A survey of the professional identity of clinical psychologists in South Africa

A thesis submitted in partial fulfilment of the requirements for the degree of

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by

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Declaration

I declare that this thesis is my own work and that any work that is not mine has been rightfully and properly acknowledged. The thesis is submitted for the degree of Master of Arts (Clinical Psychology) at Rhodes University. It has not been submitted before for any degree or examination at any other university.

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Dedication

This thesis is dedicated to my late brother, David Eadie,

who was passionate about transformation in post-apartheid South Africa.

Abstract

The mental health care needs of South Africa have shifted significantly in the post-apartheid context of changing political and socioeconomic landscapes. However, the extent to which clinical psychologists' professional identity has responded accordingly has been unclear. By establishing the practice patterns and values that should be central to the profession according to the literature, and ascertaining the extent to which these are reflected among professionals at this time, this study facilitates a re-evaluation of the professional identity of clinical psychologists in South Africa. To this end, an online survey method was used to collect data from a representative sample of 877 participants, i.e. 29,09% of the population of clinical psychologists in South Africa. Statistical analyses were implemented to address a number of key research questions concerning aspects which characterise professional identity, namely: demographic profile; work settings and roles (practices); and theoretical perspective, beliefs and attitudes (values). Findings suggest that, demographically, clinical psychologists do not mirror the clients they serve, and also that there is a large proportion of the population for whom psychological services remain inaccessible and/or inappropriate. Furthermore, the professional identity of clinical psychologists currently does not comprise practices and values which meet the mental health care needs of South Africa. A significant recommendation of the research is its endorsement of the National Health Insurance model given the promise of its role in ensuring psychology remains relevant. It is recommended that future studies expand on these findings qualitatively, and compare clinical psychology with other mental health care fields. Universities are also urged to relook at their training curricula and ensure that trainees are made of aware of issues of policy, and that areas of research and psychological assessment in complex environments are prioritised. *Keywords: Values, practices, professional identity, clinical psychologists, clinical psychology, mental health care, South Africa*

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Chapter 1 Introduction

This study explores the professional identity of clinical psychologists in South Africa. Essentially, professional identity is understood to mean "the 'sense of self' that is derived and perceived from the role we take on in the work that we do" (Erikson, 1968, as cited in Cowin, Johnson, Wilson, & Borgese, 2013, p. 84). In the post-apartheid context of changing political and socioeconomic landscapes there has been a recognised responsibility to relook at the role that clinical psychologists play in meeting the shifting needs of mental health in South Africa (Kagee, 2014). The extent to which professionals are echoing such shifts in the way they practice and in the values they endorse has, however, been unclear. It is from this standpoint that this research project set out to survey the professional identity of clinical psychologists in South Africa.

This introductory chapter offers a brief overview of the study and substantiates its rationale. The concept of professional identity is then explored. This systematic consideration of the foundational concepts of the project serves to clarify its parameters and focus its investigation.

1.1 Rationale for research

In order to contextualise the professional identity of clinical psychologists in South Africa, consideration of a number of governmental documents has proven useful in tracking the development of South African mental health policy. Firstly, the White paper for the Transformation of the Health system, released in 1997, highlighted the limitations of the South African health care system. With respect to mental health in particular, this governmental paper asserted that services were "neither appropriate nor accessible" to the majority of South Africans, especially those rurally

based (Department of Health, 1997, p.84). The case for a primary health care model was thus made, advocating a move away from institutionalised mental health care to community settings.

The introduction of the Mental Health Care Act, no.17, of 2002 further consolidated this progression, asserting the human rights of those living with mental illness - their right to sufficient care included (Department of Health, 2002). Indeed, the National Mental Health Policy Framework and Strategic Plan 2013-2020 encompasses these transformative viewpoints and conveys an encouraging sense of prioritisation of mental health in South Africa (Department of Health, 2013).

The progression reflected in these documents suggests that mental health in South Africa is finding its place in the public health arena. Debate regarding re-examination of the mental health profession in the context of post-apartheid South Africa is lively as role players work toward a better suited mental health care system (Pillay, Ahmed, & Bawa, 2013).

It is, however, important to note that alongside the optimism of this picture, exist great obstacles. Pillay, Ahmed, and Bawa (2013) highlight that professional psychology is a field that "straddles both apartheid and post-apartheid eras" (p. 46) and imply that the shifts required in order to meaningfully adapt are significant. Challenges include limited funding, insufficient posts for mental health professionals, social stigma regarding mental illness, and the high cost of training for psychologists, psychiatrists, counsellors and social workers (WHO-Aims, 2007, as cited in Kagee, 2014b; Swartz, 2006).

The rationale for this research is based on the argument that in pursuit of understanding the adaptation of clinical psychology to a changing landscape, it is vital to establish the views and perceptions of the professionals navigating these shifts. Previously, Pillay and Petersen (1996) surveyed the practice patterns of clinical and counselling psychologists (collectively) and their attitudes to transforming mental health policies in South Africa. Subsequently, Young (2013) and Goodyear et al. (2016) studied the (a) domains of practice, and the (b) values of counselling psychologists in their consideration of professional identity among those in that field. This study explores professional identity with respect to these same criteria among clinical psychologists specifically.

Findings will be reflected upon in terms of relevant literature pertaining to clinical psychology and mental health in South Africa. Prior to presenting this literature in the chapter which follows, however, the concept of professional identity is further explored.

1.2 Definition of professional identity

The aforementioned understanding of professional identity, i.e. the "'sense of self' that is derived and perceived from the role we take on in the work that we do" (Erikson, 1968, as cited in Cowin, Johnson, Wilson, & Borgese, 2013, p. 84), links identity (i.e. values) and action (i.e. practices). Kullasepp (2006) argues for a definition that suggests a dynamic relationship between these aspects (of practices and values), portraying professional identity as an "open system wherein changes constantly occur" (p. 259). Kullasepp (2006) considers the mechanisms of these changes to be complex, recognising the contribution of a number of internal and external factors. This view gives weight to the influence of individual as well as societal and national contexts in

which a profession is practiced and thereby suggests that professional identity is co-constructed. This study is thus interested in the co-construction of the professional identity of clinical psychologists within the changes taking place at national, societal and individual levels in the South African context. Castro-Tejerina (2014) points out that change is ongoing, as should be professionals' response to change, and is of the view that professional identity is most usefully seen not as an essence or a structure, but as a process.

In studying the development of professional identity among clinical psychology graduates, McElhinney (2008) concurred that 'role behaviours' (i.e. practice) and 'views of the self' (i.e. identity and the values encompassed) are fundamental components to the concept. Like Kullasepp (2006), this author also recognised the contribution of a number of internal and external factors and, based on data collected as part of a constructivist grounded theory study, proposed a model of professional identity. This model incorporates aspects of practice and of values, and accommodates the intersection of internal and external factors - all of which arguably facilitate or impede a person's ability to identify with a professional role.

Notably, McElhinney's (2008) asserts that the extent to which a professional role is internalised depends largely on whether or not there is equilibrium between a person's 'role behaviours' (i.e. practices), including a perceived level of competence and ability to meet role expectations; and their 'views of the self' (i.e. identity and the values this encompasses). Moreover, this equilibrium between practices and values is understood to rest on the fulcrum of two concepts: 'role ambiguity' and 'role conflict'; where 'role ambiguity' refers to the extent to which a shared understanding of the scope of one's responsibilities in a particular profession

exists, and 'role conflict', the extent to which there is congruence between a person's practices and a person's values in the roles they perform (Kahn et al. 1964, in McElhinney, 2008).

The concept of professional identity is thus useful in facilitating an understanding of who clinical psychologists in South Africa currently are: the practices which define their professional roles, and the extent to which these are supported by a shared scope of practice; the values which inform their professional roles, and the extent to which these are congruent with practice patterns; and the internal and external factors that shape these practices and values, e.g. gender, race[1], age, level of education and the changing political landscape of South Africa.

1.3 Chapter summary

Professional identity is thus best understood as a process of co-construction that is influenced by individual, societal and national dynamics. In considering the professional identity of clinical psychologists in South Africa, this research is interested in practices and values because they have been identified as key aspects that comprise the fulfilment of these professionals' roles in response to the changing mental health care needs of the country. Accordingly, this study aims to facilitate a re-evaluation of the professional identity of clinical psychologists, establishing the aspects of practices and values that should be central to the profession according to the literature, and ascertaining the extent to which these are reflected

[1] The use of race as a variable in research is controversial, given our history of racial segregation. However, many of the cleavages in South African society, particularly in relation to socioeconomic status, continue along racial lines due to our apartheid past. Therefore, there continues to be value in the use of these categories (Bowman, Seedat, Duncan, & Burrows, 2006).

among professionals at this time. In this way, the study promises to play a valuable role in establishing the extent to which professionals are echoing shifts in mental health care needs.

Chapter 2 Literature Review

This section explores relevant literature pertaining to the concept of professional identity insofar as it applies to clinical psychologists in South Africa. First, the field of clinical psychology is contextualised in terms of its history (briefly internationally and largely nationally) and in terms of the current status quo of national mental health in South Africa. The focus of the literature review then turns to some of the practices and values that researchers have called for in order to make clinical psychology relevant to this context. Lastly, studies that have surveyed the professional identity of psychologists previously (as briefly mentioned in section 1.1) will be overviewed, in order to provide further context to the focus of this research project.

2.1 Context

A historical overview of the development of the field of clinical psychology is considered in order to track the evolving needs of mental health care services over time, as well as to place issues in relation to clinical psychology in South Africa within a broader, international, context. Indeed, the ways in which professionals internationally have responded to these needs (of mental health care services), and shaped their professional identity accordingly, has set the stage for subsequent developments concerning the practices and values which have come to constitute clinical psychology.

2.1.1 Historical roots of clinical psychology internationally and nationally

Reisman (1991), in his account of the development of clinical psychology, reminds us that "a history has no definite beginning or end" (p. 3). Even though the first psychology clinic in the world was opened in 1896, signifying the formal origination of the field, Maher and Maher

(1985, cited in Reisman, 1991) point out that the intellectual and social fabric of the 19th century (i.e. that which gave rise to the values and attitudes that welcomed clinical psychology as a way in which to meaningfully understand human behaviour) had been developing over the preceding two centuries. Reisman (1991) states, "the content and questions of this new field, psychology, would be the same as those that perplexed philosophers, but its method of finding answers would be scientific" (p. 15).

Indeed, there has been historic debate about whether psychology - the study of mental processes and thoughts – should be considered a science or a practice. Routh (2011) asserts that clinical psychology's historical association with medicine, which was seen as "not only a profession but also a scientific field" (p. 23), played a significant role in its adoption of a scientific model to serve as its basis. While the scientific paradigm might have been most appropriate in complementing the needs of the medical settings in which the field was founded, many argue that the scientific model is not adequate in capturing the nuanced complexities which comprise the practice of contemporary clinical psychology (Lane & Corrie, 2006). The reasons for this tension become clearer upon consideration of the respective contributions of science- and practice-oriented proponents, which follows.

The field of clinical psychology is usefully contextualized by the contributions of two influential founders, William James (1842-1910) of the United States of America, and Wilhelm Wundt (1832-1920) of Continental Europe. Wundt argued for the quest of "pure knowledge" (Lane & Corrie, 2006, p. 10), advocating for measures and observations to be carried out in controlled conditions in order for phenomena to be appropriately analysed; James, on the other

hand, argued that truth is relative, particularly when it comes to human behaviour and thought, and advocated for an approach characterised by "philosophical pragmatism" (p. 10). While both these views brought value to the field, opinions differed regarding which perspective should be emphasized in the progression of clinical psychology.

In the meantime, the reverberating effects of the World Wars of the 20th century made their mark on the field of clinical psychology, significantly shaping its development. The World Wars demanded of the profession efficient and standardised tools in order to place military staff appropriately, thus progressing the practice of psychological assessment and classification. Additionally, returning veterans presented an intensified need for mental health care, thus progressing the practice of psychotherapy (Routh, 2011). The effects of these developments were particularly apparent in the United States of America, but impacted clinical psychology globally (Reisman, 1991), and according to Cooper and Nicholas (2012), "thrust it into prominence in South Africa" (p.92).

One of the ways in which South Africa was impacted on by these developments was through a certain South African psychology and sociology professor who travelled to the United States of America and Germany, based on these countries' reputation for advancing the field of psychology. Marx (2013) affirms that the purpose of the trip was to gain familiarity with international trends and thinking in psychology. Among the subjects of interest was ethnic psychology, or 'Volkëpsychologie'. Marx (2013) explains that ethnopsychology lent itself to "racist explanations" (p. 115) for which white settler colonies (like South Africa) were renowned. This author asserts that the theories of ethnopsychology are strongly believed to have influenced

opinions regarding racial and cultural differences on which apartheid - the regime that maintained racial segregation for the purposes of keeping white people in power from 1948-1994 - was based. Indeed, the psychology and sociology professor to whom the researcher refers was Hendrik Verwoerd (1901-1966), an "emblematic figure" (Foster, 2008, p. 106) who later became the prime minister of South Arica and the "architect of apartheid" (p. 106).

