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The public perception of clinical psychologists: A discursive analysis

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Abstract

The public image of psychology has recently been a topic of debate among psychologists particularly with regard to training in clinical psychology. Inherent in this debate is the question of the status of psychology in Australia in comparison to other mental health professions. Outside Australia several attempts have been made to measure the public perception of clinical psychologists but there is a paucity of contemporary Australian literature dedicated to investigating this phenomenon. In this study a discursive approach was used to critique a technique previously used to measure the public perception of clinical psychologists. The findings were twofold: first, that the nomothetic, aggregational approach is flawed when deconstructed with discursive analytic methodology; and second, that the public's perception of clinical psychologists is formed using information about other mental health professionals (namely psychiatrists), which is at best invalid, and at worst detrimental to the profession of clinical psychology. A number of recommendations are made to assist the profession of psychology in demarcating itself from other mental health professions.

The professional practice of psychology has experienced significant growth in recent times and is quickly becoming ubiquitous. Recent debate among psychologists about the state of training in professional psychology has alluded to the importance of the public perception of clinical psychologists, particularly with regard to the status of psychologists in comparison with other mental health professionals (Dyck & O'Donovan, 2003; Helmes & Wilmoth, 2004; Hopson & Cunningham, 1995; Pryor & Knowles, 2001). However, despite the proliferation of professional psychology throughout the public domain, clinical psychologists run the risk of being confused with other mental health professionals including psychiatrists, social workers and counsellors (Fall, Levitov, Jennings, & Eberts, 2000; Von Sydow & Reimer, 1998). The extant literature cites a number of reasons for the importance of clarifying the different roles of mental health professionals, which can be broadly arranged into two categories.

The first category addresses general issues around the ethical responsibility of each profession to accurately inform the public as to the nature of their role (Von Sydow & Reimer, 1998). The second category revolves around the professional, marketing, and financial issues for the mental health professions and refers to the shrinking funds for mental health services, the struggle for ownership of prescribing rights and rights to specific forms of therapy, and the general blurring of boundaries between professions (Fall et al., 2000; Wollersheim & Walsh, 1993). As Wollersheim and Walsh (1993) succinctly point out: "To reach consumers effectively, it is essential to understand their existing attitudes toward the commodity being marketed" (p. 171).

With specific regard to the profession of psychology, issues of professional identity have recently been catapulted into the spotlight following the Consensus Conference on Combined and Integrated Doctoral Training in Psychology held at James Madison University in Harrisonburg, U.S.A. The objectives and outcomes of this conference were manifold but can be summarised as an attempt to streamline the professional training of psychologists. The rationale for this is outlined by Shealy, Cobb, Crowley, Nelson, and Peterson (2004), who suggest that health-care providers in psychology currently fall into three main areas summarised as the clinical, counselling and school specialties. However, they note the poor correlation between any one individual psychologist's "specialist" training, and the place of employment and tasks ultimately performed by that

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psychologist. Moreover, they observe that the academic community, policy makers and the public are currently unable to reliably perceive substantive differences between these three specialties of professional psychology: "in fact, all three of these areas rightly note that their practitioners work with most of the same clinical populations, presenting problems, and procedures" (2004, p. 899). This clearly highlights the inadequate professional identity of psychologists as noted by the profession itself. As Fall et al. (2000) note: "If the professions themselves are uncertain about identity issues, think of the confusion the public must face when trying to choose among the various disciplines" (p. 123).

Measurement of the public perception of clinical psychologists

There are two major approaches that have been used by psychology to measure public opinion. First is the work of Webb and Speer (1986), who attempted to improve the original questionnaire methodology employed by Guest (1948). To this end they used the prototype strategy, which was constructed in four phases and can be summarised as follows. The first step was generation of the adjectives using descriptive paragraphs deemed to be typical of psychologists, psychiatrists, physicians, counsellors, teachers and scientists from 98 undergraduates, which were grouped according to frequency of appearance, resulting in a list of 40 descriptive features.

In the second step, 20 students sorted the list of 40 descriptive features into groups according to similarity of meaning. The groups underwent cluster analysis, which ultimately resulted in 11 final adjective clusters that are listed in Table 1 with the summary constructs used by Webb and Speer (1986).

The third phase involved another sample of subjects consisting of 128 undergraduates rating each of the six professions on how typically they were described by each of the 11 adjective clusters. Finally, a fourth group of undergraduates ($N = 50$) made favourability ratings on each of the 11 adjective clusters and their accompanying summary constructs.

