses that are likely to be a supportive and psychologically safe learning environment for them.

Limitations

The interviews were highly subjective to the participants it may not be possible for the data to be generalised to the whole population of working-class trainees in the UK nor across different times within society. There are possible limitations (and strengths) to using a self-identification method when recruiting working-class trainees. Although it does not rely on commonly used reductionist or oversimplistic measures of class such as IMD or a person's income, it does leave class identity open to subjective interpretation. Some studies suggested that there is often a mismatch between a person's objective and subjective class identity (Sosnaud et al., 2013). The study's methodology may have been improved by utilising a mixture of objective and subjective measures of social class as recommended by Rubin et al., (2014).

Conclusion

The research clearly indicated that working-class trainees may experience a unique personal and professional identity ('cleft habitus') that other trainees with a different social class do not. This may pose additional challenges with some existing course processes and structures

being unintentionally unhelpful or harmful. There is scope for DClinPsy courses to ensure that they create an environment that is sensitive and inclusive of working-class trainees. Although the results include some suggestions of how DClinPsy courses may achieve this, it is important that further research is conducted to capture the impact and effectiveness of these in practice.

Research Ethics Statement

Ethical permission was granted by the Bangor University, Wales, United Kingdom School of Psychology Ethics Committee.

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Appendices

Appendix A

Ethnical Approval Letter

COLEG GWYDDORAU DYNOL
COLLEGE OF HUMAN SCIENCES

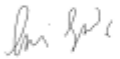
YSGOL GWYDDORAU DYNOL AC YMDDYGIADOL
SCHOOL OF HUMAN AND BEHAVIOURAL SCIENCES

E-bost/E-mail: c.saville@bangor.ac.uk
Llinell Uniongyrchol/Direct line: (01248) 388740

To whom it may concern,

I can confirm that Katie Place's research project *Bridging the social class gap: Experiences of working class trainee clinical psychologists (2022-17155)* has been reviewed by the ethics committee of the School of Human and Behavioural Sciences at Bangor University, and received a favourable opinion.

Yours faithfully



Dr Chris Saville

Cadeirydd Pwyllgor Moeseg Ysgol Gwyddorau Dynol ac Ymddygiadol
Chair, School of Human and Behavioural Sciences Ethics Committee

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Appendix B

Empirical Research Study Proposal

Research question

What are the experiences of working-class trainee clinical psychologists when acculturating to the profession?

Research aim

To give voice to an underrepresented social identity group within the clinical psychology profession, especially given that class remains an unprotected characteristic with the aim to contribute to the widening diversity and inclusion agenda.

Recruitment and participants

I plan to recruit participants from DClin programmes via a poster. The researcher is aware that the guidance for the minimum number of participants required varies and is in debate. Alternatively, a grounded theory approach may bring about more details, rich and holistic data. This is because the number of participants would be determined by data saturation, this would be when no new data is emerging. However, for this DClinPsy research project this process is not practical therefore this project will be taking advice and guidance from Braun and Clarke, 2006; Guest, Bruce and Johnson, 2006. It has been indicated that 8 to12 interviews are a suitable size for effective thematic analysis (Braun and Clarke, 2006; Guest, Bruce & Johnson, 2006).

This study will recruit participants using a purposeful sampling method. The principal investigator will share a poster on the listed public domains. If there are 8 or fewer participants, then all will be approached by the principal investigator. Contingencies will be put in place if less than the minimum participants required opt in. This will include re-posting the poster on public domains. Contingencies will be put in place to manage if more than 12 participants wish to take part. Each participant will be allocated a code and a random number generator will be employed to enable unbiased random selection of participants using https://www.randomizer.org/. The all trainees not selected will be sent an email of apology and they will be informed the maximum number of participants had been reached.

Individual that meets the following criteria will be contacted:
1) A trainee clinical psychologist on the course for at least a year,
2) Identifies as working class.

Individuals fulfilling one of more of the following criteria will be excluded:
1) Actively works with the principal investigator,
2) Has not yet starting the DClinPsy course or has qualified.

Design and procedure

The study will employ a qualitative approach using 1:1 semi-structured virtual interviews and thematic analysis (Braun and Clarke, 2006) to explore the research question and meet the research aim.

The questions that will be asked in the virtual interview will be discussed within Class Clin Psych working group and will be revised according to the feedback to ensure that the questions are meaningful, sensitive, and appropriate.

Some researchers have stated that qualitative interviews are a superior method of data collection compared to focus groups in qualitative research. Variables that quantitative research may overlook will be captured through qualitative interviews to create holistic data (Tracey, 2012). However qualitative semi-structured interviews have been criticised due to the increased risk of researcher bias (Bowling, 2002). To minimise researcher bias, the principal investigator will listen to the participants' stories in an open and accepting manner whilst asking guiding questions without directing the participants' response to avoid (Lee, 2003). Thus the semi-structured interview design includes open-ended questions in order to allow the participant to lead the interview. The flexibility in the questioning enables the principal investigator to follow issues which are of most importance to the participant in relation to the topic (Lee, 2003). This will allow themes that are most relevant to the participant to emerge and will reduce principal investigators influence in determining the content of the data collected. It is our aim for the virtual interviews to be of a conversational nature in order to gain a clear account of the participants' perceptions on well-being and resilience. Every attempt will made to ensure participants felt their views are respected, that they will come to no harm and may see the benefit in participating in the research, all participants will be treated with fairness, dignity, and equality (Beauchamp & Childress, 2009).

The interviews are investigating subjective experiences from a participant's perception; thus an interpretive constructionist view will be adopted. This approach attempts to understand the participants' world from their view, objective truth and knowledge is created from that participant's personal view (Schwandt, 1994). Additionally, the principal investigator acknowledges their own influence on the construction and interpretation of the data (Charmaz, 2008). The virtual interview will follow a process whereby the principal investigator will interpret the participant's constructions of their world. However, this approach with its positives, has a negative, because the interviews are highly subjective to the participants it may not be possible for the data to be generalise to the whole population of working-class trainees in the UK. However, the themes will offer a rich insight into the experiences of this group, which are likely to be relevant to others in the same situation.

The semi-structured virtual interview is estimated to last between 45 to 60 minutes dependent on each individual participant. The semi-structured interview will only be conducted by the principal investigator and will follow a semi-structured interview guide. The principal investigator identifies as working class which can be an advantage to be able to empathise with the participant and can create a safe place to discuss social class (Cohen & Crabtree, 2006). Research has found that it is essential to establish a rapport when virtually interviewing participants to be able to obtain relevant data on this sensitive topic (Lee, 2003; Steubert and Carpenter, 1999). Also, the principal investigator, from clinical experience has a good understanding of appropriate boundaries between professionals. However, there has been evidence that suggested when a principal investigator also has a therapeutic role, they may be inclined to adopt a therapist role when the participant talks about difficult times. Although there is not a lot of research advising on what to do about this other than the principal investigator seeking supervision and maintaining self-awareness and disclosing their therapeutic job role, this will be done in the information sheet (Schwartz *et al*., 1994).

The principal investigator will be aware of this, and all attempt and effort will be made to prevent taking a therapeutic role in the interview.

Contingency plans have been put into place if a participant cancels the semi-structured interview. Every attempt will be made for the interview to be re-arranged to include all the trainees that wish to be part of the study. However, this may not be possible within the resource and time constraints available for this DClinPsy project and participants will be notified of this.

Measures

- Name
- DClinPsy course
- Year of training
- Social identities (e.g., class, race, religion, sex; Burnham, 2018).

Data analysis

Braun and Clarke (2006) thematic analysis and theoretical perspective will be adopted and be a focus throughout the analysis. The thematic analysis allows multiple trainee's experiences to be captured and voiced. The process in which decisions were made and the themes emerged will be documented to improve rigour and transparency and apply quality checks on the data.

Diversity

The opportunity to participate in this research will be made accessible to all potential participants who meet the eligibility/inclusion criteria. If adaptations are required these will also be met as part of the reasonable adjustment policy e.g., Welsh language and larger text.