The significance of race within clinical psychology in South Africa thus cannot be refuted. Foster (2008) recounts the racialized, segregated and unequal ways in which mentally ill people were treated and detained, asserting that "British colonialism, flavoured by the local colourisation of 'race' was at the roots of this apparatus of 'othering' the mad, weird and different" (p. 97-98). Further to being complicit in limiting access to mental health services, clinical psychology was also implicated in racism through its practices, most notably the decontextualized and distorted use of intellectual testing that was employed to support racist ideologies (Barnes & Cooper, 2014; Foxcroft & Davies, 2008; Foster, 2008). Pillay and Siyothula (2006) concur, stating that the role psychology played in apartheid was "dubious" and "well recognised" (p. 725). Furthermore, these authors note that racism goes far beyond segregation; the socio-economic ramifications were significant, severely compromising black South Africans' access to social services and stability of family life in the context of migrant labour. Indeed, the convergence of race and class in South Africa is still apparent today (Seekings & Nattrass, 2006).

Foster (2008) acknowledges that psychology was divided as a field in its response to apartheid. However, those who did resist the inequalities upon which the regime insisted, and

who were outspoken in these views, were met with harsh treatment from the government e.g. being declared 'prohibited persons' and effectively exiled. As a result, this resistance lost momentum and since the official end to apartheid in 1994, psychology has had much to make up for.

Throughout these influential historical periods, the dispute concerning whether psychology is best considered a science or a practice continued. This debate culminated in the emergence of the scientist-practitioner model at the Boulder conference in 1949 where it was decided that incorporation of both these understandings was necessary to progress the field of clinical psychology (Lane & Corrie, 2006). A professional identity that acknowledged the scientific *and* practical aspects of the field of clinical psychology thus evolved in response to the needs of mental health care, globally and in South Africa (Cooper & Nicholas, 2012).

2.1.2 Mental health in South Africa

Johnston (2015) gives credence to South African psychology's "long history of grappling with culture, ethnicity, and diversity as well as seeking to provide a relevant response to her (South Africa's) needs, within an often fractured society" (p. 4). Indeed, the "relevance debate", referenced by Sher and Long (2012), is described as "a set of arguments, strategies and propositions concerned with the social responsiveness of psychology" (p.573). These authors agree that this debate should be a "historically located discussion". In the South African context, particularly following 1994, this concentrates largely around the racial incongruence that developed and resulted in "a predominantly white psychology profession and a majority black society" (Sher & Long, 2012, p. 566).

According to the South African Stress and Health (SASH) survey conducted by Herman et al., (2009), the 12-month prevalence rate of adults who have experienced a mood, anxiety or substance use disorder is 16.5%, while the 12-month prevalence of child and adolescent mental disorders in the Western Cape alone was 17%. Importantly, this study confirms there is no difference between socially defined racial or cultural groups with respect to this data (Department of Health, 2013). Yet, the development of clinical psychology within the historical context of South Africa meant that the mental health care system that post-apartheid South Africa inherited was one that favoured the white middle class and the extremely mentally ill who required institutionalisation (Freeman, 1992, cited in Pillay & Petersen, 1996).

2.1.2.1 Current mental health care needs in South Africa

Chiefly, this situation (i.e. that of a mental health care system which favours a relatively small portion of the population who require mental health care) has yielded the need to address the inappropriateness and inaccessibility of services for the majority of the South African population (Department of Health, 1997) to avoid the profession of psychology becoming irrelevant altogether, and what Pillay and Petersen (1996) refer to as "a white elephant of the apartheid era" (p. 14).

As such, it is argued that 'relevant' psychology in the South African context concerns issues of social justice and social transformation and that these issues must be its "permanent agenda" (Ahmed & Pillay, 2004, p. 631). Full engagement with these issues in professional practice is thus important, particularly in societies which negotiate a complex socio-political context such as South Africa (Ahmed & Pillay, 2004; Pillay & Kramers, 2003). When one

considers the WHO's description of mental health, which is as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community", and one considers the South African context in which people are pursuing this 'ideal', it is no wonder mental health care poses such a great challenge (Herrman, Saxena, & Moodie, 2005, p. xviv).

Perhaps one of the hallmarks of engagement with issues of social justice and social transformation as it concerns mental health in South Africa, is the challenge surrounding "mainstream, individual approaches to distress" (Ahmed & Pillay, 2004, p. 631). These approaches to distress are distinctive features of the biomedical model which is still the dominant discourse in mental health care. Swartz (1998, as cited in Kagee, 2014) points out the limitations of individually focused psychology, arguing that even if "mental disorders are experienced individually, they are also rooted in social, cultural, political and economic processes which require a broader level of analysis" (p.356) and intervention. Furthermore, Pillay and Lockhat (1997) point out that the medical model fosters a passive stance on the part of professionals where individual patients, at least those who have the insight to seek care, are waited for; and an alienating stance which insists on the institutionalisation of patients away from their communities, leaving many who require mental health care, unreached.

The biomedical model therefore poses a number of conceptual barriers to achieving mental health goals. Petersen (1998) argues for a more utilitarian view of care rather than one that uncritically utilizes the biomedical model of care, particularly for mental health in primary health care settings. Principally, this concerns preventative interventions which involve

realigning the focus from individuals to conceptualisations that are focused on the systems in which individuals are imbedded (Ahmed & Pillay, 2004). Such realignment may, for example, constitute shifts from a purely curative approach to one that is more focused on prevention as well as broader issues at play, e.g. poverty, housing, HIV/AIDS.

These practical demands have in this way challenged the biomedical model, and arguably stretched the parameters of clinical psychology's scientific foundation. Nevertheless, a call for emphasis on scientific evidence remains. Kagee (2006b) acknowledges that clinical psychology has a rich base of research from which to draw, however criticises the extent to which it is meaningfully incorporated into clinical practice in South Africa, arguing that a "significant gap exists between clinical psychology in practice and the body of research findings that exists to inform it" (p.234). Kagee (2006b) goes on to outline the detrimental effects this chasm between science and practice has on the profession of clinical psychology in South Africa, particularly with respect to the quality of care it can provide for mental health care users. Furthermore, Kagee (2006b) voices concern regarding the accountability of this care, arguing that psychological interventions are costly in terms of financial and time resources and that efforts should be made to ensure that these interventions have the best chance of success. In other words, the needs of mental health care in South Africa require not only that science and practice both be pursued, but that scientific approaches actively intersect with the practicalities of contextual applicability and adaptation, and vice versa.

(Kagee, 2006b) calls clinical psychologists to account in this respect, and advocates for the evidence-based movement, a pursuit characterised by an integration of the pragmatics of

practice and the rigour of science. He acknowledges the complexities of obtaining evidence in light of the incompatibilities outlined (cf. section 2.1.1) but asserts that evidence should be pursued within these limitations in ways that at least minimize leaps of faith regarding the effectiveness of interventions.

2.1.2.2 Current mental health service provision in South Africa

An important consideration when taking into account the needs of mental health care, is the economic cost of mental disorders which is "wide-ranging, long-lasting, and enormous" (World Health Organization, 2004, p. 16). According to Bradshaw, Norman, and Schneider (2007), the revised disability-adjusted life-years (DALY) estimates for South Africa bring to light the magnitude of mental illnesses, which rank 3rd as a category following that of HIV/AIDS and other infectious diseases.

This high level of need and the economic impact thereof, is juxtaposed by service provision of mental health care that is suboptimal. Lund et al. (2008, as cited in National Mental Health Policy Framework and Strategic Plan 2013-2020, 2013) outline aspects which characterise the current mental health care service, key points of which are paraphrased as follows: Variability among provinces of available mental health care resources; heavy reliance on psychiatric hospitals; gradual integration of mental health into general health care; little coverage of children and adolescents, or adults with depression and anxiety disorders; a ratio of mental health human resources that is 9.3 per 100,000 populations; an urgent need for mental health training of general health staff; poor measures with which to gauge mental health; a coordinating body to oversee public education and awareness campaigns; a few consumer and

family associations established in some provinces; the initiation of inter-sectorial collaboration, particularly at the national level; prioritization of funding for mental health treatment and rehabilitation; and deinstitutionalization, without the necessary development of community–based services (p. 16).

The inadequacy of this service provision highlights how important it is that resources be more efficient and widely distributed, but also that the high level of need for mental health care is managed through preventative interventions, for example. Furthermore, according to this literature mental health practitioners have a responsibility to provide evidence for the effectiveness of their interventions and contribute to the research body of clinical psychology, as well as to incorporate research into their own practice. Not only has doing so been argued to improve the quality of psychological care, it promises to facilitate communication with political stakeholders on essential issues such as funding (Kagee, 2006b).

Vogelman, Perkel, and Strebel (1992) argued not only in support of professional introspection, but also structural modification in pursuit of a psychology that effectively responds to the mental health care needs of the country. Chappell et al. (2003, cited in Lane & Corrie, 2006) affirm that "identity formation is both a strategic and a context bound process" (p. 91). As such, it is important to consider the structural modifications possible within the South Africa context, alongside reconsideration of professional identity.

One such structural shift concerns the mechanism of health financing. The proposed National Health Insurance (NHI) offers a system which pools funds, enabling access to health

services for all South Africans guided by health needs rather than socioeconomic factors (Department of Health, 2015). Implementation of this system is said to reflect values of "justice, fairness and social solidarity" (Department of Health, 2015, p. 1) and in essence challenges the view that (mental) health care is a commodity and thus at the mercy of market-related forces, suggesting it be seen instead as a social investment. According to Lwana (2016) and the Department of Health (2015), the idea of a national health financing scheme has been around since the 1920s, but this particular scheme has been forming since 2011 and has become the flagship of Dr Aaron Motsoaledi, current minister of health. Many challenges must be navigated in order to set in motion structural change of this scale. For example, the funding of the scheme is of concern, requiring high level negotiations between the Department of Health and the National Treasury. Such vast policy changes therefore do not happen overnight (Lwana, 2016); the implementation plan for the NHI is phased over a timeline of 10 years (Department of Health, 2015).

In their 1996 survey, Pillay and Petersen found that most psychologists in South Africa practiced mostly in urban areas and attended to mostly white clients/patients. This finding suggested that black populations, especially those living in rural areas, had limited access to mental health care, compared to their white, urban counterparts. These authors advocated that, in order to address this inequity, geographic redistribution of services as well as the training of black psychologists and a commitment among white psychologists to learn indigenous languages and appreciate diverse cultural perspectives, was essential. Moreover, these authors identified the mechanism of health financing as a barrier to addressing inequity of mental health service provision and hypothesised that mental health care services would remain limited to the middle class if this did not change.

The proposed NHI is in response to the Department of Health's (2015) acknowledgement that challenges regarding the effectiveness and efficiency of its health system are, indeed, largely to do with its financing system. A shift toward the NHI, a system which offers a platform for the amalgamation of private and public sector service provision, is likely to impact the kinds of practices in which clinical psychologists engage and enable them to embrace the progressive values for which the profession calls, without reticence imposed by structural limitations. For instance, this shift could mean that clinical psychologists may work with different kinds of clients and develop an emphasis on short term work that has an evidence base.

2.2 The professional role of clinical psychologists in South Africa

Swartz (2008) states that the field of mental health involves a "complex intersection between person, social, and historical context, as professional knowledge is applied to the processes of diagnosis and treatment of mental illness" (p.280). This perspective is shared by Airhihenbuwa (2007) who concurs that "professionalism operates within a social political reality" (p. 45), echoing the definition of professional identity previously outlined (cf. 1.2). The discussion thus far has highlighted a range of complexities that South Africa's historical, social and political climate brings to bear with respect to mental health care, and which must be considered as clinical psychology re-orientates itself as a profession within this context. A central question for this research project is whether or not the professional identity of clinical psychology indeed honours the intersection to which Swartz (2008) refers, i.e. that between personal, social and historical contexts, and thus appropriately pursues the meeting of current mental health needs.

It has been shown that this reorientation involves a re-evaluation of the practices and values with which the profession identifies most closely (cf. 1.2). The sections that follow address these respective aspects of professional identity in the context of the historical roots of clinical psychology internationally and nationally, and mental health in South Africa. In particular, the next two sections review the literature that signposts the kinds of practices and values that are likely to assist clinical psychologists in South Africa in responding to the mental health needs of the country.

2.2.1 Practices

Pillay et al. (2013) urge that, in order for clinical psychology to meet current mental health needs, practice patterns should be multifaceted and, as such, encompass: (i) Clinical service provision, including the use of evidence-based psychological interventions, (ii) Academic teaching and training, (iii) Research and (iv) Advisory and consultative work. The scope of practice for clinical psychologists promulgated by the Health Professions Council of South Africa in 2011 includes these domains (Department of Health, 2011). However, there is debate regarding the extent to which psychologists utilise the broadness of this scope (Pretorius, 2012).

For instance, the domain of clinical service provision has traditionally been limited to assessment and one-to-one therapy. Increasingly, arguments have been made to expand this to include less traditional service provision such as group interventions, health promotion and preventative initiatives (Pretorius, 2012). Pillay and Lockhat (1997) emphasise the need for preventative interventions to focus on children and adolescents (cf. section 2.1.2.2), pointing out that this age group constitutes almost half of the population and that services available are

"grossly insufficient" (p.1494). Furthermore, the dispersion of these services from private practice and hospital work settings to settings more accessible to the majority of the population, such as community mental health clinics, has been advocated for (Petersen & Lund, 2011; Pillay & Kramers, 2003). Pillay, Ahmed, and Bawa (2013) echo this view in their argument for service provision in non-urban settings (i.e. semi-urban, semi-rural, and rural areas) and the importance that practices shift meaningfully for different contexts.