Table 1. Adjective clusters and summary constructs from Webb and Speer (1986)

Adjective cluster	Summary construct
Cold, uninterested, introverted, odd	Alienated
Bossy, hostile, greedy, egotistical	Arrogant
Dedicated, persistent, well-trained	Dedicated
Helpful, caring, friendly, a good listener	Helpful
Curious, probing, a researcher	Inquisitive
Patient, calm, self-controlled	Patient
Deals with mental problems, studies behaviour, studies the mind	Psychological
Rich, nicely dressed, professional looking	Rich
Enjoys learning, intelligent, studious, knowledgeable, school-related, wise	Scholarly
Necessary, underpaid	Unappreciated
Understanding, understands people, well adjusted, gives advice	Understanding

Development of a secondary tool

Despite the Webb (1989) recommendation to use the prototype strategy as a whole, other studies have judged the four-phase approach to be too complex and time-consuming. The result has been a secondary tool that relies on the validity of phases 1 and 2 of Webb and Speer (1986) and simply replicates phase 3 of their study (Warner & Bradley, 1991; Wollersheim & Walsh, 1993). This approach constitutes the second method used by psychology to measure the public perception of clinical psychologists. In essence, the approach used by Warner and Bradley (1991) and Wollersheim and Walsh (1993) assumes that the words used to describe clinical psychologists and the clusters that they fall into will replicate the findings of Webb and Speer (1986). The secondary tool then replicates phase 3 of Webb and Speer (1986) by asking subjects to rate the goodness of fit of clinical psychologists to each of these word clusters. While Wollersheim and Walsh (1993) asked subjects to rank the clusters according to "desirability" in an attempt to address the issue of favourability, Warner and Bradley (1991) did not. Instead, favourability was assumed to be a function of the perceived valence of the adjective cluster.

Criticisms of the secondary tool

It can be seen therefore that the Webb and Speer (1986) original intention of casting a broader net and obtaining a spontaneous list of features to describe mental health professionals has ostensibly been reduced to just another questionnaire that asks the subject "on a scale of 1 to 10, how well do you think the word 'arrogant' or the word 'dedicated' describes a psychologist?".

In addition, a second criticism of the secondary tool is the assumption of favourability based on the perceived valence of the adjective cluster. While it seems that most people might rate the clusters summarised by the constructs *helpful* and *alienated* as positive and negative, respectively, we will see that this is not always the case.

Rationale for the study

It can be seen that while being different constructs, the profession's own perception of its identity, and the public perception of the profession's identity, are

subtly but inextricably intertwined. In conjunction with the ethical, clinical, financial and professional (marketing) factors previously outlined, it is suggested that gaining a clear and valid understanding of the public perception of clinical psychologists is a necessary and worthwhile undertaking for the profession itself.

Therefore, the first objective of this study was to challenge the validity of the adjective clusters and the summary constructs as generated by Webb and Speer (1986). It was hypothesised that a number of participants would interpret some of the seemingly negative clusters as positive, and some of the seemingly positive clusters as negative. The second hypothesis is that a number of participants would have a different interpretation for words inside a cluster that are designed to be representative of a single construct. The final hypothesis is that the imprecise public perception of clinical psychologists would be actively detrimental to the profession because people form an opinion about clinical psychologists based on other mental health professionals. Consequently, it is proposed that a number of individuals would be interviewed to obtain their views on clinical psychologists. These individuals would also have completed the secondary tool used by Warner and Bradley (1991) and Wollersheim and Walsh (1993). This would result in two distinct measures of the public perception of clinical psychologists, which can be analysed using a discursive approach (Potter & Wetherell, 1987).

Method

The secondary tool employed by Warner and Bradley (1991) and Wollersheim and Walsh (1993) was replicated and given to 124 undergraduate students from Murdoch University in Western Australia. The exact format of the questionnaire can be seen in Appendix A (note the use of the whole clusters as illustrated in Table 1 rather than the summary constructs). The questionnaire listed the 11 adjective clusters as used by Warner and Bradley (1991) and Wollersheim and Walsh (1993) and asked participants "on a scale of 1 – 10 where 1 = *not at all*, and 10 = *completely, totally, absolutely*, how well do you think each of these 11 adjective clusters describes a clinical psychologist?". This resulted in each adjective cluster obtaining a score between one and 10 with regard to goodness of fit for clinical psychologists. In addition, participants were requested to "please indicate whether you consider each of these 11 clusters to be representative of negative, positive or neutral characteristics".

Of the 124 questionnaires administered, 100 questionnaires were suitable for analysis and the initial results are given in Table 2.

Table 2. Mean score for each adjective cluster and the frequency of being ranked as either a negative, positive or neutral characteristic

Cluster	Mean score out of 10	% Negative	% Positive	% Neutral
Alienated	3.05	89	7	4
Arrogant	2.41	88	9	3
Dedicated	7.53	3	96	1
Helpful	7.49	1	98	1
Inquisitive	6.92	4	74	22
Patient	7.70	1	92	7
Psychological	8.28	0	78	22
Rich†	5.99	8	37	49
Scholarly	6.82	1	90	9
Unappreciated†	4.77	22	11	56
Understanding†	7.27	2	92	4

Note: †Clusters for which the total frequency of being ranked was <100% due to one of the clusters not being ascribed a label.

This illustrates for example, that the adjective cluster of *cold*, *uninterested*, *introverted* and *odd* (represented by the summary construct *alienated*) achieved an average goodness-of-fit rating of 3.05 out of 10. Similarly, it can be seen that 89% of the time this cluster was seen as a negative characteristic, 7% of the time it was seen as a positive characteristic, and 4% of the time it was seen as a neutral characteristic. The 100 suitable questionnaires were then analysed to gain an initial measure of the strength and valence of the attitudes towards clinical psychologists. See Appendix B for a full description of this procedure.