Since it is qualitative research, it is not about gaining a 'true' representation of the entire population, rather giving voice to some people to begin understanding their experiences. The focus would be on the identity of class although this project will hold space of intersectionality of underrepresented social identities in the profession.

Ethical issues

Ethical Approval. Due to the nature of this project, I would require School of Psychology ethics only.

Conflict of Interests. Since I am involved in the Class Clin Psych working group and other trainee forums I would only interview people that I am not already affiliated with to reduce any conflicts of interests, biases, or skewed data.

Informed Consent. In line with the BPS Code of Human Research Ethics (2010), all participants will be provided with accessible information in order to make an informed choice about participating in the research. The participant will be required to complete the consent form to state that they understand the information sheet and agree to take part in the study. The consent for will be countersigned by the principal investigator. Potential participants will be invited to meet the principal investigator, they will have received an information sheet and consent form beforehand that was distributed by email. The data will not be processed without the participants knowledge through informed consent. The signed informed consent forms will be confirmed before the interview commences.

Confidentiality. There are limitations with confidentiality because quotations from the interviews will be used in many of the outputs from the project i.e. in presentations, published documents and meetings. Also, issues may be raised in the interview in which in the interests of the patient's trainee's work with or others safety this information may require to be shared with their DClinPsy course. The interviews will be carried out virtually with the principle investigating in a private and confidential space. All the participants will be informed on these constraints in the information sheet.

Compliance. The chief researcher will ensure that the research project is conducted in compliance with the principles of the Declaration of Helsinki (1996), and in accordance with all applicable regulatory requirements including but not limited to the Research Governance Framework and procedures and any subsequent amendments.

Quality Assurance and Control. The chief investigator and clinical supervisors will be monitoring the research project to ensure that it maintains quality. The research and development department will also be monitoring this research project. Any non-compliance will be reported to Bangor University and appropriate action taken.

Feedback to participants

The research will be shared to participants and DClinPsy courses in a summary leaflet. Participants will have the option of opting-in on the consent form if they wish to receive a copy of the final thesis report.

Risk assessment

Despite the level of risk in participating being minimal, all necessary precautions will be carried out to maintain this (Oliver, 2010). As the interview process aimed to explore an experience/s which could potentially be difficult and/or upsetting. This potential risk for participants will be explicitly stated in the information sheet. Although, involving trainees in interviews for research regarding sensitive topics i.e. social identity has been reported to have therapeutic benefits because participants feel listened to and valued as an individual (Lee, 2003). Allmark *et al*., (2009) stated that this risk in minimal when the participants felt like it was worthwhile for them to talk about things that were difficult. Therefore, in the information sheet there is a clear statement of the purpose of this research and worth it can have. Due to the potential sensitivity of the topic that is being researched, at the end of the interview the principal investigator will provide the participant with a verbal de-brief. If the participants requires or requests further support the trainee will be encouraged to utilise existing support systems (Lee, 2003).

The chief and principal investigators with support from clinical supervisor will be responsible for the care of the participants and responsible for assessing the severity of the adverse responses. Participants will be reminded of their right to withdraw from the study if they experience an adverse response. The data collected from participants that withdraw from the study will not be used. The number of participants that withdraw from the study will be documented. All severe adverse responses will be reported to the sponsor within 24 hours. Any mild and moderate adverse responses will be recorded and stored on Bangor University's secure data servers. Any unexpected adverse responses will be reported to the sponsor within 24 hours.

Data storage

Anonymity and Storage of Data. The participant identifiable information will be collected will be on the consent form and social identity questionnaire based on social graces model to capture any intersections of minoritised social identities within clinical psychology (Burnham, 2018). Personal data collected will be limited to names and contact details of participants. The consent forms with the participants name and unique identification code will be stored separately from all other research material. These will be stored electronically on Bangor University's secure server. The participants name will not be used on the written transcripts or in published documents, the unique identification code will be used instead. Any other potential identifiable information in the interview will be omitted in the written transcript for example, a participant mentions their specific location this will be changed to a generic area. This is an attempt to be in line with the following Data Protection Act (1998) and the Research Governance Framework for Health and Social Care and Research Ethics Committee Approval.

The interview will be audio recorded, as soon as possible this will be copied onto the secure Bangor University's data server with limited access. The principal investigator will only have access to the audio recordings to uphold confidentiality. Then the audio recordings will be deleted from the audio recording device. This prevents accidental data disclosure and guarantees that the data will be backed up. When the audio recording device is being used, it will always remain on the principal investigators' person. When the audio recording device is not being used it will be stored in a locked bag. The recording will be anonymously transcribed by the principal investigator and identified with a unique identification code only. The anonymised written transcriptions will be stored and shared on Bangor University data server. Access controls will ensure limited to the principal investigator, supervisors, and research assistants. No data will be shared outside of this research project to protect privacy of those involved.

Data Management. The principal investigator will have primary responsibility for data collection, transcription, storing the data in a clear and secure file structure and the backup of data. Bangor University will deal with complaints and/or any breaches of data management and confidentiality. The chief investigator will be responsible for the archiving of the data.

Data Retention and Archiving. The data will be kept in Bangor University's secure data server for ten years in case of requests to see the raw anonymised data from the study, in line with Bangor University's policy. After this the data will be deleted, the chief investigator will be responsible for the archiving of this data. In the meantime, these will be stored electronically on Bangor University secure system which the principal investigator will be responsible for.

Financial information

Item	No. Required	Cost	Total cost	For office use only
Participant payments	Minimum 8 and maximum 12	£20 Voucher	Maximum £240	
TOTAL			**Maximum £240**	

Appendix C

Recruitment Poster

PRIFYSGOL BANGOR UNIVERSITY

Are you a Trainee Clinical Psychologist that identifies as working-class?

I am interested in your experiences of entering a professional career and any positives or issues you have experienced in relation to your class identity.

Although this study focuses on the social identity of class, it is important the study acknowledges and welcomes the intersectional nature of social identities to be discussed.

Being part of this study includes a social identity questionnaire and a 45-60 minutes virtual discussion where I will ask you some questions.

Please contact Katie Place at ktp20kdc@bangor.ac.uk expressing your interest in this study. I will then provide you with more information about the study and answer any questions you have. If you then decided you no longer want to be part of this study, that is okay.

You will be compensated with a £20 voucher for your participation.

This is study is part of a DClin thesis and has been approved by the Bangor University School of Psychology Ethical Committee and is supervised by Dr Christopher Saville and Dr Teresa Crew at Bangor University.

Appendix D

Participant Information Sheet

Participant Information Sheet

I am interested in working-class trainee clinical psychologists' experiences of entering a professional career.

I would like to invite you to take part in a research project. It is important for you to understand why the research is being carried out and what it will involve. Please take time to read this information, you can contact me if there is anything that is not clear, or you would like more information.

Who is the principal investigator?
My name is **Katie Place**, a Trainee Clinical Psychologist at Bangor University. This research project has been approved by the Bangor University School of Psychology Ethical Committee.

What is the purpose of this study?
This study aims to provide insights into working-class trainee clinical psychologists' experiences of entering a professional career to help develop the provision and conduct of clinical psychology training to make it accessible to people from all backgrounds.

Why have I been invited to take part?
You have received this invitation because you are a trainee clinical psychologist who identifies as being working-class. I am hoping to recruit between 8 and 12 participants for this project.

Do I have to take part?
It is up to you to decide whether you want to take part in this research project. Please take your time to decide, you can decide not to take part or to withdraw at any point during this study. You also have the right to withdraw your data after taking part and your data will not be used. If you wish to have your data withdrawn, please contact the principal investigator and your data will not be used. If you do decide to take part, you will be asked to agree to a set of consent statements.

What do I need to do?
Once you have completed the consent form, we can arrange a virtual meet up that is convenient for you. I will ask you a range of questions and this will take about 45 to 60 minutes. I will record our time spent talking together, the recording will be anonymised, and a unique identification code allocated instead of your name. The recording will be typed up as a written transcript, the recording will then be destroyed. If you tell the principal investigator something that indicates that you or someone else is at risk of harm. It is my duty to report

this to other professionals, but I would discuss this with you before telling anyone else. Quotes from the interview may be used and published in presentations, posters and written articles, all efforts will be made to ensure that you will not be identified. Being part of this will not affect your job.

