The discursive practices of clinical psychologists in private practice in the Cape Metropole

Shayni Geffen

Department of Psychology

University of Cape Town

Supervisor: Dr Wahbie Long

Word Count:

Abstract: 224A

Main Body: 10000

Abstract

The debate regarding the 'relevance' of psychology in South Africa has ensued for the past three decades. During this time, there has been extensive investigation regarding the contextual factors which hinder the effective application of the discipline. However, by comparison, research detailing the possible effects of intradisciplinary influences on creating a more applicable psychology in South Africa is less substantial. Operating from a social constructionist paradigm, this qualitative study explores the discursive practices of clinical psychologists in private practice. Semi-structured interviews were conducted with nine psychologists practicing in the Cape Metropole in the Western Cape. Based on analytic methods proposed by Potter and Wetherell, this study presents a discursive analysis of participants' discussions about working as mental health professionals in the Cape Metropolitan. Specifically, three interpretative repertoires were identified: self-presentation as concerned citizens; the overwhelming nature of the public sector in South Africa; and the profession as a market phenomenon. The data suggests that despite participants' being aware of the context of mental healthcare in South Africa; the discourses they drew on to discuss their work functioned as self-justifications for working as psychotherapists in private practice. It is therefore suggested that psychologists in private practice develop a critical awareness as to how their own language could stifle the discipline from being more socially responsive to the nature and needs of the South African context.

Keywords: clinical psychologist; discourse; private practice; relevance debate; South Africa

Introduction

In the spirit of transformation following the overthrow of the apartheid government in South Africa, the discipline of psychology recognised that it too needed to transform (Ahmed & Pillay, 2004; Macleod, 2004). This was marked by the disbanding of institutions such as the Psychological Association of South Africa (PASA) and the formation of the Psychological Society of South Africa (PsySSA). Despite these organisations attempting to be more inclusive of previously disenfranchised and disadvantaged groups, critics suggest that the current profession of psychology still may not be the best means to enhance mental wellbeing for all within the country (see Dawes, 1998; Leach, Akhurst, & Basson, 2003; Pretorius, 2012; Seedat, MacKenzie & Stevens, 2004). This critique largely stems from psychology in South Africa historically overlooking the dialectical relationship between individuals and their embodying milieu (Macleod, 2004). Currently, there is a burgeoning literature reviewing the role that contextual barriers play in hindering access to psychological services for individuals in South Africa. Examples of these contextual barriers include; a lack of mental healthcare resources throughout the country (Saraceno et al*.,* 2007), language barriers between practitioners and clients (Pillay & Peterson, 1996), and cultural conceptions of mental illness (Ruane, 2010). However, there is a dearth of research exploring whether psychologists themselves hinder the creation of a more relevant discipline of psychology. Examples of these intra-disciplinary factors include the attitudes, thoughts and discursive practices of psychologists. Gaining insight into these intra-disciplinary factors may provide a richer understanding as to why change in the practice of psychology has been torpid in the country, despite an increasing amount of literature calling for a more relevant psychology (de la Rey & Ipser, 2004; Pretorius, 2012).

Background: the 'relevance debate'

The on-going debate regarding the relevance of psychology in South Africa is complex and cannot be simply summarised (Ahmed & Pillay, 2004). Prior to democracy, this debate was largely framed as political activism, whereas nowadays it connotes "engaged scholarship" or "social responsiveness" (de la Rey & Ipser, 2004; Long, 2013a). Recent literature has even questioned whether the term 'relevance' truly encapsulates the essence of the transpiring debate (Long, 2013a). Not only is there a lack of cohesion among academics as to what the relevance debate really is about, there is also no consensus among academics as to how to operationally define a 'relevant' psychology in South Africa. Cognisant of this

conceptual opacity, this study will define the terms 'relevance', 'applicability' and 'social responsiveness' as the capability of psychology as a discipline to respond appropriately to the context-specific barriers which exist within South Africa. These local barriers to creating a more relevant discipline of psychology are understood to be of both a 'structural' and 'non-structural' nature.

Structural Barriers

Following the implementation of a democratic constitution in South Africa, the call for relevance manifested itself in two forms: the need to alter the demographic profile of psychology practitioners and to create a socially responsive discipline to execute post-Apartheid policies (de la Rey & Ipser, 2004). It was hoped that changing the racial composition of the discipline would introduce local languages and concepts (such as *Ubuntu*[1]) into the profession, thus making psychology more accessible to all within South Africa (Meyer, Moorem, & Viljoen, 2008; Stevens, 2001). Duncan, van Niekerk and Townsend (2004) note that a decade after democracy, 18% of psychologists registered with the Health Professions Council of South Africa were black[2]. Additionally, after conducting an informal survey, I found that currently almost half of the academics heading the psychology departments in South Africa are black. These findings indicate that not only has there been an increase in the number of black practitioners in the country, but there has also been an increase in black academics in decision-making positions.

However, despite attempts to encourage more black faces and indigenous languages into the discipline, training curricula and psychotherapeutic practices have undergone little change (Watson & Fouche, 2007). As Nobles (1972) observes, if local concepts are not incorporated into practice, black practitioners are likely to operate within the same Western framework and espouse exactly the same knowledge as their white counterparts. Thus, researchers posit it may be beneficial to review both the profession's demographics as well as the theoretical orientation of the discipline (Dawes, 1998; Seedat et al. 2004).

Secondly, the residue of apartheid left a racially biased distribution of mental health-care resources (Meyer et al., 2008). As a result, the minority of the country (white, middle-

[1] *Ubuntu* is a complex philosophy to define. Essentially, it is the belief that "a person is a person in relation to other people". This phrase refers to the way human beings are all interconnected. Thus, insight oriented one-on-one therapy may fail to incorporate the complex dynamics of how a person conceptualises their internal world in relation to their surrounding community.

[2] In this project, *black* is used in accordance with the Employment Equity Act (1998), namely, as 'a generic term [used to refer to] . . . Africans, Coloureds and Indians' (chapter 1, n. p.).

class people in urban settings) receive the bulk of mental health services while the majority are left disproportionately underserviced (Ahmed & Pillay, 2004; Chipps & Ramlall, 2012). The current mental health care policies in South Africa are actively aimed at addressing and altering this disparity (Rock & Hamber, 1994). However, the realisation of such policies in practice is proving to be slow (Meyer, et al., 2008). As a result, the treatment gap (failure to provide for people in need of treatment), diagnostic gap (failure to diagnose all patients with a mental illness) and research gap (failure to provide the required research to diagnose or manage an illness) are on the rise (Stein, 2012). Such failings should not be considered solely as a result of the aforementioned structural barriers, but also as a result of non-structural barriers.

Non-Structural Barriers

Non-structural barriers can be understood as people's beliefs preventing the procurement of effective psychological treatment. In South Africa, these can be seen as cultural understandings of how to address mental illness and who should provide these services (Leach et al*.,* 2004; Seedat et al*.,* 2004). In a 1997 national survey, researchers found that the public had a general perception that mental illnesses were related to stress or insufficient willpower, rather than medical causes (Stein, Wessels, Van Kradenberg & Emsley, 1997). Furthermore, people believed that such problems could be dealt with by discussion with family and peers, rather than consultation with health professionals (Stein et al*.,* 1997). Additionally, the lack of knowledge about mental illnesses and the services available all contribute to the non-structural barriers which hinder access to psychological services (Kale, 2002; Ruane, 2010).

There is a substantial body of research detailing the external factors (of both a structural and non-structural nature) which may hinder the effective application of psychology throughout South Africa. Examples include; the discipline's lack of attempt to integrate cultural beliefs into service provision, the discipline's Western theoretical standing and poor representation of indigenous African people, languages and cultural concepts. Yet, there is an absence of research detailing whether psychologists themselves (not their theoretical standings, research methods, or diagnostic tools) play a role in hindering the actualisation of a more socially responsive discipline. Examples of this would include psychologists' attitudes, thoughts and talk about psychology in South Africa. From a constructionist perspective, language is action orientated, that is; it has consequences in the world (Potter & Wetherell, 1987). Thus, the discursive practices of psychologists are of particular importance as they

possess the capability to construct and suppress change within the discipline, and ultimately, affect the course that psychology takes towards becoming more relevant within the country.