Because one of the objectives of this study was to test the validity of the secondary tool by comparing the data from the questionnaire and the data obtained from interview, it was considered best to interview participants who expressed firm opinions in the questionnaire. Therefore, participants who expressed strong and definitely weighted opinions about clinical psychologists (either positive or negative) were considered more appropriate for this study. Consequently, participants with positivity scores in the highest 25% (very positive view of clinical psychologists) and participants with neutrality scores in the lowest 25% (very firm opinions) were chosen as being representative of the participants with the strongest and most positive attitude towards clinical psychologists. A number of participants fulfilled both these criteria ($n = 15$) and the interview participants (with a strong and positive attitude towards clinical psychologists) were drawn specifically from this group. To gain interview data from participants with strong negative views about clinical psychologists, participants with positivity scores in the lowest 25% (very negative view of clinical psychologists) and neutrality scores in the lowest 25% (very firm opinions) were selected.

A number of participants fulfilled both these criteria ($n = 3$) and the interview participants (with a strong and negative attitude towards clinical psychologists) were drawn specifically from this group.

Interview format

The interview followed the same format for each participant, which allowed for responses to specific questions as well as elaboration on those responses. There were eight stages to the interview format as outlined in Table 3.

A discursive approach (Potter & Wetherell, 1987) was used to emphasise the individual nature of the data and investigate the underlying meaning of the individual's response. All participants have been de-identified, and any individuals or institutions referred to in the transcript have had their names removed to prevent identification.

Analysis and discussion

Interpretation of the clusters as a whole

The following extracts highlight instances during interview when the participants identified whole clusters that would generally be considered negative as being positive, and whole clusters generally considered to be positive, as negative. In Extract 1, L1 is responding to why she was less positive about the cluster of *helpful*, *caring*, *friendly* and *a good listener*, which she rated a 6 out of 10.

Table 3. Interview format

Stage of interview	Questions asked/points raised
1	Interview objectives outlined and consent form signed
2	Overall results outlined and participant asked to elaborate
3	Specific responses outlined and participant asked to elaborate
4	Participant outlines existing knowledge of clinical psychologists and is asked to distinguish between a clinical psychologist, psychiatrist and counsellor
5	Participant outlines where existing knowledge comes from
6	Participants describe contact with clinical psychologists (their own or a close family member's direct experience considered as relevant)
7	Opportunity for participants to add any further relevant information
8	Interview concludes, tape turned off, participants thanked and debriefed as to the nature and objectives of the study

```
Extract 1
Int:
L1:   1  ummm (.) well I think that
         (.) when you when you're
      2  going in to seek help you
         (.) you know (.) as a
      3  psychologist you don't
         want you want to help them
         but
      4  you can't be their best
         friend that doesn't you
         know
      5  like you (.) being
         someone's best friend and
         relating to
      6  them in that way (.) is not
         the best thing for them
```

In contrast to the suggestion of Wollersheim and Walsh (1993), L1 in the above extract has de-emphasised the importance of the cluster summarised by the construct *helpful*. The suggestion is that if the psychologist is helpful, caring, friendly, and a good listener, this can be counterproductive to the ultimate role of the psychologist. This sentiment is expressed clearly in lines 5 and 6 when L1 says that being someone's friend is not the best thing for them. The demarcation between helping people, which is seen as positive (line 3), and being friendly, which is seen as negative (lines 5 and 6), reflects an individual interpretation of the cluster and is an attempt to make sense of what is clearly an ambiguous cluster for this participant.

Just as the previous participant expressed the notion that being friendly can be counter-productive, other participants reframed clusters typically seen as negative as being somewhat positive. In the following extract, H reframes the cluster of *cold*, *uninterested*, *introverted* and *odd* as a positive characteristic.

```
Extract 2
Int:  1  yeah I just wondered if you
         could tell me a bit about
         that
H:    2  ummm the reason why I
         thought introverted it's
         because
      3  ummm I guess they're in
         touch (.) ahhh let me
         have a
      4  think (.) the approach
         would be that they're
         really
      5  getting into something
         they're not ummm (.) I
         guess
```

```
 6  they're very (.) not studious but I'm trying to find the
 7  right words (.) ummm well I think you need to be
 8  introverted to a certain point because you really need
 9  to be in touch with yourself and be able to get into
10  people ahhh beyond the social façade (.) which is
11  probably what clinical psychologists need to do (.) ummm
12  (.) I think they just like in terms of introversion as
13  well like obviously you know like they're knowledgeable
14  they need to be able to study and really get into the
15  book side of things and case studies and whatever ummm
16  so I guess why I think It's positive is you really need
17  to have that foundation ummm and also very inquisitive I
18  think they'd have a very to me also odd well that sort
19  of [inaudible] means inquisitive as well
```

In lines 8–11, H reframes the concept of introversion from a negative characteristic to a positive characteristic by alluding to the ability to get beyond the social façade and "get into people". Again, in lines 12–15, the concept of introversion is positioned immediately prior to a string of references designed to carry academic weight. Introversion is akin to being knowledgeable. Moreover, it suggests the ability to study and "get into the book side of things". Finally, the presence of introversion shows an ability to "get into" case studies. Rather than suggesting shyness or social awkwardness, the concept of introversion is presented as a desirable and somewhat academic quality. However, if an aptitude for introversion is seen as being useful for a psychologist, the following extract in the same interview suggests that the ability to be cold, uninterested and odd is a mandatory prerequisite.