How will my data be used?
Bangor University is the sponsor for this study based in Wales. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Bangor University will destroy identifiable data at the end of this project and keep anonymous information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we already have obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. For further information about how Bangor University processes personal data for research purposes and your data rights please visit our webpage: https://www.bangor.ac.uk/governance-and-compliance/dataprotection/documents/Data%20Protection%20Policy%20approved%20v7.1%20July%202021.pdf

Are there any disadvantages to taking part?
The research should not cause any harm however taking part will involve you thinking about and answering questions in relation to your experiences of being a working-class trainee clinical psychologist entering a professional career. If you do decide to take part and feel that negative emotions have been raised, please feel free to access support from your training course.

What happens next?
Please keep a record of this information sheet. **Please electronically fill in and return the consent form to the following e-mail address: ktp20kdc@bangor.ac.uk.** If you have any questions or concerns, please e-mail me.

Dr Christopher Saville and Dr Teresa Crew are supervisors of this research project at Bangor University:
c.saville@bangor.ac.uk or 01248 388740
t.f.crew@bangor.ac.uk or 01248 382838

Appendix E

Participant Consent Form

Consent Form

Name: _____
DClinPsy Course: _____
Year of Training: _____

Please put your initials in the boxes if you agree with the statements.

I have read and understood the information sheet.	
I confirm that I have had sufficient time to consider whether I want to take part in this research project.	
I have had the opportunity to ask questions and had them answered.	
I understand that our conversation will be audio recorded and deleted within a month.	
I understand our conversation will be typed up for analysis.	
I understand that some quotes will be used anonymously from our conversation and published in presentations and written documents.	
I understand that the anonymised written copy of the interview will be accessed by the research team and supervisors.	
I understand that my name will remain confidential and that all efforts will be made to ensure that I will not be identified.	
I understand that what was said will be kept safe and secure.	
I understand that if I tell the principal investigator that somebody including yourself might get hurt that the principal investigator will have to share this with other professionals.	
I know that I can stop, pause or leave the meeting at any time.	
I know that I can withdraw my information from the research project up until 14 days after the meeting took place.	
I agree to take part in this research project and I understand that participating is voluntary.	
I have been made aware of support services that are available if I need them.	
I know who to contact if I have any concerns or complaints about this research project.	
I am aware that this research project involves thinking about and answering questions about my own well-being and resilience.	
I know that Bangor University will securely store the anonymised written transcript of the interview for 10 years.	

Do you want to receive a summary copy of the results from this study? If so, please write you email you want the results sent to here: _____

Do you want to receive a copy of the thesis report? If so, please write you email you want the results sent to here: _____

Participant's signature: **Principal Investigators name and signature:**

Date: **Date:**

For the researcher to fill in. Unique identification code:_____

Do you want to receive a summary copy of the results from this study? If so, please write you email you want the results sent to here: _____

Appendix F

Social Identity Questionnaire

It is important that this project acknowledge and captures the intersectionality of social identities people have alongside being working-class.

The headings have been adapted from Burnham's (2018) social graces framework and known underrepresentation social identities within the profession from Leeds Clearing House equal opportunities data (2005-2021). Please tick the box that best describes you or write in your own words how you would describe that part of your social identity:

Your age range: 20-24 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐
40-44 ☐ 45-49 ☐ 50-54 ☐ 55+ ☐

Your sex e.g., female:

Your gender e.g., non-binary:

Your sexual orientation e.g., heterosexual:

Your race and ethnicity e.g., British Asian:

Your religion e.g., Buddhism:

Your disability/ies: physical condition/s ☐ learning difference/neurodivergent ☐
mental health difficulties ☐ other ☐

Any other social identities that you want to disclose:

Appendix G

Apology Email

Subject: Apologies

“Dear Trainee,

I received your expression of interest in participating in my research exploring working class trainees experience in the profession. Unfortunately, I am unable to interview everyone due to the time limitation on my DClinPsy project. Those that have been invited to an interview were randomly selected.

Sorry if this has caused any disappointment. If you would like to receive a copy of the results, please let me know via email.

Thank you for taking the time to read this email and for considering being part of my research,

Kind regards,

Katie Place,
Trainee Clinical Psychologist,
Bangor University

Appendix H

Semi-structured Interview Guide

Introduction
Read the following script:
"Hi, my name is Katie Place, I am currently a Trainee Clinical Psychologist at Bangor University. For this project I would like to discuss your experiences of being a working class trainee so will be asking you some questions and if you are not comfortable with answering any of these questions, that is okay, you do not need to respond."
Answer any questions at this point.

Confidentiality
Read the following script:
"Before we start the interview, I need to remind you about the confidentiality procedures that is on the information sheet. Most of what we talk about today and the information that you share with me will be kept private between me and you. Even though every effort will be made to keep the information you provide confidential, there are a few exceptions. If you tell me something that suggests harm to yourself or other people then it is my duty to inform other professionals to keep you and others safe. If this was the case I would talk to you first. Members of the research team and my supervisors will be able to access anonymised transcripts of the interviews as part of quality checks. It is also important that you are aware of your responsibility to ensure that the people you work with, patients and staff remain anonymous. When I write the results of this project, direct quotations will be used, but I will ensure that any details used will not identify you. It is likely that these results will get published into a research journal, will be presented at conferences and to the trust."

Consent
Read the following script:
"Can I confirm that you understand what has just been said and that you are happy to continue with the study?"
"Are there any further questions? If not, you have already signed the consent for so we will begin with the some questions about your job role."

Question prompts

Class Identity

Could you start by describing your working-class identity?

- When did you first view yourself as working-class?
- How do you feel about being working-class?
- What do you think other people think about you being working-class?
- What do you think society thinks about you being working-class?

Clinical Psychology

Thinking about working-class and clinical psychology more broadly, how would you describe the class distribution in the profession?

- What has this been like for you?

- How have you found entering the profession as a working-class person?

Training

Thinking about training specifically, is there any dialogues around class on your course?

- With peers?
- In lectures?
- In research?
- In committees?
- On placements?
- What have these conversations been like for you?

Working-class Trainee

Thinking about being a working-class trainee and the different parts of the course, how have you experienced…

- The placements?
- The academic side (assignments, research and lectures)?
- Your cohort?
- The course staff?
- Placement supervisors?
- How have you experienced holding the identity of a working-class trainee?
- With the increase in types of capital (education, social connections and wage) how have you experienced this?
- What are the parts that you feel keep you connected to your working-class identity?

Widening Access

- What are your thoughts on the widening access movement in the profession?

Intersectionality

- Are there other parts of your social identity that you feel intersects with being a working-class trainee?
- How have you experienced holding these multiple social identities as a trainee?

Ending the interview
"Thank you for your time and for answering the questions, what you said was useful and valuable. If you have found that this experience has caused you any difficulties or distress, please refer to the information sheet for places you access support. Would you like another copy of the information sheet?"

Remind the participant that the £20 voucher will be sent to them in an email to thank them for participating.

