

**THE EXPERIENCES OF COMMUNITY-SERVICE CLINICAL PSYCHOLOGISTS:  
A SELF-DETERMINATION THEORY PERSPECTIVE**

**By**

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**Dissertation submitted in fulfilment of the requirements for the degree  
MAGISTER ARTIUM**

**in the**

**FACULTY OF THE HUMANITIES  
DEPARTMENT OF PSYCHOLOGY  
at the  
UNIVERSITY OF THE FREE STATE  
BLOEMFONTEIN**

**OCTOBER 2020**

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### Declaration

I, Nicollette Mosa Utloa, 2009026275, hereby declare that the dissertation titled “The Experiences of Community-Service Clinical Psychologists: A Self-Determination Theory Perspective” is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another university or for another qualification.



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To whom it may concern:

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Language, grammar, punctuation and layout issues were addressed according to the style required by the University of the Free State using MSWord Review (Track Changes) function. The reference list and in-text citations were edited according to APA 7<sup>th</sup> edition.

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Yours faithfully,

Lydia Searle

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## Acknowledgements

First and foremost, I would like to thank God, my Almighty, for answering my prayers and providing me with purpose and direction. I would also like to extend my gratitude and appreciation to these very important individuals who have helped me along this journey:

- To Dr Nel and Mrs van Aardt, my supervisors, for your guidance, support and patience
- To my research participants for taking the time to share some of your most personal experiences with me
- To my mother, Gakeresepe Utloa, for being my prayer warrior and having unwavering belief in my abilities
- To my brother, Shimie Utloa, for your love and protection
- To Brian Setlaba and Mr and Mrs Setlaba for your warmth, love and support. I am forever grateful.
- To my friends, Nicole Docherty, Mpho Seakamela and Grace Qhanya, for being such a major emotional support system
- To Mr and Mrs Docherty, and Lerato Shawane: for your warmth and support.

Thank you.

Lastly, I would like to dedicate this dissertation to my children, Waratoa and Onalerona Utloa. Your patience has meant the world to me. You are the reason I remained strong throughout this journey. I love you.

## Abstract

This study aimed to explore and describe the experiences of community-service clinical psychologists from a self-determination perspective. The Self-Determination Theory served as a theoretical lens in understanding the motivation of community-service clinical psychologists. A qualitative multiple-case study design was used to gather rich information from participants regarding their motivation. Through the use of purposive sampling and subsequent snowball sampling, six participants were obtained. A semi-structured interview was conducted with each participant, and each individual interview was transcribed by the researcher. The transcribed interviews were analysed by thematic analysis, and themes and sub-themes were generated. Findings of the research included the experiences of the participants and how these experiences related to the three basic psychological needs indicated in the Self-Determination Theory, namely autonomy, relatedness and competence. In terms of autonomy, participants highlighted taking responsibility for the successful completion of their community service despite numerous challenges. Pertaining to relatedness, participants highlighted the importance of support from significant others as a source of motivation. Regarding competence, participants highlighted the importance of receiving support from friends, family and colleagues as a source of motivation. The study concluded that in order to persevere in challenging situations, an individual must have intrinsic motivation. The successful completion of the research participants' community-service year can be used as evidence for this conclusion.

*Keywords:* autonomy, clinical psychologist, community service, competence, motivation, relatedness, Self-Determination Theory

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## **Glossary of Key Terms**

**Autonomy:** Refers to the experience of certain actions being conducted through a choice as opposed to coercion.

**Clinical psychologist:** Refers to psychologists who provide clinical services to assess and treat mental health issues by making use the science of psychology to promote change.

**Community service:** Refers to an opportunity for professionals to improve skills within a setting with limited resources; Community service is a prerequisite to qualify as a clinical psychologist.

**Competence:** Refers to feelings of efficacy and mastery within the various activities of life.

**Motivation:** Refers to the reason why people partake in certain behaviours.

**Relatedness:** Refers to the desire to feel connected with other people.

**The Self-Determination Theory:** Refers to the macro theory of human motivation.

## **Chapter 1: Introduction to the Study**

This chapter serves as the introduction and provides a description of the study. The background and rationale of the research are discussed. In addition, the research methods and the chapter summary are presented.

### **Research Background**

Former South African president, Mr Nelson Mandela, signed the Health Professions Amendment Act, 89 of 1997, which required medical graduates to undergo compulsory community service (Du Plessis & Seekoe, 2013; Reid, 2001). This introduction of compulsory community service followed the maldistribution of health professionals in South Africa (Mkhize & Kometsi, 2008).

Community service entails working in a state healthcare facility for a compulsory 12-month period. In 2002, clinical psychologists became part of the healthcare professionals required to engage in community service (Du Plessis & Seekoe, 2013). The Health Professions Act, 56 of 1974 states that any person who holds a qualification accepted by the Professional Boards of the Health Professions Council of South Africa should undergo community service for the prescribed period of 12 months (Health Professions Act 56 of 1974). Hence, community service is viewed as a social responsibility (Department of Health, 2006).

Numerous challenges have, however, had an impact on the experiences of community-service clinical psychologists. According to Pillay and Harvey (2006), the introduction of compulsory community service for psychologists in 2002 was mostly met with negativity. These community-service clinical psychologists felt that community service would curb their career plans, placements away from urban areas would be an inconvenience, and the salaries would not be sufficient (Pillay & Harvey, 2006). The aim of this study was to explore and describe the experiences of community-service clinical psychologists. The

motivation of these community-service clinical psychologists was explored and described using the Self-Determination Theory (SDT).

The Self Determination Theory has been widely employed in research. It was an applicable theoretical model to use for this study since it serves as a method for exploring both motivation and coping processes. Given the rationale of this study, the SDT also created structure for the research because the focus was on the experiences of community-service clinical psychologists and how they managed to complete the year successfully.

### **Rationale of the Study**

The rationale of this study is exploring and describing the motivational processes during the community-service year of clinical psychologists. On the part of the researcher, this study is important in understanding motivational aspects of overcoming difficulties, particularly in the journey to becoming a psychologist.

### **Research Aim and Research Question**

The aim of this study was to explore and describe the experiences of community-service clinical psychologists from a self-determination perspective by asking the following research question: How are community-service clinical psychologists able to remain motivated to complete their community-service year successfully? The research question was addressed by conducting the following:

- Collect data through semi-structured interviews
- Transcribe data and yield open codes
- Merge open codes into three main themes
- Describe results within the self-determination framework

### **Overview of the Research Method**

A qualitative multiple-case study design (Yin, 1981) was used to provide a rich context to the phenomena under study and allow for a replication strategy (Yin, 1994).

Qualitative research uses and collects a variety of empirical material such as personal experiences, interviews and life stories that describe moments and meanings in individuals' lives (Denzin & Lincoln, 2005).

The study was approved by the Research Ethics Committee of the Faculty of Humanities at the University of the Free State. The study included the following ethical considerations: autonomy and informed consent; confidentiality and anonymity; and non-maleficence and beneficence. Furthermore, the trustworthiness of the study was enhanced through credibility, transferability, dependability and confirmability (Guba & Lincoln, 1985).

Six individual semi-structured interviews were conducted and transcribed by the researcher and thereafter, the data were analysed using thematic analysis (Braun & Clark, 2006).

### **Summary of the Chapters**

The study consists of six chapters:

**Chapter 1:** This chapter presents a summary of the research background. The research question and the aim of the study are indicated. An overview of the research methods that were employed and the results obtained is offered in addition to a summary of the chapters.

**Chapter 2:** Chapter 2 includes a comprehensive discussion regarding the development of compulsory community service and the processes and requirements of becoming a community-service clinical psychologist. Furthermore, the chapter discusses the advantages and challenges of becoming a community-service clinical psychologist.

**Chapter 3:** Chapter 3 explores motivation in psychology and provides a discussion of motivational theories and drives. The SDT is used to understand motivation. The sub-theories of the SDT are elaborated to gain a better understanding of the theoretical framework.