Teaching and training is an increasingly important component of practice with respect to the decentralisation of mental health services. According to Petersen, Lund, Bhana, and Flisher (2012), it is essential that training and ongoing supervision be provided for first and second tier health providers who receive patients at community and primary health care clinics. Petersen (1998, 2000, 2004, 2012) advocates for a 'task-shifting' approach that concerns challenging the traditionally hierarchical structure of service provision to one that is less territorial, where tasks of mental health care service delivery are shared by a variety of health professionals. 'Task shifting' thus involves the "use of specialist mental health staff in training and supervisory roles to non-specialist health workers, as a mechanism for more efficient and effective care" (Department of Health, 2013, p. 8).

The importance of research as a valued and essential practice domain of clinical psychologists has been acknowledged in section 2.1.2.1. Not only is it important to bridge the gap identified between clinical psychologists as clinicians and as rigorous researchers, it is urgent if psychology is to contribute to the stability and economic prosperity envisioned by the National Mental Health Policy Framework and Strategic Plan (previously discussed) (Department of Health,

2013). For instance, the national mental health policy framework plans to build an information system, data from which is envisioned to inform routine planning and management of interventions. Engagement by clinical psychologists in the complexities of obtaining evidence will be essential if this information system is to serve its intended function, i.e. ensure that service provision is sufficiently addressing the mental health care needs (Daar et al. 2014; Petersen & Lund, 2011).

Advisory and consultative work is another area of practice which calls for more involvement of clinical psychologists. Public health, defined as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, communities and individuals" (Winslow, 1920, as cited in Kagee, 2014, p.355) is a field which values the impact of mental health beyond the individual. Herrman, Saxena and Moodie (2005) add that public health also focuses beyond the ill, on those who are well. A perspective which combines psychology and public health is thus favoured, requiring input at the advisory and consultative level (Kagee, 2014).

Another area of practice is community psychology. While it is not a defined practice of its own (Gibson & Swartz, 2008), community psychology is worth addressing as a valuable "way of thinking about people's behaviour and well-being in the context of all the community environments and social systems in which they live their lives" (Levine, Perkins, & Perkins, 2005, p. 3). Principles of community psychology thus include an emphasis on the social context in which a person functions, a move away from traditional work settings to enable a variety of roles including consciousness raising, advocacy and social upliftment (Gibson & Swartz, 2008; Prilleltensky, 2003).

As previously mentioned, McElhinney (2008) describes 'role ambiguity' as the extent to which there is a shared scope of practice among professionals. Counselling psychologists have struggled to clarify the recognised ambiguity regarding a shared understanding of scope of practice among those in their field (Young, 2013). Watkins et al. (1986) were the first to research the professional identity of counselling psychologists in the United States of America and developed and conducted a national survey for counselling psychologists to this end. Goodyear et al. (2008) then conducted a similar survey, also focusing on counselling psychologists in the Unites States of America, in which identities, roles, and functions were compared across 15 years among 1985 and 2000 cohorts. Goodyear et al. (2016) conducted a global survey of counselling psychology, for which Young (2016, in press) lead the South African component. Pillay and Petersen (1996) considered the practice patterns of clinical and counselling psychologists (collectively) and their attitudes to transforming mental health policies in South Africa (cf. sections 2.1.2.2 and 2.2.2).

This research serves to begin a similar conversation among those in the field of clinical psychology. It can be argued that clinical psychology is at a stage, developmentally, where clarifying any confusion pertaining to its role is essential in order for meaningful progression.

2.2.2 Values

The foregoing discussion of the literature on the domains of practice reflects some of the emerging values of a more relevant clinical psychology in South Africa. Markin (2014) writes about a shared identity of psychotherapy globally, and argues for the importance of finding a

"chord that rings true for psychotherapy researchers and clinicians", adding that "our identity as psychotherapists is not so dependent on the hat we wear but on the foundation on which it rests" (p. 327-328).

With this in mind, the core values emerging from the literature include: first and foremost, social justice and transformation (Ahmed & Pillay, 2004); expansion of the medical model to include social/contextual factors in understanding mental illness (Kagee, 2014); an emphasis on evidence-based practice (Kagee & Lund, 2012); and a multi-disciplinary approach, enabling provision of an expanded clinical service, including a skills transfer approach (Pretorius, 2012; Petersen et al. 2012).

As discussed in the section which defined professional identity for the purpose of this research (section 1.2), 'role conflict' refers to the extent to which there is congruence between practice and values among a profession (McElhinney, 2008). Pillay and Petersen's (1996) study indicated that while clinical and counselling psychologists were aware that they needed to make changes to the ways in which they practiced in order to meet the needs of mental health care, there were structural barriers which prevented them from doing so. This tension illustrates an example of the way in which valuing issues of social transformation and justice does not necessarily translate to practice patterns that reflect this, posing a conflict to one's professional role and bringing one's professional identity into question. Once again, the influences of individual as well as societal context on the co-construction of professional identity are highlighted.

2.3 Chapter summary

This chapter has provided a review of relevant surveys, acquired knowledge, and theory pertaining to professional identity and clinical psychology in South Africa. Having set out briefly the historical roots of clinical psychology (internationally and nationally) and thus contextualised some of the baggage that accompanies the field (i.e. the medicalised model alongside racist and elitist practices), a review of the current mental health needs of South Africa was offered alongside a review of the challenges currently facing mental health services. Further, reference was made to current mental health policies (including NHI) that have been designed to make psychological services more accessible to the general population. The centrality of practices and values to professional identity was then explained as the review drew upon literature calling for clinical psychology to be more relevant. This chapter also touched on what constituted practices and values previously (from prior surveys) and also some of the challenges clinical psychologists face in terms of role conflict and role ambiguity – the latter being a significant rationale for this research. In this way, the literature review has brought the context of clinical psychology in post-apartheid South Africa into conversation with its professional role, and thus set the stage for professional introspection - the purpose of this research.

Chapter 3 Research Methodology

It is argued in the preceding chapters that the process of reflecting on the reported practices and values of clinical psychologists in South Africa in the context of those outlined by the literature, promises to determine the extent to which the profession is aligned with the country's current mental health care needs. This chapter outlines the research methodology employed to ascertain the views and perceptions of clinical psychologists to this end.

3.1 Research aims and questions

The focus of investigation is clinical psychologists' views and perceptions of their professional identity with respect to their domains of practice and their values. The researcher thus addresses a number of questions which have been grouped according to demographic information, practices and values, as follows:

3.1.1 Demographic information

- What is the demographic profile of clinical psychologists in South Africa with respect to gender, age, race and qualification?

3.1.2 Practices

- In what work settings are clinical psychologists predominantly working?
- What is the location of these settings?
- To what extent does the demographic profile of clinical psychologists reflect the clients the profession serves?

- To what extent does the demographic profile of clients receiving services (according to this study), reflect the demographic profile of the greater South African population?
- What aspects of professional practice currently, based on the professionals' responses, are central to clinical psychology?
    - What do clinical psychologists consider to be their primary work role(s)?
    - What are the key activities in which clinical psychologists are engaged?
- Are there factors that predict alignment or non-alignment with specific patterns of practice, such as race, age, gender, work setting (public or private domain)?
- To what extent do the practice patterns of clinical psychologists meet the mental health care needs of South Africa?

3.1.3 Values

- What are the theoretical orientations most preferred by clinical psychologists?
- To what extent does theoretical orientation influence clinical psychologists' practice?
- To what extent are the core values of clinical psychology (based on a review of the literature) rated by clinical psychologists?
- Are there factors that predict alignment or non-alignment with specific values such as race, age, gender, work setting (public or private domain)?
- What are clinical psychologists' impressions of the extent to which the role of clinical psychologists in South Africa has changed over the years?
- To what extent do clinical psychologists in South Africa feel that the profession will change in the future?

- To what extent do the values espoused by clinical psychologists lend themselves to practice patterns that meet the mental health care needs of South Africa?

3.2 Research design and methodology

This study is an exploratory inquiry that sought responses from a representative sample of clinical psychologists in order to answer the questions outlined above. While a qualitative approach would have allowed an in-depth sense of participants' views and perceptions, a quantitative approach was adopted in order to achieve the objective of reaching a broad, representative number of practitioners. The research design employed was thus that of a survey as it promised responses that would offer an overall sense of views and perceptions pertaining to professional identity of clinical psychologists across South Africa.

Van Vuuren and Maree (2002) outline the advantages and disadvantages of surveys, highlighting firstly that they are inexpensive and anonymous. Another advantage is that one can use a large sample and thereby allow for generalisability. Disadvantages, according to these authors, concern the quality of responses that can be expected from a survey. However, in the case of the survey distributed for this study, it is assumed that professionals who allocated the time to respond did so genuinely. Furthermore, ambiguities in the items were clarified through piloting the questionnaire prior to distribution. Data from the pilot phase was not included as a few changes were made to the questionnaire subsequently. Limitations notwithstanding, the survey stood out as the most appropriate method of obtaining the information required to answer the proposed research questions.

3.3 Units of analysis and sampling procedure

In the case of this project, the total population under study was that of clinical psychologists practicing in South Africa. Sample selection was done by means of purposeful sampling, a method of sampling whereby participants are selected according to certain criteria which render them relevant to the research question (Guarte & Barrios, 2006). Criteria for selection was therefore current registration as a clinical psychologist with the Health Professions Council of South Africa (HPCSA) – the body with which all practicing health professionals must register in order to practice in South Africa. Even though this criterion includes professionals who did not necessarily train in South Africa, it focuses on those practicing in this context. To date, the population of clinical psychologists in South Africa totals 3015 (Y. Daffue, personal communication, 3rd February, 2016).

The sampling of this population was largely dependent on database availability. Initially, a fraction of the population (i.e. 55%) was contacted by email via Medpages, a database of South African health care professionals. Once the HPCSA made their email database available too, which consisted of email addresses for 86% of registered clinical psychologists, the remainder of the sample group was contacted and invited to participate in the survey.

Given that email addresses were not available for the full population, sampling was complemented by 'snowballing', a technique recommended in cases where access to the sampling frames are not easily accessible (Faugier & Sargeant, 1997). Participants were asked to forward the questionnaire to their professional network of clinical psychologists, enabling access to as large a sample of relevant participants as possible.

The email communication sent to participants inviting them to partake included a URL link to the online questionnaire (cf. Appendix A). 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 incentivized, offering those who completed the questionnaire an opportunity to anonymously enter their names into a raffle for a R2000 Exclusive Books voucher.

Data was collected over two, two-month periods; mid-October to mid-December 2015 (for distribution via the Medpages database), and March April 2016 (for distribution via the HPCSA database). It is noted that reminders were sent to participants while data collection was open in order to encourage responses. The online survey platform allowed reminders to be sent to participants who had responded partially as well as those who had not responded at all. Participants could opt out of receiving further communication at any stage.

Goodyear et al. (2008) obtained an average response rate of 48.5% among their sample groups. Pillay and Petersen (1996) obtained a response rate of 30,83%. Determination of the sample size was somewhat guided by these benchmarks, however, it was taken into consideration that these studies sampled only a portion of the total population under study, so while their response rates are good, their sample sizes were not large. Response pattern was

another guiding factor, where a plateau in response volumes indicated the conclusion of data collection. This occurred at a stage when 889 professionals had responded to the survey. Some of these professionals were student and intern psychologists. Their responses were excluded, resulting in a total sample size of 877 out of 3015, i.e. 29.09% of the total population of clinical psychologists in South Africa. Given the multiple ways in which data was collected, the total number of clinical psychologists the survey reached is unknown. The actual response rate is therefore unknown but imagined to be higher than 29,09%, based on the assumption that not everyone in the total population would have received the survey.

3.4 Research instrument

The survey used for this research study was modelled on the South African component of that used by Goodyear et al. (2016), a tool that has already been successfully used in this context. The history of this survey (cf. Appendix A), however, goes back a lot further.

3.4.1 History of questionnaire

The survey was initially produced by Kelly (1961) for studying the professional identity of clinical psychologists and then refined for subsequent use by a number of researchers (Garfield and Kurtz, 1974; Norcross et al. 1982, 2012). Watkins, Lopez, Campbell, and Himmell (1986) adapted it for the purposes of conducting a national survey of counselling psychology in the United States of America. However, Watkins et al. (1986) explain that many of the items they incorporated in the survey had been used in previous surveys of clinical psychologists and psychotherapists. The items included in the evolving survey were selected on the basis of their "seeming ability to

reflect the current practice of psychology (content validity)" (Watkins et al., 1986, p. 4). In essence, the roots of the questionnaire are strong, and revisions made have been appropriate.

3.4.2 Development of questionnaire for this research project

Amendments to the survey for the purposes of this research project included making the questionnaire relevant to clinical rather than counselling psychologists, and to the South African rather than international context. It is noted that in order for future research to make comparisons among the results of this study with those of the parallel study of professional identity among counselling psychologists, considerable changes were not advisable. Although it was decided that questions not be changed for this reason, it is noted that some items were added.

A core value was added to the existing list which was originally derived from a list of counselling psychology core values. The addition concerned that of a focus on understanding thoughts, feelings and behaviour in terms of biological, psychological and social causation (as opposed to a primarily medicalised approach, i.e. one which views biological processes as casual in mental illness). Additional items were also added to ascertain the location of the various work settings in order to make some comparisons with the findings of Pillay and Petersen (1996) and thus track change over time in this respect. Although the questionnaire already had an item inviting participants to indicate whether or not they were influenced by evidence-based practice, further items were added in order to ascertain more information such as the extent to which they felt influenced by the movement. A professional key activity added was Forensic Assessment to better reflect the scope of practice specific to clinical psychology. Furthermore, three professional activities were added based on the review of the literature (Cf. section 2.2.1),

namely: Advocacy and health promotion, Community psychology, and Programme evaluation and monitoring. Lastly, additional items were added in order to ascertain demographic information of clients seen, including their age, race and language.