Appendix I

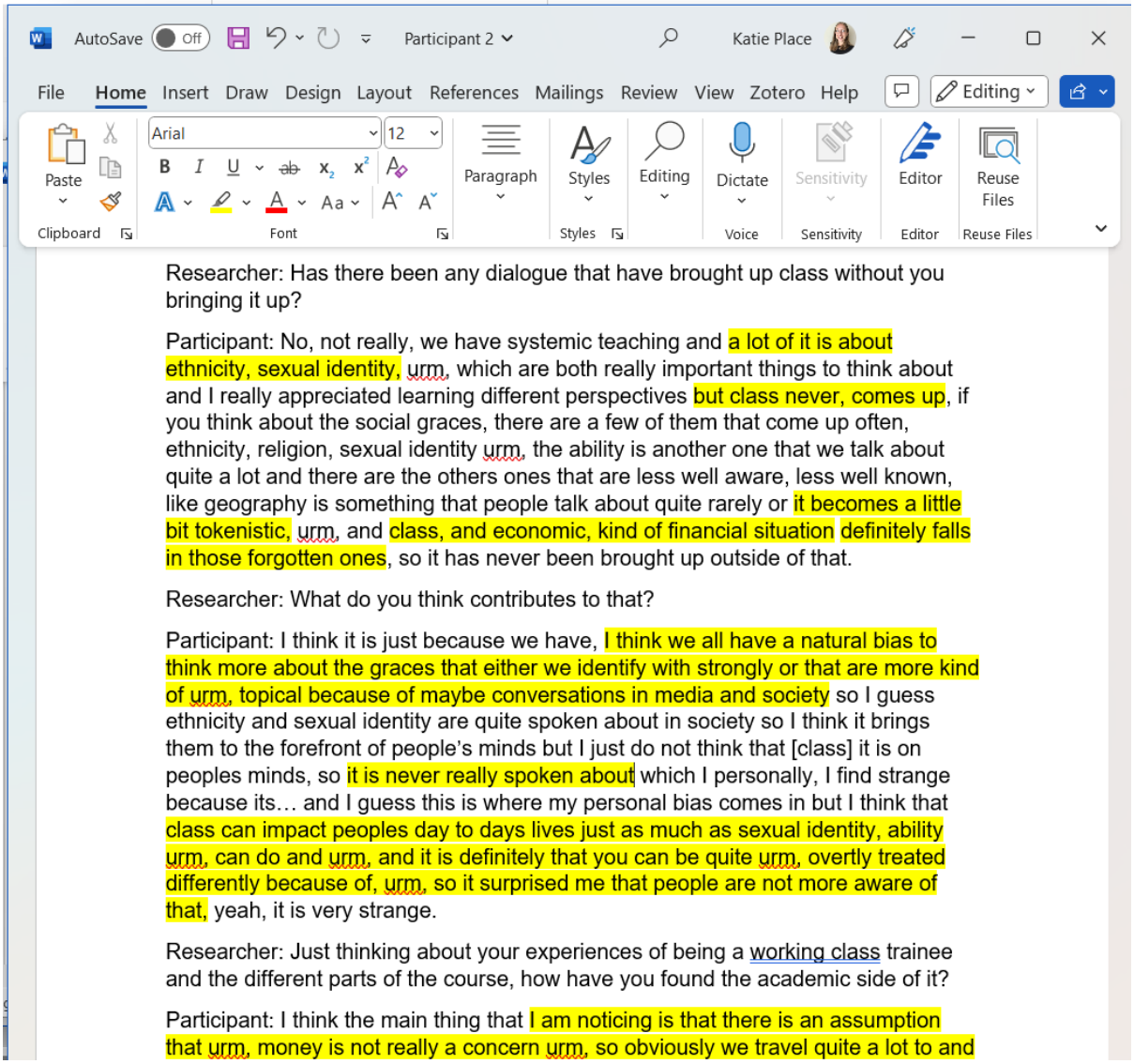
Braun and Clarke's 6 Step Model to Thematic Analysis

Stage	Process	Example
1	Familiarization	Conducting the interview, transcribing the audio recording, reading, and re-reading the transcriptions and making notes of possible interests.
2	Generating initial codes	Coding interesting features in the data across all the transcripts.
3	Searching for themes	Collating similar codes together by printing off coded data quotes and manually sorting them into groups. This process included collapsing and clustering codes into broad topics.
4	Reviewing potential themes	The potential themes were checked against the transcripts to ensure they meaningfully captured the data. The potential themes were explored and discussed in supervision.
5	Defining and naming themes	Through discussions in supervision and exploring what each theme captures and how they are separate yet interconnecting, in turn produced the model in Figure 1.
6	Producing the report	Presenting the themes in a way that tells a coherent story about the data with supporting extracts that answered the research question.

Appendix J

Data Analysis Example

A transcript extract identifying codes:



Researcher: Has there been any dialogue that have brought up class without you bringing it up?

Participant: No, not really, we have systemic teaching and a lot of it is about ethnicity, sexual identity, urm, which are both really important things to think about and I really appreciated learning different perspectives but class never, comes up, if you think about the social graces, there are a few of them that come up often, ethnicity, religion, sexual identity urm, the ability is another one that we talk about quite a lot and there are the others ones that are less well aware, less well known, like geography is something that people talk about quite rarely or it becomes a little bit tokenistic, urm, and class, and economic, kind of financial situation definitely falls in those forgotten ones, so it has never been brought up outside of that.

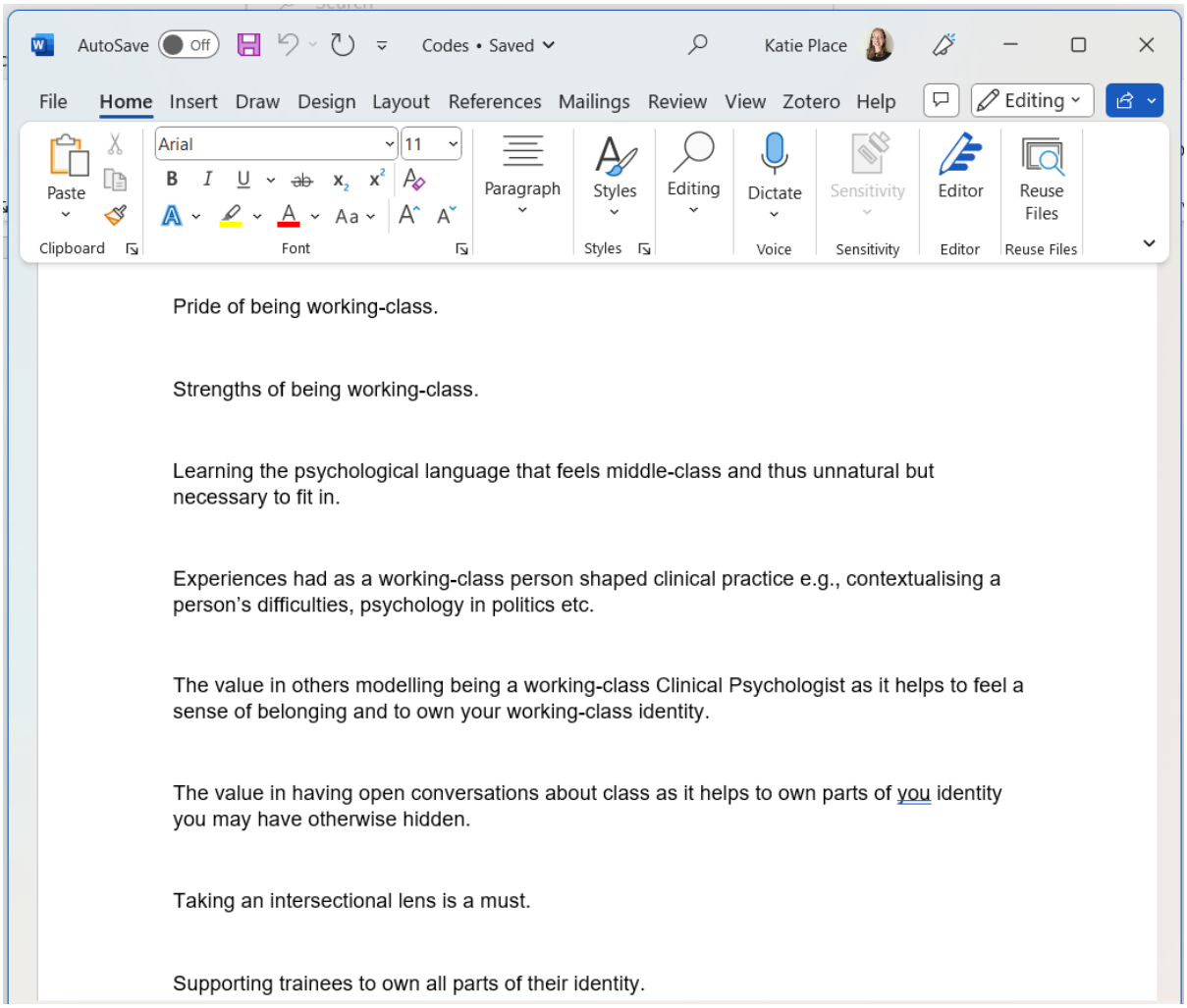
Researcher: What do you think contributes to that?