How clinical psychologists in private practices in urban spaces in South Africa make sense of their work is of particular interest, as their modes of therapy and physical location have been criticized for being detached from the South African context (Peterson, 2005; Pretorius, 2012).

Framing and defining clinical psychology in private practice in South Africa:

According to the American Psychological Association (APA, 2012, para. 1) "Clinical psychology is a field which amalgamates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development."

Firstly, from the above excerpt it is evident that the conventional goal of clinical psychological practice is to alter the individual rather than the context (Peterson, 2005). However, in South Africa, the aim of producing an autonomous, responsible individual may be subsequent to alleviating more immediate external, contextual burdens (Meyer et al., 2008). According to Seedat, Duncan and Lazarus (2001), the principles of clinical psychology (ameliorating the individual rather than their environment) may not represent the most effective practice of psychology for changing the lived experiences of many within the South African context.

Secondly, the effectiveness of one-on-one, 'insight-oriented' psychotherapy may be inferior to that of a community-specific therapy which provides skills and strategies that promote successful coping within a given context (Watson & Fouche, 2007). According to residents of Mamelodi township in Gauteng, for example, traditional psychotherapy fails to explain "the goals of therapy, how it would help, and provide reasonable time limits to reach goals" (Ruane, 2010, p. 221). Moreover, being a psychotherapist may not be the most essential role for psychologists to play in South Africa. Hickson and Kriegler (1991, p. 792) state that

> the mission of a psychologist in the South African context should be essentially that of a proactive, educative and preventative change agent. The vision of the future professional psychologist should be that of a mental-health facilitator and consultant rather than primarily or exclusively that of a therapist.

Dawes (1998) argues that much of traditional clinical psychology in South Africa has had little relevance to the problems facing the poor in the country. Moreover, when it has paid attention to these populations, the discipline has used models which are unsuited to understanding the local conditions of life.

Thirdly, with over a quarter of the country unemployed (Statistics South Africa, 2013), and psychologists in the private sector charging an hourly rate of between R650 and R850 (W. Long, personal communication, April 30, 2013), it is unclear how psychologists in private practice make sense of the availability of their work for the majority of the population. Seedat and colleagues (2001) state that the formation of community psychology in South Africa was largely in response to the limited amount of people who could afford to see a psychologist. These same sentiments are reiterated by Abel and Louw (2009) when discussing the conception of the registered counsellor category in South Africa. Ancillary to these relatively new developments within the discipline of psychology in the country, there has been an unmistakable call within academia for psychologists to move out of a private practice framework and into communities, schools, prisons and non-governmental organisations (Pretorius, 2012).

Finally, just as researchers have noted that psychological services in the country need to move out of private practice, so too have they noted the importance for psychological services to move out of urban spaces (Burns, 2011). Most South Africans living with mental illness are clustered in rural areas; however the location of both public and private health care resources is mostly stationed within the cities (Ahmed & Pillay, 2004). Thus, there is a disjuncture between the bulk of practising clinical psychologists and the geographical areas which are in the most need. In the Western Cape in South Africa, the Cape Town Metropolitan is considered to be the most urbanised district (Punt et al., 2005); hence, this study will specifically focus on this region of the province.

The ‘relevance debate’ regarding psychology in South Africa has ensued for over three decades. During this time, there has been much investigation regarding the contextual barriers which hinder the effective application of the discipline. However, research detailing the possible effects of intradisciplinary influences on creating a relevant psychology is relatively wanting. From a social constructionist framework, language is considered both constituted by, and constitutive of, the world around us (Potter & Wetherell, 1987). Thus, there is a need to consider how psychologists’ discursive practices play a role in hindering the capability of psychology as a discipline to respond appropriately to the barriers that exist in the country. It is of particular importance that the discursive practices of clinical psychologists who operate

in private practice in urban spaces in South Africa be explored as these intersections have been critiqued for being irrelevant to the nature and needs of the majority of the South African population (Macleod, 2004).

Aims and Objectives

The objective of this project is to explore the ways in which clinical psychologists in private practice in the Cape Town Metropole construct and frame psychology in South Africa through their talk. Specifically speaking, it aims to gain insight into what discourses these clinicians draw on when framing their work within the broader context. The position taken in this study is that psychology is a socio-political project, rather than an objective, value-neutral one (Macleod 2004). The aim of regarding psychology in this way is that it emphasises the need to produce psychological knowledge and practices that not only reflect the socio-political concerns of the country, but also contribute to overcoming the multiple sources of social inequities and diffractions present in contemporary South African society – as well as the mental wellness issues attached to these. This need is best met through both theoretical developments as well as practical implementation (Pretorius, 2012). The theoretical developments should foster critical dialogue and debate, while practical implementations should address contextual, socio-political issues of South Africa. This understanding of psychology does not advocate for the abandonment of traditional Western psychological theories. However, it does advocate that the deployment of these theories and modes of practice be rooted in the local context.

Main Research Question

The main research question in this project is:

"What discourses do clinical psychologists in private practice draw on when talking about their work as mental health professionals in the Cape Metropolitan area?"

Theoretical Framework

Since this study is concerned with examining the constitutive function of language, the theoretical framework guiding this study is social constructionism. Despite this paradigm becoming an increasingly influential approach in making sense of the world around us, no singular definition exists (Potter, 1996; Willig, 2001). However, there are certain tenets to which most researchers (including myself) subscribe when employing this constructionist paradigm. Social constructionism is rooted in the assumption that what we experience and perceive is not a direct reflection of the local milieu, but rather a specific reading of these conditions (Burr, 2003). Similarly, the content of the interviews were not viewed as neutral

texts, but rather as products of the interviewees' positions as clinical psychologists in private practice (Potter, 1996).

Secondly, social constructionism is founded on the understanding that our environment comprises of multiple knowledges as opposed to an essentialist, all-encompassing truth (Willig, 2001). These knowledge claims are dynamic and constructed in relation to the social, cultural and political arrangements at a given time within a particular space (Burr, 1998). It is through various social interactions and processes, particularly language, that these knowledges are constructed, produced and reproduced (Burr, 2003). Hence, in this instance, interviews, as inherently social interactions, provide a means to gain access to multiple subjectivities.

Language is considered not only to communicate these subjectivities but also to provide the mechanism for structuring thought and performance within people's experiences and interactions (Burr, 1998). Therefore, language is considered to be constructive of reality (Potter, 1998; Potter and Wetherell, 1987). The discourses that the participants draw on through their talk about the profession are regarded as constructed by and constructive of their profession. Thus, changing the discursive practices of clinical psychologists may provide a way to create a more socially responsive discipline in South Africa.

A concluding statement must be made that advocating for a different, more socially responsive system is not at odds with the social constructionist paradigm. Indeed, social constructionism is not value-free and has the political intent of aspiring toward change (Foster, 2003). Furthermore, arguments put forth by Edwards, Ashmore and Potter (1995) emphasise that constructionism does not aim to deny the existence of the material world, but rather aims to explore the ways in which such reality is constructed and understood. Thus, social constructionists are less concerned with what may lie behind such discourses and they concentrate rather on the social consequences of the constructions and performances of discursive practices. This highlights the place of social constructionism as a tool for social reform (Burr, 2003; Wetherell & Potter, 1992). Ultimately, the use of this paradigm whilst advocating for a more socially responsive discipline of psychology, does not indicate in a conflict of interests.

Method

Research Design

Qualitative Research

This project incorporates a qualitative research design. Qualitative research is an open-ended, inductive, exploration that exposes data which would otherwise remain concealed in

metric methodology (Willig, 2001). Indeed, statistics are not suited to analyzing the discursive practices of clinical psychologists. Furthermore, qualitative methodology allows us to situate those that we study in their given context and explore the social locations they occupy within such a space (Marecek, 2003). This project did not aim to generalise a hypothesis to the broader population. Rather, it focused on a particular cohort due to its social location of being clinical psychologists operating in private practice in the Cape Metropole (Marecek, 2003; Willig, 2001).

In qualitative methodology, language is regarded as a manifestation of norms, discourses and social organisation of the world around us (Willig, 1998). It is also considered constitutive of these aforementioned configurations (Potter & Wetherell, 1987).Thus, the talk employed by the participants when discussing their work will reveal which discourses they draw on and which ones remain silent. The most prominent of these shall be unpacked in this project by discourse analytic techniques as proposed by Potter and Wetherell.