Extract 3

```
Int:  1  and just in that cluster again there was a couple of
      2  other adjectives like cold and uninterested and
      3  ┌odd
H:    4  └mmhmm
Int:  5  they were in the same cluster as introverted and you
      6  rated that cluster as positive so I wondered if you
      7  could just sort of fill me in a bit on what on you know
      8  your thinking of (.) why cold and uninterested and odd
      9  might be positive characteristics as well
H:   10  that was in the same cluster
Int: 11  Yeah
H:   12  ummm well uninterested [.] uninterested could be
     13  looking at like so obviously clinical psychologists
     14  can't be too emotional
Int: 15  ┌sure
H:   16  └they've got to have this façade like
     17  they're there you're telling them stuff and I think if
     18  they showed too much emotion it can't be a positive
     19  thing cos you're reacting to what people are saying and
     20  it might deter them from going on or continuing or you
     21  know so I think you need to have that kind of where the
     22  person just gives and you can just absorb without
     23  showing too much (.) cold (.) I mean obviously that can
     24  be interpreted as cold but it's not really it's just you
     25  know just kind of a you know a blank page you know cos
     26  you don't want to give any clues away to how you're
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      27  seeing and judging this
          person kind of thing so
Int:  28  sure and odd?
H:    29  [laughs] I dunno it just
          happened to be in
      30  ┌that cluster
Int:  31  └sure [laughs]
```

In lines 13 and 14 H equates interest in the client with being too emotional and thus justifies the psychologist being uninterested in the client. In addition, the statement is preceded with the descriptor *obviously* to indicate that this is general knowledge and therefore indisputable. In lines 23–27 the characteristic *cold* is identified as having multiple interpretations. An obvious interpretation is that cold is cold; however, it is also acknowledged that for a psychologist, being cold can suggest a degree of objectivity or neutrality. Finally, the adjective *odd* is dealt with according to its proximity to the other descriptors. H laughs as if to dismiss the notion that odd can be justified as a positive characteristic, but then goes on to provide some insight as to why odd should be open to individual interpretation.

```
Extract 4
H:     1  but it's an interesting
          interpretation odd odd
          what does
       2  odd mean I mean just it's
          very subjective odd
          ┌you know
Int:   3  └sure
H:     4  what someone might think
          is odd to someone isn't
          odd to
       5  someone else and people
          might perceive them as
          being odd
       6  because they're
          introverted and you know
          all that I mean
       7  just cos odd is different
          to what society wants
          people
       8  want society wants
          extroversion da da da and
          cos you're
       9  opposite to that maybe I
          thought that's why odd
          was in
      10  there cos people perceive
          them as odd
```

In these extracts H has provided a number of reasonable and valid explanations as to why being cold, uninterested, introverted and odd should be seen as positive characteristics. Finally, H is asked to summarise these explanations in an alternative definition of the adjective cluster.

```
Extract 5
Int:   1  └yeah could you summarise
          you
       2  obviously think they're
          positive characteristics
H:     3  Yeah
Int:   4  and ummm you've explained
          very well why you think
          they
       5  are positive
          ┌characteristics
H:     6  └yeah
Int:   7  about the ahhh distance
          and the (.) ummm yeah the
       8  distance that they help
          put between people and
          I just
       9  wondered if you could
          give me another word or
          you know
      10  an indication as to why
          that's ummm another word
          really
      11  as to why that's positive
H:    12  [inaudible] but I'd
          say objective I
          think it'd be
      13  objective
```

Thus the explanatory work that justifies the transition of *cold*, *uninterested*, *introverted* and *odd* from seemingly negative characteristics to patently positive characteristics is complete. When one sees the descriptors *cold*, *uninterested*, *introverted* or *odd*, one can consider the object of these descriptions to be academic, knowledgeable, and, most importantly, objective. A psychologist is not cold, they are objective; a psychologist is not uninterested, they are objective; neither are these same psychologists introverted or odd; they are, of course, objective.