Participant: I think it is just because we have, I think we all have a natural bias to think more about the graces that either we identify with strongly or that are more kind of urm, topical because of maybe conversations in media and society so I guess ethnicity and sexual identity are quite spoken about in society so I think it brings them to the forefront of people's minds but I just do not think that [class] it is on peoples minds, so it is never really spoken about which I personally, I find strange because its… and I guess this is where my personal bias comes in but I think that class can impact peoples day to days lives just as much as sexual identity, ability urm, can do and urm, and it is definitely that you can be quite urm, overtly treated differently because of, urm, so it surprised me that people are not more aware of that, yeah, it is very strange.

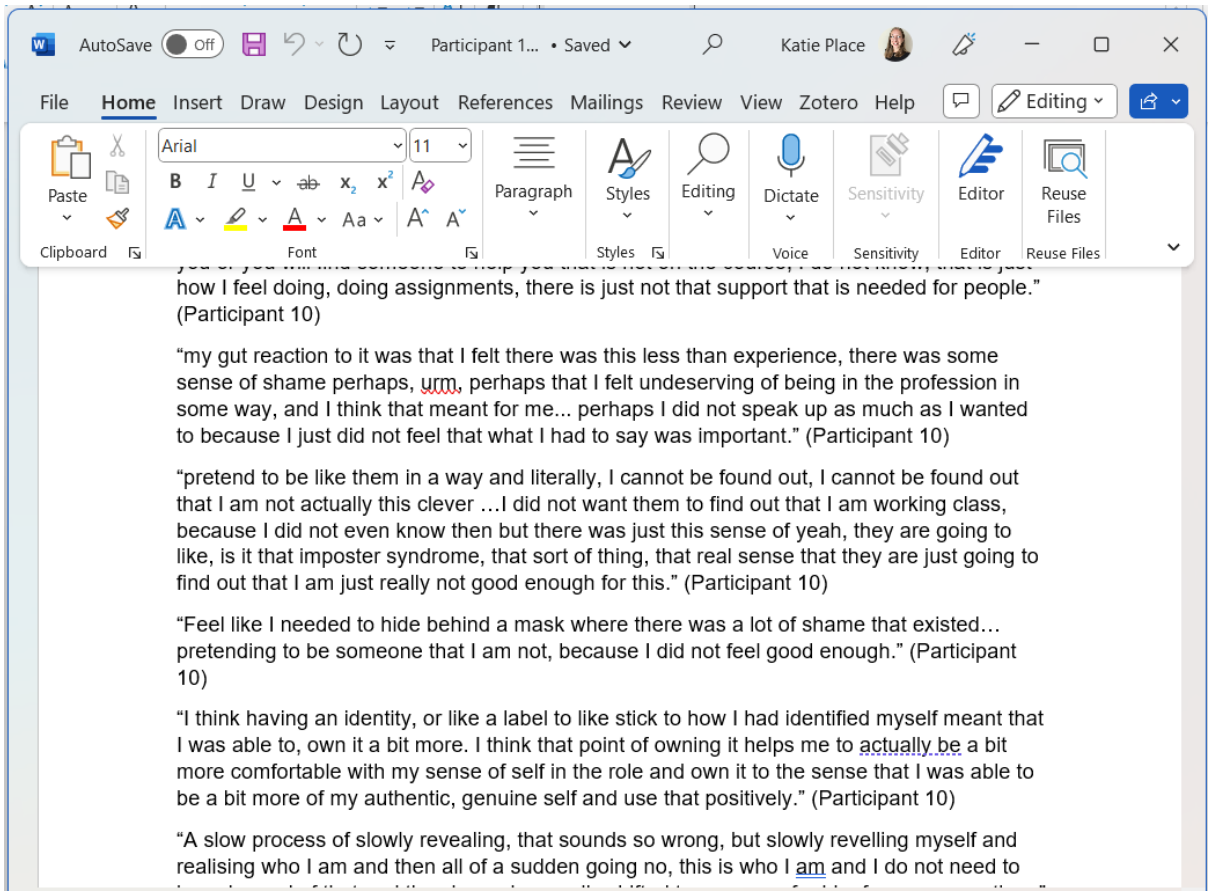
Researcher: Just thinking about your experiences of being a working class trainee and the different parts of the course, how have you found the academic side of it?

Participant: I think the main thing that I am noticing is that there is an assumption that urm, money is not really a concern urm, so obviously we travel quite a lot to and

A sample of identified codes:



A sample of a participants' quotes that informed the codes:



A photo of manually sorting quotes and codes into potential themes:

Chapter 3

Contribution of Theory and Clinical Practice

Implications for future research and theory development: Defining and Measuring Social Class

An interesting theme across both the empirical and systematic review papers was the issue of defining and measuring social class. It is important to note that theoretical frameworks of social class were shaped by the historical and political context they were developed, often focusing solely on men. Social class can be defined through multiple theoretical frameworks such as those defined by Marx, Weber, Goldthorpe, Warner, and Bourdieu (Bourdieu, 1987; Goldthorpe, 1987; Warner, 1949; Weber, 1958; Marx, 1848). It feels important to explicitly consider the multiple frameworks as well as the ones used in this thesis. Marx conceptualised social class as being determined by the extent a person controls the means of production (Marx, 1848). Those that owned the means of production were referred to as the bourgeoisie and those that did not were referred to as the proletariat, with the bourgeoisie exploiting the proletariat for their gain. The bourgeoisie were people that own companies, and the proletariat were people that sell their labour. In the UK, the bourgeoise are the people who hold most of the wealth (and thus power) and the proletariat being everybody else. However, the proletariat would include all people that sell their labour despite huge differences in income (e.g., manager v. administrative assistant) and different social status that comes from their job roles. Differentiating class into two groups of people does not account for the stark differences within the proletariat group. There were some developments due to this issue such as Marx's petit bourgeoisie, which are people who owned the means of small productions (e.g., farmer or independent shop owner). A neo-Marxist class called the professional managerial class (PMC) was developed to differentiate jobs requiring extensive mental effort (e.g., academics and clinical psychologists; Ehrenreich & Ehrenreich, 1979).

Rather than differentiating social classes based on the means of production, Weber (1958) stressed that social class was determined by economic differences, with these differences impacting a person's life opportunities. For example, the less economic status a person has the more likely they were to die prematurely. Thus, Goldthorpe created further social class separation based on economic status their occupation provided. He identified eleven categories presented in Table 1, these differentiated between self-employment, working for others, and owning companies (Goldthorpe, 1987). In addition, he also emphasised the ability for upward and downward social mobility across class categories, Weber would argue that social mobility could improve a person's life opportunities. Goldthorpe placed particular emphasis on how accessing further education or specialist skill training can support social mobility. However, he did not consider the possible barriers and structural inequalities that may impede social mobility and assumes that society is meritocratic (the harder you work the more you will achieve; Bloodworth, 2016). For example, a person who attended private school and an elite university would be more likely to gain a job with a higher income and at a higher managerial level despite having the same qualifications as someone who attended a public school, and a newer 'polytechnic' university (Moreau et al., 2006). Weber and Goldthorpe's frameworks influence how the government attempt to capture social class (Socioeconomic Status: The Government, 2018). The first government-led measure of social class was developed in 1911 as the Registrar General's Social Classes (RGSC; which was renamed as social class in 1990) simplifying Goldthorpe's eleven social class categories to six. This continues to be the primary measure used with slight adaptation and adjustments from the RGSC such as the National Statistics Socioeconomic Classification that expanded to eight social class categories (NS-SEC: National Statistics, 2010). The UK Government's definition and measurement of social class based on economic status via occupation has largely not changed for the past 100+ years.

Table 1.

Goldthorpe's (1987) eleven social class categories.