Sample

Access to this sample was gained via the selection of registered clinical psychologists from the websites: www.psychotherapy.co.za, www.findhelp.co.za, www.medpages.co.za and www.therapistdirectory.co.za. A purposive sampling strategy was used. The final sample consisted of nine clinical psychologists in private practice from four different areas in the Cape Town Metropolitan: City Bowl District (City Bowl); Southern Suburbs (Claremont, Kenilworth); Northern Suburbs (Bellville, Durbanville) and Atlantic Seaboard (Green Point, Camps Bay). Participants from these areas were 'randomly' selected based on their numerical ranking on the websites' regional pages (for example, the sixth listed psychologist from each of the four different regions in the Cape Town Metropole were contacted). The above process controlled for any further demographic sampling bias which may have arisen from such a sampling strategy. Participants were contacted via an email (Appendix A). In total, 39 psychologists were contacted, of which twelve responded expressing their willingness to participate in this study. Of these twelve, one was no longer working in private practice, and a further two were only able to participate at a later time in the year. Since there was a limited response rate, an additional psychologist from the Cape Winelands region (Stellenbosch) was also included in this research project. Table One, on the following page, details the pseudonyms of the participants, their age range, gender, race, language of practice and preferred therapeutic modality of the participants.

Table One: Demographic characteristics of participants

Participant	Age Range	Gender	Race	Home Language	Therapy Preference
Mark	30-40	Male	White	English	Integrative
Martha	60-70	Female	White	Afrikaans/English	Integrative
Candice	20-30	Female	White	English	Psychodynamic
Graham	20-30	Male	White	English	CBT
Laura	40-50	Female	White	English	CBT
Sharon	60-70	Female	White	Afrikaans/English	Psychodynamic
Betty	30-40	Female	White	English	Psychodynamic
Kim	40-50	Female	White	English	CBT
Daniel	40-50	Male	White	Afrikaans/English	CBT

The skewed race and gender composition of the sample reflects the broad demographic profile of clinical psychologists in the country, with women and whites comprising the large majority (Gentz & Durrheim, 2009). Furthermore, the fact that all of the participants practiced in either English or Afrikaans, also reflects the language of practice of the profession at large (Pillay & Petersen, 1996).

Data Collection Tools and Procedure

Data was collected via one-on-one, face-to-face, semi-structured interviews. The semi-structured nature provided a platform for the interviewee's thoughts and discursive practices to emerge (Wetherell & Potter, 1992). In keeping with this data collection technique, the interview material was only partially designed prior to the actual data gathering to comprise the interview schedule (Appendix B). All of the interviews were conducted at a time and place of the participant's choice. The length of interviews ranged from 34 minutes to 80 minutes, with the mean length being 53 minutes. The interviews were recorded using a portable voice recorder and were subsequently transcribed in preparation for the data analysis. The transcription system used is described in Appendix C.

Data Analysis

Discourse analysis was used to analyze the interviews. Bearing the research question in mind, this project aimed to understand discursive practices as being reflective and constructive of social practices rather than as linguistic composites, cognitive practices or constructions of objects. Furthermore, this project is not concerned with the locus of power or ideological underpinnings within the text. This analysis merely investigates the 'talk'

amongst psychologists in private practice and the function of the discourses they draw on in their talk. Thus, the work of Potter and Wetherell provided the guide for this analysis.

Potter and Wetherell (1987) veer away from utilising the term 'discourse' and find it preferable to talk of interpretative repertoires. These are linguistic devices that people actively draw on when constructing actions and events. Interpretative repertoires are systems of signification or building blocks used for understanding the content of discourses (set of meanings, conversations and metaphors) and how this content is organised. Thus, interpretative repertoires can be considered as a cluster of multiple discourses (Potter, Wetherell, Gill, & Edwards, 1990). I alternate between the terms discourse and interpretative repertoire when discussing the findings of this project.

Potter and Wetherell (1987) note there is no set method for analysing discourses or interpretative repertoires. Instead, there is a broad theoretical framework "which focuses attention on the functional and constructive dimension of discourse" and should be coupled with the researcher's skill at "identifying significant patterns of consistency and variation" (Potter and Wetherell, 1987, p. 169).

In my study, themes were extracted across interviews to identify recurring consistencies within the data. Following this, the analysis moved beyond what was being said (or not said) and focused on discerning the presenting 'function' in the speaker's language. Here, I trawled through the data again, investigating the ways in which the participants' talk 'acted' to perform certain constructions of 'psychology' and 'being a psychologist'. After this, the data was examined for variations between and within the participants' talk. According to Potter and Wetherell (1987), variations between descriptive accounts of the same phenomenon are just as noteworthy as consistencies, as they provide textured evidence of the dialogical ways in which people interpret and negotiate the world around them. In the final step, the interviews were reread to find any metaphors or tropes- which the participants drew on when talking about their work as clinical psychologists. Potter and Wetherell (1987) state that tropes should not be considered as superficial, stylistic ornamentations of discourse. Instead, tropes should be considered as devices by means of which people frame their talk and come to make sense of their surrounding world. The use of one trope as opposed to another provides insight into the way participants construct their experiences as psychologists (Wetherell & Potter, 1992). This process continued until a sufficient level of saturation was attained (Taylor, Bogdan, & Walker, 2000).

A final point must be made that by presenting social constructionism as my theoretical framework and discourse analysis as my method of analysis, I am not suggesting that there is a distinct separation between the two. Foster (2003) posits that, in fact, the two cannot be prised apart, and may be regarded as a theory-method itself.

Ethical Considerations

Ethical approval for conducting this study was granted by the Psychology Department Ethics Committee of the University of Cape Town.

Harm to Subjects

Each interview was conducted at a place and time of the participant's choice so as to minimise any inconvenience. Since neither the subject matter nor the sample was considered to be of a particularly sensitive nature, this somewhat decreased the chances of emotional distress which may have emerged through the interview process. Nonetheless,to protect the professional reputation of the participants, all names, the areas in which the participants practice and other identifying data were removed from all drafts and the final project.

Informed Consent

All participants were asked to sign informed consent forms which explicitly stated that their participation was of a voluntary nature (Appendix D). After signing the consent form, I verbally confirmed that participants had a full understanding of the interview process as well as their right to not answer questions or withdraw at any time (Willig, 2001). Participants also signed a form consenting to interviews being audio-recorded (Appendix E).

Confidentiality and Privacy

All consent forms and collected data were kept, password protected, on my computer with no one having access to them. Additionally, the interviews were self-transcribed, further simplifying issues of confidentiality.

Limitations of the Project

There were two major limitations in this project. Firstly, the small sample size (nine) makes it extremely difficult to generalise this project's findings to all clinical psychologists in private practice in the Cape Town Meteropole. However, the aim of this project was not to generalize findings to a broader population, but rather to explore the discursive practices of these individual participants (Babbie & Mouton, 2007). Moreover, despite the small sample size, the findings of this project still contribute to understanding why the movement toward a more meaningful and relevant practice of psychology has been torpid in the country.

Secondly, since I was the sole researcher in this project, these findings were just one means of organising the data, and if the data is trawled through by a second set of eyes, there could be a variation in interpretation. Thus, due to the subjective nature of such an analysis, the technique of 'coherence', as proposed by Potter and Wetherell (1987), was used as a means to ensure validity in this study. In the writing of this project, I tried my utmost to ensure that all analytic claims were rooted in text. Furthermore, I made a deliberate effort to assess that there were no 'loose ends' in the discussion, as this would have resulted in the project being an incomplete and incoherent piece of work. Potter and Wetherell (1987) note that this analytic technique for ensuring validity is not watertight; however, qualitative methodology rejects the idea that there can ever be positivist, infallible criteria within the social world (Taylor et al., 2000).

Reflexivity

Critical to qualitative designs is the researcher's employment of a reflexive lens throughout the research process. Reflexivity as a theory posits that the mere existence of the researcher will influence both the process and product of the research endeavour. This theory further emphasises the impossibility of the researcher remaining 'outside of' his/her subject matter while conducting the research (Taylor et al., 2000).