**Chapter 4:** Chapter 4 provides an overview of the rationale and the aim of the study. In addition, the data collection and analysis are discussed. Lastly, the ethical considerations and the trustworthiness of the study are addressed.

**Chapter 5:** Chapter 5 includes a summary of the themes and the sub-themes in relation to the three basic needs of the SDT. These theme and sub-themes were derived from using thematic analysis to analyse the transcriptions. The participants' experiences are discussed using literature on SDT and are supported by direct quotations.

**Chapter 6:** This chapter includes an integrated discussion of the results and addresses the literature on SDT and other motivational theories. In addition, the implications and limitations of the study together with recommendations for future research are presented.

## **Chapter 2: Community-Service Literature Review**

### **Community Service**

This chapter presents a variety of discussions pertaining to the community-service year. These discussions include the development of this compulsory year of service, the process and requirements of becoming a community-service clinical psychologist and the challenges and advantages of the community-service year.

These discussions are aimed at the contextualisation of clinical psychology community service as it is implemented within the South African context.

### **Community Service Revisited**

Bender (2008) stated that terms such as community engagement, community outreach and community-based engagement are often used synonymously to describe community service. According to Netshandama (2010), the Higher Education Quality Committee (HEQC) (2004) defines community service as “applied learning which is directed at specific community needs and is integrated into an academic programme and curriculum” (p. 343). In addition, community service may hold some form of educational credit, may be assessed by a certain board and may or may not take place in a working environment (Netshandama, 2010). Green and Haines (2000) define community service as the effort of different stakeholders to improve the quality of life of people living in the community in which the service takes place. In addition, the World Health Organization (2001) stated that providing mental healthcare within the communities and closer to the patients’ homes assists in eradicating the imbalance of healthcare resources between urban and rural areas. In considering these definitions, it is evident that service to the community is an effort to assist in the planned betterment of the community by increasing well-being and creating solutions to a variety of problems.

It is important to note that community service can take place in a variety of domains such as social work, legal services and healthcare. For the purposes of this study, community service is discussed from a mental healthcare perspective.

### **Community Service as a Compulsory Component of Professional Accreditation: Why and How?**

According to the *Declaration of Alma-Ata*, health is a fundamental human right (World Health Organization [WHO], 1978). The conference held 6–12 September 1978 at which the *Declaration of Alma-Ata* was adopted expressed the need for all governments, health workers and communities to promote and protect the health of all global citizens (WHO, 1978). In view of this declaration, governments are held responsible for ensuring adequate and accessible healthcare services and social measures for all citizens (Reid, 2001). Following this declaration, a number of countries throughout the world attempted to introduce community service within graduate programmes (Reid, 2001).

Countries worldwide have incorporated community service in different ways. From 1975, the National Youth Service Corps in Nigeria made it compulsory for all graduates from tertiary institutions to enter into one year of community service. Despite community service not being compulsory in Pakistan, graduates who had served a minimum of three years community service in impoverished communities received preference in terms of employment opportunities. In the United States of America, medical graduates were given the opportunity through the National Health Service Corps to repay study loans by providing community service in impoverished communities. Furthermore, Canada ensured the inclusion of programmes in tertiary institutions that served to educate and encourage student participation in community service. These programmes were included as motivation to students to serve rural areas after receiving their qualifications (Reid, 2001).

In South Africa, the HEQC argued that community service is an important educational activity because it emphasises the importance thereof for both students and citizens alike. Community service is recognised as a diverse group of programmes and organisations (Netshandama, 2010). The influence of the *Declaration of Alma-Ata* and South Africa's 'White Paper on the Transformation of Health Systems' (Republic of South Africa, 1997) on South Africa's primary healthcare system has resulted in a positive shift towards an integrated healthcare system. Among other recommendations, the White Paper recommended that non-governmental organisations and communities should be involved in mental health services. In addition, communities should be involved in developing programmes to educate people and support users of mental health services (Mkhize & Kometsi, 2008).

In order to implement the recommendations of the White Paper, former South African president, Mr Nelson Mandela, signed the Health Professions Amendment Act in 1997, which required medical graduates to undergo compulsory community service. The first 26 community-service doctors began their community service in July 1998, with 1 088 community-service doctors beginning their community service in January 1999 (Du Plessis & Seekoe, 2013; Reid, 2001). This introduction of compulsory community service followed the maldistribution of health professionals in South Africa. Healthcare services were separated according to racial groups during the apartheid era and facilities with the best resources were, therefore, located in the urban areas to serve the white population. As the vast majority of the black population was located in rural areas and the so-called homelands, the healthcare facilities in these areas were often under-resourced (Burns, 2011; Cooper, 2014; Mkhize & Kometsi, 2008). In 2000, Former Deputy Minister of Education, Smangaliso Mkhathshwa, stated that psychologists are vital in assisting South Africans with the social and mental problems that are impeding the country's ability to partake in a globally competitive environment. Community service was thus introduced to lessen the impact of the shortage of

mental healthcare professionals in disadvantaged areas of the country. Community service serves as a strategy to eradicate past social injustices by offering services in disadvantaged areas (Pillay & Harvey, 2006).

In 1998, a one-year compulsory community service was implemented by the South African government to deal with the shortages of healthcare workers in the health sector. Community service entails working in a state healthcare facility for a compulsory 12-month period. In 1998, medical practitioners became the first healthcare practitioners to undertake compulsory community service. In 2002, clinical psychologists were included as healthcare professionals required to engage in community service (Du Plessis & Seekoe, 2013). The registration of clinical psychologists engaging in community service is regulated by the Health Professions Act 56 of 1974, and the Act states that any person who holds a psychology qualification that is accepted by the Board should undertake training as a community-service clinical psychologist for the prescribed period of 12 months (Republic of South Africa, 1974). The National Department of Health states that the core objective of community service is to improve the accessibility of healthcare services to all citizens (Du Plessis & Seekoe, 2013). Mahlathi (2006) states that the process is also aimed at providing “young professionals with an opportunity to develop skills, acquire knowledge, behavioural patterns and critical thinking that will help them in their professional development” (p. 1). Community service is also a mechanism for redressing past inequalities, including the power and resource imbalances in South Africa that arose due to apartheid. It is important to pay attention to impoverished communities because studies have shown the existence of higher depression and suicide rates in rural communities than in their urban counterparts (Xu et al., 2000). By introducing community service, more professionals are exposed to rural areas, thus improving rural communities’ access to the services that they need (Jordans et al., 2018; Xu et al., 2000).

Community service also serves as an opportunity for professionals to improve their skills and gain confidence in working in settings with limited and/or minimal resources. Community service shows these professionals that it is possible to work in such settings and hopefully, they will encourage more professionals to choose to work in rural areas (Reid, 2001).

Moreover, professional associations such as the Psychological Society of South Africa (PsySSA) have made major contributions in terms of changing the state of mental healthcare and psychology in South Africa (Siyothula, 2019). The PsySSA has hosted a number of seminars, talks and workshops that addressed issues such as the role of public service psychology in the National Health Insurance, clinical supervision for psychology trainees working in low-income African contexts, and implications for the curriculum in community psychology. Veldsman (1996) and Wolff (2003) note that the profession of psychology must serve as a role model for reconciliation in South Africa to rectify the past injustices of apartheid.

Therefore, community service relates to not only the social responsibility but also the economic responsibility expected by the government from the graduates to repay the investment of taxpayers' money for training opportunities. However, this repayment is in the form of service to uplift the community rather than financial payment (Department of Health, 2003).

### **Process of Becoming a Community-Service Clinical Psychologist in South Africa**

Formal training in psychology is considered relatively new in South Africa since it was introduced less than 50 years ago. In order to register as a psychologist, the rules and regulations of the Health Professions Council of South Africa (HPCSA) gazetted by the Department of Health (2008), the regulatory board for Professional Psychology training, stipulate that the applicant must have successfully obtained the following: (a) an

undergraduate degree in psychology; (b) an honours degree in psychology; and c) a master's degree in an applied psychology programme.

