An analysis of the professional identity and experiences of clinical psychologists in South Africa

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By

Tarryn Kaela Shnier

Supervisor: Professor Lisa Saville Young

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Abstract

The discipline of psychology, and the profession of clinical psychology in South Africa has made marked strides over the nearly 30 years since the end of the apartheid era. However, there is little known about the professional identity and experiences of clinical psychologists in South Africa. This study involved conducting a critical incident analysis of the experiences of 410 clinical psychologists in South Africa, in order to identify possible commonality in experiences and what meaning these experiences have for the professional identity of clinical psychologists in South Africa. Findings suggest that professional identity is greatly influenced by experiences involving interactions with mental health care users, and experiences working within multidisciplinary teams. These findings are discussed in connection with existing literature that details concepts of professional identity and South African psychology, in order to establish clarity on the professional identity of clinical psychologists in South Africa.

Table of contents

List of Figures

Chapter 1 Introduction

This study explores the professional identity of clinical psychologists in South Africa by individually analysing 410 psychologists' reported critical incident- which is an incident that stands out as significant to them in the previous twelve-month timeframe. These incidents will aid in developing more clarity about the professional identity of clinical psychologists in South Africa.

Chapter 2 Literature Review

This section aims to provide a summary of the existing literature surrounding the concept of professional identity and clinical psychologists' professional identity in South Africa. A brief overview of the origins of clinical psychology internationally will be explored, followed by the history of clinical psychology in South Africa. The current status of clinical psychology internationally will be touched on, to give context to the discussion of the current status of clinical psychology in South Africa. Studies that have explored the experiences and professional identity of clinical psychologists, trainee psychologist and other relevant parties will be reviewed to highlight the importance of conducting this research. This overview will provide the basis on which professional identity will explored.

2.1 Context

2.1.1 History of clinical psychology internationally

In a chapter on the evolution of clinical psychology, Pomerantz (2017) describes how the discipline first began. They link the origin of clinical psychology back to professionals such as William Tuke and Eli Todd, who Pomerantz argues were the first to shape psychology as a field during the 1700s and 1800s. The so-called 'founder' of the discipline of clinical psychology is identified as Lightner Witmer, as Witmer oversaw the transformation of clinical psychology from a predominantly academic discipline to a discipline that was to be applied and practiced instead. In addition to transforming clinical psychology into a practice, Pomerantz describes how Witmer founded the first scholarly journal detailing clinical psychology and established the first psychology clinic. However, the discipline and profession of clinical psychology only became popularised as a result of the World Wars, specifically World War II (Pomerantz, 2017). During this time, Pomerantz notes that the

discipline evolved in order to accommodate the pressure that came as a result of the increased need for mental health services for soldiers returning from the war. During this time, Pomerantz states that psychological assessment was widely used, as soldiers were assessed for suitability for combat and field. In addition, psychotherapy was also in demand during this time due to soldiers who had adverse experiences returning from war (Pomerantz, 2017).

2.1.2 History of clinical psychology in South Africa

Whilst South Africa was not directly involved in World War II, the effect of the war influenced clinical psychology in South Africa, and the discipline was as a result "thrust into significance in South Africa" (Cooper & Nicholas, 2012, p. 92). In contrast with the history of clinical psychology internationally, clinical psychology, and the discipline of psychology in general in South Africa, is tainted by the role it played in supporting apartheid.

Psychology as a discipline was used as a means for the national party to substantiate racial segregation in South Africa. Hendrik Verwoerd, who is frequently described as the 'father' of apartheid and served as a prime minister during the apartheid era, studied psychology abroad and used psychology to justify apartheid (Cooper & Nicholas, 2012; Pillay, 2016). Verwoerd was particularly interested in 'ethnic psychology' and how he could use this to justify the oppression and segregation of the majority in South Africa (Cooper & Nicholas, 2012).

As a result of psychology being used to justify inequality and oppression, the discipline has been criticised for using measures such as standardised testing, for example, IQ tests to support apartheid. Standardised testing methods are mainly designed for use in Western contexts, and when used in a South African context results can be skewed for a variety of reasons including having to take a test in English which for many South Africans is

not their home language or second language. Western produced psychological assessment measures do not factor in indigenous knowledge forms (Pillay & Kramers-Olen, 2014).

During World War II, psychological assessment was used to justify why Black South Africans were more suited for hard labour than Whites (Laher & Cockcroft, 2014). Laher and Cockcroft (2014) note that the National Institute of Personnel Research (NIPR), led by Simon Biesheuval, focused mainly on this argument. Cooper and Nicholas (2012) state that while the NIPR was not "overtly racist [the NIPR] provided the 'scientific' basis for the inferiorization of blacks" (p. 98).

2.1.3 Current status of clinical psychology internationally

Literature detailing the roles, duties and activities of clinical psychologists internationally does not differ significantly from context to context. Clinical psychologists are generally understood to engage in psychological assessment, psychological intervention, research, supervision, teaching, consultation, psychological formulation, and administration (Cheshire & Pilgrim, 2004; Huey & Britton, 2002; Kramer et al., 2014; Linden & Hewitt, 2018). McMahon (2018) states that the many roles that clinical psychologists take on and the extensive training they undertake "tends to produce flexible, capable practitioners but can leave the clinical psychologist feeling like a 'jack-of-all-trades' and 'master of none'" (p. 217). Other commonalities in the literature suggest that clinical psychologists are trained and expected to work in multidisciplinary teams, apply a scientist-practitioner model, and engage in evidence-based practice (Cheshire & Pilgrim, 2004; Huey & Britton, 2002; Linden & Hewitt, 2018). McMahon (2018) states that clinical psychologists are required to engage in continued professional development and training. Clinical psychologists can work in the

public or private sector, and training and education differs depending on the country but does not differ significantly.

2.1.4 Current status of clinical psychology in South Africa

According to the Health Professions Council of South Africa (HPCSA, 2019) in the document detailing the minimum standards for the training, clinical psychology is regarded as a specialist field of psychology in South Africa that "provides continuing and comprehensive mental and behavioural healthcare to individuals and groups across the lifespan" (p. 2).

The HPCSA (2019) describes that this service is done by clinical psychologists, who are trained to engage in activities such as, "the assessment, diagnosis, evaluation, and treatment of psychological and mental health disorders that range from mild to severe and complex" (p. 2-3). This definition of clinical psychology and the framing of clinical psychologists' activities in South Africa shows significant similarities with that of the international definition and activities discussed above. The professional identity of clinical psychologists in South Africa is moulded upon engagement in these activities and adherence to the definition, as the HPCSA is the governing body in which clinical psychologists must register in order to practice. The HPCSA (2019) outlines the speciality of clinical psychology as compared to other fields of psychology by stating that clinical psychologists, "deliver a range of high-intensity psychological interventions with demonstrated effectiveness in treating mental health disorders and psychological distress associated with medical conditions" (p. 3). Given the close relationship between clinical psychology and medical contexts in the treatment of more severe mental illness, clinical psychologists' professional identity would differ from the professional identity of other fields of psychologists, for

example, counselling psychologists. Young and Saville Young (2019) discuss the difficulties of distinguishing clinical psychology from particularly counselling psychology in South Africa, and note the debate surrounding the scope of practice in distinguishing the overlap. Young and Saville Young (2019) state that, in an attempt to distinguish this overlap, an amendment was made in 2011 that stated that clinical and counselling training should be separated from the beginning of professional training, rather than combining them in the first year. The scope of practice was amended in 2011 in an attempt to make this distinction, and this distinction seems to be that clinical psychologists work with cases on the more severe psychopathology spectrum compared to counselling psychologists (Young & Saville Young, 2019). Young and Saville Young (2019) state that this distinction is not often seen in practice, as the large amount of clinical psychologists in private practice (Cooper & Nicholas, 2012; Deane, 2016; Young & Saville Young, 2019) results in them not seeing patients on the high end of the severe psychopathology spectrum, which are often seen in psychiatric facilities. This continued debate surrounding scope of practice has resulted in a lack of clarity about the professional identity of clinical psychologists in South Africa.