3.4.3 Content of questionnaire

As with the Watkins et al. (1986) survey and surveys upon which theirs was based, the questions used for this project examines five broad areas, namely: personal characteristics, theoretical perspectives, professional activities, training and career satisfaction, and career experiences. The questionnaire consisted of 70 items and is estimated to have taken participants approximately 30-40 minutes to complete. The discussion that follows details the components of these questionnaire sections (cf. Appendix A).

3.4.3.1 Personal characteristics.

This section of the questionnaire offers context to responses by asking participants to identify their gender, age, race, sexual orientation, academic qualification(s), registration category/(ies), and year of registration. Furthermore, personal characteristics promise to indicate the extent to which the sample of clinical psychologists reflects diversity relative to society, and also whether any of these personal characteristics predict particular values and/or practices.

3.4.3.2 Theoretical perspectives

The theoretical perspectives section asks participants to identify their theoretical orientations and specify the extent to which these influence their practice. Responses to this area

of inquiry were anticipated to also offer insight with respect to prominent tendencies, such as that toward shorter rather than longer-term intervention.

3.4.3.3 Professional activities

This section explores typical activities in which professionals are engaged, including the settings in which these activities take place, the client groups with whom these take place, and the other professionals involved. The extent to which these activities are influenced by the evidence-based movement is also explored. As such, this section promises to capture the roles performed and the scopes of practice utilized.

3.4.3.4 Training and career satisfaction

This section, which asks professionals about their training and career experiences, including that with personal therapy, explores (among other things) the way in which they value their field. This section also speaks to the relevance of professionals' training to the practice in which they now find themselves. Data captured from this question has been stored for use in future studies as it does not relate directly to the focus of this research project.

3.4.3.5 Critical incident

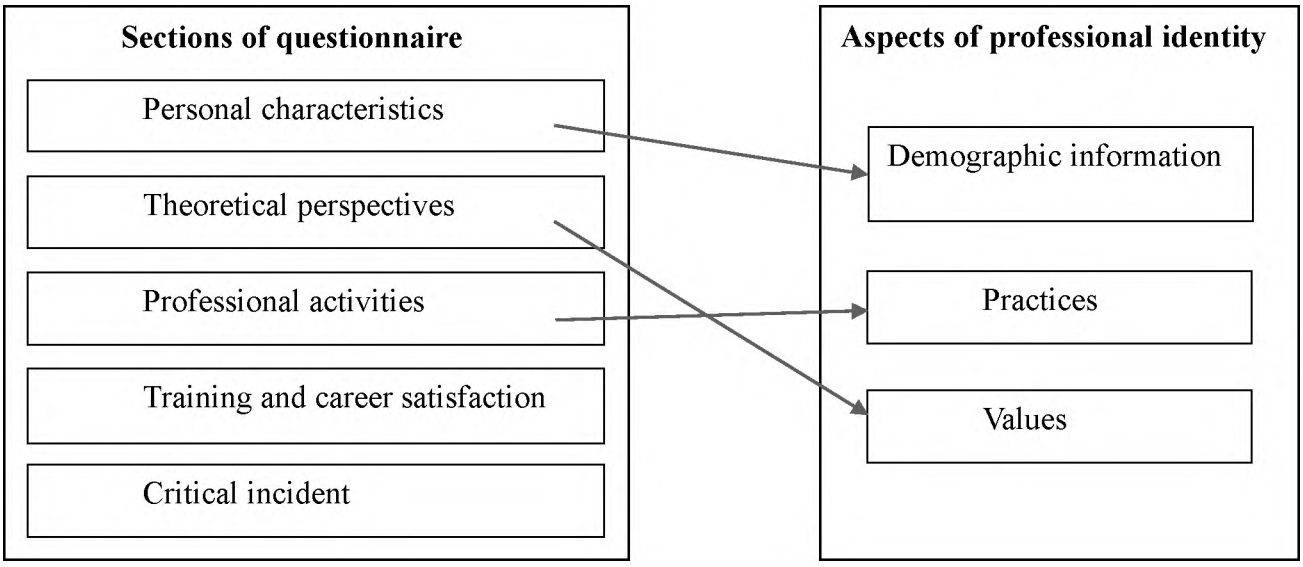
This section is an extension to the original questionnaire and seeks qualitative data by asking professionals to cite an incident that particularly stands out in their personal practice or work as a clinical psychologist. Data captured from this question has also been stored for use in future studies and does not form part of this research project.

3.4.4 Validity and reliability of questionnaire

Durrheim (2002) advises that, when considering the psychometric properties of a measure, issues of validity and reliability must be taken into account. Validity concerns the extent to which the measure measures that which it claims to measure (Durrheim, 2002). Reliability concerns the dependability of an instrument, i.e. the extent to which the measure obtains consistent results over time (Durrheim, 2002). The validity and reliability of the survey used has not been psychometrically determined. However, professional identity is not a psychological construct per se, and it is understood that the domains covered represent the primary components of the professional identity, as outlined in the literature review.

The researcher does not utilise every aspect of the questionnaire for the purposes of this research. Figure 1 below serves to clarify the links between the respective questionnaire sections and the corresponding aspects of professional identity on which this research project focuses. The section concerning training and career satisfaction is not linked as it does not relate directly the focus of the research. Similarly, the section concerning the critical incident is not linked, as this aspect of the survey lies beyond the scope of this project.

Figure 1. Diagrammatic representation of links between sections of the questionnaire and corresponding aspects of professional identity



3.5 Data analysis plan

Once the data was collected it was analysed using descriptive and inferential statistical techniques. The statistical literature makes a distinction between Likert scales (which is the sum of a number of Likert items) and single Likert items (Clason & Dormody, 1994). Because single items cannot be considered to provide interval level data, these are analysed using non parametric tests (Mann-Whitney, Kruskal-Wallis, and chi squared). Scales, on the other hand, are commonly treated as interval level data and analysed using parametric tests (e.g. t tests) (Dawis, 1987). Although it would be more appropriate to report the median and mode of the single Likert items, the mean and standard deviations are reported instead to enable comparison with the studies that are based on the same questionnaire and have reported results in this way (e.g., Goodyear et al., 2016).

Additionally, since the data is subjected to a number of statistical tests, α is set at 0.01 rather than the usual 0.05 to reduce the familywise error rate which is the probability that a family of comparisons contains at least one Type I error rate (Brace et al. 2003). In other words, lots of tests increase the likelihood that some significant findings are obtained by chance, so a more stringent significance level was used to reduce this likelihood.

3.6 Ethical considerations

This study posed no significant ethical challenges. Nevertheless, there are ethical factors to be taken into account with all research and to this end the researcher considered ethical principles which Durrheim and Wassenaar (1999) recommend be kept central in order to maintain ethical standards, i.e. autonomy, non-maleficence, and beneficence.

The autonomy of participants was ensured by means of informed consent, outlined in the introductory section of the questionnaire (cf. Appendix A). Additionally, the privacy of responses was ensured by keeping these on a password protected file and only publishing aggregated, anonymised data. Respondents were free to opt out by simply exiting the questionnaire. Participants were able to access the survey link anonymously. This study posed little harm to participants, and honoured the ethical obligation that it result in an outcome that is of benefit to research participants and to society. Ethics approval for the research was provided by the Research Projects and Ethics Review Committee of the Psychology Department of Rhodes University (on 13 May 2015).

3.7 Chapter summary

This chapter outlined the aims and central research questions that characterise the research project. It also detailed the methodological steps taken in order to address these questions which broadly consist of an online survey methodology whereby participants completed a 70-item questionnaire that addressed domains of professional identity. The data yielded is presented in the chapter that follows.

Chapter 4 Results

This chapter reports the survey responses of 877 clinical psychologists in South Africa, a sample size 29,09% its total population. It is noted that not all respondents answered all the items, so this response rate varies slightly from item to item. Data is presented according to demographic information; work settings and roles (practices); and information about participants' theoretical perspectives, beliefs, and attitudes (values).

4.1 Demographic information

Information pertaining to participants' gender, age, training level and race, is presented in this section. In order to reflect the extent to which the sample is representative of clinical psychologists in South Africa (and thus findings generalizable to this population), the demographics of the overall population, according to the HPCSA database, are presented alongside (Y. Daffue, personal communication, 30th May, 2016).

4.1.1 Gender

Table 1 which follows shows that the large majority of participants are female. Two participants identified as transgendered. Another two participants did not identify as male, female or transgendered; one participant specified they are gender non-conforming while the other did not specify his/ her gender. The proportions of male and female participants (i.e. 30,01% and 69,66% respectively) closely mirror that of the overall population excluding the 82 people for whom gender is unknown (χ^2 (1) = 0.04; p = 0.83).

4.1.2 Age

Table 1 below also shows that the majority of participants were in the age band of 30-39 years old, whereas the most represented age band among the overall population is 40-49 years old. Nevertheless, the average age among the sample was 44 years and 7 months (n = 867, SD =12,19; range 23-82 years), which falls within the age band most represented by the overall population. Individual ages were not captured for the population, making a direct comparison of average age impossible. However, the data available is sufficient in suggesting that the sample is representative of the population of clinical psychologists with respect to age. Number of years' post-qualification experience among participants averages at 14,26 (SD = 10,58).

Table 1.
Clinical Psychologist's gender and age

	Sample		Population	
	N	%	N	%
Gender				
Female	606	69,66%	1998	67,57%
Male	260	29,89%	877	29,66%
Transgendered	2	0,23%		
Other	2	0,23%	82	2,77%
Total	870	100,00%	2957	100,00%
Age				
<30 Yrs	90	10,38%	137	4,67%
30-39 Yrs	266	30,68%	765	26,09%
40-49 Yrs	231	26,64%	868	29,60%
50-59 Yrs	164	18,92%	649	22,14%
60-69 Yrs	99	11,42%	366	12,48%
70-79 Yrs	16	1,85%	101	3,44%
80+ Yrs	1	0,12%	46	1,57%
Total	867	100,00%	2932	100,00%
	M	SD		
Overall Age	44,06	12,19		
Number of years' experience	14,26	10,58		

4.1.3 Race [2]

The researcher has used "African" to refer to "African black", and "Black" to include African, coloured and Indian in the correlations analyses between racial divisions of black, white, and other variables. It is also noted that the researcher is following convention, which is that 'black', 'white' and 'coloured' are lower case, but 'African' and 'Indian' capitalised because these names are based on geographical areas.

Of the 844 participants who indicated their race, the proportions of African, white, Indian and coloured participants were 18,13% (n = 153), 71,80% (n = 606), 5,21% (n = 44) and 4,86% (n = 41) respectively. The racial proportions appear to be consistent with the broader population demographics (χ^2 (3) = 5.29; p = 0.15). However, the comparison is between proportions of known race groups. 23% of Clinical Psychologists did not indicate their race, making any certain comparison between the sample and the population racial demographics impossible. Table 2 below outlines this information.

Table 2.
Clinical psychologists' race

	Sample		Population	
	N	%	N	%
African	153	18,13%	500	20,87%
White	606	71,80%	1632	68,11%
Coloured	41	4,86%	109	4,55%
Indian	44	5,21%	155	6,47%
Other	33	3,91%		
Unknown			561	23,41%
Total	844	100,00%	2396	100,00%

[2] The research refers to the footnote (cf. p. 5) in which the problematic use of race categories is acknowledged.

4.1.4 Highest earned degree

Table 3 below reflects participants' highest earned degrees. The majority hold a Masters degree while 18,13% hold a Doctorate level qualification.

Table 3.
Highest earned degree

	N	%
Masters (MA / MSocSci / MSc / MCom / MEd)	710	81,70%
Doctorate (PhD / DPsych / DLitt et Phil)	159	18,30%
Total	869	100%

4.2 Work settings and roles (practices)

This section presents data that concerns the practice patterns of clinical psychologists.

4.2.1 Work settings

Tables 4 and 5 which follow reflect participants' primary and secondary work settings and the locations thereof, respectively. The majority of clinical psychologists work in Private Practice (48,48%) as their primary work setting. The next most represented primary work setting is that of Hospitals (General/ Psychiatric) (10,36% and 10,91% respectively). The primary work setting least represented is that of Medical Schools (0,55%).

Table 4.
Clinical Psychologists' primary and secondary work settings

	Primary work setting		Secondary work setting	
	N	%	N	%
Community Mental Health Clinic	28	3,87%	19	4,60%
HIV Clinic/ Centre	2	0,28%	0	0,00%
Outpatient Clinic	7	0,97%	14	3,39%

General Hospital / Medical Centre	75	10,36%	24	5,81%
Psychiatric Hospital / Centre	79	10,91%	51	12,35%
University Counselling Centre	10	1,38%	10	2,42%
Private Practice	351	48,48%	150	36,32%
Corporate/ Business	26	3,59%	18	4,36%
Correctional Services (Prisons)	16	2,21%	2	0,48%
University, Psychology Department	43	5,94%	27	6,54%
University, Other Department	10	1,38%	11	2,66%
Medical School	4	0,55%	3	0,73%
Non-Governmental Organisation	16	2,21%	26	6,30%
Other	57	7,87%	58	14,04%

Table 5 below indicates that urban and semi-urban locations are strongly favoured in terms of primary and secondary work settings, while rural and semi-rural locations are grossly underrepresented in comparison.