Psychology programmes are offered at numerous universities in South Africa. Students may apply for an applied master's degree in psychology at any of these universities and will be subjected to a selection process. It is important to note that selection criteria vary among these universities. However, factors such as academic performance, life and work experience and an orientation towards communities are used to select the most suitable candidates (Pillay et al., 2013). Students are required to register in one of the following specific categories: Counselling Psychology, Clinical Psychology, Industrial Psychology or Educational Psychology (Pillay & Johnston, 2011). Training programmes at these various institutions differ in terms of theoretical orientations taught. However, the universities demonstrate some commonalities; they mostly use the scientist-practitioner model (Pillay et al., 2013).

Following selection into the master's programme, students are required to complete one to two years of coursework. The master's programme comprises lectures to gain theoretical knowledge, a research dissertation, practical experience in terms of psychotherapy, and assessments under the supervision of a senior psychologist (De Freitas, 2013). Upon successful completion of the first and/or second year of the programme, the HPCSA requires that the student registers as an intern psychologist. The HPCSA regulates Professional Psychology training and stipulates that the internship programme should be completed on a full-time basis for a period of 12 months. Internship sites are approved and accredited by the HPCSA based on a number of factors such as the content of training programmes, facilities, equipment, multi-professional team availability, supervisory staff availability and patient types. Furthermore, the HPCSA conducts periodic inspections of these internship sites to determine their efficacy and suitability (Pillay & Johnston, 2011).

During this internship programme, the intern psychologist receives supervision and exposure to a multi-disciplinary team. In addition, the intern should be exposed to a wide range of therapeutic and assessment experiences to expand their practical experience (Department of Health, 2008; Pillay & Johnston, 2011). In earlier years, clinical psychology internship programmes were only located within psychiatric hospital settings. However, this has changed in recent years, with training also being offered at general hospitals, clinics and correctional facilities to expose interns to different settings (Pillay & Johnston, 2011). Following the successful completion of the internship programme and submission of the mini-dissertation, clinical psychology interns are required to write the Board examination of the HPCSA before they are allowed to commence with community service (Department of Health, 2008; Pillay et al., 2013; Pillay & Kritzinger, 2007).

In conclusion, academic requirements, internship, passing the Board Examination and completion of community service thus serve as prerequisites for professional registration as a clinical psychologist (Pillay & Harvey, 2006).

### **Community-Service Challenges**

Numerous challenges have, however, had an impact not only on the quality of mental healthcare services provided to the abovementioned communities of South Africa but also on the experiences of community-service clinical psychologists. According to Pillay and Harvey (2006), the introduction of compulsory community service for psychologists in 2002 was mainly met with negativity. These community-service clinical psychologists felt that community service would curb their career plans, placements away from urban areas would be an inconvenience, and the salaries would not be sufficient (Pillay & Harvey, 2006).

Following a study conducted on the first community-service clinical psychologists, Pillay and Harvey (2006) reported that some psychologists had to share office space and some were not provided with stationery. There were issues regarding the lack of access to

basic psychometric tests, to play therapy equipment and to secure filing cabinets for the safekeeping of confidential patient files. Some participants reported safety concerns and uncertainty regarding their roles in their community-service placements (Pillay & Harvey, 2006). Language barriers were also an issue that made communication with patients from these rural areas a serious challenge for some of these community-service clinical psychologists (Pillay & Harvey, 2006).

According to Pillay and Johnston (2011), the large populations being served in these disadvantaged communities mean that brief contact sessions are the reality, which impedes the quality of therapeutic sessions. Swarts (2013) identified certain factors that contribute to the challenges experienced by community-service clinical psychologists. The lack of money and access to transport inhibits patient accessibility to services at their local healthcare facilities. In addition, due to the misinformation that exists about psychology, patients were often not informed when being referred to a psychologist. This resulted in patients being suspicious of the therapeutic process, which ultimately hindered the therapeutic alliance. The effect of this was that patients only attended the first session and never returned for the follow-up sessions. A lack of in-patient psychiatric facilities was also viewed as a challenge; patients requiring hospitalisation were often discharged despite further treatment being recommended by the community-service clinical psychologist. The lack of adequate supervision was also reported as an issue (Swarts, 2013).

Rohleder and Miller (2006) identified challenges experienced by community-service clinical psychologists in prison placements. Posts for community service in the Department of Correctional Services (DCS) were introduced in 2005. Eisemann (1990) reported the difficulties of working therapeutically in a prison environment such as threats to one's personal safety and working in a hostile environment. Gaum et al. (2006) identified that it may be challenging to build a therapeutic relationship based on trust because offenders are

often suspicious of prison staff and are sometimes resistant to rehabilitation. Similar to psychologists working in previously mentioned settings such as hospitals, community-service clinical psychologists working in prisons also found that available space was often a challenge. Safety and security was a primary concern for these community-service clinical psychologists because they were placed in prisons that housed dangerous criminals who had committed violent crimes. Staff members had reportedly been either threatened or physically harmed by some inmates, which reinforced the fear for their safety. In addition, the DCS took no action to remediate concerns and requests raised regarding personal safety. Together with these safety concerns, the unavailability of prison staff due to either staff wandering off during shifts or to staff shortages was also a concern (Rohleder & Miller, 2006).

In addition to the concerns mentioned above, community-service clinical psychologists working in prison settings felt that the lack of clarity regarding their role in prisons resulted in conflict between them and other prison staff. These community-service clinical psychologists reported that they were often required to conduct assessments and compile reports for the parole board. Not only did this contribute to the mistrust of the inmates towards these community-service clinical psychologists but also gave rise to ethical issues such as conducting assessments without informed consent from the inmates (Rohleder & Miller, 2006). While the community-service clinical psychologists felt that their actual role was to assist inmates with mental health issues and their emotional distress and well-being, the parole board reportedly held the idea that the role of a community-service clinical psychologist was to support early parole in order to deal with overcrowding in these prisons. A sense of isolation was also felt by the community-service clinical psychologists within the prisons where they worked due to the nature of therapy. Therapy is conducted in a private area and thus, the community-service clinical psychologist may not have a chance to engage with other psychologists within the prison.

Another identified challenge was the lack of response from the DCS regarding complaints, which resulted in feeling a lack of support. These community-service clinical psychologists were new to this environment and reported the lack of supervision from a qualified clinical psychologist. Hence, they had to take responsibility for their own supervision by consulting with and paying a private senior psychologist to assist.

Anger also stemmed from the feeling of being forced into completing community service in order to qualify and register with the HPCSA as an independent practitioner. Moreover, due to placements away from home, these community-service clinical psychologists reported frequent feelings of isolation from their friends and families (Rohleder & Miller, 2006).

### **Community Service: What Works?**

Despite the aforementioned challenges, there have been reported advantages to community service. Benefits indicated by community-service practitioners in general have been the desire to remain loyal to help their own communities and to continue working in community-based work environments (Weidner, Stone, Latimer-Cheung, & Tomasone, 2018).

According to Siyothula (2019), introducing community service has (although limited) contributed to mental healthcare services that are currently lacking in rural areas. Weidner et al. (2018) indicated that community service is beneficial to both the community-service provider and the recipient thereof. Previous research by Furco (2002) indicated short-term and long-term community-service benefits within several domains such as the educational, personal and vocational domains. Bonadio and Tompsett (2018) believe that community service is beneficial to community members because it provides them with access to various services. These services include family therapy, individual and group therapy, psycho-educational workshops and suicide prevention.

In a study conducted at a university in Canada by Soria and Thomas-Card (2014), undergraduate students reported that community service increased their willingness to work in community-based workplaces after the completion of their postgraduate qualifications. It was also found that community service had a positive outcome on the critical thinking skills of students and practitioners (Vogelgesang & Astin, 2000).