Clinical psychologists form part of multidisciplinary teams (MDT) in hospital settings, working with psychiatrists, nurses, social workers, and other health professionals. Pillay (2016) notes that clinical psychologists have experienced difficulties working in MDTs, these difficulties include that "some psychologists in state hospitals find their autonomy as mental health practitioners eroded through undue influences of the medical model" (p. 153). Pillay (2016) argues that clinical psychologists need to protect their role in MDTs as the contribution of clinical psychology is fundamental in many settings that MDTs exist in and that clinical psychologists are clinicians and use “all of the mental health diagnostic techniques and provide interventions of all types, excluding pharmacological

treatments" (p. 153). Copper and Nicholas (2012) note that in addition to engaging in the above-mentioned activities, clinical psychologists have also increasingly acted in a forensic capacity, assessing mental capacity in referrals from court cases.

Psychologists are required to register with the HPCSA in order to practice, and have to engage in continued education, with one-quarter of this training to be in ethics, in order to maintain their license and be allowed to practice (Cooper & Nicholas, 2012).

Evidence-based practice is an essential topic of discussion for South African clinical psychology. Many have argued that the adherence to evidence-based practice is necessary in the South African context because it allows for the majority of the population, who were denied access to mental health care in the past, access to the services. Kagee (2014) states that "the requirement is for social policy to be evidence-based so that financial, material, and human resources can be deployed in such a way so as to maximise the likelihood of success" (p. 353). If this requirement is not met, the population in need of these services will be denied these services again, "The South African mental health care system… cannot afford to continue supporting costly and time-consuming interventions if their effectiveness is unknown" (Kagee, 2014, p. 353).

Evidence-based practice as an imperative relates to the need for social justice in South Africa. Kagee (2014) states that, "From a social justice perspective, agitating for appropriate, evidence-based social services, including psychological treatment, is both a human rights and an epistemological imperative" (p. 355). It is argued that evidence-based services and interventions should be based around ongoing problems that face South African society such as "community and gender-based violence, child and sexual abuse, drug and alcohol abuse, medication non-adherence among those living with a chronic illness, and risky sexual

behaviour leading to infection with HIV and other sexually transmitted infections" (Kagee, 2014, p. 359). In addition to the need to focus on these problems and engage in conversation surrounding these problems, clinical psychologists need to engage in conversations surrounding the stigma of mental illnesses in communities, as "It has been determined that the stigma associated with behavioural and mental health problems is the single most significant barrier has to be overcome in efforts to promote well-being" (Pillay et al., 2013, p. 50).

Kagee (2014) argues that South African psychology cannot survive and thrive having a basis and using only Western models. Instead, the focus needs to shift toward indigenous knowledge, community focus, and prevention measures. However, this shift has been slow and often fractured as Kagee (2014) states that the field of indigenous knowledge "has not moved beyond the level of rhetoric to claim credible space in South African psychology" (p. 359).

2.1.4.1 Training and Experiences of Trainee Clinical Psychologists in South Africa

Pillay et al. (2013) and Pillay (2016) note that clinical psychology training in South Africa is considered to be of a high standard and that training programmes produce competent professionals, as evidenced by the "international recognition of locally trained clinical psychologists and the eagerness of high-income countries to employ them" (Pillay et al., 2013, p. 47).

Clinical psychology Master's training is a three-year qualification, with the final two years comprising of an internship year and then a year of compulsory paid community service, with formal registration as a clinical psychologist with the HPCSA at the end of

internship training and passing the board exam (Cooper & Nicholas, 2012; Pillay et al., 2013). Clinical psychology students are required to complete their internship year at a state health-care facility and at least half of their internship year in a psychiatric setting (Pillay et al., 2013; Pillay, 2016). Pillay et al. (2013) notes the issue of incomplete dissertations, and this has resulted in, "unnecessarily lengthened periods of training, with many poor communities that would have been serviced by these Community Service psychologists being disadvantaged by the delays in their assumption of duty" (p. 47).

The theoretical content, models, and precise scope of training differ between different training programmes in South Africa. However, Pillay et al. (2013) state that all training programmes fall within the globally used 'scientist-practitioner model'.

Pillay et al. (2013) note that after apartheid, more academics that were located at historically disadvantaged Black universities moved to historically white universities, which resulted in a lack of experienced academics at already disadvantaged institutions, "institutions previously disadvantaged by apartheid could continue to struggle against the tide, even in post-apartheid South Africa" (Pillay et al., 2013, p. 47). This suggests that the location of training could influence the professional identity of clinical psychologists.

Pillay et al. (2013) discuss the highly competitive selection process for clinical psychology, as each training institution generally only accepts a handful of students a year. A concern regarding this process is the small number of psychologists that qualify, compared to the urgent need for mental health services in the country. However, Pillay et al. (2013) state that, "the advantages of closely supervised, thorough, and intensive training far outweigh the disadvantages" (p. 48).

2.2 Experiences of Clinical Psychologists Internationally

While literature is limited on the experiences of clinical psychologists, the following section will discuss documented experiences such as burnout, feelings of helplessness, perceived competence/incompetence, and therapeutic confidence, and the importance of continued education and training (Hammond et al., 2018; McMahon, 2012, 2018; McMahon & Hevey, 2015).

Hammond et al. (2018) explore burnout in solo-practising clinical psychologists in Australia. According to Hammond et al. (2018), burnout is "conceptualised as a syndrome that consists of emotional exhaustion, depersonalisation, and decreased personal accomplishment" (p. 1). Hammond et al. (2018) discuss the symptoms related to burnout, and state that these symptoms are long-lasting and recur over time, these symptoms include "mental stress, fatigue, decreased personal accomplishment, negative affect, depersonalisation, reduced productivity and motivation, and insomnia" (p. 9). According to Hammond et al. (2018), inconducive work environments, too many cases to manage, long hours of work, lack of resources and inadequate facilities also lead to burnout in clinical psychologists. Another theme included that it is often thought by society and clients that the client's needs and rights override that of the clinical psychologist, instead of the needs and rights of both parties being balanced. Hammond et al. (2018) identified protective factors linked to managing burnout and avoiding burnout. These protective factors included supportive interpersonal relationships, continued education, peer support, and clinical supervision. Hammond et al. (2018) also provide a reason for the lack of information about the experiences of clinical psychologists, being that the confidentiality being an ethical principle "makes it incredibly difficult to trace the experiences of clinical psychologists over time" (p. 10).

McMahon (2018) discusses the concept of confidence of clinical psychologists in their work, particularly in practising psychotherapy. McMahon (2018) states that psychotherapy is "challenging, complex work… it calls for confidence in one's therapeutic approach, as well as an ability to tolerate and value uncertainty and vulnerability" (p. 218). McMahon (2018) and McMahon and Hevey (2015) suggest the common themes associated with a lack of confidence in clinical psychologists' role as psychotherapists include the feeling of training being fragmented and even inadequate compared to other psychotherapists, the need for clinical supervision and the effectiveness of this, and being able to connect emotionally with clients during psychotherapy. An important issue that emerged was the feeling of perceived incompetence in less experienced clinical psychologists, and the view that their training did not adequately prepare them, as seen in the statement "if I was better trained, I wouldn't feel so lost and so incompetent" (McMahon, 2018, p. 224). McMahon (2018) argues that clinical psychologists tussle with the "tension between working with the head and the heart within the clinical psychology profession" (p 224) and the balance between objectivity and empathy. The importance of supervision in developing confidence was a significant theme in the research conducted by McMahon (2018), "the need to have somewhere to go for support for their therapeutic work…essential to survival" (p. 224).