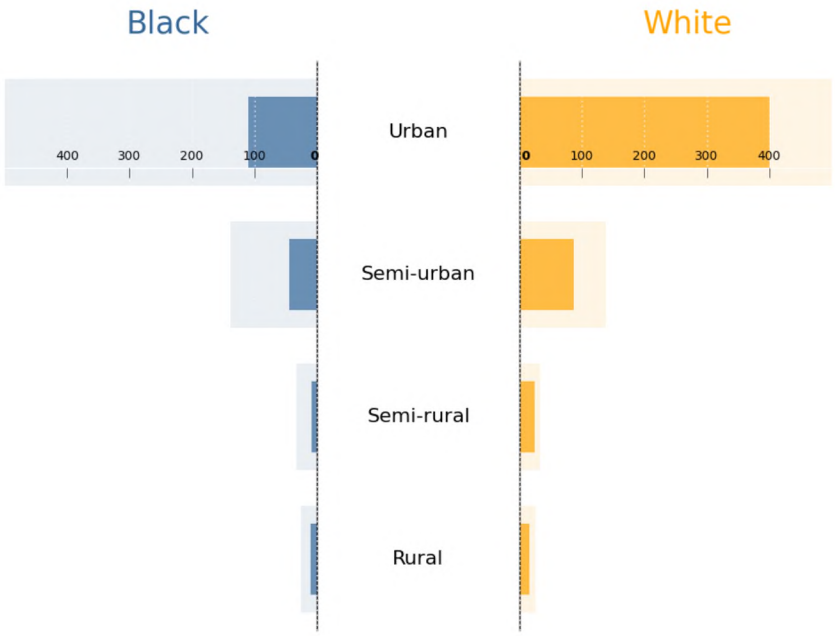
Table 5.
Location of Clinical Psychologists' primary and secondary work settings

	Primary work setting		Secondary work setting	
	N	%	N	%
Urban	525	72,82%	290	73,79%
Semi-urban	138	19,14%	76	19,34%
Rural	25	3,47%	10	2,54%
Semi-rural	33	4,58%	17	4,33%

There has been a push for the field to be more demographically representative and the researcher is interested to see what impact, if any, has this had (cf. sections 2.1.1, 2.1.2 and 2.1.2.1). Aspects of professional identity which are shown to have a statistically significant relationship with race are therefore considered. Black and white respondents are not evenly distributed across the categories of rural, semi-rural, urban and semi-urban, a difference that is

statistically significant (χ^2 (3) = 11.71; p = 0.01). As a proportion, white respondents are much more likely than black respondents to be in urban areas, as depicted in Figure 2 below. As with the figures that follow, the light shaded areas indicate the total number of responses to the relevant item, while the darker shaded areas indicate the responses applicable to the respective variables.

Figure 2: Graph depicting relationship of race and work setting location



White respondents are also more likely to work in private practice than black respondents, a difference that is statistically significant (χ^2(1) = 35.68; p < 0.00), as depicted in Figure 3 below. As with the other figures, the light shaded areas indicate the total number of responses to the relevant item, while the darker shaded areas indicate the responses applicable to the respective variables.

Figure 3. Graph depicting the relationship between practitioners' race and private practice/ not in private practice work settings

Table 6 below reflects the demographics of those receiving psychological services, as indicated by the sample group when asked to specify the age range, race, and primary language spoken of their clients.

Table 6.
Demographic information of clients

		N	%
Age	0 - 5 years	14	1,40%
	6 - 12 years	73	7,28%
	13 - 18 years	94	9,37%
	19 - 35 years	425	42,37%
	36 - 65 years	374	37,29%
	65 years and older	23	2,29%
	Total	1003	100,00%
Race	Black	203	28,12%
	White	325	45,01%
	Coloured	60	8,31%

	Indian	19	2,63%
	Other	115	15,93%
	Total	722	100,00%
Language	Xhosa	20	2,44%
	English	560	68,38%
	Zulu	30	3,66%
	Afrikaans	100	12,21%
	Sotho	32	3,91%
	Ndebele	4	0,49%
	Swazi	3	0,37%
	Tsonga	1	0,12%
	Tswana	20	2,44%
	Venda	5	0,61%
	Other	44	5,37%
	Total	819	100,00%

Participants' responses indicating the race of most of their clients were coded as white, black and diverse. Not surprisingly, the profile of clients seen in private practice is disproportionally white ($\chi^2(2) = 120.76$; $p < 0.00$), reflecting the way in which race in South Africa also connotes class as a result of past inequities that persist. The graph in Figure 4 below shows that the large proportion of white clients are seen in private practice while the opposite is true of black clients. As with the other figures, the light shaded areas indicate the total number of responses to the relevant item, while the darker shaded areas indicate the responses applicable to the respective variables.

Figure 4. Graph showing race of clients seen in private and not private practice work settings

4.2.2 Primary work roles

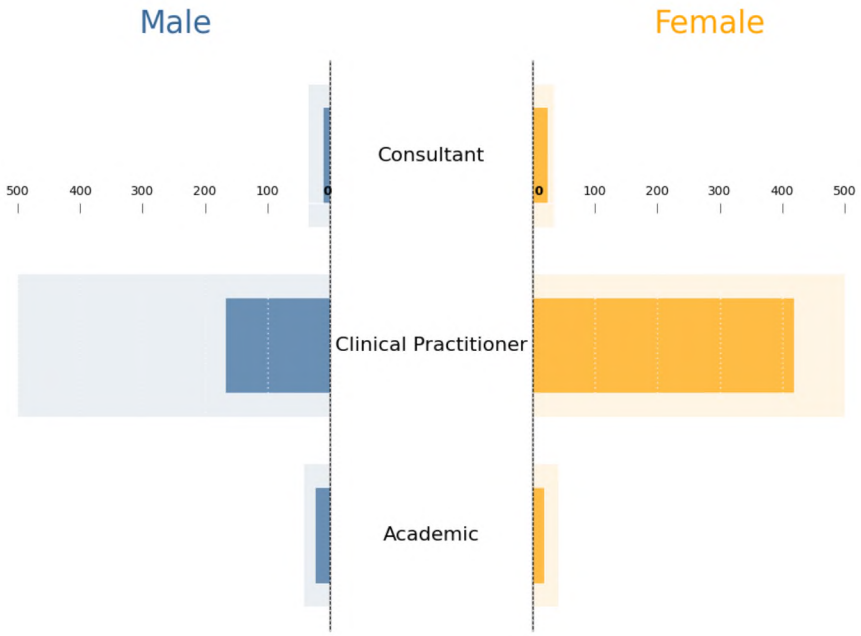
Table 7 below outlines the primary work roles of participants and indicates that the vast majority (80,83%; n = 586) describe their primary role as Clinical practitioners. The next largest representation of a work role was that of Academic (7,17%; n = 52). It is noted that responses of 'Academic' and 'Supervisor' were combined to reflect more closely the domain of 'academic teaching and training' as outlined by the Scope of Practice (Department of Health, 2011).

Table 7.
Survey participants' primary work role

	N	%
Clinical practitioner	586	80,83%
Academic	52	7,17%
Consultant	34	4,69%
Researcher	8	1,10%
Other	45	6,21%
Total	725	100,00%

The primary work roles were recoded to exclude those very few in number because of the chi-squared assumption regarding the size of each entry in the table, making the roles that are not prevalent difficult to interpret (Brace et al., 2003). The 'other' category was also recoded given its vagueness. Taking the three most popular roles, which are clinical practitioner, academic and consultant, differences in proportions are significant for gender (χ^2 (2) =13.84; p = 0.00) but not race (χ^2 (2) = 4.95; p = 0.08). The gender difference suggests that male respondents are more likely to be academics than female respondents. It appears that very few clinical psychologists are primarily researchers. As with the other figures, the light shaded areas indicate the total number of responses to the relevant item, while the darker shaded areas indicate the responses applicable to the respective variables.

Figure 5. Graph depicting correlation between gender and primary work roles among clinical psychologists in South Africa



4.2.3 Engagement in key activities

Table 8 below reports the proportions of participants who indicated engagement in 15 key activities. Of the participants who indicated they engaged in these respective key activities, the average percentage of time devoted to each is reported alongside. The majority were engaged in Administration (77.65%; n = 681), spending on average 15,93% (SD = 9,62) of their time on this activity; and Counselling/ Therapy (76,28%; n = 669), spending on average close to half their time on this activity (48,84%; SD = 23,06), making it the activity which participants engaged most extensively in terms of time spent. The least dominant activities in terms of time spent were Career Assessment and Career Counselling. Since these activities are not typically part of clinical psychologists' scope of practice, the next lowest activities were considered, i.e. that of

Advocacy and health promotion, Programme evaluation and monitoring, and Community psychology.

Table 8.
Proportion of clinical psychologists who report engaging in key activities

	Proportion engaged in activity		Percent time devoted to key activity	
	N	%	M	SD
Administration	681	77,65%	15,93	9,62
Assessment: Personality and Intellectual	375	42,76%	10,27	11,87
Assessment: Neuropsychological	293	33,41%	9,35	16,06
Assessment: Forensic	286	32,61%	8,59	13,79
Assessment: Vocational/ Career	205	23,38%	2,06	7,10
Clinical Supervision	437	49,83%	8,75	8,10
Advisory and Consultation	338	38,54%	10,97	14,82
Counselling/ Therapy	669	76,28%	48,84	23,06
Prevention Activities	307	35,01%	7,62	7,24
Research	323	36,83%	10,21	13,03
Teaching/ Training	353	40,25%	9,86	12,72
Career Counselling	167	19,04%	0,86	2,53
Advocacy and health promotion	205	23,38%	3,42	5,19
Community psychology	224	25,54%	5,12	8,71
Programme evaluation and monitoring	213	24,29%	4,08	8,37

Since Counselling/ Therapy was indicated as being the dominant key activity in terms of time spent, it was felt a closer look at the modalities of therapy that participants engaged in would be useful. Table 9 below reports that the majority of participants who indicated they engaged in individual counselling/ therapy spent, on average, 75,74% (SD = 19,22) of their time devoted to this modality. The least dominant modality of counselling/ therapy was group counselling/ therapy.

Table 9.

Proportion of clinical psychologists who report engaging in various therapy modalities and % time devoted to each

	Proportion engaged in modality		Percent time devoted to modality	
	N	%	M%	SD
Individual counselling/ therapy	681	36,63%	75,74	19,22
Group counselling/ therapy	307	16,51%	14,06	15,61
Couples counselling/ therapy	480	25,82%	16,06	12,76
Family counselling/ therapy	391	21,03%	12,01	11,60

T-tests were done to explore the relationship between various dichotomous grouping variables and the percentage time given to the key activities of assessment, counselling/ therapy, administration, community engagement, and research. Only significant results are reported here. These tests indicated that women, in contrast to their male counterparts, spend a greater proportion of their time doing admin ($t = 3.00$, df = 717, $p = 0.00$), doctoral practitioners, in contrast with practitioners who hold a masters level qualification, spend a greater proportion of their time doing community engagement ($t = 2.68$, df = 720, $p = 0.01$) and research ($t = 3.29$, df = 720, $p = 0.00$), black practitioners, in contrast to their white counterparts spend a greater proportion of their time doing assessment ($t = -2.66$, df = 699, $p = 0.01$) but less therapy ($t = 2.90$, df = 699, $p = 0.00$), and private practitioners, in contrast to not-in-private practitioners, spend a greater proportion of their time doing therapy ($t = 11.68$, df = 717, $p = 0.00$), less community engagement ($t = -3.10$, df = 717, $p = 0.00$) and less research ($t = -4.67$, df = 717, $p = 0.00$).

Participants indicated they spent an average of 59,24% (SD = 32,85) of their practice engaged in evidence-based practice. When asked to indicate the extent to which participants were influenced by the evidence-based movement on a scale of 1 to 5 (where 1 = Not at all and 5 = Very much so), the mean response was 3 (SD = 1,32). Those not in private practice more

strongly endorsed evidence-based practice than those in private practice. The mean ranks of private practitioners and non-private practitioners were 329.81 and 363.56, respectively (U = 54164.50, Z = 2.26, p = 0.00).

4.3 Perspectives, beliefs, and attitudes (values)

This section presents data that concerns the values of clinical psychologists.

4.3.1 Theoretical orientation

Table 10 below indicates that the dominant model of theoretical orientation for clinical psychologists is Psychodynamic (49,32%; n = 396), followed by Eclectic (40,97%; n = 329) and Systems (24,42%; n = 172). The theoretical orientation least preferred was Adlerian (0%).

Table 10.
Clinical Psychologists' preferred theoretical orientation

	N	%
Eclectic	329	40,97%
Cognitive/ Cognitive-behavioural	97	12,08%
Behavioural Therapy/ Learning	85	10,59%
Psychoanalytic (Freudian)	34	4,23%
Psychodynamic (Neo-Freudian)	396	49,32%
Rogerian/ Person-Centred	23	2,86%
Humanistic-existential	122	15,19%
Gestalt	5	0,62%
Systems	172	21,42%
Sullivanian/ interpersonal	4	0,50%
Adlerian	0	0,00%
Narrative/ Postmodern	22	2,74%
Total	1289	160,52%

Since the second dominant theoretical orientation was indicated to be "Eclectic", this is elaborated upon in Table 11 which follows. Table 11 indicates that 'Synthetic' is the dominant type of 'Eclectic' while 'Atheoretical' was the least dominant type of 'Eclectic'.