Interpretation of different words in the same cluster

The following extracts highlight instances during interview when participants judged some adjectives of the cluster as having one meaning, and other adjectives in the cluster to have another meaning. The rationale for this is to challenge the validity of the clusters as a whole based on the question "is the distillation of people's spontaneous descriptive prose into clusters of single words valid?" The following extract from L2, whose scores were relatively negative towards clinical psychologists, suggests it is not.

```
Extract 6
Int:   1  so is what you're
          suggesting that the
          clusters can be a bit
       2  contradictory some times
L2:    3  the words are
          contradictory
Int:   4  can you give me an example
L2:    5  (.) ok enjoys learning,
          intelligent, studious,
       6  knowledgeable, school
          related and wise umm (.) a
          lot of
       7  people enjoy learning umm
          someone that's stayed at
       8  school as long as they
          should or have to got to
          get a
       9  degree must have enjoyed
          learning
Int:  10  mmhmm
L2:   11  intelligent (.) yes but
          lots of people are
          intelligent
Int:  12  mmm
L2:   13  umm studious (.) that has
          some negative
          connotations I
      14  suppose (.) ummm you know
          that sort of geek thing
Int:  15  sure
L2:   16  ummm (.) knowledgeable
          well should be
          knowledgeable or
      17  you wouldn't be in that
          sort of a position (.)
          school
      18  related (.) that's going
          back to the studious and
          geeky
      19  sort of thing
Int:  20  mmmm
L2:   21  and wise (.) wise to me
          tends not to fit in with
          the
      22  other words (.) wise is
          (.) you can be all of the
      23  previous things and not
          necessarily wise
```

Despite the question posed by the interviewer in lines 1 and 2 suggesting the contradictory nature of the clusters as a whole, in line 3, L2 orients the interviewer to the notion that the individual words inside each of the clusters are contradictory. The example provided is the cluster summarised by the construct *scholarly*, which contains the descriptors *enjoys learning*, *intelligent*, *studious*, *knowledgeable*, *school-related* and *wise*. L2 concedes a degree of similarity between the adjectives *enjoys learning*, *intelligent*, *studious* and *knowledgeable* (with various caveats along the way such as "lots of people are intelligent"), but does not agree that the adjective *wise* belongs in the cluster. This is stated unequivocally in lines 21–23 with the notion that "wise tends not to fit in with the other words . . . you can be all of the previous things and not necessarily wise".

Confusing the role of psychologists and psychiatrists

As Helmes and Wilmoth note: "anecdotal evidence suggests that ignorance of the skills of psychologists among other healthcare professions and the public is a matter that warrants immediate efforts by organised psychology in Australia" (2004, p.42). While Webb (1989) observes the tendency of the public to place clinical psychologists and psychiatrists in the same category, she makes no comment on this phenomenon. Despite this, the seeming interchangeability between these two professions would seem to be a fundamental point to consider when discussing the public perception of clinical psychologists. An immediate question that arises is whether or not the public are making judgments of clinical psychologists based on what they know about psychiatrists. The following extract suggests very strongly that this does occur while simultaneously highlighting some of the negative implications for the profession. J has rated both the clusters of *cold*, *uninterested*, *introverted* and *odd* and *bossy*, *hostile*, *greedy* and *egotistical* as 7 out of 10.

```
Extract 7
Int:   1  I just wonder if you can
          elaborate a little bit
          on both
       2  of those clusters
J:     3  ummm that reflected my
          experience with umm
          clinical
       4  psychologists umm well
          when I was fourteen I was
       5  admitted into AAA
          hospital and there I was
          placed with
       6  umm firstly I was put
          with two normal
          psychologists and
       7  umm they wanted to do a
          family therapy and all
          this sort
       8  of stuff and my mum spat
          it and she wouldn't do
          family
       9  therapy so they put me
          onto a clinical
          psychologist and
      10  umm basically I I was in
          there for four weeks and
          the
```

11 four weeks that I was under the clinical psychologist
12 all I got was sort of like I just got told what to do
13 what to eat what to wear when to get up when I could sit
14 down I just found it like I wasn't even able to open my
15 mouth even if I did it didn't make a difference cos no
16 one listened to me anyway it was like don't listen to
17 her it's not her talking it's the eating disorder it it
18 I lost my self I lost my personal value I didn't have a
19 personal value anymore to the clinical psychologist I
20 only had the value of the disease (.) and umm then when
21 I was fifteen I went into BBB Hospital ⌈here
Int: 22 ⌊mmhmm
J: 23 and I was put under a clinical psychologist called
24 doctor X (.) and umm (.) he was terrible
25 absolutely terrible like I was in there for twenty four
26 hours and in that twenty four hours umm I was accused of
27 being bulimic in the first twenty four hours because I'd
28 eaten what they'd given to me and I hadn't gained weight
29 over the twenty four hour period they accused me of
30 being bulimic and then they took away things like I had
31 a room and I was paying like my parents paid something
32 like four thousand dollars for me to stay there to do
33 the clinic that they had there (.) and umm I didn't see
34 him in the first day I just got a message from the nurse
35 saying that he was not impressed with me and that he was
36 punishing me by taking away the television in my room
37 (.) and the bathroom in my room he was locking and I
38 wasn't allowed to use the bathroom and if I wanted to
39 use the bathroom I had to call a nurse to watch me go to
40 the bathroom I was fifteen years old and I found this
41 ridiculous and umm so that was in the first twenty four
42 hours and in the second twenty four hours I was there
43 for two days I still didn't see him even though I'm
44 paying him sort of three hundred dollars a day to come
45 and see me and analyse me I didn't see him again he just
46 looked at my chart apparently in the morning and a nurse
47 came in and said to me look he's still not happy about
48 aaah you're not allowed any visitors anymore and your
49 telephone's been taken away you're not allowed to you
50 can't make a phone call if you want to talk to your
51 parents you've got to go to the nurses desk and ring
52 your parents from there and you're only allowed to talk
53 to them for two minutes (.) excuse my language but you