In an article by McMahon and Hevey (2015) confidence of clinical psychologists in providing psychotherapy also reflected the feelings of inadequate training reported by McMahon (2018). McMahon and Hevey (2015) state that feelings of incompetence and not being confident in their role providing psychotherapy is also because "therapeutic work is emotionally demanding and usually carried out in privacy with clients, meaning that practitioners have few natural opportunities for feedback in relation to their work" (p. 196). McMahon and Hevey (2015) state that confidence is impacted by supervision, and the better

the quality of supervision, the more confident the clinical psychologist feels. McMahon (2018) and McMahon and Hevey (2015) state that therapeutic confidence is also impacted by whether the clinical psychologist engages in personal therapy.

2.3 Professional Identity

Using the overview of the history of clinical psychology in South Africa and internationally, the current status of clinical psychology, the literature pertaining to clinical psychologists' training, and the documented experiences of clinical psychologists, the concept of professional identity is now explored.

According to Wagstaff and Quartiroli (2020), professional identity can be defined as "a constellation of professional self-concept attributes, beliefs, values, motives, and experiences people use to define themselves in specialised, skill- and education-based occupations or vocations" (p. 2).

Wagstaff and Quartiroli (2020) argue that professional identity is shaped in three ways. The first is that professional identity results from a "socialisation process and rhetoric, exposing an individual to information regarding the meanings associated with a profession" (Wagstaff & Quartiroli, 2020, p. 2). The second is that professional identity is not static and evolves in different periods of time engaging in the profession (Wagstaff & Quartiroli, 2020). Thirdly, Wagstaff and Quartiroli (2020) state that an individual's "life experiences influence professional identity by clarifying one's priorities and self-understanding" (p. 2).

Lancaster and Smith (2002) argue that professional identity is what distinguishes a profession from other professions and is determined in many ways including "the specialised knowledge and skills associated with the training, delineation of boundaries for areas of

expertise, professional activities, and the recognition of the profession at various levels: the general public, employers, other professionals, and legal authorities" (p. 48).

Wagstaff and Quartiroli (2020) apply a "6-dimension model of professional identity" to sports psychology (p. 3). These dimensions are that a professional is able to "demonstrate knowledge of a profession"; "articulate philosophy of the profession"; "establish expertise required of members of the profession and understand members' professional roles"; "validate attitudes toward the profession and oneself"; "be engaged in professional behaviours expected of members"; and "interact with other professional in the field" (Wagstaff & Quartiroli, 2020, p. 3). These dimensions contain the roles and practices of a clinical psychologist as mentioned previously, such as working in multidisciplinary teams, practising ethically, engaging in activities such as psychotherapy, and other duties.

Meijers and Lengelle (2012) argue that professional identity is not merely an internal construct, but it is rather influenced by a combination of internal and external factors that result in the formed identity, stating that a professional identity "is not constructed by the individual alone…but can only emerge and exist as a result of an interaction with others" (p. 159). Professional identity is not static but evolves as individuals and their situation changes, and the learning process that occurs from this. Meijers & Lengelle (2012) therefore argue that identity is "a practice ('doing identity rather than having one') of articulating, performing and negotiating identity positions in narrating career experiences" (p. 159).

2.3.1 Professional Identity of Clinical Psychologists

Lancaster and Smith (2002) state that in the past, the professional identity of clinical psychologists was distinctive from other professions and other fields within psychology due to the application of the scientist-practitioner model, as argued previously by Pillay et al.

(2013). However, Lancaster and Smith (2002) argue that this can no longer be used to distinguish clinical psychology as "the model is not unique to clinical psychology and therefore cannot be regarded as defining its identity as a speciality" (p. 48).

Lancaster and Smith (2002) argue that "If two or more professions, or specialities within a profession, lay claim to the same set of tasks and expertise, there will inevitably be a struggle for control and a testing of boundaries" (p. 48). This argument is especially relevant to the conversations surrounding the scope of practice of clinical psychologists as compared to, for example, counselling psychologist, as demonstrated by Young & Saville Young (2019).

The argument surrounding the risk of the blurring of the scope of practice of clinical psychology is summarised by Lancaster and Smith (2002) in the following statement, "Without a secure identity base, the profession of clinical psychology becomes more vulnerable to competition from other professions (e.g., medicine, nursing, social work), and from other specialities within psychology (e.g., counselling psychology, educational and developmental psychology)" (p. 48).

In the South African context, the exploration of clinical psychologists' professional identities is vital because of the history of apartheid and the changes that have come about since then end of apartheid that have implications for the contexts in which clinical psychologists work and live. Cowin et al. (2013) argue that professional identity is influenced by context and interaction. Therefore, it is worthwhile to investigate this in a South African context, where the norms and values of the profession of clinical psychology have changed drastically over the course of over 25 years.

Chapter 3 Research Methodology

This study forms part of a broader research project by Deane (2016), which involved a quantitative analysis of the professional identity of clinical psychologists in South Africa. The current study utilises the data collected from a question posed by Deane. Flanagan's (1954) critical incident technique (CIT) was used in this study to explore the professional identity of clinical psychologists in South Africa. According to Butterfield et al. (2009), the CIT "explores what helps or hinders in a particular experience or activity" (p. 268). In the case of this investigation, the activity is practising as a clinical psychologist in South Africa. The CIT is a methodology in this study rather than just a method used because a methodology, "provides guidance throughout a research study, offering one approach that links the goal of the study to the unit of analysis, to the methods for data collection and analysis, and to the reporting format" (Viergever, 2019, pp. 1066–1067). The CIT consists of five detailed steps, step one being "ascertaining the general aims of the activity to be studied"; step two is "making plans and setting specifications"; step three is "data collection"; step four involves the "data analysis"; and the fifth and final step is "data interpretation and report on the findings" (Butterfield et al., 2009, p. 267).

3.1 Research Aims and Questions

The aim of this research is to investigate South African clinical psychologists' experiences of their work in order to begin to map out a sense of the professional identity if clinical psychologists in South Africa.

The research questions posed are:

What are South African clinical psychologists' experiences of their work?

What are the implications of the findings for the professional identity of clinical psychologists in South Africa?

3.2 Research Design and Methodology

The methodology employed in this research is the critical incident technique. This research is exploratory in nature. The aim is to explore what the experiences of clinical psychologists in South Africa are and what implications this has for clinical psychologists' professional identity in the South African context. A qualitative approach to the research is appropriate because it allows for a detailed perspective from clinical psychologists about their experiences in their own words. The research design used was a survey as it allowed for a larger and more representative group of participants to be reached from various geographical locations and cultural contexts in South Africa.

Applying the CIT to this investigation, the first two steps of the CIT have been completed (Butterfield et al., 2009). The first step, which is to ascertain the general aims of the activity being studied (Butterfield et al., 2009), has been completed. The activity being studied is practising as a clinical psychologist in South Africa, and the literature review chapter gave an overview of the general aims of this practice. The second step, which is making plans and setting specifications (Butterfield et al., 2009), has also been completed. According to Butterfield et al. (2009) this step involves "defining the types of situations to be observed; determining the situations relevance to the general aim; understanding the extent of the effect of the incident on the general aim; deciding who will make observations" (p. 269). The type of situation is a critical incident that has occurred in the clinical psychologists' personal work or practice within the twelve months prior to participation in the study conducted by Deane (2016). The participants were asked explicitly to state what stood out as

particularly important from the incident, which will provide the extent of the incident's effect. An anonymous survey was used in the data collection, so deciding who would make observations was not necessary as the survey is a self-report measure.