Some community-service clinical psychologists in South Africa also reported positive experiences and benefits of community service. In a study conducted by Pillay and Harvey (2006), 90% of the participants felt that they had made a positive contribution to the communities that they served. They also reported on an improvement in their confidence regarding their professional abilities.

The Department of Health (2003) reported that many healthcare practitioners threatened to immigrate to other countries in order to avoid compulsory community service. Contrary to this report, a large majority of practitioners have taken up posts in South Africa (Department of Health, 2003). Pillay and Harvey (2006) reported that the salary of the community-service clinical psychologists is similar to that of an entry-level government clinical psychologist. Furthermore, it was reported that community-service workers are eligible for a scarce skills allowance. The majority of participants in the study noticed an improvement in their knowledge and their personal and professional growth during. Community service was, therefore, seen as a valuable learning experience (Pillay & Harvey, 2006).

## **Conclusion**

Community service has been introduced globally to assist disadvantaged communities. South Africa in particular has introduced community service to address past injustices and thus, it is compulsory for healthcare workers, including clinical psychologists.

This process of community service involves both the aforementioned advantages and challenges.

The rationale for community service is to ensure the integration of mental healthcare into primary healthcare in order to make mental health services more accessible in communities (Swarts, 2013).

## **Chapter 3: The Self-Determination Theory Literature Review**

### **Introduction**

This chapter explores motivation in psychology by defining related concepts and providing discussions of motivational theories and drives. These theories can be deemed important in understanding different strategies for the purpose of the enhancement of human performance. In order to understand motivation further, the SDT is discussed. Furthermore, sub-theories of the SDT are elaborated to gain an understanding of the theoretical framework and its premises. Lastly, both local and international research using the SDT as a theoretical lens is presented.

### **The Concept of Motivation in Psychology**

The concept of motivation is introduced in this chapter to understand the reasons for individuals partaking in certain behaviours. Motivation is employed in multiple contexts such as school and work environments. Multiple theories have been used in order to provide different perspectives of human motivation.

According to Graham and Weiner (1996), motivation is “the study of why people behave and think the way they do” (p. 63). Motivational studies focus on choice of behaviour, the length of initiating the activity and how hard the individual works on the activity. Moreover, the individual’s persistence, thoughts and feelings while engaging in the activity have also been issues of focus (Graham & Weiner, 1996). The role of physiological needs or drives has been used in early psychological theories. The Drive Reduction Theory (Hull, 1951) states that there is the need for certain elements in individuals’ lives that contribute to their well-being and progression in life. The fulfilment of these needs leads to equilibrium whereas a deficiency of these needs leads to disequilibrium (Taormina & Gao, 2013). Furthermore, Freud (1957) identified basic drives and made use of these to explain what motivates individuals to perform specific actions. The concept of ego defences links to

motivation in that ego defences are relevant to personality and development (Freud, 1957; Plutchik, 1995). According to Corr et al. (2013), personality is said to be influenced by motivational systems such as rewards and punishments. These motivational systems have an influence on avoidance or drive behaviour. In turn, these behaviours contribute to the actions portrayed in each individual's personality traits. Freud (1957) further believed that driving forces develop as individuals move through psychosexual stages and influence how individuals interact with their environment.

Numerous other theories of motivation have been posed to explain human behaviour. Through experimental psychology, Clark Hull (1943) indicated that a physiological deficit or a need, not an instinct, is what drives individuals to engage in behaviours that result in the offset of the need. Stimulus-response linkages (otherwise understood as habits) could assist with direction but not the action needed. Therefore, an unsatisfied need is what produces a drive (Hull, 1943).

Guided by Gestalt principles, Lewin's (1939) Field Theory states that behaviour is influenced by both the person and their environment. According to this theory, three factors determine an individual's motivational force to reach an environmental goal. These factors are (a) tension (the magnitude of a need), (b) valence (the properties of the goal object), and (c) the psychological distance of the person from the goal (Lewin, 1939). Lewin's (1939) conceptualisation of motivation is in terms of tension, which moves the individual towards goals set for themselves.

Abraham Maslow's theory on the Hierarchy of Needs is a needs-based motivational theory that has sparked much debate and research. Maslow (1943) identified five human needs, namely physiological, safety, love, esteem and self-actualisation needs. Deficient needs comprise the needs for balance, security, love, intimacy and sex. The individual needs

involve finding understanding, finding meaning, the ability to be creative and discovering one's life purpose (Maslow, 1972).

On the first level of Maslow's Hierarchy of Needs, there are physiological needs. Deficiencies on this level, as well as on the other four levels, serve as motivation for the individual to seek these needs (Maslow, 1943). The second level comprises the safety-security needs, which include appropriately reacting to danger in order to facilitate survival. The third level comprises belongingness or love needs and according to Maslow (1943), when the needs of the first two levels are fulfilled, people begin to develop a need for social relationships with others. The fourth level, the esteem needs, comprises esteem of the self (the evaluation and respect one has for oneself) and the esteem from others (the respect one receives from others regarding their nature and personality). The fifth level, which comprises the self-actualisation needs, can be described as the desire of individuals to reach their full potential (Maslow, 1943).

Vroom's (1964) Expectancy-Valence Theory of Motivation proposes that individuals will decide to act in a certain way because their behaviour may lead to an expected result. Therefore, it is predicted that an individual will choose to carry out an activity that will have the strongest or weakest negative force (Vroom, 1964). Porter and Lawler (1968) built upon Vroom's (1964) Expectancy-Valence Theory of Motivation. They proposed a model of intrinsic and extrinsic work motivation. According to the Expectancy-Valence Theory of Motivation (Vroom, 1964), intrinsic motivation occurs when individuals take part in an activity for no particular reason and find the activity interesting and satisfying. In contrast to intrinsic motivation, extrinsic motivation comes from the possibility of tangible rewards that may result from taking part in the activity and not because the activity is interesting. Porter and Lawler (1968) propose that structuring the environment to have both intrinsic and extrinsic rewards will lead to higher satisfaction.

Covington (1984) posits that contemporary theories of achievement motivation stem from earlier theories that stated that basic needs such as hunger are the most powerful determinants of behaviour. This physiological approach presented obvious limitations, and researchers expanded their view to include learnt drives (or psychological motives) such as the need for belongingness and achievement. Covington (1984) further proposes that one's ability to succeed at something is influenced by the way parents accept their children, enforce rules and allow their children to explore the world within set and clear boundaries. Atkinson (1964) posed the Theory of Achievement Motivation as a learnt drive. This theory states that one's need for achievement stems from experiencing the conflict between striving to be successful and avoiding failure. This takes place when an individual compares their performance in certain activities with that of other individuals.

The theories presented above provide the basis for understanding human motivation through a variety of lenses. A related concept is that of *self-determination*, referring to human motivation and the relevance to functioning. The SDT of Deci and Ryan (1985) serves as the theoretical framework for this study.

### **The Self-Determination Theory**

The SDT originated from psychologists Edward Deci and Richard Ryan in their work that was first introduced in 1985. According to Deci and Ryan (1985), the SDT shows the role of self-determination in the coping process. The SDT is a macro theory of human motivation, and the belief is that motivation behind behaviour has a possible impact on physical, psychological and emotional functioning (Deci & Ryan, 2002). According to Ryan (1995), the SDT is an organismic psychology in that the assumption is that people have a desire and are active towards participating in activities that lead to psychological growth. Deci and Ryan (2002) indicate that the SDT explains the 'what', 'why' and 'how' of behaviour. These are significant questions in terms of the context of this research study

because the motivation of community-service clinical psychologists to complete their community-service year is of importance. The ‘why’ of behaviour can be explained through intrinsic and extrinsic motivation and the ‘what’ of behaviour can be explained through motivational influences. Lastly, the ‘how’ question can be answered through the examination of the degree to which the individual’s needs are satisfied (Deci & Ryan, 2000).