Social class category	Description
I	High-grade professionals, administrators, and officials such as managers or owners of large companies.
II	Lower-grade professionals, administrators, and officials such as managers in small companies or supervisors.
IIIa	Routine non-manual employees such as administration and sales with high income.
IIIb	Routine non-manual employees such as administration and sale with low income.
IVa	Small owners of small businesses with employees.
IVb	Small owners of small businesses without employees
IVc	Farmers and smallholders and other self-employed workers.
V	Lower-grade technicians such as supervisor of manual work.
VI	Skilled manual workers.
VIIa	Semi-skilled and unskilled manual workers.
VIIb	Agricultural and other workers.

Warner separated social classes into six categories based on a person's income, education, occupation, and occupation's social status in America as displayed in Table 2, identifying lower class as those that work with their hands and middle class as those working in offices (Warner, 1949). Often, the six categories are collapsed into three; upper, middle and lower (or working)-class. These three classes are arguably the most common categories

spoken about (e.g., in media and in casual conversations) in the UK. Warner's framework for social class stressed that it must take into consideration the social status attached to said employment (Warner, 1949). For example, a person may own the means of illegal drug production. However, it is not a respected job in society thus does not come with social status and respect. Compared with doctors who sell their labour to the NHS with a lower wage yet are very well-respected in society. In addition, the social status of occupations may change over time. The level of respect a profession has in society gives it a particular social status within the class system. Professions may earn the same income, and the social status that is attached may differ considerably, such as a coffee barista and a junior doctor, with the latter having a higher social status. Thus, the social status a profession has is associated with the level of education required as well as the income earned. From this framework of social class, the objective measurement of income, education level and occupation to conceptualise social class were developed and commonly termed socioeconomic status (SES). Socioeconomic status has been a popular measurement used across disciplines both clinically, academically and in research. Alternatively, subjective social class measures were also developed based on income, education level and occupation. For example, Alder et al., (2000) devised a ladder with 10 levels to position oneself on, the top of the ladder represented the highest income, education levels and occupation statuses in society.

Table. 2

Warner's (1949) six categories of social class.

Socia Class Category	Description
Upper-upper	Old family money.
Lower-upper	Business and professional men with some education and high income.
Upper-middle	Business and professional men with some education and moderate income.
Lower-middle	Small businessmen such as teachers or foremen.
Upper-lower	Manual labourers that are respected in society.
Lower-lower	Those that are poorly respected in society such as people that are homeless or unemployed.

A more comprehensive theoretical framework of social class was developed by Bourdieu (1987). Rather than conceptualising social class only on economic and some social factors (social status of a job) he highlighted the importance of social, and cultural factors. The more economic, social, and cultural capital a person has the higher their social status. Social capital refers to assets, access to power or opportunities that are gained through the network of relationships a person has. For example, parents that have connections to people recruiting for a specific job can pass inside knowledge to their children applying for the job. Cultural capital is made up of a range of beliefs, behaviours, tastes, interests and so forth. For example, dressing in a suit, driving a Jaguar 4x4 and enjoying playing golf may be more aligned with middle-class cultural capital compared with dressing in a tracksuit, driving a Renault Clio, and enjoying watching soaps on TV may be more aligned with working-class

cultural capital. Bourdieu acknowledged the relationship between differing levels of economic, social, and cultural capital has on a person status within society. It has been notoriously difficult to measure social and cultural capital contributing to dominant measures of social class focusing on economic capital only.

More recently, the BBC funded the development of an objective measure of social class named the Great British Class Survey (GBCS; Savage et al., 2013). The GBCS also updated the categories of social classes in Britain taking into consideration Bourdieu's framework of economic, social, and cultural capital. The seven categories displayed in Table 3 were the precariat, emergent service workers, traditional working class, new affluent workers, technical middle class, established middle class and the elite. The GBCS measured economic capital by income, savings, and property ownership. The GBCS measured cultural capital on preferences for leisure activities and interests, highbrow cultural capital was associated with interests in classic music, historic architecture, museums, art galleries, jazz, and the theatre. Emergent cultural capital was associated with interest in video games, social networking, socialising, gym, and popular music concerts. The GBCS measured social capital by measuring the types of people they knew based on their professions. The GBCS has been praised for highlighting the stark social class differences across geographical regions and to highlight that inequalities also reside in social and cultural capital, not just economic capital (Divine et al., 2015). However, there has been a plethora of critics of the GBCS, and with it being a new measure there are few studies exploring its validity, reliability, and usability (Payne, 2013; Scott 2013). Before utilising this measure within research and clinical practice, research is required to determine its validity, reliability, and usability. I also wondered what the impact of changing the names, boundaries and classifications of social class has on people. Whether those who strongly identify as working-class, but may be classified as new affluent worker, would view adopting this new class identity.

Table 3.

The Great British Class Survey's seven categories.

Social Class Category	Description
Elite	Very high economic, social, and highbrow and emerging cultural capital.
Established Middle Class	High economic, social capital with both highbrow and emerging cultural capital.
Technical Middle Class	High economics capital, low social capital, and disengaged with both highbrow and emerging cultural capital.
New Affluent Workers	Moderate economic capital, some highbrow, mainly emerging cultural capital and low social capital (although varied).
Traditional Working Class	Low economic capital but more assets (more likely to own their house), low social capital with low cultural capital.
Emergent Service Workers	Low economic capital, moderate social capital, and high emerging and low brow cultural capital.
Precariat	Low economic, social, and cultural capital.

Due to the complex nature of defining and measuring social class, an alternative method is self-identification or self-reporting of one's social class. Although this can prevent relying on reductionist and over simplistic measures, literature suggested that some people tend to over identify with being working-class despite appearing to have had a middle-class life e.g., attended private school and having parents that were in higher managerial positions (Friedman et al., 2021). The function of over identifying with being working-class was

associated with deflecting attention away from privileges (e.g., economic, social, and cultural capital) their social class grants them that they then benefit from (e.g., better life opportunities). Overidentification often took the form of taking onboard their family's historical social class background (e.g., grandparents) as their own. In contrast other research found self-identification a successful and more holistic method (Crew, 2020).

In addition, and often not cited in class-based literature is Yosso (2005), the community wealth framework that introduces other forms of capital that an individual may have given that they hold minoritised social identities. Yosso developed the framework for people's experiences of minoritised racialised groups. This framework could be applied to social class identities and help shift the narrative within literature and society from a deficit focus ('What capital am I lacking?') to a strength-based focus ('What capital do I gain with having a minoritised social identity?'). Deficit focused narratives can lead to harmful and unhelpful stereotypes (e.g., working-class people as lacking intelligence), can be internalised as it is something about them as a person that is defective or lacking (e.g., a belief that as a working-class person they lack intelligence), and continues to position others as superior (e.g., other social class groups are more intelligent; Yosso, 2005). A strengths-based focus can empower individuals to embrace the strengths that come with their social class identity. Although a strengths-based focus is not to undermine or diminish the existence and the detrimental impact inequalities and classism can have on a person and the importance of addressing these.

Alternatively, rather than attempting to measure an individual person's social class status, community-level factors are used instead. For example, the Participation of Local Areas (POLAR) measures the likelihood of young people attending higher education in an area, with a higher likelihood indicative of a higher social class. POLAR uses a person's post code when they were 17 years old to determine the quintile of their POLAR score. This is a

measure of social class that is used by the Doctorate in Clinical Psychology (DClinPsy). Also, the Index of Multiple Deprivation (IMD) was designed to measure areas of poverty however it is also commonly used measure to determine a person's social class based on the community they reside in. Broadly speaking, the seven factors of IMD include the rate of low income (including unemployment), rates of unemployment (seeking or wanting work), rates of people in education/training (e.g., college or university), health/disability (mortality and poor physical and mental health rates), crime rates, housing services (affordability) and living environment (quality of housing and outdoor spaces such as air quality and road accidents). However, it is possible for individuals in areas of 'high deprivation' to have a high social class status. Community-level factors fail to capture people from low social classes that live in areas of low deprivation where class divisions are exacerbated and concentrated. Therefore, there are issues with applying a community measure for information on individuals (ecological fallacy).