Thus, it is important to acknowledge that I conducted this research project from a critical viewpoint. After studying critical approaches to clinical psychology in my undergraduate degree in 2012, I seriously started considering if the current profession of clinical psychology, operating in South Africa, is really the best means to enhance mental wellbeing on a mass scale within our country.

I explicitly chose not to express my views directly to the participants, nor did I conduct the interview from a 'devil's-advocate' perspective, as is often suggested by discourse analysts in order to obtain variability-rich data (Harper, O'Connor, Self & Stevens, 2001), yet it would be naive to presume that my views did not alter the course of the produced dialogue. To what extent they did is uncertain; however, the primary purpose of qualitative research is not concerned with such measurement, but rather with recognition that you as a researcher have an effect on the research process (Augoustinos, 1998).

I made use of my identity as a psychology honours student to gain access to practicing psychologists in the profession. While I was similar to the participants in terms of race, class and nationality, participants frequently rather referred to the fact that we both belonged to the

profession of psychology as a means of connecting. An example of this is provided by Daniel when discussing the competitive nature of psychology training in the country:

> *I'm glad that that is behind me, getting into the Masters course. I'm sure you know, you have to try a lot.*

This phraseology: ' *I'm sure you know',* indicates that Daniel finds no need to emphasise the hardship of getting into the Master's course for psychology, as he presumes it to be known amongst all within the discipline.

Finally, usually in qualitative research it is common that the intersection of the researcher's identity constructs (race, class, employment) situates them within a more powerful social location compared to the participants. However, since I 'matched' the participants along lines of race and class, and the participants were professionals within the field while I was only a student, this was not the case. Yet, despite our similarities and their social locality within society, it does not nullify the complex power dynamics within the data collection and analysis process. At the end of this day, I was still the researcher in this process and their words were still my data.

Analysis and Discussion

After immersing myself in the data, three interpretative repertoires emerged when participants spoke about their work as mental health practitioners: self-presentation as concerned citizens, constructions of the South African context as overwhelming, and constructions of the psychology profession as a market phenomenon.

Self-presentation as concerned citizens

This interpretative repertoire focuses on how participants discursively presented themselves as concerned citizens. Through their talk, participants demonstrated awareness and concern about the state of mental healthcare in South Africa. The purpose of this interpretative repertoire is not to theorise the 'true nature' of the self (i.e. how the participants conceptualise themselves), but rather explore how the self was constructed via their discursive practices (Gergen, 1985). The following clusters of metaphorical frames dominated participants' presentations of their professional identity as concerned citizens: 'the giver', 'the socially aware', and the 'passive private practitioner'.

The giver:

Eight of the nine participants constructed themselves as 'givers' through their talk. This 'giving' manifested itself through fee negotiations as well as through dissemination of psychological knowledge. All eight participants spoke of taking on clients at reduced rates. Seven participants even reported seeing clients on a pro-bono basis. Kim was one of the few who expounded a particular case in which she took on a client for free:

> *I have been working with someone for a while, their medical aid has been paying, they ran out of funds, we weren't quite ready to finish the work yet, so I am offering a free, kind of, holding session until she is able to finance more.*

Four participants also expressed that their way of 'giving back' was through the dissemination of psychological knowledge. This was achieved by hosting community information talks (Candice), informative blog sites (Mark and Martha) and sending out newsletters to their clients (Betty and Candice). In relation to the work which her practice does, Candice said:

> *We do, like, talks for free, like, at schools. We do information sessions for parents to come to, like about bullying or something, you know what I mean- you don't have to be a patient, anyone can come. So, you really have to give back as well, you can't just say: "Here I am! Come see me! Pay money!" like, it does not work.*

In general, the reason for participants to give of themselves was largely related to the tough economic realities of their clients ("*they ran out of funds"*). However, these extracts also suggest a second reason as to why participants engage in 'giving'. In both Kim and Candice's talk, 'giving' was constructed as a means to an end. For example, Kim's offering of pro-bono sessions was framed as being on condition that the client would be able to *finance more* in the near future. Similarly, Candice did not discuss 'giving' for the betterment of the community but rather to promote her practice's recognisability in the community.

Thus, while participants discursively constructed themselves as 'givers', this 'giving' was characterised as a conditional arrangement (either to attract more clients or hold on to existing ones). This conditionality speaks to a broader discourse of commodification of the discipline of psychology. Fairclough (1992, p. 207) defines commodification as "the process whereby social domains and institutions, whose concern is not producing commodities in the narrower economic sense of goods for sale, come nevertheless to be organised and conceptualised in terms of commodity production, distribution and consumption."

Attaching ideas of future payment or the promise of potential clients to the notion of what it means to 'give back' underscored that participants drew on notions of production, distribution and consumption when talking about their work as mental health professionals in the Cape Metropole. The commodification of the profession will be discussed in further detail under the construction of the profession as a market phenomenon.

Five participants also spoke about the importance that the current profession of psychology in the country gives back for the greater good. However, the rhetoric surrounding this giving was not based on what a giving discipline psychology is, but rather the importance that the discipline develops a consciousness of giving. When speaking about the profession of psychology in South Africa, Candice commented:

> *I think there must be, like, a consciousness, an awareness of how we need to use everything we have learnt to use it in a way that can benefit the most people more of the time rather than a small higher earning percentage of the population*.

Sharon also expressed similar sentiments about the need for practitioners in private practice to give of themselves:

> *I think it's very easy to become isolated in a middle class, suburban bubble and I think that it behoves all of us, in private practice, to attempt to stay connected to South African realities in whatever way one finds to do that, I mean, we all have something to offer, in terms of the giving of our time or expertise in various ways, whether that's*

through NGO's or whether it's through people you make yourself available to who wouldn't otherwise be able to see you.

In the above extract, the trope of a 'bubble' is used to convey the detachment of practitioners' current professional setting – working in a suburban, private practice – from the lived realities and needs of most South Africans. Sharon emphasised that it is through giving that psychologists can break this bubble and stay connected to South African realities. Yet Sharon's language in this excerpt does not reflect what a giving discipline psychology is, but rather, the need for psychologists in private practice to give for the greater good.

Goffman's (1959) work on self-presentation describes the ways in which an individual may engage in strategic activities to convey a positive impression of self. This discursive strategy of highlighting the deficits within the general environment (such as the profession's lack of contextual awareness and giving), which is then juxtaposed with one's individual status as the do-gooder (the giver) serves to present the self in a positive light (Goffman, 1959).

Although participants' talk about the discipline's lack of awareness and detachment from the South African realities speaks to the heart of critiquing the relevance of psychology in South Africa, none of the participants used the terms 'relevance', 'relevant' or 'social responsiveness' throughout the interviews. The absence of this term 'relevance' from participant's talk may allude to the fact that this 'relevance debate' regarding psychology in South Africa is one that has largely one of rhetoric, and has yet to permeate the practices of the profession**.** Only one participant, Daniel, used the word 'applicable' on a single occasion:

I think psychology in South Africa has a real challenge in terms of it being more generally applicable, so that the majority of the population can access it.

Furthermore, unlike the two preceding extracts of Candice and Sharon, Daniel does not linguistically construct himself as being a part of creating an applicable discipline. This is noted by the absence of the word 'we' within his talk (Potter & Wetherell, 1987). He

externalises the undertaking of creating a *more generally applicable* discipline, thereby not holding himself as accountable in overcoming this *real challenge*.

The socially aware:

This sub-discourse concerns the way in which participants' presented themselves as being aware of the current social and economic realities in South Africa. This was largely communicated by participants referencing the unaffordable nature of psychological services for the majority of the population and the treatment gap within the country (Stein, 2012). Mark referred to one-on-one psychotherapy in private practice in South Africa, as '*a luxury, it's a complete luxury'*.

Participants also expressed their social awareness through commenting on the negotiations they have made in their own therapeutic practice. These negotiations are consistent with the previous self-presentation of 'the giver'. The discursive moves in seven of the interviews constructed the case that due to the fact that there is a contextual problem (discursive indication of being socially aware), participants have needed to give of their time or negotiate their practice to accommodate themselves to the situation (discursive indication of being a 'giver'). This was reflected in the reasons Laura gave for not practicing long-term therapy:

> *No, to be honest, and it's not because of a scientific reason, but people cannot really afford to be in therapy for longer than about 12 weeks. That's the reality I'm finding.*

Like Laura, all of the other participants were aware of the socio-economic realities for most of their clients, and did make certain negotiations. These negotiations involved changing the regularity (e.g. Daniel) and length (e.g. Kim) of the therapeutic relationship. However these negotiations all took place within the confines of traditional clinical psychotherapeutic practice as previously outlined by the APA (2012).