	54	know like what are you doing do you know what I mean
	55	like I may I may have something wrong with me but that
	56	doesn't mean you can just treat me like you are and umm
	57	(.) so I pretty much spat the dummy said look I'm
	58	leaving I'm discharging myself and they said look you're
	59	only sixteen years old you can't do that I was fifteen
	60	at the time and they said you're only sixteen years old
	61	you can't do that we're gonna put you in the psych ward
	62	and I said I beg your pardon and so they took me
Int:	63	sorry to interrupt you but do you mean they were going
	64	to umm have you sectioned (.) involuntarily admitted
J:	65	mmhmm into the psych ward and I said no you're not and I
	66	like I picked up the phone and I rang my parents and my
	67	parents came down and they had an interview with doctor
	68	X and doctor X told my parents that (.) he's
	69	been seeing me every day for half an hour and talking
	70	to me and saying that my attitude towards the program
	71	was terrible blah blah blah and blah blah blah
	72	of course my parents believed him and he's going ohh if
	73	your daughter's saying she hasn't seen me it's the
	74	eating disorder talking and I hadn't even seen the bloke
	75	hadn't seen the bloke since the day I got I got admitted
	76	and I saw him for five minutes then and that was when my
	77	main attitude of clinical psychologists being rude and
	78	sort of just not caring at all as to how you feel and
	79	what you say (.) and that's why I I accept that like you
	80	know a big percentage of them probably wouldn't be like
	81	that but the ones that I have been in contact with (.)
	82	have been and considering the amount of money that I've
	83	paid them (.) it wasn't worth it
Int:	84	ok (.) is doctor X a clinical psychologist
J:	85	I believe so yes

This is a poignant and distressing account of J's interaction with the medical system for treatment of an "eating disorder". However the eating disorder diagnosis was eventually retracted and J was re-diagnosed with a metabolic disorder with the primary symptom of difficulty achieving weight gain. J's impression of clinical psychologists as measured by the questionnaire can be seen in her scores of 7 out of 10 for the clusters *cold*, *uninterested*, *introverted* and *odd* and *bossy*, *hostile*, *greedy* and *egotistical*. In addition, these negative sentiments are powerfully reinforced in her interview statements. Moreover, in lines 76–79, J draws a clear link between her interactions with Dr X and her "main attitude of clinical psychologists being rude and sort of just not caring at all". However, in this instance, J has based her opinion of clinical psychologists on the actions of a mental health professional who is actually a psychiatrist. The interviewer was aware of this during the interview process and queries J's understanding of the clinician's professional status in line 84. However, J confirms the notion that as far as she is concerned, Dr X is a clinical psychologist.

This distinction between a "normal psychologist" and a "clinical psychologist" is made in the early part of this extract in lines 6–9 during J's initial admission to AAA hospital. On the basis of her later categorisation of Dr X as a clinical psychologist, it is possible that her reference to a "normal psychologist" refers to a clinical psychologist and her reference to a clinical psychologist refers to a psychiatrist. Whatever the details of categorisation are in the first admission

referred to by J, the second admission to hospital forms the basis for her attitude towards clinical psychologists and can be considered as firm evidence that individuals can (and do) form opinions of clinical psychologists (sometimes extraordinarily negative), on the basis of their experience with psychiatrists.

Conclusion

A number of conclusions can be drawn from the work outlined in this paper regarding the public perception of clinical psychologists, the validity of the questionnaire developed by Webb and Speer (1986), and the demarcation of clinical psychologists from other mental health professionals. With regard to the validity of the questionnaire, two main objections arise.

First, it seems clear from the data that individuals can interpret seemingly positive adjective clusters as negative and seemingly negative clusters as positive. The first example cited in this paper is the decreased significance of being helpful, and the suggestion that it may be counterproductive to the ultimate role of the psychologist as offered by L1. The second example is the reframing of *cold*, *uninterested*, *introverted* and *odd* as positive characteristics by H. As well as being present in the interview data, this phenomenon is also clearly outlined in Table 2, which shows a number of generally negative characteristics being judged as positive. It can be seen therefore, that a fundamental flaw in the secondary tool as employed by Warner and Bradley (1991) is the assumption of favourability based on the perceived valence of the adjective cluster. This provides some direction for the profession of psychology, which needs to be cognisant of the need to include favourability ratings in any studies that claim to provide a measure of public perception.