3.3 Units of analysis and sampling procedure

To answer the research questions and achieve the research aims, the subjective experiences of clinical psychologists practicing in South Africa were required. The units of analysis were thus the critical incidents cited by the participants. Critical incidents can, as described by Viergever (2019), "be generally defined with regard to health services research to be factors, events, behaviours or experiences that result in satisfaction/dissatisfaction with care or that promote or detract from good quality delivery of care" (p. 1070). The research population was all clinical psychologists registered with the Health Professions Council of South Africa (HPCSA).

The sample for this research was obtained by Deane (2016) for a quantitative investigation of the professional identity of clinical psychologists.

The participants were contacted using the HPCSA's database via email. Therefore, this research employed purposive sampling, as the research question is refined to only clinical psychologists practising in South Africa. Snowball sampling was also employed as participants were asked to send the survey to other registered clinical psychologists that may not have received the email in order to reach a larger population. (Deane, 2016).

3.4 Data collection

Data for this research was collected by Deane (2016) for the quantitative analysis of the professional identities of clinical psychologists in South Africa. Deane (2016) employed

an adapted version of a survey that had been refined by Goodyear et al. (2016) in a study focussing on counselling psychologists globally. The survey has been adapted and refined multiple times but was originally developed by Kelly (1961), to study the professional identity of clinical psychologists (Deane, 2016). The critical incident question was posed to participants at the end of the survey conducted by Deane (2016), this was the first adaption of the survey to include a critical incident. This was included for a qualitative analysis to take place, and this analysis was not conducted by Deane (2016) as it was not within the scope of the research. Deane (2016) states that the critical incident section was included to be used in future studies and is "an extension of the original questionnaire and seeks qualitative data by asking professionals to cite an incident that particularly stands out in their personal practice or work as a clinical psychologist" (p. 33).

Deane (2016) describes the process of email communication with the participants:

> The email communication sent to participants inviting them to partake included a URL link to the online questionnaire… Those who followed the link and completed the online questionnaire contained therein did so out of voluntary choice. Participants had the option to discontinue their involvement at any stage and were assured of anonymity. It was clearly communicated to potential participants that, even if they received more than one invitation to complete the survey, that they be sure to complete the survey only once. Furthermore, the online survey settings prevented multiple responses from the same IP address. Participation was incentivised, offering those who completed the questionnaire an opportunity to anonymously enter their names into a raffle for a R2000 Exclusive Books voucher. (p. 29)

Deane (2016) states that the data was collected over two periods from October 2015 to April 2016. Participants were sent reminders to largen the sample size.

The critical incident open-ended question posed in the survey conducted by Deane (2016) was:

> Please think back over the past 12 months and then describe one incident that particularly stands out as having been significant to you in your personal practice or work as a clinical psychologist (whatever your work setting and responsibilities)
>
> a) A brief description will suffice. But please make sure that a reader can understand what happened.
>
> b) What was there about this situation that made it stand out as particularly important to you?

3.5 Data Analysis Plan

The data collected by Deane (2016) in the critical incident question posed was analysed using Flanagan's (1954) critical incident technique (CIT), more specifically the fourth step of the method (Butterfield et al., 2009). There are three stages within the fourth step to analyse the data (Butterfield et al., 2009). The first is "Determining the frame of reference" (Butterfield et al., 2009, p. 271). The frame of reference in this study is to analyse the experiences of clinical psychologists in South Africa, and the impact that these experiences have on their professional identity.

The second stage involves "Formulating the categories derived from grouping similar incidents" (Butterfield et al., 2009, p. 271). These categories were formed to determine the effect of the incident on the clinical psychologist and their professional identity.

The third and final stage of analysing the data is "Determining the level of specificity or generality to be used in reporting the data" (Butterfield et al., 2009, p. 271). According to Butterfield et al. (2009), this stage is determined "by practical considerations such as project budget, number of people available to analyse the data, the extent to which a few general behaviours will be useful compared to several dozen specific behaviours, and so on" (p. 271).

The data in this investigation was systematically sifted through and analysed. In the data collection process conducted by Deane (2016), 889 professionals responded to the survey; however, the sample size was adjusted to 877 to exclude student and intern psychologists. 476 participants answered the critical incident question, and 412 participants did not. The 476 participants are not excluding student and intern psychologists for the current investigation, firstly because of the literature highlighting the importance of trainee psychologists' experiences. Secondly, the answers stand alone and are anonymous. Hence, specification of whether the participant is a trainee or not is unknown.

As an anonymous survey was used in the data collection, it was not possible to follow up with participants who had not answered the questions posed in enough detail or to follow up and clarify these issues. For validity reasons that will be discussed in the discussion chapter of this study, these responses have been excluded. Several participants answered 'none', 'N/A', etc., to the question, and these have also been excluded. Exclusions have also been made in cases where the importance of the incident is not clear or has not been stated. The total number of critical incidents that were excluded was 66. Thus, the final data set included 410 critical incidents.

The data was analysed by going through each critical incident described by the participants, and separating the information yielding the incident's context, helping incident

and/or hindering incident. During this stage, the information was kept in the participant's words, to ensure that any important language or phrasing was not missed- which may change the meaning or importance of the incident in the analysis.

After the incidents were placed in their context and helping and/or hindering incidents were established. The formulation of categories began. This formulation involved splitting the incidents into positive experiences of work, negative experiences of work, and significant experiences of work. Significant experiences of work was utilised in the incidents that could not be deemed as positive or negative This formulation took place in a funnel process. Some of the incidents had more than one experiences, and this resulted in a total of 429 experiences found in the data set. There were 192 negative experiences, 162 positive experiences, and 75 significant experiences. The appendix illustrates the process of data analysis, namely putting the processing of the incidents into their contexts, yielding helping and/or hindering factors, creating categories, and adding further funnelling these categories into broader themes.

3.6 Ethical Considerations, Reliability and Validity

This study did not pose any significant ethical challenges, as the participants provided informed consent, the participants remained anonymous, and the participants could withdraw from the research at any time.

During the stage of interpreting the data and reporting the results, the relevant and applicable credibility checks associated with the CIT will be considered, and then reported on in the limitations section at the end of this study. (Butterfield et al., 2005). The relevant credibility checks are; "Exhaustiveness"; "Participation rates"; "Placing incidents into categories by an independent judge"; and "Theoretical Agreement" (Butterfield et al., 2009, pp. 274–278).

Chapter 4 Findings

The participants reported a total of 429 experiences related to their critical incidents. 66 of the participants responses were excluded. The remainder of the experiences were split into positive experience of work, negative experience of work, and significant experience of work. There were a total of 162 positive experiences of work, 192 negative experience of work, and 75 significant experiences of work. The significant experiences category has been added for the incidents that the participants did not provide the importance of the incident for their professional identity.

For this study, three categories were identified in relation to the aim of investigating South African clinical psychologists' experiences of their work in order to begin to map out a sense of the professional identity if clinical psychologists in South Africa. These three categories that will be focused on are: ‘positive outcome with clients’, ‘negative experiences working within a multidisciplinary team’, and ‘positive experiences working within a MDT’. These categories and their corresponding subcategories are now reported.

While there were other important themes found in the data, these three experiences were the most common and significant and will thus be focused on. Some of the other important common experiences were ethical dilemmas, the lack of understanding of the role of clinical psychologists, debates surrounding scope of practice, the impact of client suicide on clinical psychologists, and the importance of peer supervision and interaction.