When exploring how to make psychology more relevant and meaningful within the current social, economic and political context of South Africa, the need to change traditional modes of clinical therapeutic practice has been brought to the fore extensively by both scholars (Macleod, 2004; Macleod & Howell, 2013) and recipients of psychological services

(Ruane, 2010). Paired with this call for re-examining the theoretical principles that guide clinical psychology practice in the country, there has also been talk of clinical psychologists needing to reconsider their role in providing mental healthcare services (Pretorius, 2012). Scholars have suggested that clinical psychologists should give thought to assuming the role of 'social activists' in order to provide socially responsive interventions (Ahmed & Pillay, 2004). However, three participants explicitly emphasised that their role as psychologists did not involve being social activists. Daniel said:

> *You know, of course it is important- the contextual stuff, as you know is very important, but should a psychologist do that? I am not so sure about that- for instance, this advocacy thing- um, now perhaps, in this regard, I am a bit old school, because when I was growing up, my image of a psychologist was someone who works pretty much one-on-one, perhaps with small groups and stuff like that... And perhaps these days people go into studying psychology think differently about it. But if they don't, now then, I think we have a problem…let's say all of them think of psychologists like I do- as people who primarily do therapy- it is not the same type of person who goes out into the community and does activist work, and does advocating work, and does social work, it's not the same type of person.*

From Daniel's talk, it is evident that he has a clear awareness of the problematic, socio-political, *contextual stuff* in South Africa. However he is concerned as to whether a clinical psychologist is the *same type of person who goes out into the community and does activist work, and does advocating work, and does social work.* Daniel uses the trope of 'old school' to relay a particular image about his professional identity (Potter & Wetherell, 1987). From this 'old school' stance, psychologists are *people who primarily do therapy*. The use of the term 'old school' serves as a self-justification for Daniel practicing psychotherapy in private practice as it implies that this is just the way he was brought up and trained to think about psychology.

This extract also indicates that Daniel had a particular way of framing and understanding the work which psychologists should be doing- namely, psychotherapy. None of the other participants constructed their work (or the work of psychologists in general) as

anything other than to administer psychotherapy. The consequence of this is that it ignores the multiple functions that psychologists as mental health practitioners can – and are needed to – play in the South African context.

Atkinson, Thompson and Grant (1993) have argued that the role of a psychotherapist with the intent of curing people of their psychological illness is only one of the many roles a counsellor/psychologist can assume. Rather, a mental health practitioner's job (especially in lower and middle income countries) should depend on certain contextual factors. Depending on the intersection of these factors, psychologists and counsellors should operate in ways that best suit their clients' circumstances (see Appendix F for further explanation).

Thus, while participants were socially aware about the mental healthcare context in South Africa (particularly about inaccessibility of mental healthcare resources); this 'awareness' did not include being aware of the actual role that psychologists can – or are required to – assume in this context.

Self-presentation of the passive person

When responding to the question of why they chose private practice, four of the participants constructed themselves as passive actors in this decision. The South African government was usually constructed as the active agent who shaped this decision for them. Sharon commented:

> *Most of us are in private practice because the possibilities for earning a living in any other way are very, very small, there are very, very few state posts. So if you want to make a living as a psychologist, if you don't get one of those hens' teeth positions then you have no choice but to be in private practice.*

Placing one's self as a passive agent in an unfavourable situation is a discursive strategy used in talk to promote a positive self-presentation (Mallinson & Brewster, 2005).

The function of participants' constructing themselves as passive rather than active agents is to shift responsibility for why they are working in an space which they often refer to in their talk as only benefiting *a small higher earning percentage of the population* (Candice) and being *detached* (Kim) from the needs of the South African realities (Potter & Wetherell, 1987).

Interestingly, later on in the interview when Sharon was asked if this was the reason as to why she chose private practice, she responded by saying:

I chose private practice because of the kind of work that I want to do.

Sharon's rhetoric about practicing in private practice undergoes change, indicative of variation to suit her argument (Potter & Wetherell, 1987). At first, she constructed the argument that most people, herself included (as illustrated by the word 'us') are in private practice because there are few *possibilities for earning a living in any other way.* However, when directly asked if these were her reasons as to why she chose private practice, she responded in the negative. Sharon provided a general argument of the few jobs in the public sector to justify her placement in the private sector, even when her reason for being in this setting is not akin to this argument. Ultimately, the purpose of this 'general talk' serves to mitigate actions which may be seen as incongruent with the realities of the day, and further serves to present the self in a positive light (Goffman, 1959).

Overall, the data indicates that the participants engaged most frequently in discursive strategies that promoted positive self-presentations. This was illustrated in the metaphorical frameworks they drew on when presenting their selves as concerned citizens through their talk. Participants acknowledged the disjuncture between the accessibility of their work in private practice and the lived realities of the majority of the population. However, they engaged in discursive self-justifications that indicated they had no choice in the setting of their career.

The overwhelming nature of the public sector in South Africa

There was broad agreement amongst participants =about the profession of psychology in the public sector in South Africa. Words such as 'overwhelming' (e.g. Betty), 'diabolical' (e.g. Laura) and 'dire' (e.g. Martha) were among those used to describe that sector. Participants spoke of how the lack of external resources was a major barrier when it came to administering effective therapeutic intervention. Candice asked:

If someone comes to you and they don't have food, shelter, a husband that hits them, whatever- how are you going to sit them down to talk about their mental wellbeing?

Similar questions were posed by Betty when recounting her internship experience in a rural region in South Africa:

> *It's just such hard work because there is just a lot of context based, societal based difficulty, that you just think- how, how are we going to deal with this? The violence against women and against children, and the rape and the poverty and the drinking, oh, and the tik[3], it's overwhelming.*

The function of describing the public sector in South Africa in this manner is twofold. Firstly, the discursive strategy of constructing a situation (the public sector in South Africa) as unmanageable and overwhelming functions as an external self-justification for not participating in that setting (Holland & Meertens, 2002). These sorts of self-justifications are used when people employ external excuses to justify their actions or lack thereof (Holland & Meertens, 2002).

Secondly, the above extracts also highlight the disjuncture between psychotherapy and the current reality of the public sector in South Africa. Based on the participants' talk it appeared that, as psychologists, they were not equipped to deal with *context based, societal based difficulties*. Candice even noted how her training as a social worker stood her in better stead for helping people in the public sector in South Africa:

> *I think the social work training helped me a lot because, like, if someone comes to you and they are disabled, whatever, then I can go "Do you have a grant?" So I have a little bit of a three dimensional view than if I just did psychology.*

The notion that clinical psychology training in South Africa does not prepare students for the lived realities within the country has been well documented (see: Ahmed & Pillay,

[3] *Tik* is a South African slang term for the drug 'methamphetamine'.

2004; de la Rey & Ipser, 2004). Gentz and Durrheim (2009) found that clinical psychology graduates from the University of KwaZulu-Natal reported there was a notable disconnect between their university training and the presenting problems in the public sector in South Africa. Ancillary to this claim that psychology training does not equip practitioners for realities in the public sector, this project's findings demonstrate that through their talk of the South African context, participants constructed the public sector as hindering them from doing the work of 'psychologists' (i.e *working with people's mental wellbeing*).

When reflecting on his work in the public sector, Graham commented that:

> *you are not giving great therapy most of the time, you can often go through months without feeling like you have been a real therapist at all. It's a very different set-up of the picture you have in your head of a person walking in, is motivated and who wants to talk about the issue- I mean that's what you are trained in.*

While this excerpt emphasises the disjuncture between psychology training and the presenting problems in the public sector, it also speaks to the idea that the public sector in the country hindered Graham from being a *real therapist*. Four of the other participants drew on a similar discourse. For example, when Laura recounted her internship year in a rural under-resourced setting, she said that *the state of the public sector is not ideal to administer effective therapy.*

The idea that the public sector is not an *ideal* place to be an effective psychologist or *give great therapy* functions as a justification as to why participants locate to private practice. This paired with the characterisation of the South African context as 'overwhelming' and 'dire' further serves as a discursive self-justification for non-participation within the public sector.