Table 11.
The type of 'eclectic' clinical psychologists indicated best described them

	N	%
Atheoretical (no preferred theoretical approach)	43	9,15%
Synthetic (integrates a diversity of contemporary theories)	292	62,13%
Technical (uses a variety of techniques within a preferred theory)	135	28,72%
Total	470	100,00%

Table 12 below reflects that the majority of participants felt their practice is "repeatedly" and "often" influenced by their theoretical orientation (i.e. 42,36%; n = 355) and 41,17% (n = 345), respectively.

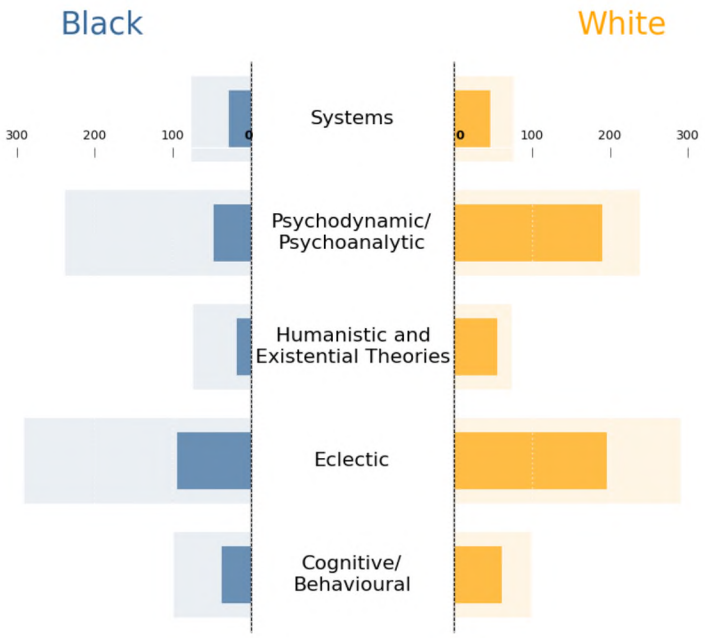
Table 12.
Extent to which theoretical orientation influences practice

	N	%
Never	12	1,43%
Seldom	33	3,94%
Occasionally	87	10,38%
Often	345	41,17%
Repeatedly	355	42,36%
Not Applicable (if I have not engaged in psychological practice)	6	0,72%
Total	838	100,00%

The theoretical orientations were collapsed into five categories, where 'Cognitive/ Behavioural' includes 'Cognitive/ Cognitive-behavioural' and 'Behaviour Therapy/ Learning'; Humanistic and Existential theories' includes 'Rogerian/ Person-Centred', 'Humanistic-existential', 'Gestalt', and 'Narrative/ Postmodern'; and 'Psychodynamic/ Psychoanalytic' includes 'Psychoanalytic (Freudian)' and 'Psychodynamic (Neo-Freudian). 'Eclectic' and 'Systems' remain as is. Notably, black and white respondents are not evenly distributed across the five broad theoretical orientations, a difference that is statistically significant ($\chi^2(4) = 18.07$; $p = 0.00$). As a proportion, white respondents are more likely than black respondents to be affiliated to psychodynamic/psychoanalytic orientations. As with the other figures, the light

shaded areas indicate the total number of responses to the relevant item, while the darker shaded areas indicate the responses applicable to the respective variables.

Figure 6. Graph depicting the relationship between race and theoretical orientation among clinical psychologists



In contrast, differences between theoretical orientations according to gender are not significant ($\chi2(4) = 8.74$, $p = 0.07$). Likewise, differences in both age and post-qualifying experience according to primary theoretical orientation are not significant ($\chi2(4) = 0.65$, $p = 0.96$; $\chi2(4) = 6.77$, $p = 0.15$), neither are the differences in theoretical orientation in private practice and not in private practice statistically significant ($\chi2(4) = 6.02$, $p = 0.09$).

A Kruskal-Wallis test showed that there was a statistically significant difference in endorsement of evidence-based practice between practitioners of the five broad theoretical orientations, $\chi2(2) = 42.05$, $p < 0.00$, with a mean rank paired score of 432.15 for

cognitive/behavioural orientation, 345.66 for an eclectic orientation, 311.99 for Humanistic et al, 279.82 for psychodynamic/psychoanalytic orientations, and 307.61 for systems orientations. Pairwise comparisons among the five groups were conducted. The results of these tests indicate a significant difference between the cognitive/behavioural orientations and all other orientations.

4.3.2 Core values

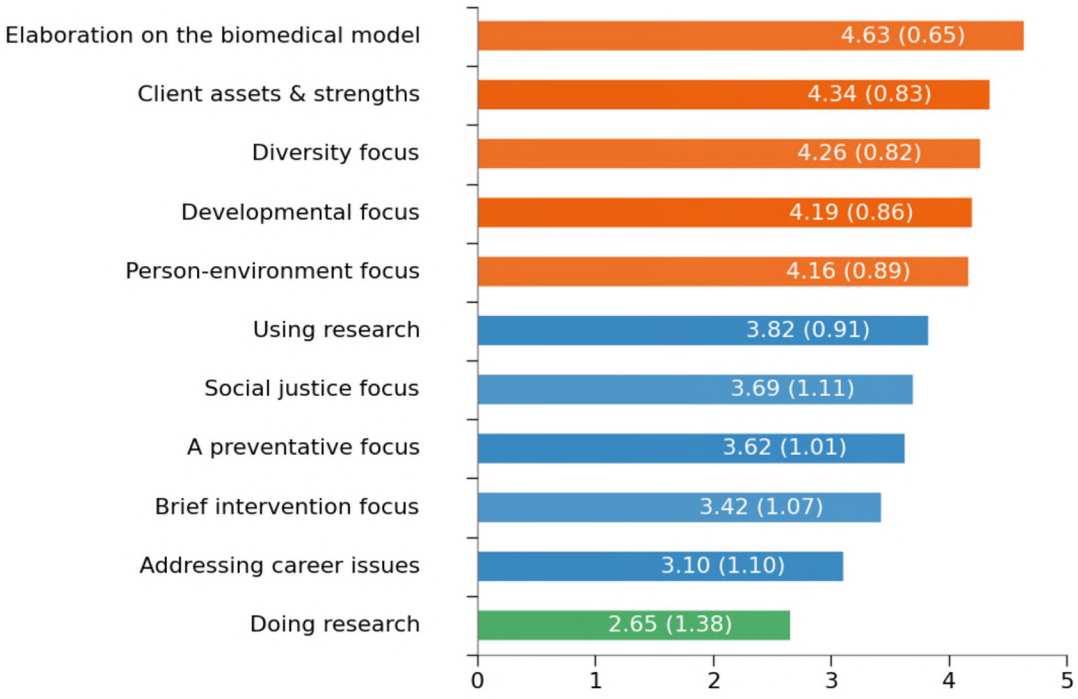
According to a 5-point scale (where 1 = Not at all and 5 = Very much so), respondents were asked to rate the extent to which 11 core values informed their practice as clinical psychologists. Table 13 below outlines respondents' respective ratings of each value.

Table 13.
Mean ratings of clinical psychology core values

	M	SD
A focus on understanding thoughts, feelings and behaviour in terms of biological, psychological and social causation (as opposed to a primarily medicalised approach, i.e. one which views biological processes as causal in mental illness).	4,63	0,65
Attention to people's assets, strengths, and resources, regardless of degree of disturbance	4,34	0,83
A focus on diversity, as well as a consideration of sociocultural context and systemic barriers in making sense of and understanding people's experiences	4,26	0,82
A focus on developmental issues and developmentally appropriate interventions across the lifespan	4,19	0,86
A focus on person-environment interactions rather than exclusively on either the person or the environment	4,16	0,89
Drawing on research to inform practice	3,82	0,91
A focus on social justice and the necessity, when appropriate, to advocate for just causes that promote the welfare of others	3,69	1,11
A focus on preventive interventions	3,62	1,01
An emphasis on relatively brief interventions	3,42	1,07
A focus on career-related issues and concerns pertaining to the workplace (e.g. career decision-making, transitions, adjustment, goal setting, exploration etc.)	3,10	1,10
Producing research that adds to knowledge of clinical psychology related topics	2,65	1,38

Figure 7 below illustrates this data clustered into three groups based on the mean values and where breaks in the data were noted. The first cluster indicated the values most highly endorsed included: a focus on understanding thoughts, feelings and behaviour in terms of biological, psychological and social causation (as opposed to a primarily medicalised approach, i.e. one which views biological processes as causal in mental illness), clients' assets and strengths, a diversity focus, a developmental focus, and a focus on the interaction between person and environment. The second cluster indicated moderate endorsement of the following values: using research, a social justice focus, a preventative focus, brief intervention focus, and addressing career issues. Lastly, on its own in the third cluster was the least endorsed value of conducting research.

Figure 7. Graph depicting clustered mean ratings (SD in parenthesis) of clinical psychology core values



In order to establish the correlation between values, and factors such as race (white/ black) and work setting (private practice/ not private practice) a Mann-Whitney test was employed. Statistically significant differences between white and black participants with respect to levels of endorsement of certain values were noted. Black participants indicated higher endorsement for Career/Vocational aspects ($U = 24881.00$, $N_1 = 291.55$, $N_2 = 379.41$, $p = 0.00$, $Z = -5.33$), Brief interventions ($U = 28729.00$, $N_1 = 299.60$, $N_2 = 352.87$, $p = 0.00$, $Z = -3.24$), Prevention ($U = 24675.50$, $N_1 = 291.12$, $N_2 = 380.82$, $p = 0.00$, $Z = -5.48$), Producing Research ($U = 27724.50$, $N_1 = 296.37$, $N_2 = 354.97$, $p = 0.00$, $Z = -3.54$), Diversity ($U = 27058.50$, $N_1 = 296.87$, $N_2 = 369.93$, $p = 0.00$, $Z = -4.65$), and Social justice ($U = 27418.00$, $N_1 = 297.62$, $N_2 = 362.10$, $p = 0.00$, $Z = -3.91$).

This analysis also indicated that there are statistically significant differences between participants in private practice and those not in private practice with respect to levels of endorsement of certain values. Participants not in private practice indicated higher endorsement with respect to: Brief interventions ($U = 40495.00$, $N_1 = 286.56$, $N_2 = 351.63$, $p = 0.00$, $Z = -4.63$), Producing Research ($U = 37529.00$, $N_1 = 276.67$, $N_2 = 355.95$, $p = 0.00$, $Z = -5.59$), and Person-environment interactions ($U = 45619.50$, $N_1 = 302.82$, $N_2 = 338.56$, $p = 0.01$, $Z = -2.62$).

The results further indicate that men are more likely to value research ($U = 36414.50$, $N_1 = 299.58$, $N_2 = 350.62$, $p = 0.00$) while, women are more concerned about diversity than their male counterparts ($U = 39327.50$, $N_1 = 333.17$, $N_2 = 293.99$, $p = 0.01$).

Clinical psychologists were asked about their impression of the extent to which the role of clinical psychologists in South Africa has changed on a 5-point scale (where 1 = Not at all and 5= Very much so). Table 14 below reflects mean responses of 3,10 (SD = 1,24) and 3,26 (SD = 1,24) with respect to changing roles since 1994, and over the next 10 years respectively.

Table 14.
Clinical psychologists impression of the extent to which the role of clinical psychologists in South Africa has changed; 1 = Not at all 5 = Very much

	M	SD
Since 1994	3,10	1,22
over the next 10 years	3,26	1,24

4.4 Chapter summary

This chapter reported on the results obtained from a nationwide survey that asked respondents about various aspects of their professional identity as clinical psychologists in South Africa. The significance of these results will be discussed in the chapter that follows.

Chapter 5 Discussion

This chapter discusses the results of the survey, as reported in the preceding chapter. Its structure takes the same form as that of the Results chapter, and, accordingly, considers findings with respect to demographic information, work settings and role (practices), and information about participants' theoretical perspectives, beliefs and attitudes (values). This framework offers a systematic way in which to address the questions posed by this research project, as previously outlined (cf. section 3.1).

5.1 Demographic information

The demographic information of participants reported concerns that of gender, age, race, and level of qualification. The sample is considered to be demographically representative of the total population of clinical psychologists. Therefore, findings observed within the sample can be generalized to the population it represents.

5.1.1 Gender

This study found that clinical psychologists in South Africa are mostly female, which concurs with Richter and Griesel (1995) who observed that the number of females in the field of clinical psychology increased substantially post 1994. According to the American Psychological Association, this trend is however not unique to South Africa, nor is it unique to the field of psychology (Willyard & Douce, 2009). Pillay and Kramers (2003) speculate that this pattern is reflective of economies which evolve to value social services, a domain constituted by issues typically tended to by females.

Concern has been expressed regarding poor male representation in psychology, and there is also the argument that when professions become feminised, working conditions, salaries and status tend to decline (Richter & Griesel, 1995). It is possible that a largely feminised psychological workforce may compound the pattern that it is largely women who access psychological services, perpetuating the stereotypically gendered trend that emotions are women's work. This is a concern given the high rate of gender based violence (men against women) and the high number of boys and men in jail (Cusack, Deane, Wilson, & Ciarrochi, 2004).

The strong representation of females could, however, also be advantageous to the field. Willyard and Douce (2009) note that, when considering the development of psychological theories, it has generally been men who have contributed toward theories focused on the individual and women who have contributed toward theories focused on the collective. Since the latter (i.e. a focus on communities and societies rather than merely on individuals) is what the field is calling for currently (cf. section 2.2.1), and research is still largely neglecting social issues (e.g. housing and socio-economic inequalities) in favour of individual issues (e.g. stress and psychopathology), orientating the development of psychology in this way is considered favourable (Macleod & Howell, 2013).