It is said that people are driven by multiple factors, both internal and external. The SDT examines the type of motivation used by individuals at any given time. Through the examination of factors that move an individual to perform certain actions, the SDT attempts to recognise the types of motivation, each of which has outcomes regarding learning, performance, personal experiences and well-being (Deci & Ryan, 2000). Through examining how motivation is developed and maintained, the SDT can also account for passivity, feelings of estrangement and ultimately, psychopathology (Deci & Ryan, 1995).

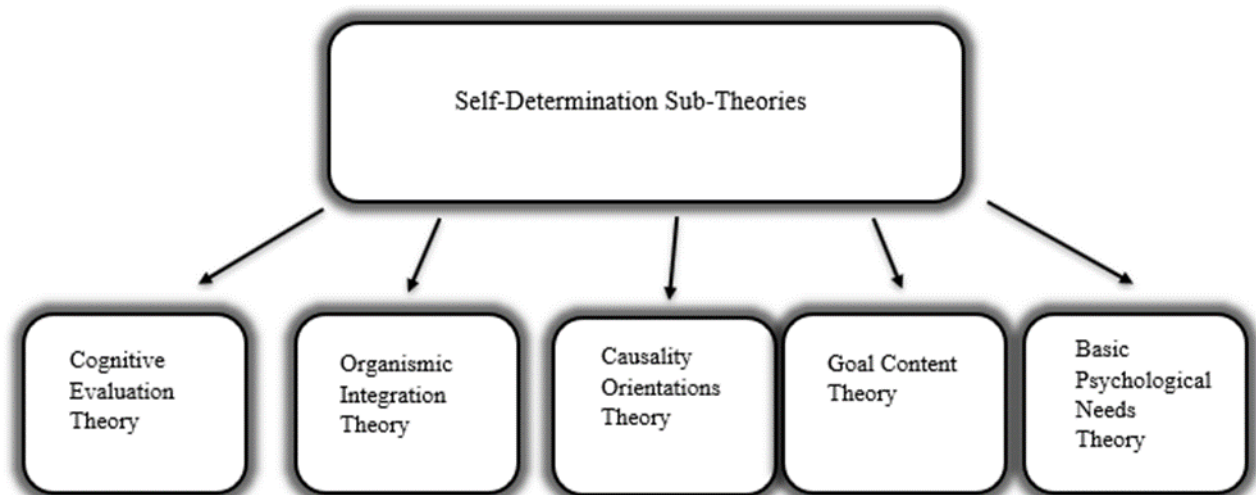
Furthermore, the SDT refers to three fundamental and universal human needs, namely the need for autonomy, the need for competence and the need for relatedness (Deci & Ryan, 2002). This is known as a sub-theory of the SDT, namely the Basic Psychological Needs Theory (BPNT) (a detailed discussion is presented hereinafter). These three needs are said to be essential in directing optimal functioning in humans since there are needs for growth, social development and the maintenance of personal well-being (Deci & Ryan, 2000). The SDT proposes that satisfying all three needs leads to prosperity and optimal functioning, whereas if the needs are unmet, there is a disruption in functioning. Need satisfaction arises from the personal experiences of an individual and heavily relies on what an individual’s environment can offer (Rasskazova et al., 2016). Understanding human behaviour requires examination and understanding of the innate psychological needs that humans require, namely the needs for autonomy, competence and relatedness.

## The Self-Determination Sub-Theories

The theoretical framework of the SDT comprises five sub-theories. These sub-theories contribute to the general propositions of the SDT and are discussed briefly in the sections below.

### Figure 1

*Five Sub-Theories of the Self-Determination Theory*



### *Cognitive Evaluation Theory*

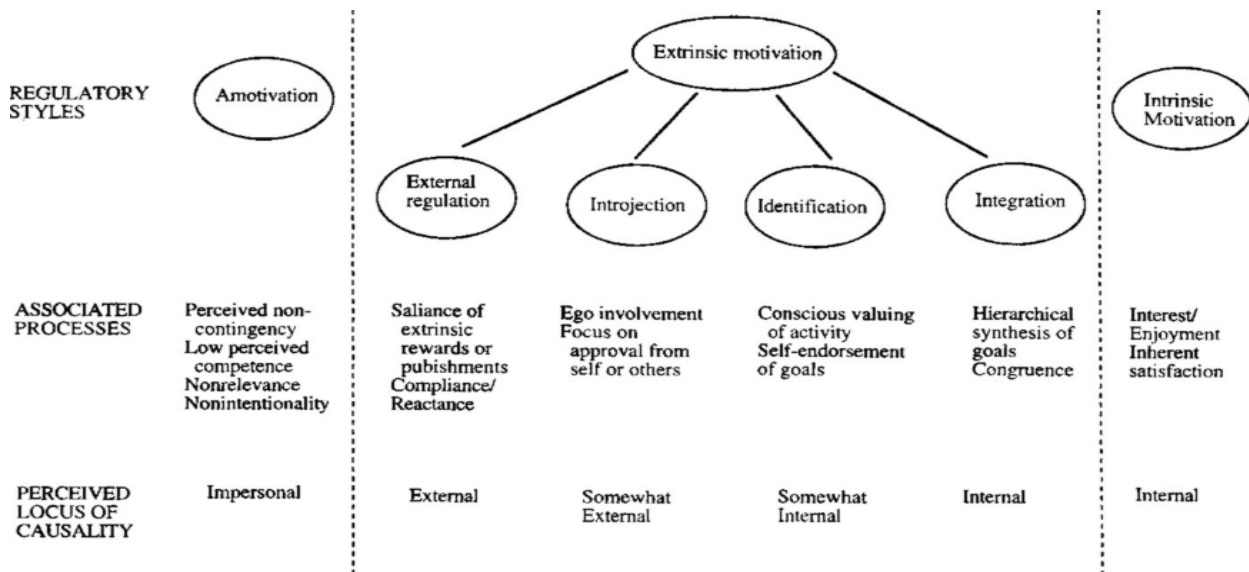
The Cognitive Evaluation Theory (CET) is a sub-theory that poses how interpersonal contexts and social interactions either assist or thwart intrinsic motivation. Intrinsic motivation can be defined as partaking in an activity for its own sake without the expectation of an external reward. Autonomy and competence are, therefore, important needs in facilitating intrinsic motivation, and the interruption of these needs may have a negative effect on intrinsic motivation. The CET also explains how factors such as deadlines, rewards,

external pressure, surveillance and evaluations can have an effect on both autonomy and competence and how these particular factors may increase or decrease intrinsic motivation (Ryan, 2009).

The study by Deci (1971) shows that activities that are challenging and that receive positive feedback increase intrinsic motivation because of higher competency. When feeling competent, one perceives that they are responsible for their own successful performance and thus have the ability to reach their stated goal (Gagné & Deci, 2005). Alternatively, when a person receives negative feedback, this feedback decreases feelings of competency, thus undermining both intrinsic and extrinsic motivation.

### ***Organismic Integration Theory***

The Organismic Integration Theory (OIT) is a sub-theory that discusses how extrinsic motives are internalised by a person. Internalisation exists on a continuum from external regulation, introjection and identification to integration. These forms of regulation can exist simultaneously; however, they tend to differ in their levels of autonomy. Integrated regulation is said to be the most autonomous form of extrinsic motivation, whereas external regulation is the least autonomous. Research regarding the SDT indicates that the more autonomous one's motivation, the more likely one will be persistent and determined to succeed in a particular activity (Ryan, 2009).

**Figure 2** (Deci & Ryan, 2000)*Organismic Integration Theory Spectrum of Motivations*

The OIT states that self-determination exists on a continuum of amotivation (completely lacking self-determination) to intrinsic motivation (consisting completely of self-determination). Existing between amotivation and intrinsic motivation is extrinsic motivation with different types of regulations. External regulation is the least self-determined, whereas introjected, identified and integrated regulation becomes more self-determined. Furthermore, the OIT differentiates between autonomous motivation and controlled motivation. Autonomy thus involves thinking through one's actions and acting with a choice. Hence, intrinsic motivation is an example of autonomous motivation because this occurs when a person engages in an activity because of enjoyment. In contrast, engaging in an activity because of pressure results in controlled motivation. Autonomous motivation and controlled motivation are, therefore, described as intentional because they result in an activity being performed. On the contrary, amotivation has a lack of intention and motivation (Gagné & Ryan, 2005). When an activity is found to be uninteresting, it requires extrinsic motivation, which is said to be externally regulated. Another type of external regulation

occurs when the value associated with an activity and the behavioural regulation that follows have been internalised. Internalisation occurs when a person combines their values and attitudes and the external regulation of behaviour is transformed into internal regulation and, therefore, no longer depends on external contingencies (Gagné & Deci, 2013).