4.1 Category 1: ‘positive outcome with clients’

Positive outcomes with clients as a category was the most commonly reported experience by the participants. This category accounted for a quarter of the total number of

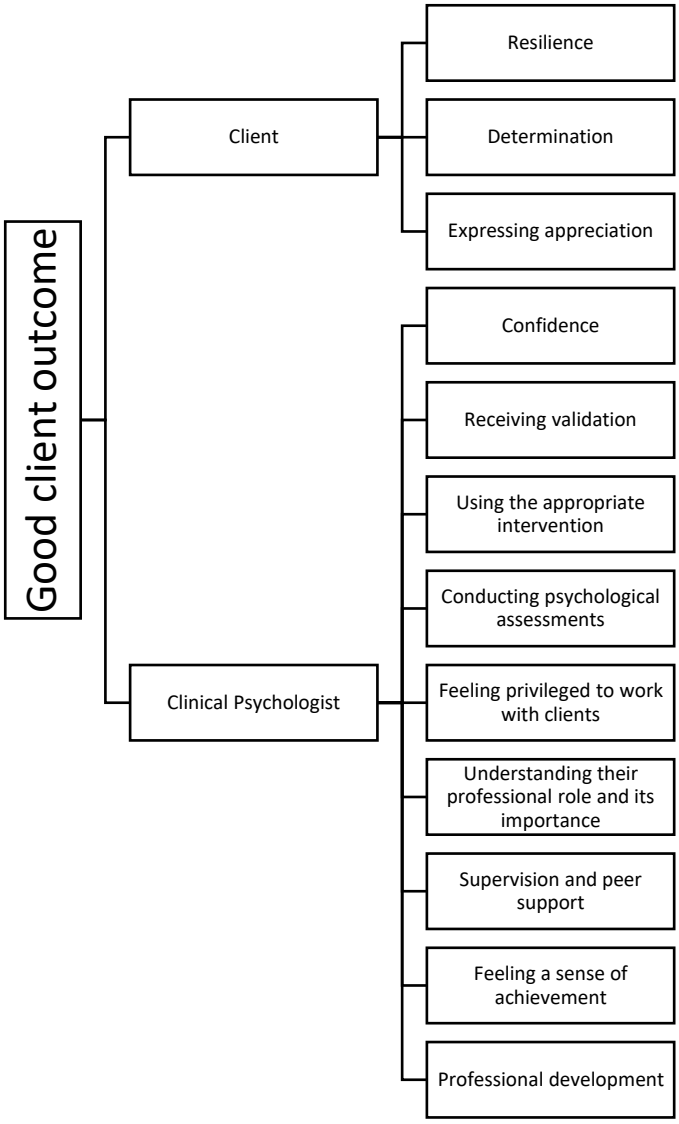
experiences reported. The most common subcategories included: clients expressing appreciation, therapeutic progress with clients, and reflection after a positive outcome with a client.

Important experiences detailing good client outcome that were also detailed in the data set were: good client outcome resulting from conducting assessments, using culturally appropriate explanations and metaphors to aid in a client's understanding of mental illness and thus breaking down the stigma of seeking mental health services, clinical psychologists correctly diagnosing clients who had been misdiagnosed by other professionals which resulted in a better quality of life for the client, making progress with long-term clients through rapport and building a therapeutic relationship, client's expressing their appreciation for the therapeutic space and the help that the clinical psychologist provided, the clinical psychologist recognising the client's resilience and determination and this influencing therapeutic progress, receiving validation in the work as a clinical psychologist, aiding the client towards self-empowerment, feeling privileged that they are able to do their work and feeling privileged that clients put their trust in them, making progress with particularly challenging clients, understanding their role as a clinical psychologist and this role guiding to a positive outcome for the client, good client outcomes and therapeutic progress increasing the clinical psychologist's confidence in their role, increased confidence and positive outcome for clients after seeking supervision and peer support, competence in combining theory and practice, strong therapeutic alliances aiding in therapeutic progress, feeling a sense of achievement, reflection of the power of therapy, acknowledging the importance of the role of a clinical psychologist and being cognisant of the responsibilities that accompany this role, competency in choosing the right approaches and interventions and being flexible and

reflective when making this choice, and good outcomes resulting from the clinical psychologist engaging in professional development.

Figure 1: Diagrammatic representation of ‘good client outcome category’ and related subcategories

4.2



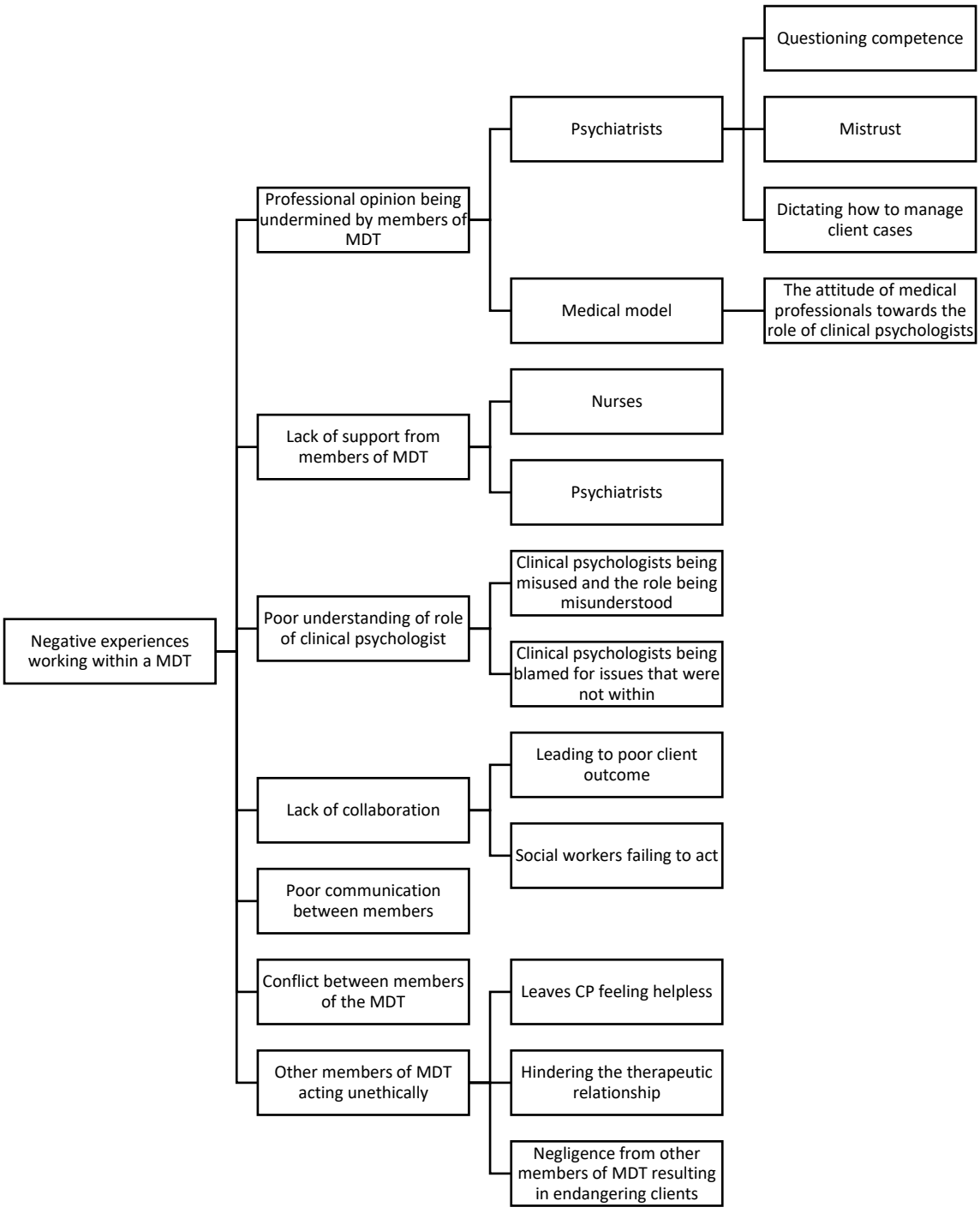
Category 2: ‘negative experiences working within a multidisciplinary team’