Second, the data show that individual words inside the clusters possess incongruent characteristics that make it difficult for the participant to judge the clusters as a whole (as the questionnaire developed by Webb & Speer actually requires them to do). An example is the incongruence between the adjective *wise* and the remaining words inside the cluster summarised by the construct *scholarly*. L2 makes this distinction clearly in the comment "you can be all of the previous things and not necessarily wise" (extract 6 lines 22–23). Other examples include the distinction between being patient and self-controlled but not calm, and being cold, uninterested and introverted, but not odd. This suggests strongly that the distillation of people's spontaneous descriptive prose into a cluster of single words is not a valid method for capturing the true public perception of psychologists. Rather than collecting, aggregating and then analysing the data, it seems likely that a more valid method is to collect the data and then analyse it. If necessary the individual results can be aggregated after analysis to give a broader and more comprehensive picture of the public perception of clinical psychologists. This aggregation of the data after it has been analysed ensures that genuine and significant differences in public perception of the profession between individuals are taken for what they are: naturally occurring and meaningful variations on the norm rather than statistical noise or error.

Limitations

There are three potential criticisms of the approach taken in the present work including the type of population used, the specific methodological limitations of conducting interviews and the limitations of qualitative research in general.

First, the use of an undergraduate university population in this study can be partly explained with reference to the populations used by Webb and Speer (1986), who developed the original questionnaire and also employed an undergraduate university population. Consequently, any attempt to challenge the validity of their approach would gain in legitimacy by using the same population.

Second, Potter and Wetherell (1987) note at least two methodological limitations of conducting interviews and analysing the data. The first revolves around the tendency to analyse the words (or the transcript of the words) rather than the intended meaning of the words. The second limitation is similar and refers to the potential subjective bias regarding the recording and interpretation of the data. These are valid concerns and although discourse analysis and conversation analysis are similar, interested readers are directed to the writings of Levinson (1983), who notes a number of theoretical distinctions between the two that suggest that the above criticisms could be significantly ameliorated using a strict conversation analysis methodology.

Finally there is significant debate about the merit of qualitative approaches in general and what they can offer to the discipline of psychology. Traditional research in psychology has employed a positivist approach and focused on the importance of obtaining an average from a large pool of subjects. Therefore, criticism of qualitative research centres around concerns of researcher bias and lack of objectivity in general, and the ability to generalise from the study sample to the population in specific. In addition, issues of representativeness (the subjects studied are seen as atypical), and the capacity of qualitative approaches to replicate their findings is often questioned. With a small sample ($N = 10$) and a patently qualitative approach, this paper is subject to a number of these criticisms including

representativeness, reproducibility and generalisability. However, a number of authors outline some of the advantages of qualitative research. For example Sacks (1992) offers a theory based on the notion that any particular culture will show order at all points. This suggests that a macro approach based on an aggregationist model is not the only way, and a micro approach focusing on the detail in individual cases and in individual environments will reveal important properties of the culture as a whole. Consequently, the data obtained from 10 participants (or one participant) can be seen to illuminate important properties of the whole and can serve as a valid indicator of performance and functioning in the system at large. Some of the advantages of this micro, qualitative approach include a rich level of detail not often obtained in quantitative research; the ability to illuminate the individual nature of data and the inherent explanatory work and underlying meaning of the individual's response, which makes it an ideal tool to gain insight into the individual's perception of a particular group, concept or construct; and the ability to account for the specific situation of the research. Interested readers are directed to Kidder and Fine (1997), who provide a useful account of some of the history and advantages of qualitative research. Moreover, for an introduction to the ongoing and robust debate about quantitative versus qualitative research, interested readers are directed to Burman (1997) and Wagner (1995). Finally, with regard to exploring the validity of analysing single-subject conversation, interested readers are directed to the writings of Sacks (1972, 1992), and Silverman (1998).

Nevertheless, despite the advantages of qualitative research outlined above, further qualitative studies of the public perception of clinical psychologists would be useful to strengthen and support the findings presented in this paper.

Future research and suggestions

The reasons for different interpretations of, or incongruence between, clusters is worthy of discussion. Potter and Wetherell (1987) note the traditional understanding of the development of public perception whereby an individual forms an opinion (e.g., "caring") based on the object (for example a clinical psychologist). This is in contrast to the theory espoused by social representations, which has an additional dimension referred to as a representation. In social representations theory, the individual observes the object, constructs a representation of the object and then forms an opinion based on the representation rather than the object itself (Potter & Edwards, 1999). Because social representations are mental entities that take into account existing beliefs and value systems, they can be used to explain attitudes and actions towards an object of representation and allow for a more complex and holistic understanding of the object. It seems possible that members of the public form a perception of clinical psychologists based on their subjectively constructed, individual representation of what a psychologist is, or how they see a clinical psychologist should be. This provides some direction for future research that may benefit from using a social representations model when investigating public perception of the profession.

Other possible areas of interest include the effect of direct experience of a clinical psychologist (defined throughout this paper as either the individual's own, or a close family member's direct experience with a clinical psychologist in a therapeutic situation), and the public's knowledge of the training required to be a psychologist and the clinical tasks performed. It may be noteworthy that all of the three participants who displayed a negative attitude towards clinical psychologists had direct experience of them. This is in contrast to only three out of the seven participants who displayed a positive attitude towards clinical psychologists. Further research could focus on this finding and investigate the significance (if any) of direct experience of a clinical psychologist on the ultimate opinion of clinical psychologists.