The way in which participants spoke about psychology in South African stood in stark contrast to the discursive constructions of psychology overseas. Martha noted how there is more of a *psychological culture overseas where people will part with their money easier*. Five other participants stressed that there was far better state support from countries abroad in comparison to South Africa.

In these, what Betty described as "*better off countries",* the work of psychologists as activists, counsellors or change agents may not be as contextually needed as it is in South

Africa. The function of contrasting the South African context to such places serves as even more of a justification for participants not partaking in the public sector within the country. Secondly, these comparisons also shift the blame of the poor uptake of psychological services onto the '*unpsychologised nation'* (Graham) that represents South Africa. When, in reality, a more plausible explanation of this poor uptake is the financial unaffordability of the type of therapy.

I feel that it is important to reiterate that participants' constructions about the public sector are not dissimilar to the present state of resources in the public sector in the South African context. In 2008, the South African Stress and Health Study (SASH) revealed that of a nationally representative sample of South Africans, only 28% of severe and 24% of mild mental disordered cases received any treatment (Williams et al., 2008). However, the discursive strategy of constructing a situation as unmanageable and not an ideal place to do this specific work serve as a justification for not participating in that setting. Thus, once again, participants acknowledged the disjuncture between the accessibility of their work in private practice and the lived realities of the majority of the population. However, they engaged in discursive self-justifications to indicate that, due to the nature of their work, they are best suited to private practice.

The object of this interpretative repertoire is the profession of psychology in South Africa. Through their talk, all of the participants constructed the profession of psychology as a market phenomenon. This was seen in the vocabulary participants used to discuss the discipline. Some examples include describing the profession as being a *tough industry* (Mark), and full of *barriers to entry* (Betty, Kim and Daniel).

Furthermore, all of the participants explicitly referred to their practice as a business. When I asked Graham about whether there was anything important which he felt like I hadn't covered in the interview, he stated:

> *I think the one thing that psychologists talk about when you do get together is sometimes the difficulty of running the business.*

Not only did the participants speak about their practice as a business, but they also referenced the problematic intersection between running their practice as a business and the ethical considerations of being a psychologist. Graham continued:

> *I think the one thing that psychologists talk about when you do get together is sometimes the difficulty of running the business, um like the ethical ideals of seeing clients and the reality that this is actually a business for you and how you approach things like, "I just can't afford to pay- can I get a discount?" and chasing money- how do you do that?*

Parker (1992) makes the point that when a speaker reflects on his/her way of speaking, this is a tell-tale sign that a counter-discourse is lurking in the background. In this case, Graham is aware of this contradiction of the commodification of the discipline and the discourse of the concerned citizen (particularly the metaphorical framework of 'the giver'). That is, how can a concerned citizen go '*chasing money*'? The function of this discursive self-reflection is not only to manage such contradiction, but it also functions to deflect blame (Parker, 1992). This idea of 'deflecting blame' was more explicit in Mark's talk about the profession:

> *I had difficulty with starting private practice, because I have never been in business- this is a business- for myself before.*

By Mark reflexively saying that *this is a business,* he implies that that is just the way the profession works, and there is nothing he can do to change it.

The consequence of discursively constructing the profession as a market phenomenon advocates for the development of a psychology that is "financially rewarding, globally competitive, and internationally recognised" and whose "service outputs are graded according to international standards and priorities" (Long, 2013b, p.1). This discourse deters from the discipline focusing on rooting international theories and modes of practice within

the local context- what Dawes (1998, p. 5) labels as an "imperative to increase the local relevance of applied psychology".

This construction of the profession as a market phenomenon was not just a matter of vocabulary, but also a matter of genre. While discourse can be considered a way of signifying a particular perspective (such as a commodification discourse), 'genre' is considered to be the use of language associated with a specific social activity (Fairclough, 1993). Eight of the participants drew on discourses which were related to an 'advertising genre' (Fairclough, 1992a, p.210). For example, Candice said:

> *I know in the Northern Suburbs, there's psychologists in almost every block and it's really difficult to just start… it's like the advertising situation – how do you, you know, make yourself look more appealing than the next therapist.*

This idea of needing to make *yourself look more appealing than the next therapist* encapsulates the advertising genre (Wernick, 1991). Ancillary to this advertising genre is that of a culture of competition (Fairclough, 1992a). Within the interviews, participants frequently referred to the competitive nature of the discipline. Furthermore, this competitiveness was described as occurred on a horizontal level (among clinical psychologists) rather than on a vertical level (between different professions). In fact, all participants spoke about how they enjoyed working as part of multidisciplinary teams. Laura even said *the only thing I miss about working in the public sector, is being a part of multidisciplinary team.*

This camaraderie with other professions did not extend to other psychology practitioners, however. When discussing what it is like to be a psychologist in private practice in the Cape Meteropole, Kim stated:

> *Practices are businesses. There is a lot of protectionism around, and an anxiety around you stealing patients, or even sharing information, so everything comes at a cost in the private practice world I feel.*

This idea of a monopoly of services (reflected by the *anxiety around you stealing patients*) and vying for the same pool of people harks back to the idea of the commodification of the discipline. Ultimately, it constructs 'patients' as 'consumers' (Fairclough, 1993; Wernick, 1991).

Summary and Conclusions

One cannot claim, based on the findings of this research, that the discourses which clinical psychologists draw on when discussing their work are inimical to the creation of a more relevant discipline of psychology in South Africa. However, it can be said that the discursive practices of these nine psychologists served as justifications for their detachment from the nature and needs of the South African context.

With regard to this study's main research question, the data suggests participants drew on three interpretative repertoires when discussing their work as mental health professionals in the South African context. The first, *concerned citizenship*, illustrates how participants discursively constructed their professional selves as being *giving*, *socially aware* (but not socially active) and as practicing in private practice as a result of a *passive rather than an active choice*. Secondly, participants' construction the public sector in South Africa as overwhelming indicates that such a space is *not an ideal place to do therapy* (Laura) or *be an effective therapist* (Graham). Finally, the participants' choices of vocabulary used to describe the profession, as well as the embodying genre of advertising, constructed the profession of psychology as a market phenomenon.

While these interpretative repertoires may seem discrete, often a single excerpt of text would draw on all three. In reference to her work with employee wellness programmes, Martha said:

> *I consider that to be my community service. I mean, it's many, many hours work for only R350. So it's not an income generating business in a sense, no, it gives me an income, but what I am saying is, it's like community service because people, for instance, packers at Makro who could never afford it get a chance to see a therapist.*

Martha's discussion of community service presents herself as a concerned citizen, specifically as a giver. She considers the fact that she only charges R350 for *many hours work* as giving because it does not generate as much income as her private practice business. Martha also references the financial inaccessibility of psychological services for the majority of people in South Africa. Furthermore, Martha highlights the disjuncture between ideas of concerned citizenship (in the form of community service) and her practice as an *income generating business* through the self-conscious reflexive statement of: "*no, it gives me an income, but what I am saying is."*

Even though the interpretative repertoires of concerned citizenship and the profession as a market phenomenon may seem at odds with one another, participants managed this contradiction through their discursive practices. Thus, due to the interconnectedness of these three interpretative repertoires, it is plausible to suggest that they serve one meta-function. While the data suggests that participants' are aware of the disparity between mental health care resources in South Africa; the discourses they drew on to discuss their work functioned as self-justifications for practicing psychotherapy and working as private practitioners in urban settings. For example, while Daniel recognises *the contextual stuff* (i.e. the state of mental healthcare resources in South Africa) he still uses of the trope *old school* serves to justify his practicing psychotherapy and working as a private practitioner. Similarly, Sharon noted:

> *I mean, the most mental health professionals you have in South Africa are in private practice, most South Africans cannot afford private health professionals- spot the problem.*

However then speaks about how she is in private practice due to the type of work she enjoys

The findings of this study suggest that in order to change factors which may hinder the effective application of the discipline, practising psychologists would need to employ a critical, reflexive gaze examining how their own language could stifle the discipline from being more socially responsive. As Long (2013b, p. 9) notes: "given the

constitutiveness of discourse, it is impossible to create a profession accessible to all South Africans while neglecting to analyse the discipline's discursive order."