Many of the participants in this study reported negative experiences working within a MDT. The number of negative experiences working within a MDT were far more than that of

positive experiences. The participants reported a range of different types of negative experiences working within a MDT, with the most common being experiences of being undermined by other professionals within the MDT, negligence of other members of the MDT resulting in a negative impact on a patient, lack of support within the MDT, and poor collaboration within the MDT. The subcategories that will be discussed are: being undermined by other professionals within the MDT, and poor collaboration in the MDT

Important experiences detailed in the data set included: other members of the MDT, commonly psychiatrists, dismissing, undermining, and belittling the clinical psychologist's professional opinion, lack of collaboration within the MDT, poor communication between members of the MDT, the role of a clinical psychologist being misunderstood, being misused, other professionals hindering and impeding the therapeutic relationship between a client and a clinical psychologist, conflict with other members of the MDT, other members of the MDT failing to play their role and acting unethically, feeling helpless when recommendations are not taken seriously and the client being impacted, clinical psychologists being blamed for issues not within their role in the MDT, the lack of understanding that colleagues have about the role of a CP, other members of the MDT breaching confidentiality, in hospital settings feeling unsupported by nursing staff, psychiatrists questioning the clinical psychologist's competence and telling the clinical psychologist how to manage their patient, mistrust from psychiatrists, failure of social workers to act on clinical psychologists recommendations, negligence from other members of MDT resulting in endangering clients, lack of support within the MDT, clinical psychologists taken for granted, the attitude of medical professionals towards the role of clinical psychologists, and negligence of MDT resulting in client death.

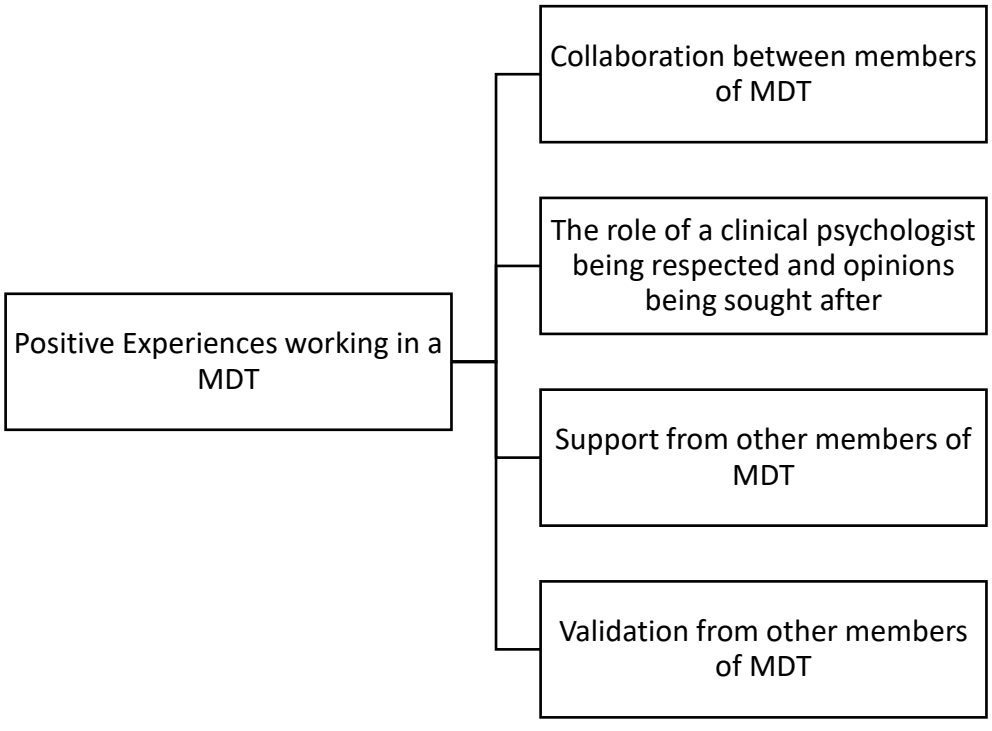
Figure 2: Diagrammatic representation of ‘negative experiences working within a MDT’ category and related subcategories



4.3 Category 3: ‘positive experiences working within a MDT’

While there were more negative experiences working within a MDT than positive experiences working within a MDT, positive experiences working within a MDT was an important category in the data set. Positive experiences working within a MDT as a category can be broken down into subcategories such as collaboration of a MDT resulting in progress or positive outcome for a client, discussions within the MDT resulting in new ideas and treatment plans for clients, clinical psychologists reporting on the importance of MDTs in treating patients that require multiple interventions and working together to make a suitable programme for a client, feeling supported by other professionals in the MDT, mutual respect between members of a MDT, being able to reflect as a team rather than individually, validation resulting from a professional opinion being respected and valued, the opinions of clinical psychologists being sought after, and being able to engage in cases and areas that would not be accessible without being a member of a MDT.

Figure 3: Diagrammatic representation of ‘positive experiences working within a MDT’ category and related subcategories



Chapter 5 Discussion

In this chapter, the categories ‘positive outcomes with clients’, ‘negative experiences working within a MDT’, ‘positive experiences working within a MDT’, and ‘negative experiences attributed to contextual factors’, which were procured from the critical incident data, will be discussed and compared to the relevant recent literature. This section explores the implication of the findings on the professional identity of clinical psychologists in South Africa. The meaning that the psychologists made from their experiences will be used to formulate an idea of clinical psychologists' professional identity in South Africa.

5.1 Positive outcome with clients

A positive outcome with clients was the most commonly reported category by the participants. The reported experiences related to the positive outcome varied, with the most common being receiving appreciation from clients, therapeutic progress, and reflection on performing the role of a clinical psychologist.

5.1.1 Clients expressing appreciation

The impact and meaning of clients expressing appreciation were present in many of the experiences reported by the participants related to a positive outcome with clients. This subcategory seems to be linked to the participants feeling validated and having confidence in their role. Many participants reported the positive impact of having a client express appreciation or reach out after termination of services to thank the clinical psychologist.

Participants that reported experiences of clients expressing appreciation stated that this was significant because it served as a reminder of the importance of the work that they do. Critical incident 171 demonstrates the significance of the client expressing appreciation

for the participant, as the participant reports receiving a call from an ex-patient, whom they did not think that they had a significant impact on, and the client told them that, “therapy had been the most important thing in her life and to tell me of the changes she had made”. This appreciation impacted the participant's confidence and the importance of feeling validated in their role as a clinical psychologist. McMahon and Hevey (2015) discuss that therapeutic confidence is based on three factors, these being “practitioner experience…, personal experience…, and knowledge” (p. 196). The implication of this finding for clinical psychologists' professional identity in South Africa is that confidence and competency in the role as a clinical psychologist are important for a strong professional identity. The concept of therapeutic confidence and competence in the role as a clinical psychologist as seen in the participant’s experience demonstrates that professional identity is formed by both internal and external factors, and is influenced by a professional’s interaction with others (Meijers & Lengelle, 2012). The basis of therapeutic confidence as stated by McMahon and Hevey (2015) is related to the ways that Wagstaff and Quartiroli (2020) state that professional identity is shaped as it demonstrates that professional identity is a process and will evolve with a clinical psychologist’s experiences, both professionally and personally and that different experiences that yield different meanings for the participants will aid in this ongoing process of professional identity formation.

McMahon and Hevey (2015) argue that the importance of therapeutic confidence is that “it is likely that psychologist’s confidence as a therapist helps to enhance his or her effectiveness and foster the common therapeutic conditions” (p. 196). This indicates that therapeutic confidence is beneficial for the client as well as the therapist, as receiving positive feedback, validation, and appreciation from clients will increase perceived competence, and increase confidence, leading to a more robust professional identity. McMahon and Hevey

(2015) also emphasise that while therapeutic confidence is important for client outcome, lack of confidence in the role as a clinical psychologist is not uncommon and can occur at any time throughout a career. McMahon (2018) argues that an essential part of being a clinical psychologist is the "ability to tolerate and value uncertainty and vulnerability" (p. 218). It can therefore be concluded that whilst therapeutic confidence will aid in a good client outcome and a strong sense of professional identity, a lack of confidence or questioning competence in a professional role is does not equate to a weaker professional identity- instead, it is how the clinical psychologist reflects and manages this uncertainty.