Finally, with regard to the implications of inadequate demarcation from other mental health professionals for the profession of clinical psychology, it can be seen that confusion among members of the public can (and indeed does) lead to judgments about clinical psychology being made on the basis of information about other mental health professionals. To aid in delineating clearly between the role of the psychiatrist and the psychologist it is recommended that the profession embark on a public awareness campaign to clearly describe the role of psychologists as well as outlining a number of the strengths that are associated with the profession.

These strengths include a commitment to using clinical interventions, which have been heavily researched in gold standard studies and found to be effective (cognitive behavioural therapy for depression, for example). Unlike many other professions that simply refer to relevant clinical research, psychology has a strong history of evaluating, appraising and critiquing the extant literature. While not exclusive to psychology, this formidable academic skill means that psychologists are well-placed to critique and analyse the methodology of complex studies from various disciplines and not just psychological research literature. Furthermore, psychologists are the sole users of a number of psychometrically sound assessment tools that can add meaningful data to the clinical picture. The majority of other mental health professionals

(including psychiatrists) are not licensed to administer or interpret these tools, which provides psychology with a meaningful, valuable and unique string to its bow. Additionally, the practice of hypothesis testing in clinical assessment and intervention, although not unique to psychologists, has a long history in psychology (Bernstein & Kerr, 1993; Kendall & Norton-Ford, 1982). Finally, the recent developments at the Consensus Conference on Combined and Integrated Doctoral Training in Psychology, which are designed to provide a link between psychology training and tasks performed, can be seen as a further way in which the profession can clearly and distinctly outline its role to members and use that clarification as a platform to deliver the message to the public. For the sake of the profession it seems imperative that professional psychology in Australia undertakes a campaign of clarification and demarcation to ensure that the role of clinical psychologists is well-articulated and clearly understood by members of the public and other health-care professionals.

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Appendix A. Questionnaire based on the secondary tool developed by Wollersheim and Walsh (1993) and Warner and Bradley (1991)

Name: ____________________

Student number: __________________

Phone number: _________________________

Email address: ________________________

Questionnaire

On a scale of 1 to 10 where 1 = *not at all* and 10 = *completely, totally, absolutely* how well do you think each of these 11 adjective clusters describes a clinical psychologist.

In addition, please indicate whether you consider each of these 11 clusters to be representative of *positive, negative* or *neutral* characteristics.

1. cold, uninterested, introverted, odd _____
2. bossy, hostile, greedy, egotistical _____

3. dedicated, persistent, well trained _____
4. helpful, caring, friendly, a good listener _____
5. curious, probing, a researcher _____
6. patient, calm, self-controlled _____
7. deals with mental problems, studies behaviour, studies the mind _____
8. rich, nicely dressed, professional looking ______
9. enjoys learning, intelligent, studious, knowledgeable, school-related, wise _____
10. necessary, underpaid _____
11. understanding, understands people, well adjusted, gives advice ______

Appendix B. Procedure for obtaining a measure of positivity, negativity, neutrality, and strength of attitude towards clinical psychologists from the questionnaire data

The scores out of 10 for each of the 11 adjective clusters that were ascribed a positive label were added together. Similarly, the scores out of 10 for each of the 11 adjective clusters that were ascribed a negative label were added together. A measure of positivity towards clinical psychologists was then obtained by subtracting the total negative score from the total positive score. High scores on the positive scale indicated a positive attitude towards clinical psychologists and low scores indicated a negative attitude towards clinical psychologists.

Following this, the scores out of 10 for each of the 11 adjective clusters that were ascribed a neutral label were added together. Because both the positive and negative dimensions indicated a degree of feeling of some sort (by definition, either a positive or negative feeling) a measure of neutrality was obtained by adding the positive and negative scores together and subtracting this total from the neutral score. For example, if the positive and negative scores were low and the neutral score was raised, a high measure of neutrality would be indicated by a high score. In contrast, if the positive and negative scores were raised and the neutral score was low, a low (or negative) score would indicate a low measure of neutrality.

Consequently, each participant achieved an overall positivity score and an overall neutrality score. The positivity scores ranged from 8 to 85 ($M = 43.4$). The neutrality scores ranged from -10 to 95 ($M = 45.63$). These scores were then ranked in ascending order. Positivity scores in the lowest 25% ($N = 26$) were considered to represent participants with the least positive attitude towards clinical psychologists. Conversely, positivity scores in the highest 25% ($N = 26$) were considered to represent participants with the most positive attitudes towards clinical psychologists. A similar process was carried out with the neutrality scores. Consequently, neutrality scores in the highest 25% ($N = 24$) were considered to represent participants with the most neutral attitude towards clinical psychologists, and neutrality scores in the lowest 25% ($N = 26$) were considered to represent participants with the least neutral attitude towards clinical psychologists.