Thus, I advocate for *critical language awareness* (CLA) as outlined by Fairclough (1992a; 1992b) as the tool with which to bring about this process. CLA would provide

clinical psychologists with the knowledge to initiate change in their own discursive practices and the discursive practices of the profession as a whole. This is done by helping them become conscious of the practices they are involved in as "producers and consumers of text" (Fairclough, 1992a, p. 239). Through this consciousness, clinical psychologists in private practice can become far more aware of the constraints and exclusive nature of their talk and the social forces and interests which shape it (such as a market-oriented discourse).

Studies, such as this one, which advocate for the discipline to become the subject of its own reflexive gaze represent an important effort in challenging intradisciplinary factors which prevent the discipline from becoming more socially responsive to the nature and needs of the South Africa context and its people. Specifically, this study has contributed to existing knowledge which advocates that there is a "moral obligation" on psychologists' part to change the discourses which operate within the discipline (Pretorius, 2012, p. 10).

This study has essentially explored what discourses clinical psychologists draw on when talking about their work as mental health professionals in the Cape Metropolitan area. Future research should not only consider the discursive practices of other mental health practitioners who occupy similar spaces, but it should also review the discourses which operate at training institutions. Exploring these macro-settings may provide context to the discourses which these practicing psychologists drew on. Furthermore research should consider how other intradisciplinary factors such as the thoughts and attitudes which operate in the discipline. This will allow for a richer, more holistic understanding whether the discipline's discursive practices may be inimical to creating a more socially responsive discipline..

References

Abel, E., & Louw, J. (2009). Registered counsellors and professional work in South African psychology. *South African Journal of Psychology, 39*(1), 99-108.

Ahmed, R., & Pillay, A. L. (2004). Reviewing clinical psychology training in the post-apartheid period: Have we made any progress? *South African Journal of Psychology, 34*(4), 630-656.

American Psychology Association (2012). *About clinical psychology.* Retrieved from: http://www.apa.org/divisions/div12/aboutcp.html.

Atkinson, D. R., Thompson, C. E., & Grant, S. K. (1993). A three-dimensional model for counseling racial/ethnic minorities. *The Counseling Psychologist*, *21*(2), 257-277.

Augoustinos, M. (1998). Social representations and ideology: Towards the study of ideological representations. In U. Fick, (Ed.), *The Psychology of the Social* (pp. 156-169). England: Cambridge University Press.

Babbie, E., & Mouton, J. (2007). *The Practice of Social Research*. Cape Town, South Africa: Oxford University Press

Burns, J. K. (2011). A mental health gap in South Africa- a human rights issue, *The Equal Rights Review*, *6*, 99-113.

Burr, V. (1998). Overview: Realism, relativism, social constructionism and discourse. In I. Parker, (Ed.), *Social Constructionism, Discourse and Realism* (pp. 13-27). London: Sage.

Burr, V. (2003). *Social Constructionism* (2nd ed). London: Routledge.

Callaghan, J. (2005). Becoming a psychologist: Professionalism, feminism, activism. *Annual Review of Critical Psychology*, *4*, 139-153.

Chipps, J., & Ramlall, S. (2012). Research in lower middle income countries – recommendations for a national mental health research agenda in South Africa, *African Journal of Psychiatry*, *15*(6), 432-435.

Dawes, A. (1998). Africanisation of psychology: Identities and continents. *Psychology in Society, 23*, 4-16.

De la Rey, C., & Ipser, J. (2004). The call for relevance: South African psychology ten years into democracy. *South African Journal of Psychology, 34*(4)*,* 544–552.

Duncan, N., van Niekerk A., & Townsend, L. (2004). Following apartheid: Authorship trends in the South African Journal of Psychology after 1994. *South African Journal of Psychology*, *34*(4), 553-575.

Edwards, D., Ashmore, M., & Potter, J. (1995). Death and furniture: The rhetoric, politics and theology of bottom line arguments against relativism. *History of the Human Sciences, 8*(25), 25-49.

Employment Equity Act (1998). *Employment Equity Act Number 15 of 1998*. Retrieved from: http://www.labour.gov.za/docs/legislation/eea/act98-055.html

Fairclough, N. (1992a). *Discourse and Social Change.* Cambridge: Polity

Fairclough, N. (1992b). *Critical Language Awareness*. London: Longman.

Fairclough, N. (1993). Critical discourse analysis and the marketization of public discourse: The universities. *Discourse and Society*, *4*(2), 133-168.

Foster, D. (2003). Social psychology. In L. Nicholas (Ed.), *Introduction to Psychology* (pp. 233-280). Cape Town, South Africa: University of Cape Town Press.

Gentz, S., & Durrheim, K. (2009). Psychological expertise and governmentality in democratic South Africa: A tracer study of master's graduates from UKZN. *Psychology in Society, 37*, 18-38.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, *40*(3), 266-275.

Goffman, E. (1959). *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday.

Harper, D. J., O'Connor, J., Self, P., & Stevens, P. (2008). Learning to use discourse analysis on a professional psychology training programme: Accounts of supervisees and a supervisor. *Qualitative Research in Psychology*, *5*(3), 192-213.

Hickson, J., & Kriegler, S. (1991). The mission and role of psychology in a traumatised and changing society: The case of South Africa. *International Journal of Psychology*, *26*(6), 783-793.

Holland, R. W., Meertens, R. M., & Van Vugt, M. (2002). Dissonance on the road: Self-esteem as a moderator of internal and external self-justification strategies. *Personality and Social Psychology Bulletin*, *28*(12), 1713-1724.

Kale, R. (2002). The treatment gap. *Epilepsia*, *43*, 31-33.

Leach, M. M., Akhurst, J., & Basson, C. (2003). Counselling psychology in South Africa: Current political and professional challenges and future promise. *Counselling Psychologist, 31*, 619-640.

Long, W. (2013a). Rethinking relevance: South African psychology in context. *History of Psychology*. *16*(1), 19-35.

Long, W. (2013b). 'Market relevance', 'social relevance', and psychology in South Africa. *South African Journal of Psychology*, 1-12. doi: 10.1177/0081246313504695.

Macleod, C. (2004). South African psychology and 'relevance': Continuing challenges. *South African Journal of Psychology*, *34*(4), 613-629.

Macleod, C., & Howell, S. (2013). Reflecting on South African Psychology: Published research, 'relevance', and social issues. *South African Journal of Psychology*, *43*(2), 222-237.

Mallinson, C., & Brewster, Z. W. (2005). 'Blacks and bubbas': Stereotypes, ideology, and categorization processes in restaurant servers' discourse. *Discourse and Society*, *16*(6), 787-807.

Marecek, J. (2003). Dancing through minefields: Toward a qualitative stance in psychology In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design* (pp. 49-69). Washington, DC: American Psychological Association.

Meyer, W. F., Moorem C., & Viljoen, H. G. (2008). *Personology: From Individual to Ecosystem.* Johannesburg: Heinemann African Perspectives.

Nobles, W. W. (1972). African philosophy: Foundation for a black psychology. In R. Jones (Ed.), *Black Psychology* (pp. 280-291). New York: Harper Row.

Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.

Peterson, I. (2005). In search of transformative community practice. *Psychology in Society, 32*, 89-91.

Pillay, Y. G., & Petersen, I. (1996). Current practice patterns of clinical and counselling psychologists and their attitudes to transforming mental health policies in South Africa. *South African Journal of Psychology*, *26*(2), 76-80.

Potter, J. (1996). Discourse analysis and constructionist approaches: Theoretical background. In J. Richardson (Ed.), *Handbook of Qualitative Research Methods for Psychology and the Social Sciences* (pp. 125-140). Leicester: BPS Books.

Potter, J. (1998). Fragments in the realization of relativism. In I Parker (Ed.). *Social Constructionism, Discourse and Realism* (pp. 27-47). London: Sage.

Potter, J., & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour.* London: Sage.

Potter, J., Wetherell, M., Gill, R., & Edwards, D. (1990). Discourse: Noun, verb or social practice? *Philosophical Psychology, 3*(2), 205-217.

Pretorius, G. (2012). Reflections on the scope of practice in the South African profession of psychology: A moral plea for relevance and a future vision. *South African Journal of Psychology*, *42*(4), 509-521.