The experiences of clients expressing appreciation also seemed to have prompted the participants' reflection on their role as clinical psychologists. Critical incident 272 demonstrates the effect of this appreciation on the professional identity of the participant, in which the participant, who was doing their community service year, explains an experience with a client, "who burst into tears in the middle of our session and thanked me for understanding her. It was a moment of understanding the significance of my own human-ness in my work as a psychologist". This moment of understanding and reflection of their work as a psychologist has an influence on their professional identity. In the investigation conducted by Hatcher et al. (2012) exploring what psychotherapists learn from psychotherapy with their clients, it was determined that psychologists gain knowledge from their clients through a strong therapeutic relationship and this "augments their wisdom both personally and professionally" (p. 11). This further suggests that clinical psychologists' professional identity is greatly influenced by interactions with clients when conducting activities such as psychotherapy.

5.1.2 Therapeutic progress with clients

The importance of therapeutic progress with long-term or more challenging clients was a common experience reported by the participants. A sense of achievement for the participant and the client seemed to be the underlying meaning in these experiences.

This sense of achievement is demonstrated in critical incident 383 in which the participant had a long-term client whom they describe as “chronically suicidal and has suicide attempts and multiple hospitalisations over the years”. Importantly, this critical incident does not focus on an outcome but rather focusses on the importance of the progress for the patient. The participant notes that the patient “managed to get herself to emergency services before she harmed/attempted suicide” and this resulted in the participant feelings “great joy at her accomplishment and sign of agency emerging”. This suggests that professional identity may be influenced by a clinical psychologist’s effectiveness in their role rather than just the role itself which is supported by the dimension model developed by Wagstaff & Quartiroli (2020) which states that professionals must be able to perform the expected roles of a profession effectively. This incident also suggests that making progress with particularly challenging clients can be linked to confidence and competence, as this results in professional progress for the clinical psychologist as well as therapeutic progress for the client.

A number of participants reported incidents in which they were able to diagnose clients whom other professionals had previously misdiagnosed. This demonstrates the unique role of a clinical psychologist, as well as the professional implications such as increasing confidence in the role of a clinical psychologist. Making the correct diagnosis demonstrates the importance of competency in performing the activities of the profession as stated by the HPCSA (2019) which include “the assessment, diagnosis, evaluation, and treatment of psychological and mental health disorders” (p. 2). Clinical psychologists' professional

identity in South Africa is rooted in these activities, as they are necessities in practicing ethically and competently in the profession.

Critical incident 474 also demonstrates the participant's effectiveness in their role as a clinical psychologist as well as the impact of a client's therapeutic progress on the participant. This detailed the participant's experience of telling a young borderline personality disordered patient what their diagnosis is and the resulting "understanding, relief and hope" for the client that came from this. The participant further notes that the client has since made significant strides in their recovery and functioning stating that the client will be attending university the following year which is something "she and her family did not even dare hope could happen". As seen in this incident, the value of the participant providing the client with a diagnosis and the resulting therapeutic progress demonstrates competency and contributes to their professional identity.

Experiences relating to using culturally appropriate explanations in understanding mental illness shows competency in being a clinical psychologist in the South African context, which would make this professional identity unique to clinical psychologists practicing in South Africa. As mentioned in the literature, the stigma surrounding mental illness in South Africa is a significant obstacle in mental health-seeking behaviours (Kagee, 2014). Breaking this stigma with clients and communities, resulting in positive outcomes and therapeutic progress is essential for a clinical psychologist practicing in South Africa.

5.1.3 Reflection after a positive outcome

A number of participants reported incidents that stood out because of the client's resilience and determination, resulting in a positive outcome for the client. Participants who reported feeling privileged to work as a clinical psychologist emphasised the trust that

patients put in the psychologist and the responsibility that comes with this trust. The feeling of privilege will impact the clinical psychologist's professional identity as it will strengthen this identity. Critical incident 330 demonstrates this reflection, whereby the participant explains the significance of "terminating with long term patient, made me realise anew how privileged we are, as well as the ethical responsibility we carry for people that share their lives with us on such a deep, trusting and meaningful way". This recognition of responsibility and privilege will strengthen the participant's professional identity. This incident also demonstrates the importance of understanding a clinical psychologist's role was reported by many participants. This understanding has implications for therapeutic confidence, competence, and professional identity. Clinical psychologists with an understanding of the role that is expected within the profession will have a stronger sense of professional identity.

5.2 Negative experiences working within a MDT

Negative experiences working within a MDT were more prevalent than positive experiences in the data analysis. The most commonly reported negative experiences involved clinical psychologists being undermined within the MDT, mostly by psychiatrists, as well as lack of collaboration and support within the MDT.

5.2.1 Being undermined by other professionals within the MDT

Participants reported incidents of their professional capacity as a clinical psychologist being undermined by other members of the MDT. The majority of these reported incidents involved psychiatrists undermining the participants, with the consensus that the medical model was seen to be more important than psychological intervention. Participants noted experiences where psychiatrists or other medical fraternity members disregarded their professional opinion and questioned the participant's clinical judgement. Critical incident 154

demonstrates this issue as the participant states that “the problem I’m experiencing in my work place is being told by psychiatrist on how to case manage my patient”. This demonstrates the negative impact on the participant because of having their professional competence questioned by a team member. Critical incident 161 concurs with this experience as the participant states that their team has had repeated experiences of being criticised by psychiatrists. These findings concur with the statement made by Pillay (2016) that, “some psychologists in state hospitals find their autonomy as mental health practitioners eroded through undue influences of the medical model” (p. 153). Although clinical psychologists perform a unique role within MDTs, this role is often not valued by other professionals within the MDT, which has negative implications for clinical psychologists' professional identity. This suggests that the emphasis on the medical model in hospital settings may result in hierarchies being formed within the MDT. This hierarchy undermines a clinical psychologist’s expertise and competency, which may result in a negative outcome or lack of progress for the client.

5.2.2 Poor collaboration and lack of support in MDT

Poor collaboration and lack of support within the MDT was another common experience within this category. The poor collaboration had adverse effects on the participants and, in some incidents, the patient. Several participants reported that lack of support from other members of the MDT resulted in them being in harmful situations. Negligence of other members of the MDT is also included in the subcategory because of the negative implications for patients.

Many participants in the critical incidents reported poor collaboration within the MDT resulting in poor patient outcome. The experiences of poor collaboration mainly involved

recommendations made by the participants not being implemented, or their clinical judgement being ignored by other members of the MDT. Critical incident 193 details a participants experience in which a patient attempted suicide due to the “negligence of a medical officer”. The participant states that although they had performed their role in the case which that they “arranged for his admission and notified the doctor on duty of the urgency of the case”, the doctor’s failure to act in a timeous manner and perform their role on the case resulted in the participant being called “when the patient attempted to kill himself and was involved in trying to restrain the patient who eventually cut himself badly”. This incident demonstrates that working within a MDT is only effective if the members collaborate in the patient's best interest. Experiences such as this can have a negative effect on the professional identity of clinical psychologists in South Africa, because of the frustration of fulfilling their role on the MDT, but other members failing to collaborate with them.