It can be agreed that a person's social class represents a position within a societal context (Wright, 2005). However, what determines a person's position in a social context remains debatable and impacts how it can be measured. When there are competing and conflicting ways to determine a person's position in a social context it becomes difficult to draw boundaries around social identity groups (e.g., is there such a group as working-class, if so, what makes someone working-class and how are the working-class different from other groups?). Social identities are a social construct thus heavily dependent on the context (e.g., country, year, politic landscape) in which they are being defined. This means that research and in clinical practice, social class is being measured in various ways which was evident in the systematic review paper. The variations in the way social class can be defined and measured make it difficult to compare, interpret and apply research findings. As it may be that studies claiming to explore social class differences are exploring differences between

individuals' incomes or between people's educational attainments or between types of areas people live in. Therefore, when reviewing existing literature or considering measuring social class, these must be carefully considered when interpreting the results to ensure that over-generalisations are minimised. It is also important that it is acknowledged that there will be some people that the existing measures of social class fail to capture and represent.

Additionally, due to the competing and conflicting ways to conceptualise and measure social class it was difficult to devise a screening tool to determine participants eligibility in the empirical research study. I personally and academically align with a Bourdieusian framework of social class as I felt it offered the most comprehensive conceptualisation. The GBCS offered an updated measurement based on Bourdieu however, this did not feel suitable or practical to utilise. Especially as the social class categories in the GBCS are not (yet) embedded in UK society nor are they in the language people use to define their social class identity. Measures that aligned with other frameworks of social class such as Marx or Weber felt at risk of failing to screen people that identify as working class. Utilising a Marxist or Weberian framework would have also shaped the study (the type of questions asked and interpretation of the transcripts), such as Marx would have viewed all trainees as proletariat or PMC with questions focusing on exploitation. The empirical research study took the stance that social class is socially constructed and was primarily interested in individual experiences. Thus, it felt most appropriate to opt for self-identification method, especially as other existing measured felt reductionist or lacked validity and reliability. Due to the possible draw backs to using a self-identification method and alongside my biases, I initially judged some participants presentations to place them in a different social class group (due to cultural capital such as their accent, dress sense, and vocabulary). However, the first set of questions encouraged participants to share what they thought made them working-class. From this conversation, I was reassured that their answers aligned with having low economic, social

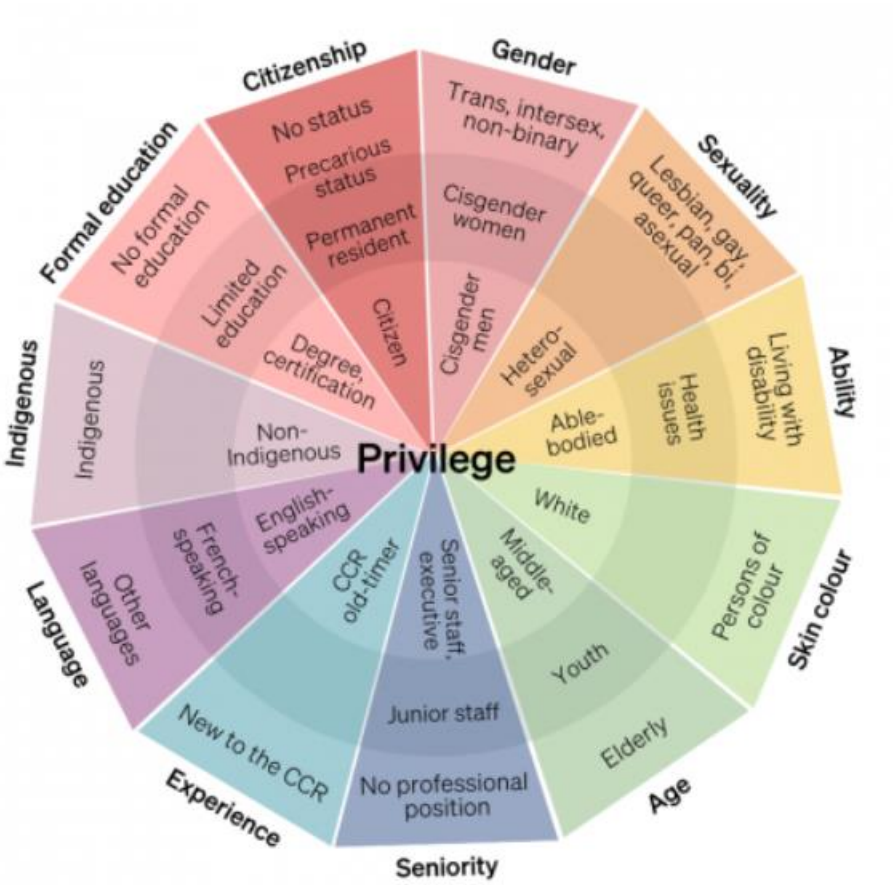
and/or cultural capital associated with being working-class. It also prompted a reflective thought during the data collection stage of wondering what has happen for them to present themselves as belonging to a different social class group? As well as a self-reflective thoughts on how I perceive working-classness and the way I attribute characteristics to social class given my social identities and life experiences.

Implications for future research and theory development: Intersectionality

A pertinent issue across the systematic review and empirical paper that made up the thesis was the complexity of taking an intersectional approach. Social identity does not occur in silos and people hold multiple identities at one given time that may afford a person power, privileges, and social status thus shaping their experiences. This concept has been demonstrated in the wheel of privilege model displayed in Figure 1 with the identities closer to the outside holding the least power and privilege (Canadian Council for Refugees, 2023). There have been multiple variations of the wheel of privilege to include neurodivergence, social class and religion. The wheel of privilege demonstrates that a white, heterosexual working-class man with a doctorate degree would hold more power, privilege, and social status than a white, homosexual, working-class man with no formal qualifications or training. The systematic review and empirical research study focused primarily on the social identity of class and although held in mind other social identities it did not explicitly integrate them (Social Graces model: Burnham, 2018). Although research focusing on a part of a person's social identity is warranted, it is important that the limitations of this approach are acknowledged such as the theory or research risking being reductionist, over generalised and over simplified.

Figure 1.

The Wheel of Privilege



In practice for the empirical paper, it was difficult to integrate some aspects present in the data in the final themes. For example, there were commonalities with being homosexual or bisexual and working class or neurodivergent and working class that intersected with feelings of shame and hiding parts of oneself. At times it appeared that the intersect of multiple social identities shaped trainees' experiences and was sometimes difficult for them to be sure that what they were describing was related to their class identity. As it may have been possible that there were other parts of their identity that had more of an influence such as being a care leaver, their race, sexuality and neurodivergence. In the systematic review studies, there was also data that indicated an interaction when social identities intersected

such as social class, age, ethnicity, and gender on whether a person found it difficult to engage in psychological therapies. However, this data was not extracted for the review as it did not relate to the review question. The empirical paper and systematic review primarily focused on social class and may have unintentionally conceptualised experiences as class related when they may have been associated with other social identities or an intersection of these. It may also be that people tend to over-identify with some social identities they hold over others, for example; a person may feel that their identity is strongly defined by being homosexual or black rather than their working-class status. At times this may open opportunities in existing theories and research for class experiences and/or differences to be interpreted as sexuality or race-related and vice versa when it may be more appropriate to take an intersectional approach. I think that an intersectional approach to social identities would enrich theories and research by providing a comprehensive and holistic view embedded in the reality that social identities are complex and multifaceted.

Implications for Clinical Practice: Doctorate in Clinical Psychologist Programmes

The focus of the empirical research study was on working class trainee clinical psychologists' experiences on the DClinPsy. The findings could be explored by the programmes across the UK to review its structure, processes and how working class trainees experience their specific programme. The programmes vary, and some courses may have more to work on than others, and the areas to work on may also differ. It is important that before the findings are generalised that the programmes assess its validity and applicability to them. It is also important to note that the specific details of the changes required for class to be perceived as visible and what needs to be put in place to support trainee's to experience pride about their social class identity and integrate it their professional identity may also differ between courses. However, the findings highlight common factors that trainees across a range of DClinPsy programmes report were unhelpful and helpful. These factors can act as a

starting point when understanding working class trainees' experiences and reviewing its programme. Programmes can begin to ask themselves; 'Is social class acknowledged?', 'Is class talked about on the programme?', 'How is it talked about?', 'Are programme/placement/lecture staff open about their social identities including class?', 'Are there unintentional assumptions being made about trainee's social status?', 'Are there protected spaces to explore their personal and professional identity?'.