Punt, C., Pauw, K., van Schoor, M., Nyhodo, B., McDonalds, S., Chant, L., & Valente, C. (2005) *A profile of the Western Cape Province: Demographics, poverty, inequality and unemployment,* Retrieved from: http://ageconsearch.umn.edu/bitstream/15619/1/bp050001.pdf

Rock, B., & Hamber, B. (1994). *Psychology in a future South Africa: The need for a national psychology development programme.* Retrieved from http://www.csvr.org.za/wits/papers/papbrbh.htm

Ruane, I. (2010). Obstacles to the utilisation of psychological resources in a South African township community. *South African Journal of Psychology*. *40*(2), 214-225.

Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D., & Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, *370*(9593), 1164-1174.

Seedat, M., MacKenzie, S., & Stevens, G. (2004). Trends and redress in community psychology during 10 years of democracy (1994-2003): A journal based perspective. *South African Journal of Psychology, 34*(4), 595-612.

Statistics South Africa (2013) *Quarterly labour force survey: Quarter 1 (January to March), 2013* [Press release] Retrieved from: http://www.statssa.gov.za/news_archive/Docs/QLFS_Press_statement_Q1_2013.pdf

Stein, D. J. (2012). Psychiatry and mental health research in South Africa: National priorities in a low and middle income context. *African Journal of Psychiatry, 15*, 427-431.

Stein, D. J., Wessels, C., Van Kradenberg, J. & Emsley, R. A. (1997). The mental health information centre of South Africa: A report of the first 500 calls. *Central African Journal of Medicine, 43*(9), 244-246.

Stevens, G. (2001). Racism and cultural imperialism in the training of black clinical psychologists in South Africa: Identity, ambiguity and dilemmas of praxis. In N. Duncan, A. van Niekerk, C. de la Rey & M. Seedat (Eds.), *Race, Racism, Knowledge Production and Psychology in South Africa* (pp. 45-59). New York: Nova Science.

Taylor, G., Bogdan, S., & Walker, T. (2000). Qualitative psychology. In A. E. Kazdin (Ed). *Encyclopaedia of Psychology* (pp. 219-230). Washington, D.C: Oxford University Press.

Watson, P. & Fouche, F. (2007). Counselling psychology in South Africa. *International Association of Applied Psychology, 56*(1), 152-164.

Wernick, A. (1991). *Promotional culture: Advertising, ideology and symbolic expression*. London: Sage.

Wetherell, M. & Potter, J. (1992). *Mapping the language of racism*. New York, NY: Harvester Wheatsheaf.

Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H. & Kessler, R. C. (2008). Twelve-month mental disorders in South Africa: Prevalence, service use and demographic correlates in the population-based South African stress and health study. *Psychological Medicine*, *38*(2), 211-220.

Willig, C. (1998). Social constructionism and revolutionary socialism: A contradiction in terms. In I. Parker (Ed.), *Social Constructionism, Discourse and Realism* (pp. 91-105) London: Sage.

Willig, C. (2001). *Introducing Qualitative Research in Psychology*. Buckingham, UK: Open University Press.

APPENDIX A:

Email to psychologists requesting participation

Dear

My name is Shayni Geffen and I am currently doing my honours in psychology at the University of Cape Town. A large component of this course involves conducting exploratory research and compiling a research report. I have chosen to explore what it is like being a clinical psychologist. I have randomly selected you off the website www.psychotherapy.co.za to ask if you would consider being a part of my research study. This would involve meeting at a time and place of your choice for a semi-structured interview.

The interview should not take more than an hour and the utmost care shall be taken in ensuring your anonymity throughout this research process.

This study has been ethically approved by the Ethics Committee of UCT's Department of Psychology and the Reference Number for this study is PSY2013-019. Please feel free to contact Ms Rosalind Adams (rosalind.adams@uct.ac.za) in case you would like to talk to someone on the ethics committee about this study. If you have queries about the project itself, you are welcome to contact my supervisor, Mr Wahbie Long, at wahbie.long@uct.ac.za.

Furthermore, please do not hesitate to contact me with any enquiries. I look forward to hearing from you.

Best wishes

Shayni Geffen

APPENDIX B:

Interview Schedule

1) Can you please give a detailed account of how you came to be a practising psychologist?
2) Why did you choose clinical psychology in particular?
3) What type of theory guides your therapy?
4) What are some of the most presented issues which unfold in these rooms?
5) Why did you choose private practice?
6) What do you find most enjoyable about your work?
7) What do you find most challenging?
8) Have you ever worked within the public sector of psychology in this country, if so, could you please detail your experiences.
9) What are your thoughts about psychology in South Africa?
10) Is there anything else which you wish to add about practicing as clinical psychologist?

APPENDIX C:

Transcription System:

All of the participant's words were copied down verbatim, including grammatical errors.

Quotation Information:

[ ] Brackets indicate words which have been inserted into quotation for extra clarification

e.g.: *if the finances are a problem* [for the client],

… Ellipsis indicates that part of the transcription has been purposely omitted

e.g.: *When working in such a setting… it's just- the state of the public sector is not ideal to administer effective therapy.*

- Indicates pauses or changes in the speakers train of thought which manifested in their talk. Pauses were not timed.

e.g.: *It's a very different set-up of the picture you have in your head of a person walking in, is motivated and who wants to talk about the issue - I mean that's what you are trained in.*

APPENDIX D:

Informed Consent Form

Informed Consent Form

UNIVERSITY OF CAPE TOWN

DEPARTMENT OF PSYCHOLOGY

Practicing as a Clinical Psychologist in the Cape Metropolitan Area.

1. **Purpose**

This study explores the experiences of clinical psychologists in the Cape Metropolitan area. I am a research student from the Psychology department at the University of Cape Town.

2. **Procedures**

- I will interview you about your experiences as a clinical psychologist in South Africa
- By interviewing you I hope to find out what it is like to be a clinical psychologist in South Africa
- The interview should take about an hour; however, you are free to speak to me for a shorter or longer period.
- Participating in this study is voluntary. You are free to end the interview at any time with no penalty or any other consequences.

3. **Risks, Discomforts & Inconveniences**

- This study poses a low risk or harm.

4. **Privacy and Confidentiality**

- Interviews will take place in a private place of your choice at your convenience
- Any information you share is strictly confidential. You will remain anonymous throughout the research process. You have the right to request that any information

you have shared be removed from the study. Should any publication result from this study, you will not be identifiable in any way.

- A tape recorder will be used to record the interview. If you would like the tape recorder to be switched off at any time you have the right to request this.

5. **Contact details**

If you have questions, concerns, or complaints about the study please contact Shayni Geffen on 0826703607 or Wahbie Long at the Department of Psychology, University of Cape Town (UCT) at wahbie.long@uct.ac.za .

6. **Signatures**

{Subject's name}_____ has been informed of the nature and purpose of the procedures described above including any risks involved in its performance. He or she has been given time to ask any questions and these questions have been answered to the best of the investigator's ability. A signed copy of this consent form will be made available to the subject.

_____

Investigator's Signature Date

I have been informed about this research study and understand its purpose, possible benefits, risks, and discomforts. I agree to take part in this research as a subject. I know that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to enjoy.

_____

Subject's Signature Date

APPENDIX E:

Audio-Recording Consent Form

Practicing as a Clinical Psychologist in the Cape Metropolitan Area.

This study involves the audio recording of your interview with the researcher. Neither your name nor any other identifying information will be associated with the audio recording or the transcript. Only the researcher will listen to the recordings.

The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your name or practice name) will be used in presentations or in written products resulting from the study.

By signing this form, I am allowing the researcher to audio record me as part of this research.

Participant's Signature:

_____Date:_____

APPENDIX F:

Atkinson and colleague's (1993) model for multicultural counselling

The model below, created by Atkinson and colleagues (1993), depicts the intersection of the three factors which mental health practitioners must take into account in order to administer contextually relevant services. These factors include: the locus of problem etiology (internal or external); goal of helping (remediation or prevention); acculturation of client to context (low or high). As the model illustrates, these factors fall on a continuum and should not be considered as dichotomous variables. Depending on the intersection of these three factors, mental health practitioners can assume the role that would best suit their context. Examples of these roles include: advisor, facilitator of indigenous support systems, consultant, counselor, advocate, facilitator of indigenous healing systems, change agent and/or psychotherapist (Atkinson et al., 1993).