### ***Causality Orientations Theory***

According to the sub-theory Causality Orientations Theory (COT), a person who is autonomy orientated is likely to engage with what they find interesting. When a person is control-orientated, they engage with an activity on account of being controlled by society and the expectation of a reward. Impersonally orientated people realise their lack of control and competence, and this lack becomes their focal point. Therefore, this theory examines how people's orientations towards certain activities affect their motivation (Ryan, 2009).

Furthermore, individuals who embrace an autonomy causality orientation rely on motivation that is self-determined in order to put their plans into action. In contrast, individuals who embrace control causality orientation rely on external controls to guide their levels of motivation (Reeve, 2012).

Reeve (2012) further states that the CET studies the social psychology aspect of the SDT. In comparison, the COT studies motivation from a personality perspective and, therefore, the causality orientations of these individuals can be differentiated from other personality types such as those found within the Big Five personality traits (Costa & McCrae, 1992).

### ***Goal Contents Theory***

According to the Goal Contents Theory (GCT), extrinsic goals and materialistic rewards such as fame and prestige do not enhance the satisfaction need or contribute positively to well-being even when they are successfully attained (Deci et al., 2017). Instead, goals such as personal growth, successful relationships and positive contributions to the

upliftment of one's community enhance the satisfaction need and, therefore, positively contribute to well-being. The GCT also examines how goals with intrinsic aims yield better outcomes than goals with more external aims (Ryan, 2009).

### ***Basic Psychological Needs Theory***

The last sub-theory, the BPNT, connects basic needs to well-being. According to the BPNT, the fulfilment of a need has a direct influence on well-being. These needs are considered important in understanding the *what* (i.e., content) and the *why* (i.e., process) of goal pursuits. According to Deci and Ryan (1985, 2002), the SDT differentiates between the content of the goals and regulatory processes by which outcomes are achieved. The effects of goal pursuits and attainment are precipitated by the extent to which people are able to fulfil their basic psychological needs while they pursue desired outcomes (Deci & Ryan, 2000). The degree to which an individual's basic psychological needs are satisfied is related not only to their motivation but also to their well-being. This contributes to the individual's need for growth and optimal functioning. This need for growth and optimal functioning is related to being intrinsically motivated and hence, the more likely the individual will be in seeking greater challenges (Deci & Ryan, 2000).

**Autonomy.** Deci and Ryan (2000) define autonomy as the need for individuals to experience their behaviour as a choice as opposed to being coerced. Autonomy involves people's desire to do what they consider useful to them. An individual, therefore, feels autonomous when his/her behaviour is of freewill but once coerced, the individual feels alienated to the self (Rasskazova et al., 2016; Ten Cate et al., 2011).

Another concept that links to autonomy is intentionality. Intentionality is deemed important because behaviour is understood in terms of one's intentions to act in a way that produces certain results whether the behaviour is implicit or explicit. Certain intentional behaviours can be used to express oneself by initiating and regulating the behaviours through

choice. These types of behaviours are characterised by autonomous initiation, and the person who takes part in them is described as being self-determined. Other intentional behaviours are forced by environmental circumstances and, therefore, do not represent the true sense of having a choice. This type of behaviour is described as controlled behaviour (Deci & Ryan, 1987).

According to Ryff's (1989) model of psychological well-being, self-actualisers can be described as displaying autonomous functioning. People who are fully functional can be described as having an internal locus of evaluation, which means that they do not seek approval from others but rather evaluate themselves according to their own standards. By evaluating themselves according to their own standards, they express their freedom from social norms and expectations (Ryff, 1989).

**Competence.** Competence is defined as the need to feel efficacy and mastery in terms of the various activities in life. Once an individual receives the necessary support to acquire certain skills, expertise and constructive feedback, it leads to a feeling of competence (Deci & Ryan, 2000; Rasskazova et al., 2016). Furthermore, the need for competence motivates people to seek challenges that are useful in their lives, and this leads to a constant desire to uphold these skills and capabilities (Ten Cate et al., 2011).

Rodolfa et al. (2005) define competency as possessing the appropriate qualifications and the ability to understand and carry out certain actions in an effective manner. Merely possessing knowledge regarding a topic does not equate to competency. Competency requires an action to be carried out using critical thinking and careful decision-making. According to Ryff's (1989) model of psychological well-being, competency is related to what is termed environmental mastery. Environmental mastery is defined as the ability to manage one's life and the environment in which one lives (Ryff, 1989).

The diathesis-stress model of achievement processes (Boggiano, 1998) is a model that shows that behaviour techniques that are autonomy supportive produce an intrinsic motivational attitude. This intrinsic motivational attitude is expected to lead to adaptive achievement patterns such as perceived competence. From a developmental perspective, Guay et al. (2001) pose that autonomy-supportive ways of engaging with children encourage an intrinsic motivational orientation within them, thus having a positive effect on their perceived competence. This is contrary to making use of controlling techniques that are deemed to be perceived as indicating incompetence.

Feelings of incompetence in individuals may result in negative self-evaluations. These evaluations can negatively influence one's motivation and have been linked to burnout, stress and the premature cancellation of achieving set goals (Thériault & Gazzola, 2006). Uncertainty, insecurities and self-doubt about one's abilities may also result in feelings of incompetence (Thériault et al., 2009).

**Relatedness.** According to Deci and Ryan (2000), relatedness is defined as an individual's desire to feel connected with other people. Relatedness is experienced when an individual feels a sense of support and a sense of being cared for by those around them and vice versa. This sense of connectedness applies to both significant others and the person's community. Isolation and exclusion can lead to feelings of disconnection from others (Ten Cate et al., 2011).

Furthermore, Baumeister and Leary (1995) view the need for strong bonds and stable interpersonal relationships as the need to belong. The authors believe that people who are integrated into social networks and those who are content with their connections with others tend to live longer. Moreover, those who are integrated into social networks are said to possess better mental and physical health (Baumeister & Leary, 1995). Reis et al. (2000) show that engaging in different types of social activities can lead to the feeling of relatedness

towards others. The following activities, which are not exhaustive, are said to lead to the feeling of relatedness: communication regarding certain personal matters, engaging in shared activities, having friends one can spend time with, feeling as though one is appreciated and understood, engaging in pleasurable activities, and avoiding conflict that has the potential to lead to disengagement (Reis et al., 2000).

Autonomy, competence and relatedness have shown to be important contributors to the optimal functioning of humans and the maintenance of well-being (Deci & Ryan, 2000). With this in mind, the use of the SDT in research is discussed in the following section.

### **Use of the SDT in Research**

The SDT has been used and acknowledged in numerous studies. These studies include contexts such as social activity, education, healthcare and work.

Within the context of social activity and relatedness, a study by Reis et al. (2000) was used, and relatedness correlated with the existence of a positive mood and vitality. Engaging in conversations regarding matters of importance, feeling understood and appreciated, and engaging in pleasant activities also positively linked to relatedness. Therefore, social activity was said to predict the feeling of relatedness and, therefore, positively influenced well-being (Reis et al., 2000).

When the SDT was applied to healthcare, Patrick and Williams (2009) found that autonomy support displayed by medical practitioners towards their patients led to patients internalising this autonomy and feelings of competency related to their health behaviours. Need-supportive medical education was also found to promote the well-being of both medical practitioners and their patients.