Shaping and designing DClinPsy programmes to ensure class is visible can support working class trainees to integrate it into their professional identity, contributing to their development. In turn, this is likely to increase the visible representation of working class clinical psychologist as they are likely to have embraced thus show case this part of themselves (rather than hide or change it). This could support working class aspiring clinical psychologist and future trainees to feel a sense of belonging within the profession, shifting the face of clinical psychology away from being exclusively middle-class. It is possible this could have an impact on the number of working class people applying or pursuing the career. It may also have an impact on the proportion of working class people gaining a place on the DClinPsy so it is aligned with what is expected (20% rather than 7%). Additionally, supporting trainees to integrate their capital (referring to Yosso's 2005 model) they have from being working class and bringing it into their clinical practice could benefit services and those accessing services (e.g., providing an alternative perspective). With research supporting the benefits of having a diverse staff team not only benefiting the service, the people accessing the service but also the staff team themselves (Broughton et al., 2008; Smith et al., 2000).

Implications for Clinical Practice: Adult Psychological Therapy Services

The finding from the systematic review highlight that there are difficulties for working class people when engaging with psychological therapies, although the underlying mechanisms as to why and what can help engagement remains unclear. Interestingly, most of the studies in the review were from Improving Access to Psychological Therapies (IAPT) services. There are a range of services in the UK providing psychological therapies for adults that are thus not represented in the systematic review such as secondary mental health and third sector agencies (e.g., Mind). It may be that there is an issue at the point of data collection for these other services which means social class information is then not available for analysis to be able determine if engaging in psychological therapies for working class adults within those services is also a difficulty. An implication for clinical practice would be for services to review their routine demographic data collection process to a) ensure they collect demographic data and b) that it includes social class. It may also be that despite services collecting social class data, an investigation of whether this was associated with engagement in psychological therapies has not been conducted. A hope from this review would be to highlight the need, importance, and value for this research to take place which might support protected time in clinicians job plans for research.

Implications for Clinical Practice: Policies and Legalities

The empirical and systematic review papers in this thesis add to the evidence and support the stance that social class should be a protected characteristic. The aim of legally protecting characteristics is to address significant ongoing discrimination across various domains such as employment, housing, education, and health. Thus, legally protecting characteristics shapes policies and processes such as employee recruitment. Without protection, a person could be denied an opportunity due to their social class e.g., their accent,

their postcode, or any other indicator of a person's class. Therefore, it is legal to treat a person unfairly in work, housing, education, and health settings based on their social class (also referred to as classism). Promoting and often resulting in a society that functions on hereditary aristocracy rather than meritocratic systems. Despite a plethora of evidence highlighting discrimination in relation to a person's (low) social class across employment, education and health, and the impact it can have on a person's life opportunities, it is not currently a protected characteristic (a synthesis of the evidence is captured in the British Psychological Society (BPS) report: Make it 10, 2022). Current protected characteristics are: age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, race, religion, sex and sexual orientation. Rather, the Equality Act (2010) advises and encourages consideration to be given to any inequalities resulting from a person's social class status. However, this is not a legally bound duty resulting in the UN Committee on Economic, Social and Cultural Rights (2016) highlighting the UK's failure to address inequalities resulting from a person's social class status. There are some examples in the UK where consideration and action have been attempted to address inequalities relating to social class such as 'A More Equal Wales' (2021) and 'Equality and Cohesion Plan' in Newham (2011) and contextual admission and recruitment processes. However, there are ongoing campaigns and petitions for widespread action to take place across the UK and the protection of social class (Just Fair, 2017; BPS: Make it 10, 2022). There are complexities that must be thoughtfully addressed to make social class a protected characteristic such establishing a clear and universally accepted criterion that can disentangle the impact of social class from other social identities. These are extremely challenging to address because social class is multifaceted and may result in legal disputes over class classification when there are discrepancies from one's self-identification. The impact of not protecting social class can result in poor routine data collection (as evidenced in the systematic review in

which most studies that collected routine data were Improving Access to Psychological Therapy services), denial of class inequalities and discrimination, perpetuation and maintenance of class inequalities and discrimination and reduced power to address issues and evoke change. These raise questions such as, how can social class be defined and measured in a composite way? How and will inequalities and discrimination associated with social class be addressed if not a protected characteristic? If social class was protected how could this be effectively implemented? Why is social class not part of routine data collection? Does social class need to be protected to be part of routine data collection?

The empirical and systematic paper suggested some actions that can be taken to be part of the process of addressing inequalities resulting from a person's social class status. Firstly, it would be for individuals and systems to acknowledge that there are social class inequalities at an individual, systemic, and societal levels. To then be aware of the impact these may have on individuals which may require educating oneself and/or others on social class and inequalities, discrimination and classism that can exist. Additionally, it is important that individuals acknowledge their own social class status and the possible power, privileges, and advantages this may afford someone and how this may differ from others. An acknowledgement of the intersection of their social identities and the differing possible power, privileges, and advantages this may afford someone and how this may differ from others. It is important to actively consider economic, social, and cultural barriers that may be present for individuals as well as the process of internalising external narratives about social class which may impact self-esteem. Once social class and its impact has been acknowledged, it is essential that action is planned and carried out to address these inequalities. Some actions may be providing additional support, developing structures that protect time and space to for helpful and meaningful conversations about social class to take place in environments that are felt to be psychologically safe, ensuring working-class people

are represented within workforces, and positioning and contextualising people's experience within oppressive, unequal, and discriminatory societies.

Interpersonal Reflexivity

In addition to explicitly stating an individual reflexive statement in the empirical study it is important to also acknowledge the role the research team had on shaping the systematic review and empirical study in terms of the theories used, the methodology, and analysis. The research team comprised of myself and two supervisors (Teresa and Chris), all coming from differing professional backgrounds and interests. I came from a clinical psychology background and interested in working class trainee clinical psychologists; Teresa came from a sociological background and interested in working class academics and Chris works as a researcher on a DClinPsy programme with a broad interest in social identity. Having differing professional backgrounds meant we brought different perspectives and skills to the team. I brought first hand experience of being a working-class trainee clinical psychologist and experiences from working clinically as well as psychological perspectives. Teresa brought specific sociological theories and concepts when understanding social class as well as knowledge on conducting qualitative research. Chris brought specific theories and concepts when understanding social identity as well as knowledge on conducting a systematic review.

It was important that as a research team there was space to explore each other's professions, our personal class identities as well as our roles in discussions and decision making regarding the thesis. Chris was affiliated with the DClinPsy course and research team thus held more power regarding meeting expected standards. Teresa specialised in supervising social class (particularly working class) projects thus held more power regarding the underpinning theory and conceptualisations. Whereas the thesis was my project, so it was

important to ensure the topic areas, frameworks, methodology and analysis were aligned with my interests, positionality, and skill set. When there were any points of uncertainty the research team engaged in an open discussion of varying perspectives for me to consider. For example, how to measure social class in the empirical paper, Teresa leant towards self-identification and Chris leant towards utilising measures and following discussions I chose to use self-identification. Where appropriate, others were also invited to offer their guidance, expertise, and knowledge to the research team such as the local academic librarian (to support with refining systematic review questions, the search terms and selection of databases) and another member of the DClinPsy research team (to support with the qualitative analysis and meeting expected standards). Overall, having a range of perspectives, theoretically and personally offered opportunities for shared learning, rich discussions, and an amalgamation of knowledge.

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Word count

Thesis summary/abstract: 240

Chapter 1: Systematic Review

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Main text (excluding title pages, abstract, tables, figures, and references): 4,549

Tables and figures: 742

References: 1,456

Total word count: 7,274

Chapter 2: Empirical Research Study

Abstract: 124 (+5 key words)

Main Text (excluding title pages, abstract, tables, figures, references and appendices): 7,344

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References: 1661

Appendices: 4,751

Total word count: 14,175

Chapter 3: Contributions to theory and clinical practice

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References: 505

Total word count: 5,313

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