It is conceded that these arguments are based on traditional stereotypes of gender, to which many take exception. Furthermore, these arguments do not explore the quality of the client-practitioner interaction, which Pillay and Kramers (2003) argue is likely to be impacted since "male and female professionals may deal differently with mental health problems" (p. 58).

Therefore, perhaps what is more useful than considering the extent to which the profession of psychology misrepresents its clients with respect to gender, is to consider the complexities this brings to the therapeutic interaction.

Eagle and Long (2011) highlight the sensitive context of psychotherapy, which "brings both client and therapist into close proximity with potentially competing values, beliefs and ideologies" (p.337). Gender is one such issue, as is culture and race (discussed later). These authors acknowledge that differences are not easily explored for fear of offending the other, but that they nonetheless should be. Eagle and Long (2011) call upon psychotherapists' ethical responsibility to tread sensitively in these areas, particularly when working with clients in the throes of trauma when vulnerability can be heightened.

5.1.2 Age

Clinical psychologists in South Africa are shown to be widely represented in terms of age (ranging from 23 to 82 years old with a midpoint of 45 years old). The finding that the average number of years of post-qualification experience is 14,26 years (SD = 10,58) suggests that careers in the field of psychology are typically characterised by longevity, a firm advantage. It is interesting that neither age nor experience were highlighted as statistically significant determinants of any particular area of professional identity.

5.1.3 Race

When considering the high number of white clinical psychologists in the field, which is 71,80% of participants in this study and 68,11% of clinical psychologists in South Africa (Y.

Daffue, personal communication, 30th May, 2016), Swartz, Gibson, and Gelman (2002) point out that professions in general were historically "white-dominated" (p.11), that the profession of psychology was no different, and that this demographic distortion is simply a relic of the apartheid era. However, as previously mentioned, the field of psychology is particularly racially loaded in its history (cf. section 2.1.1). Indeed, Manganyi (2013) reminisces that when he embarked on his career in the 1960's, "it was as if Africans were not expected to train as clinical psychologists!" (p. 280).

Even though there has been an increase in the number of black psychologists, especially since 1994 as good quality higher education became increasingly accessible to black people (Pillay & Siyothula, 2006), the transformation of professional training of psychology has been slow (Ahmed & Pillay, 2004). The finding of this current study which indicates, promisingly, that black psychologists (including African, coloured and Indian) comprise 31,89% of the clinical field, is compared with that of Pillay and Siyothula (2006) who found that black African psychologists comprised 14,2% of the field a decade prior. Even though this is not a comparison of exact groups, it is an observation that points to some progress. Increasingly, there is an emphasis on ensuring that training groups are diverse (Pillay & Kramers, 2003). The findings of this study certainly support this, indicating that it is black psychologists who are more likely to work in rural settings and more likely to work with black clients, and therefore more likely to increase access to services among those previously disadvantaged in this respect. Cooper and Nicholas (2012) propose that the more demographically diverse the field becomes, the more people will become familiar with its services and be encouraged to access these as mental health users, or pursue clinical psychology as professionals themselves.

Given the fact that South Africa's history is not only multicultural but also multilingual, it is noted that the racial categories which constitute the profile of clinical psychologists tell an additional story (Cooper & Nicholas, 2012). It is stated that "language is the diagnostic and therapeutic instrument of the psychologist" (Pillay & Kramers, 2003, p. 57). Pillay and Siyothula (2006) concur, expressing concern that service provision in a medium other than one's home language can compromise its quality. Despite the fact that it is recorded that the majority of South Africans are multilingual and able to speak English, South Africa has 10 other official languages: isiZulu is the most frequently spoken (23.8%), followed by isiXhosa (17.6%), and Afrikaans (13.3%) (StatsSA, 2005, in Pillay & Siyothula, 2006). Findings of this study contrast with this picture, indicating that services are predominantly offered in English (68,38%) and Afrikaans (12,21%) and that African languages are poorly represented, with only a small portion (3,66%) of participants indicating they conversed with their clients in isiZulu and an even smaller portion (2,44%) in isiXhosa.

The need for greater multilingual and multicultural representation among clinical psychologists is thus indicated by the findings of this study. On the other hand, Pillay and Kramers (2003) assert that it is "a fallacy to believe that all of the previously oppressed groups are intimately au fait, linguistically or in worldview, with each other" (p. 58). The provision of multilingual and multicultural services thus poses a significant challenge, requiring increased representation, but also sensitive engagement with the complexities these differences bring.

5.1.4 Highest earned degree

The findings of this research study which indicate that 18,13% of clinical psychologists hold a doctorate level qualification may suggest a level of status to the field, however, the level of qualification takes on more meaning when paired with practice patterns and values, as discussed later.

In closing the discussion pertaining to the demographic information of clinical psychologists, and in addressing the related research question, it is summarised that the field of clinical psychology comprises professionals who are: mostly female, mostly middle aged, mostly white, and mostly have a masters degree qualification. It is, however, noted that there is a growing number of black psychologists in the field, and that these psychologists tend to service those who have traditionally not been able to access services, suggesting that training programmes are and should continue to prioritise equity and redress in their selection programmes.

5.2 Work settings and roles (practices)

5.2.1 Work settings

To recap the work setting results, what was found was that most of those who responded tended to practice mostly in the private sector, and mostly in urban areas. Furthermore, this is significantly correlated with race, indicating that it is largely white clinical psychologists who prefer private practice work settings in urban locations. Notable is that the clients seen in private practice are mostly white, while clients seen not in private practice are mostly black. This suggests that the South African health system is still very much two-tiered which is divided along racial and

socio-economic lines, as described by the Department of Health (2015). This resulted largely from the apartheid system which saw black people excluded from opportunities to progress in terms of wealth. Although there is a growing middle class, race and class still tend to converge in South Africa (cf. section 2.1.1). It is therefore not surprising that those who can afford private mental health services are largely white and those who cannot are largely black. This points to a worrying racial division within psychology and suggests that psychology has significant work to do in order to increase its accessibility to those who have historically not been able to access psychological services.

Another argument is that this trend (i.e. of mental health care being concentrated in private work settings in urban locations) resulted from, on the one hand, the concentration of care in cities due to the movement of labour to these areas and increased numbers in need of care, and on the other hand, the need for treating many psychiatric patients in inpatient settings (Swartz, 2008). The latter is no longer as necessary for as many patients as it was in the past, as progressions in treatment available lends itself more favourably to community-based care. However, while there has been a policy shift away from institutionalised mental health care, the community settings positioned to provide supplemental care have not been adequately augmented (Department of Health, 2013). This highlights the need for services in non-urban settings. The findings of this study suggest that clinical psychology is currently not meeting this need.

When considering psychologists' work settings and the locations thereof over time, comparisons are made with the findings of Pillay and Petersen (1996). These authors found that 47,7% of their participants worked in private practice, consistent with the finding of this study in

which 48,48% of participants indicated private practice as their primary work setting. Pillay and Petersen (1996) also found that 80% of their participants were located in urban areas, slightly more than the 72,82% of participants in this study. Despite the need for mental health care services to move away from private practice settings and urban locations, there has been no significant shift with regard to where psychologists work over the past two decades. This suggests that market values are influencing where psychologists locate themselves and that these are somewhat impervious to changing policy imperatives and mental health needs amongst disadvantaged populations.

Also under consideration, is those with whom psychologists work. The demographics of the population of South Africa, and therefore the clients requiring mental health services in South Africa are characterised as follows: by race as 80% African, 8,24% White, 8,79% Coloured, and 2,47% Indian/ Asian; by gender as 51% female; and by age as 30% aged 0–14 years and approximately 8% 60 years and older (Statistics South Africa, 2015). This differs from the demographic profile of clients the profession currently serves, according to this study, particularly with respect to age and race; a finding which suggests that clinical psychology continues to be inaccessible and/or perceived as irrelevant to a large proportion of the population.

The majority of clients seeking services are shown to be white (i.e. 45,01%), which is in stark contrast to the broader demographics where white people only comprise 8,24% of the South African population. Furthermore, most clients seeking services are adults (42,37% within the age bracket of 19-35 years and 37,29% in the age bracket 36-65 years), whereas adolescents/children in fact comprise 30% the population of South Africa. This finding echoes

concern raised in the National Mental Health Policy Framework and Strategic Plan 2013-2020 (Department of Health, 2013) regarding poor coverage of children and adolescents with respect to mental health care service provision (cf. section 2.1.2.2), as well as the finding that a focus on prevention is only moderately endorsed as a value (cf. section 4.3.2). Moreover, this finding which relates to practice and values in relation to prevention, and to children and adolescents, highlights the influence of market-related forces. For example, a school programme aimed at preventing depression may struggle to obtain funding. This finding perhaps also says something about teachers/parents not knowing when their children's difficulties are psychological in nature.

5.2.2 Primary work roles

Of the three most popular work roles, i.e. Clinical practitioner, Academic, and Consultant, it is surprising that results showed male respondents are more likely to be Academics than women. Universities lag in terms of equity (Pillay & Kramers, 2003) and the explanation may be that academic careers are slow in the making, requiring a longer period of time over which transformation can take place. The implications of this finding are thus significant, suggesting equity targets for employing psychologists at universities should not be 50/50 for male/ female clinical psychologists at universities but rather 30/70.

It is somewhat concerning that very few clinical psychologists are primarily researchers. This is at odds with the evidence-base emphasis in clinical psychology internationally where producing research is a key component of the profession. Research as a key activity (rather than a primary role) is further considered in the following section.

5.2.3 Engagement in key activities

Results of this study show that counselling/ therapy, the most prominent of the key activities in terms of the proportion of clinical psychologists it engages as well as time spent, is shown to be skewed largely (75,74%) toward individual modalities. Considering the ratio of mental health human resources that is 9,3 per 100,000 populations (Department of Health, 2013) and the inadequacy of services, particularly available to children and adolescents (Pillay & Lockhat, 1997), this mode of intervention is simply ineffective and inadequate (cf. 2.1.2.1). Moreover, it is reactive rather than preventative. While this may have been an acceptable model in the past when the proportion of the population requiring mental health care was restricted, it no longer suffices.

An interesting finding of this study is that the key activity of assessment mostly engages black psychologists, a group whose voice was not only absent but sorely misrepresented in this area of practice, historically (Cooper & Nicholas, 2012; Nicholas, 2014). Perhaps this a function of where black psychologists are located, i.e. more in not in private practice work settings, where waiting lists for this service are long and indicate a high need for assessment services among disadvantaged communities.

It is established that the greater the poverty the greater the likelihood of disability (Brown & Pollitt, 1996). Furthermore, South Africa has an educational system that is two-tiered; the wealthy have an educational system which is much more advanced and able to support various needs, whereas children in poorer settings who are not able to afford this level of service are struggling academically and failing for all kinds of reasons, resulting in assessment referrals.

One could therefore speculate that the higher need for psychological assessment among not in private work settings is influenced by an intersection of factors relating to race, class and the educational system.

It is also worth pointing out that psychological assessment is possibly the only task that is unique to psychologists (as opposed to other mental health care professionals), yet it is one shown to occupy only a small proportion of work time. There is concern here that clinical psychology is neglecting a skill set that is unique to applied psychology, and that this has the danger of diluting clinical psychology's contribution to multi-disciplinary teams. What is of further concern is that the tools for assessment are not sufficiently adapted for effective use in multicultural contexts (Foxcroft & Davies, 2008; Foxcroft, Roodt, & Abrahams, 2013), an aspect of psychological assessment that is requiring focused attention and probably not getting it if many psychologists are not actively engaged in this area of practice.

Research is another example of an area of practice that is shown to be neglected by clinical psychologists. This is significant because research is in fact outlined as a central area of practice, with evidence-based practice specifically listed as part of the scope of practice (Department of Health, 2011). The researcher refers back to the discussion about the Boulder conference, which highlights the scientific *and* practical aspects of the field of psychology, and thus portrays evidence-based practice as one of the central pillars of psychology, historically (cf. section 2.1.1 and 2.1.2.1).

Engagement in research, although more prolific among doctorate-level practitioners, is in fact shown to be less about professionals' qualification levels, and more about being in work settings other than private practice which lend themselves to research pursuits (e.g. paid research in academic settings, or programme monitoring requirements involving research in public settings). This is possibly explained by the assumption that many masters-level psychologists are registered for PhDs, which means they do research for the qualification. Nevertheless, this finding challenges the view that in order to contribute to research, a doctoral qualification is needed. Furthermore, this finding perhaps has implications for research funding allocations which may be better directed toward PhD research by psychologists working in public settings.

Interestingly, evidence-based practice is more strongly endorsed by clinical psychologists not in private practice work settings, also a group shown to be especially involved in research themselves. This suggests that conducting research oneself is likely to lead to one consulting research. Therefore, the profession of clinical psychology in general should be encouraging research if it is to endorse evidence-based practice.

It could be argued that not in private practice work settings require more innovative treatment strategies, which prompt professionals to seek proven interventions. It is also noted that private practice offers a perverse incentive; the longer clients stay in therapy, the more practitioners earn, particularly in relation to research (which does not pay the way clients do). Outside of private settings, there is less benefit to keeping clients in therapy, and more incentive for using brief approaches with proven efficacy and effectiveness.

It is of great concern that areas of practice that make clinical psychology distinctive from other professions are not evidenced in practice. As with the neglect of assessment, neglect of research and evidence-based practice threaten to dilute the professional identity of clinical psychologists and, most concerning, compromise its relevance to the current mental health needs of the country.