In a study by González et al. (2014), the SDT was applied in order to examine the degree to which the satisfaction of the basic psychological needs explained the connection between the socioeconomic statuses of people and their physical and mental health. The

results of this study indicated that the satisfaction of basic psychological needs mediated the negative association between socioeconomic statuses and physical and mental health (González et al., 2014).

Within the context of education and motivation, the SDT was applied in a study by Reeve (2002). It was found that students thrive academically when they are autonomously motivated and benefit when educators support their autonomy. It was found that when the control approach was used by educators, for example, punishments and rewards were used to reinforce or to drive behaviour towards extinction, this led to underperformance. When supporting students' autonomy, students experienced feelings of self-control and due to an internal locus of control were more motivated to perform better academically (Ten Cate et al., 2011).

A South African study by Naudé et al. (2016) explored the experiences of first-year psychology students regarding academic success. This study made use of the SDT to explore these experiences. It was found that all participants had a tendency to make positive rather than negative comments regarding their experiences. Participants from the group of students who performed better academically attributed their success to having a genuine interest in the discipline of psychology and to being committed to their studies (integration). Social support was also mentioned as a contributing factor to their success (relatedness). Whereas some participants felt incompetent because of not knowing what to expect in their first year of studies, others felt competent as a result of having a positive attitude and taking responsibility for their academics. Overall, this study indicated that students' behaviour moves along a continuum, ranging from externally motivated behaviour to internally motivated behaviour (Naudé et al., 2016). When considering the OIT, participants made comments that ranged from external regulation to introjection. Although this study investigated externally motivated

behaviours, it concurs with the fact that externally rewarded behaviours can contribute positively to one's feelings of autonomy in an educational setting (Naudé et al., 2016).

Another South African study examined how the role of peers, family, lecturers and workload affected the basic need satisfaction of pharmacy students (Basson & Rothmann, 2018). It was found that family and friends contribute significantly to the psychological needs of these students. Workload also had a significant effect on autonomy and sense of relatedness (Basson & Rothmann, 2018). This is because when the students have a high workload, they feel that they do not have time to spend with family and friends or to engage in activities of their choice.

According to a study by Jacobi (2018), the basic need for autonomy is an important factor in motivating students. Students feel that their autonomy is supported when different instructional strategies are used (Jacobi, 2018). Strategies such as allowing learning options to be flexible, providing a rationale for the task at hand that is meaningful, giving choice regarding language of instruction and considering any complaints that students have regarding the tasks at hand reinforced their feelings of autonomy (Jacobi, 2018).

Furthermore, by providing students with a balance of course requirements and freedom of discussions, setting clear class routines and presenting them with positive feedback increased the students' feelings of competency and further increased their levels of motivation. Lastly, group work, effective feedback and being in close proximity increased students' feelings of relatedness, which also positively contributed to higher levels of motivation within the classroom (Jacobi, 2018).

## **Conclusion**

In view of the information provided above, it is clear that the SDT has been widely used in research. Since the SDT serves as a method of exploring both motivation and coping processes, it was thus an applicable theoretical model to use for this study. In addition, given

the rationale of the study, the SDT created structure for the research since the focus was on the experiences of community-service clinical psychologists and how they are coping.

## **Chapter 4: Research Methods**

### **Introduction**

This chapter provides an overview of the methods used in this study. The rationale of the study, the research question and the aim of the research are presented. Furthermore, data collection and analysis are discussed. This is followed by ethical considerations and the trustworthiness of the study.

### **Revisiting the Rationale**

The rationale of this study is exploring motivation processes during the community-service year of clinical psychologists.

### **Revisiting the Research Aim and Research Question**

The aim of this study was to explore and describe the experiences of community-service clinical psychologists from a self-determination perspective by asking the following research question: How are community-service clinical psychologists able to remain motivated to complete their community-service year successfully? The research question was addressed by the following:

- Collect data through semi-structured interviews
- Transcribe data and yield open codes
- Merge open codes into three main themes
- Describe results within the self-determination framework

### **Research Design**

This study made use of a multiple-case qualitative research design. A qualitative research approach was employed because qualitative research is suitable for providing an in-depth understanding of the experiences of research participants (Flick, 2009; Ritchie et al., 2014). According to Bansal et al. (2018), qualitative research offers insights that can challenge and expose certain theoretical directions. Quantitative research is numerical and

can be transformed into data displays. In contrast, qualitative research is said to use and collect various empirical material such as personal experiences, interviews and life stories that describe moments and meanings in the lives of individuals (Denzin & Lincoln, 2005). Furthermore, Kalof et al. (2008) state that qualitative research focuses on the meanings and motivations that underlie personal experiences and the meanings that people attach to things. Qualitative research is about interpretation (Denzin & Lincoln, 2003) and focuses on subjective meanings of behaviour. Individuals thus give their own account of their behaviour, attitudes and motivations (Aspers & Corte, 2019). In addition, the researcher can draw observations from the data, and by using inductive theorising, the researcher can elaborate on understudied contexts (Bansal et al., 2018).

Furthermore, a multiple-case study design (Yin, 1981) was employed to provide a rich context to the phenomena under study and to allow for a replication strategy (Yin, 1994). According to Yin (2009), case studies are used for the purpose of exploration. Additionally, case studies may be used to describe certain situations or to test explanations as to why certain events occurred.

A single-case study may be used to test a theory and, therefore, can be used in the same way as a critical experiment (Stouffer, 1941). In contrast to single-case study designs, multiple-case study designs allow conclusions to be made from a group of cases. The multiple-case study design is said to be appropriate when it is believed that there may be the same phenomenon in a variety of situations (Yin, 1994). Each case is conducted thoroughly. The collection of these numerous case studies on the same topic is thus used to replicate or to confirm the results.

## **Research Participants and Sampling**

### ***Sampling Procedure and Research Participants***

According to Schatzman and Strauss (1973), the selection of participants should be in relation to the aim of the study. For this study, the inclusion criteria were as follows:

Participants had to be able to communicate in English. They may have studied at any of the recognised universities in South Africa and may have completed their community service in any of the nine provinces. In addition, participants had to have completed their community-service year between 2014 and 2020. Lastly, participants had to give informed consent before partaking in the study. Race, gender and age were not included as criteria.

The participants were selected using purposive sampling (Palys, 2008) since selection was based on the characteristics of a certain population, namely community-service clinical psychologists who completed their community-service year between 2014 and 2020. At the outset, purposeful sampling was the most appropriate sampling procedure, with the aim of the research identifying potential participants. Vasileiou et al. (2018) state that purposive sampling is used to provide richly textured data that is most relevant to what is being studied. Potential research participants were identified by the Secretary of the Department of Psychology who provided lists of students who had completed their Master's in Psychology at the University of the Free State.

Potential participants were contacted by the researcher through e-mail. This gave them the option to respond or to ignore the e-mail. The inclusion criteria were included in the e-mail to ensure that potential participants matched the study's criteria. Details regarding the research study were included, and the potential participants had the opportunity to participate in the study or to decline. The aim of the research was explained within the e-mail and the option of a face-to-face interview or a telephonic interview was offered. Potential participants were also informed about the estimated length of the interview. Those who were willing to

participate in the study were sent an informed consent form to sign. This form contained additional information pertaining to the study and informed them that they were free to withdraw from the study at any time.

There were many responses to the sent e-mail. Two of those contacted were willing to participate in the study, but many declined. After several months of attempting to recruit participants, the researcher made the decision to use another sampling procedure, namely snowball sampling. Burns and Grove (1993) define snowball sampling as a convenience non-probability sampling method that is applied when there is difficulty in accessing participants with target characteristics. With this sampling method, existing research participants recruit future participants among their acquaintances (Naderifar et al., 2017).

It is important to note that this study resulted in a small sample size (six participants). According to Cronin (2014), data collection can still be rich despite a small sample size. Morse (2000) stated that the more usable data collected from each participant, the fewer the participants needed. It is important to keep in mind the scope of the study, the nature of the topic and the data quality.