Another experience that the participants reported relating to negative experiences within a MDT is other members of the MDT being a hindrance to the therapeutic relationship between the participant and client. Critical incident 51 demonstrates how the therapeutic relationship can be impacted as a result of the negligence of another member of the MDT. The participant states that “after a series of therapy sessions, my client (14) was asked to attend a panel meeting with the multidisciplinary team. After I requested that the child not be present whilst her case is discussed (it would be in conflict with our therapy, which is more strategic and indirectly orientated), the social worker called the child in and belittled her in front of her family and other professionals. She got hysterical and I had to remove her from the situation”. This negative experience has consequences for the therapeutic relationship as well as for the client. In addition, the clinical psychologists’ recommendation was ignored in this situation which resulted in a negative client outcome. Similarly, critical incident 118

details negligence from other members of the MDT, which resulted in the “contamination of a private therapeutic process through heads of staff and management personnel leading to termination of services and ultimately disappointing the client and damaging the therapeutic relationship”. These experiences demonstrate that professional identity will be impacted by these types of negative experiences working within MDT because professional identity is influenced and formed around internal and external factors, including interactions with others. (Meijers & Lengelle, 2012; Wagstaff & Quartiroli, 2020).

5.3 Positive experiences working within a MDT

Positive experiences working within a MDT is a crucial point of discussion in the analysis of clinical psychologists' professional identity in South Africa because the experiences reported by participants are examples of the strides that have been made in the profession and the potential that a well-functioning MDT has. The subcategories discussed along with the implications for professional identity are ‘collaboration between members of a MDT’ and ‘support from other members of a MDT’.

5.3.1 Collaboration between members of a MDT

The importance of a clinical psychologist is demonstrated in this category as they perform a unique role within the MDT and their scope of practice allows them to collaborate with the other members of the MDT to provide multiple methods of treatment, for example providing interventions such as cognitive behavioural therapy along with a psychiatrist prescribing medication. Critical incident 234 demonstrates the positive impact that this collaboration has on the patient and the professional; the participant states that “often at the psychiatric facility that I work there are difficult patients. Watching a MDT come together in order to form a cohesive treatment plan with relevant parties makes me grateful to be part of

a multi-disciplinary team". This reported experience shows the importance of effective MDT in hospital settings and the role the clinical psychologist plays in an MDT.

Another critical part of this subcategory is reflecting as a team rather than reflecting individually and having support in this reflection. The participants also noted the importance of being respected and valued and having their professional opinions sought after.

Critical incident 102 details the MDT managing a difficult patient. The participant states that "Through discussions with the multidisciplinary team a behavioural programme was initiated. This was then integrated into therapy and theoretically orientated through and existential approach. The patient has since greatly improved. The integration of existential and behavioural approaches alongside active involvement from all team members has been critical to my professional development". This experience demonstrates the potential that effective collaboration has within a MDT, as well as the crucial role that a clinical psychologist has within a MDT, demonstrating competency and a strong professional identity through collaborating with other professionals.

Critical incident 316 gives a thorough example of good collaboration within a MDT and a clinical psychologist being respected within a MDT. This experience demonstrates how professional identity is constantly evolving and how it is formed through interactions with others, in this case other medical professionals.

> Within the medico-legal context, on a daily basis the experts (health care practitioners) collaborate and refer to each other. We rely on one another's reports and findings to make a conclusion regarding the functioning of patients. Neurosurgeons (almost every time) refer to Clinical Psychologists for opinions regarding the neuropsych functioning of clients. This stands out for me because it is a collaborative

> approach. I feel like part of a team and my opinions matter. This is not like when I worked in a mental health institution several years back where the Psychiatrist is the only person with an opinion and Psychologists are completely disregarded. I enjoy being part of a team. We may not speak face to face, but our reports address one another and our respective opinions. In this context, Psychologists opinions are sought after and respected.

Mutual respect within the MDT is important for professional identity because of the common negative experiences that many clinical psychologists have in that they aren't taken seriously in their role, compared to psychiatrists and doctors.

5.3.2 Support from other members of a MDT

Having support from other members of the MDT was another important subcategory detailed by the participants. This support strengthens the clinical psychologist's professional identity while in many cases also results in a positive outcome with the client.

Critical incident 160 states the importance of this support stating that the work of the MDT stood out for them as "a very strong therapeutic alliance is required to manage high risk patients". This was in the case of a "high risk adult patient with diagnosis of Bipolar Mood disorder and Borderline Personality traits and complex family dynamics, that did not divulge crucial information to me to manage risk appropriately. Patient was then referred to state facility where can be managed in a team setting". Support within the MDT had a positive effect on the participant and on the patient.

Support within the MDT is important to professional identity in situations that prove to be particularly challenging to a professional. Critical incident 230 demonstrates the impact

of this support on the professional identity of the clinical psychologist. The participant stated that,

> A child that I work with tried to commit suicide while admitted as an in-patient. It was very traumatic for the whole team- and really challenged us about how to think and support the child. While very harrowing it really challenged us and I think as a result we worked well together as a team to come up with solutions.

Chapter 6 Conclusion

In conclusion, the most common and influential experiences that clinical psychologists face in their work have been identified and discussed as positive outcomes with clients and positive and negative experiences working within multidisciplinary teams.

The experiences of positive outcomes with clients are influenced by clients expressing their appreciation, therapeutic progress, and reflecting after positive outcome. Negative experiences working within a MDT are related to being undermined by other members of the MDT, and poor collaboration and support within the MDT. Positive experiences working within a MDT were related to collaboration between members resulting in a good outcome, and having support from the MDT.

The most prominent implication that these findings have on the professional identity of South African clinical psychologists is that professional identity is co-constructed by the interactions with others, such as clients, colleagues and MDTs. This co-construction of internal and external factors is present in all of the discussed categories, which is supported by Lancaster and Smith, 2002; Meijers and Lengelle, 2012; Wagstaff and Quartiroli, 2020.

There were significant methodological and theoretical difficulties in this research. The limitations of this study are that much of the data was not able to be interpreted because the survey was anonymous, and the CIT relies on thorough information from participants which acquired through multiple interviews, which was not possible in this case. The data set was representative because of the size, however, because of the data collection technique and the subsequent methodology that was chosen, the value-laden nature of qualitative research was not able to be achieved.

Recommendations for further research to identify the professional identity of clinical psychologists in South Africa should involve conducting thorough interviews with clinical psychologists and conducting a thematic analysis on the reported experiences, or a critical incident methodology with the benefit of being able to follow up with the participants to ensure scientific rigour. It is also recommended that in the case of particularly vivid accounts from participants that are traumatic in nature, debriefing should be offered to the individual analysing the data, because of the potential for secondary trauma.

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Appendix

A. Example from data analysis process (page 26 of 114)

NO	CONTEXT	HELPING	HINDERING	CATEGORIES	THEMES
121	CP's patient in a psychiatric unit had been diagnosed with cancer and refused treatment because patient believed this could prolong stay in the unit. One of the medical staff on the unit forced patient to disclose her health status over the phone to her family in front of staff.	Incident reminded CI of role to protect the humanity of every patient.	CP felt that this was an infringement on patients rights and embarrassing and distressing for patient. Incident made CP think that stress an throughput pressures can lead well-meaning professionals to be unempathetic to psychiatric patients	MDT, breach of confidentiality	Negative experience of work- MDT/ breach of confidentiality
122	Colleague of CP was stalked by a past patient at the psychiatric clinic where they worked.		CP felt unsafe at work as the past patient would often arrive at the gate.	unsafe work environment	Negative experience of work- context, client/ unsafe work environment
123	CP working with a client suffering ongoing and continuous trauma		For a time this left the CP feeling paralysed.	ongoing trauma of client, lack of movement impacting CP	Negative experience of work- client/ secondary trauma, lack of progress
124	CP states that at university the distinction between clinical and counselling psychology is often questioned.	The involvement with other universities have impacted positively on this and changed positions in the department.	The HOD of the department is a counselling psychologist and a post modernist-minimising the importance of aspects such as assessment. CP states that this can cause conflict as they are a CP with a passion for the subject.	distinction between clin and counselling psychology. Conflict of this	Negative experience of work- colleagues/ distinction between clin and counselling psych