The key activity of community engagement is shown to be most engaged in by psychologists not in private practice. Given that the NHI has the potential to promote integration of the private and public sectors, its introduction could have a positive impact on this key activity for which the relevance debate calls, requiring those in private practice to engage in community interventions more actively.

Career Assessment and Career Counselling is understandably the key activity least engaged in as it is more typically part of counselling psychologists' scope of practice. Although those who indicated they spent time on this activity indicated that they spent only a small proportion of their time on it (M = 0,86% SD = 2,53), the fact that 19,04% of clinical psychologists engaged in this activity, suggests that there may be a lack of awareness of the details of the scope of practice even if clinical psychologists are aware of its existence. Alternatively, the overlap in key activities suggests that the boundaries of practice are inevitably blurred between counselling, clinical and educational psychology.

These findings suggest that shifts in mental health care needs are not being reflected in the practice patterns of clinical psychologists. The fact that racial cleavages, and the

corresponding disparity between private and public work settings, are replicated in the professional practice of clinical psychology presents a crisis of relevance. Practice patterns seem to be determined more by economic demands and a capitalist/market value base (i.e. clients largely of a particular class and race who comprise a small percentage of the population) than by policy imperatives which are more aligned with the mental health needs of the greater population as well as a social justice or human rights value base. This contrasts starkly with repeated calls to the contrary. Pillay and Petersen (1996) argued structural issues as the most significant barrier which prevented professionals from engaging in more progressive and responsive practice patterns, rather than a reluctance to adopt the values upon which these are based. This study shares this standpoint, echoing a resounding endorsement for the NHI model which is likely to enforce structural changes.

The researcher speculates that the demands of a relatively small percentage of the population is what shapes services, but considers that it is also what is available that shapes these demands. Further, what is available is also shaped by theoretical orientations which are influenced by training universities' affiliations. In addition to the practices which are available, the practitioners' demographics may also be determining clients seen. This research shows that the demographic of the practitioners is correlated with the demographic of clients seen (white practitioners are seeing white clients, whereas black practitioners are seeing more demographically diverse clients). On the other hand, it is indicated the white psychologists work mostly in private settings, whereas black psychologists work mostly in not in private settings. So it may be that the demographics of practitioners is not directly a determinant of the demographics of clients seeking services, but there certainly is a correlation. Work settings that

tend to be largely private practice are determining what role is being played by clinical psychologists and part of why areas of practices such as assessment, research, and brief therapy, are waning. It is concerning that private practice is thus seemingly immune to policy which advocates for a much wider group of clients.

In comparison to the practices which the literature propose should be central to clinical psychology currently, results show that the field is lacking engagement in a number of these, namely: Prevention activities (e.g. psychoeducation, outreach, program development); Expansion of counselling/ therapy to include modalities other than individual work (e.g. group, couple and family counselling/ therapy); Advocacy and health promotion, A dispersion of service provision from private practice and hospital work settings to settings more accessible to the majority of the population e.g. community mental health clinics; and Work settings located in non-urban areas (i.e. semi-urban, semi-rural, and rural areas). The practices of clinical psychologists therefore do not meet the current mental health care needs of South Africa. Furthermore, the division of practices (with respect to private and not in private work settings) speaks to a concerning level of 'role ambiguity' (cf. section 1.2) among the profession, undoubtedly compromising its identity.

5.3 Perspectives, beliefs, and attitudes (values)

The discussion now focuses on values and explores the extent to which professionals in fact value what the literature suggests they should, even if these values are not reflected in their practice patterns.

5.3.1 Theoretical orientation

Theoretical orientation was deemed by participants to be an important issue, who indicated that theoretical orientations impacted their practice to a great extent. Even though professionals indicated moderate engagement with evidence-based practice, the prominent theoretical orientation, i.e. Psychodynamic, is that least supported by evidence (Kagee & Lund, 2012). This perhaps points to a misunderstanding of what evidence-based practice is, as outlined by Kagee and Lund (2012).

It was further indicated that white clinical psychologists were significantly more likely to be affiliated with psychodynamic/psychoanalytic orientations than their black counterparts, suggesting the "theory-strong and data-weak tradition" characteristic of psychology in South Africa over the past few decades, persists (Kagee & Lund, 2012, p. 112). Efforts are being made to adapt psychodynamic theory to the South African setting (Swartz et al. 2002; Berg, 2012) as well as to embrace the complexities of obtaining evidence (Kagee, 2006a). It is possible though that psychoanalytic practices are not doing enough to demonstrate their relevance to non-western contexts. In the interim, psychologists in South Africa are having to cast their net widely in search of orientations which are appropriate to its diverse settings, perhaps offering some explanation for the popularity of the Eclectic theoretical orientation shown in the results.

Less surprising is the significant correlation evident between theoretical orientation and evidence-based practice, which indicates a stronger affiliation to CBT among those who engaged in evidence-based practice. This finding supports the argument that clinical psychology

programmes who want to promote the current scopes of practice should offer CBT as this inevitably promotes evidence-based practice.

5.3.2 Core values

The value most endorsed by clinical psychologists was that which expands on the biomedical model, which is interesting given the foundational role of this model in the development of clinical psychology. It is interesting that while respondents endorsed this value strongly, they endorsed the related value, which asks about environmental influences, much less strongly, suggesting the traditional biomedical model is in fact still dominant. Other values in the first and most endorsed 'cluster' (cf. Figure 6 in section 4.3.2) include the more traditional values. The values only moderately, and that least endorsed, include the less traditional yet more progressive values, and indeed the values which the South African literature propose should be central to clinical psychology currently.

Race, work settings and gender were shown to be significant predictors of values among participants in the study. Essentially, the values endorsed most by black psychologists and those not in private practice are the values for which the literature calls. The values predicted by gender were research and diversity, where male psychologists were more likely than female psychologists to endorse research (in line with the fact the male psychologists are more likely to be academics), and female psychologists were more likely than male psychologists to endorse diversity (perhaps because females are more likely to have a sense of what it is to be oppressed).

Because there are race differences in whether or not participants work in private practice (cf. Figure 3 in section 4.2.1) - possibly to do with the fact that white psychologists are compromised by not being able to speak languages other than English or Afrikaans and therefore struggle to work in settings other than private practice - some of the determinants of clinical psychologist' values might be more to do with work setting rather than race. Emphasis on brief work, for example, might have more to do with the fact that the economic forces in private practice do not favour short term treatments. The same is probably true for valuing the production of research. Also, people tend not to seek private therapy to prevent problems. One might speculate that racial differences in diversity and social justice could be because black participants, who have more likely experienced and witnessed injustice, are more sensitive to such issues. The same could be said of women, as noted earlier. Importantly, these interpretations suggest that it is the locations and work settings of clinical psychologists' practice that is determining their values, rather than policy and the national mental health needs.

It is interesting to note that clinical psychologists were only marginally more optimistic about their changing professional role over the next 10 years than since 1994. This is disheartening, especially with the introduction of the NHI on the horizon and the promise of its positive impact on the structural landscape of mental health in the country.

In closing, it appears that the values endorsed by clinical psychologists are congruent with the practices with which they engage (e.g. individual therapy in urban areas with white clientele). While this does not reflect 'role conflict' (cf. section 1.2), it is concerning as the

values do not lend themselves to practices that are responsive to the mental health care needs of the country.

5.4 Chapter summary

While the demographic findings are somewhat encouraging, (i.e. that clinical psychology has seen an increase in black psychologists, promising particularly since black psychologists, according to the findings, are more likely to endorse the values and practices needed in our country). However, practices and values in general have not shifted. As conveyed in the discussion of results of the survey, the practice patterns of clinical psychologists fall short of the practices for which the relevance debate calls. Furthermore, the values for which the literature calls are endorsed only moderately by clinical psychologists, and not prioritised as much as the more traditional (and less progressive) values. In this way, the professional identity of clinical psychologists is currently not one that meets the needs of the mental health care needs of South Africa. The implications of these results discussed will be outlined in the concluding chapter which follows.

Chapter 6 Conclusion

This research project has surveyed the current status quo of clinical psychologists in South Africa. Discussion of the study's findings in relation to relevant literature has offered a reflection on the profession, both in terms of identifying the practices and values that are relevant to the mental health needs of the country, and ascertaining the extent to which these are reflected by clinical psychologists in South Africa at this time.

6.1 Summary of findings

It has been shown that the demographic profile of clinical psychologists in South Africa does not mirror that of the clients the profession purports to serve with respect to race, language and gender (cf. section 5.1.5). While efforts are being made to transform the demographic profile of clinical psychologists, progress on this front is slow and it is thus necessary to also engage sensitively with the complexities this demographic misrepresentation brings.

The practices of clinical psychologists in South Africa are shown to fall short of those recommended for adequately meeting the current needs of South African mental health. Services are evidently divided in terms of private and not in private work settings, reflecting a two-tiered heath system divided along racial and socioeconomic lines. Furthermore, this study shows that there is a large part of the population for whom psychological services remain inaccessible and/ or inappropriate. The profession has a responsibility to not only respond to the needs of clients who seek psychological care and shape services accordingly, but to proactively make appropriate services available and accessible, and to invite those who do not actively seek services to do so. Not only is the practice of clinical psychology risking irrelevance in this way, it is also guilty of

neglecting core areas of practice (i.e. research and assessment), and also risks losing something of its identity if this pattern persists.

The progressive values for which the relevance debate calls are only moderately endorsed, indicating somewhat of a discrepancy between values emphasised by policy and values endorsed by clinical psychologists currently. What is more, this is most notably the case among clinical psychologists in private work settings, suggesting that policy imperatives are not reaching professionals in private practice where market forces prevail.

When considering the argument that professional identity is co-constructed by individual, societal and national factors, an important observation is that the professional identity of psychology appears to reflects the split at the societal level.

6.2 Recommendations

Firstly, in order for clinical psychology to remain relevant, the field should be strongly endorsing the NHI model of health financing. This structural intervention promises to merge the currently split, two-tiered health system by introducing policies that impact on private practice settings, which the findings of this research project suggests have remained impervious to national policy imperatives. For example, activities of community engagement, research and evidence-based practice are shown to be more active in not in private work settings. The introduction of the NHI will likely enable these values to be more actively endorsed across work settings.

Other structural interventions could take place at the level of medical aids, who have played a role in pushing up the cost of psychological services so that they are out of reach for the average South African. Perhaps the Health Professions Council of South Africa could explore incentivising community engagement with continued professional development CPD points.

Secondly, the findings of this research have implications for universities who train clinical psychologists. It is important that training programmes continue to prioritise equity and redress in the candidates that they select. In particular, programmes are encouraged to seek out candidates who are more likely to work in non-urban and rural settings, suggesting also that language proficiency needs to become a focus in selections. The finding that men continue to be underrepresented in psychology in general suggests that training programmes also need to remain mindful of gender diversity in their selection.

Training universities are also urged to relook at their curriculum and ensure that the current issues and relevant policies relating to the professional identity of clinical psychologists are captured therein. For example, findings support the argument that training universities should prioritise research, with an emphasis on evidence-base practice; as well as psychological assessment, with an emphasis on its use in multicultural contexts. In terms of theoretical orientations, training programmes are encouraged to offer CBT as this inevitably promotes evidence-based practice. Psychoanalytic therapy needs to relook at the extent to which it is accessible to black populations – by embracing short term psychodynamic approaches and by prioritising the production of research with regard to effectiveness. Another implication for training programmes is an emphasis on childhood intervention and prevention. Training

programmes may want to encourage creative ways in which to honour the more progressive values and move away from traditional modes of practicing which are shown to compromise relevance to the current mental health care needs.

Thirdly, the findings of this research have implications for research funding allocations which are shown to perhaps be better directed toward PhD research by psychologists working in public settings. It would be important to ensure that time is put aside in the working week for this research and that it continues to be a valued aspect of psychological work in this setting.

Since language is indicated as a significant domain of misrepresentation among psychologists and clients, an implication could be that translators and their role be more formalised and better established. Additionally, it is recommended that clinical psychologists who do not speak an African language consider developing proficiency that is sufficient to offer psychological services.

6.3 Limitations

A limitation of this study concerns the fact it is only focused on one profession of mental health when of course there are many others. It would be valuable, for example, to explore comparisons with other mental health professions, especially that of counselling psychologists. It is possible that the initial use of Medpages in the sampling procedure – a resource which reflects mainly private practitioners – may have skewed the sample.

The questionnaire had a number of limitations to it. For instance, participants' first and second languages were not captured. In addition, participants were not given the opportunity to indicate their clients' gender. When asked to indicate work setting, the option 'Hospital' did not specify public or private. The survey also confined the researcher to use of counselling psychology values. Although these were added to in order to compensate for this partiality, it is still considered a limitation. Finally, survey research means that the interpretations of the research are subjective and may not always echo those offered by the participants.

6.4 Recommendations for future research

Based on this research, future research questions could explore professional identity from a qualitative perspective, obtaining a deeper understanding of clinical psychologists' views and perceptions. It would also be valuable to compare clinical and counselling psychology surveys.

6.5 Closing summary

It has been mentioned that "our identity as psychotherapists is not so dependent on the hat we wear but on the foundation on which it rests" (Markin, 2014, p. 327-328). Perhaps though, if the hats we wear continue to be unsuitable for the occasion, the foundations on which they rest will begin to erode. This research project thus echoes the calls for change that makes psychology more relevant and highlights a sense of urgency in doing so.

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Appendix

A. Online questionnaire

(The online questionnaire follows on the proceeding page)