Ultimately, six participants were interviewed; three participants preferred face-to-face interviews and two participants were interviewed via Skype. The last participant was interviewed using both Skype and telephonic means due to network challenges.

### ***Data Collection***

Correspondence via e-mail continued with the participants who agreed to participate in the study. Each participant was given the option of an in-person, telephonic or Skype interview. Participants indicated their availability and from this information, interview dates and times were arranged. Interviews conducted in person had financial implications for the researcher since there was an obligation to travel to the respective provinces to interview the participants. There were no financial implications for these participants. Interviews conducted

telephonically and via Skype were convenient for the participants and the researcher because there were no travel costs involved.

Interviews were conducted over a period of 12 months in order to gain an in-depth understanding of the experiences of community-service clinical psychologists and how they managed to cope during their community-service year. The interviews were semi-structured and consisted of both open- and closed-ended questions (See Appendix C). Semi-structured interviews are a versatile and flexible technique for small-scale research (Drever, 1995; Kallio et al., 2016). Galletta (2012) states that an advantage of semi-structured interviews is that they allow for reciprocity between the participant and the researcher. Furthermore, a semi-structured interview allows the researcher to ask follow-up questions based on the participant's responses (Polit & Beck, 2010). This allows the participant to express their thoughts, experiences and feelings and thus the gathering of rich data. Lastly, the interviews were recorded with the participants' consent and transcribed by the researcher.

### ***Data Analysis***

The data were analysed using thematic analysis according to Braun and Clark (2006). Thematic analysis requires the application of six steps to the transcribed interviews. The six steps are as follows:

- a) Familiarisation with the data
- b) Generating initial codes
- c) Searching for themes
- d) Reviewing themes
- e) Defining and labelling the themes
- f) Producing the report

**Step 1: Familiarisation with the data.** The first step was for the researcher to familiarise herself with the collected data by listening repeatedly to the audio recordings.

This was done immediately after the interviews so that transcribing the information was easier. By reading through the transcriptions, potential themes were identified, which were given initial codes.

**Step 2: Generating initial codes.** This step involved re-reading the transcripts and making note of any information deemed interesting. This information was given a code in the form of a number. To generate the codes, the researcher organised the interview transcripts into paragraphs in a table. Recurring themes were given the same codes, and new codes were given to new themes. The codes that were initially generated are presented in Table 2.

**Table 1**

*Initial Codes*

Number of code	Description of code
1	New environment
2	Safety
4	Adapt
5	Sharing with other
7	Case presentations
8	Rule differences
9	Ethical dilemmas
10	Consultation
11	Creativity
13	Learning gap
15	Independence
16	Learning
17	Support
18	Off-site workshops
19	Being selective
25	Establishing identity

Number of code	Description of code
26	Validation
28	Distance
29	Community- service location
31	Well-being
33	Patient challenges
35	Patient influx
36	Filing system mismanagement
40	Valuable supervisors
43	Changing lives
45	Patient compliance
47	Lack of structure
48	Taking initiative
49	Acceptance need
50	No collaboration
51	Exposure
52	Relatedness
53	Connecting
56	Challenging
57	Debriefing
59	Being a professional
60	Loneliness
62	Lack of support
63	Language and translation
64	Physical resources
65	Performance
66	Emotional control

**Step 3: Searching for themes.** A review of the codes was performed by the researcher, and possible themes were identified. Sub-themes were also identified.

**Step 4: Reviewing themes.** After reviewing the initial themes, the researcher further narrowed the themes and grouped similar codes together. This resulted in the formation of three main themes and eight sub-themes.

**Step 5: Defining and labelling themes.** The themes were named in order to represent the codes grouped within the theme accurately. The themes and sub-themes were given definitions to ensure their relevance. In addition, these themes and sub-themes were reviewed by the researcher's supervisors.

**Step 6: Producing the report.** This is the last step of analysis according to Braun and Clarke (2006). In this step, the researcher selected examples from the transcripts to support the main themes and sub-themes. These themes and sub-themes together with the extracts were used to answer the research question. The report was produced by integrating information collected from the participants in addition to supporting literature.

### **Ethical Considerations**

An important part of conducting research is the continuous consideration and application of ethical principles (Allan, 2016). Ethical clearance to conduct this research was granted by the Research Ethics Committee of the Faculty of Humanities at the University of the Free State. The ethical clearance numbers are UFS-HSD2018/1422 and UFS-HSD2018/1422/2702 (See Appendix B). Other ethical principals were also considered such as autonomy and informed consent, confidentiality and anonymity, and non-maleficence and beneficence.

#### ***Autonomy and Informed Consent***

Autonomy is defined as the right of agreement or refusal (Giordano et al., 2007). The participants' autonomy was respected in that their participation was voluntary and they had the right to withdraw from the research study at any time. Sandu and Frunza (2019) state that informed consent is a written, dated and signed decision given by an individual who is

capable of giving consent. Research participants agree to participate in a research study after being informed about the nature of the research, the risks and the benefits (Bulger et al., 2002; Sandu and Frunza, 2019). The informed consent form was discussed with the participants, and they were given an opportunity to ask questions pertaining to the form. Participants signed the form voluntarily, thus agreeing to participate in the research study.

### ***Confidentiality and Anonymity***

Koggel (2003) states that confidentiality involves a relationship of trust in which a participant shares private information with a researcher with the expectation that this information will not be shared without permission. Participants were given pseudonyms to protect their identity, thus guaranteeing confidentiality and anonymity.

### ***Non-Maleficence and Beneficence***

Patel and Wright (2019) define non-maleficence as causing no direct harm to an individual. Beneficence is defined as actions taken to improve or benefit the situation of others. The welfare of research participants must be considered (Patel & Wright, 2019). In order to ensure that no harm was done to the participants, the researcher made it clear that they could withdraw from the study at any time. Participants were also provided with the contact details of a psychologist in the event that they required debriefing following the interviews. None of the participants of this study required debriefing following the interviews.

### **Trustworthiness**

Guba and Lincoln (1985) state that trustworthiness in qualitative research can be enhanced through credibility, transferability, dependability and confirmability.

### ***Credibility***

Credibility is the consistency derived from the reality of participants and the way in which this reality is presented. Credibility is enhanced through prolonged engagement, which

involves lengthy and prolonged contact with participants. The triangulation of data by using different sources and methods and the opportunity for peer debriefing by engaging with a peer professional ensured honesty by the researcher (Guba & Lincoln, 1985). According to Cutcliffe and McKenna (1999), by sharing interpretation of research data with other colleagues, an opportunity to challenge emerging themes is created. Tong and Dew (2016) posit that strategies used to maximise credibility include asking relevant questions during interviews to encourage in-depth responses and describing the findings in detail. By asking semi-structured questions during the interviews, participants provided in-depth information regarding their experiences. Engagement with the researcher's supervisors regarding themes in the research helped in identifying relevant themes. Furthermore, credibility was determined through the process of theory and researcher triangulation.

### ***Transferability***

Transferability refers to the ability to apply findings made in research to similar fields and contexts (Guba & Lincoln, 1985). According to Tong and Dew (2016), most qualitative studies are small in order to provide detailed information, and this makes generalisability of the research impossible. Therefore, transferability is the extent to which concepts and theories can be relevant in different settings. This entails the ability to compare results in one study to different contexts such as different regions, populations or other theoretical frameworks. The transferability of this study was done by providing detailed descriptions of the research methods and the process followed.

### ***Dependability***

Guba and Lincoln (1985) state that carrying out an audit by a competent external auditor to examine results in a dependability judgement is necessary. Tong and Dew (2016) describe dependability as the coherence across methods, data and findings of the research. Moreover, researchers are encouraged to record and transcribe data. Dependability was

enhanced in the current study by recording all research decisions in a research diary. This was done by noting the dates, specific activities done, the aims of the activities and the outcomes thereof together with personal observations and reflections of the researcher.

### ***Conformability***

Since qualitative researchers bring in their own skills and biases into the research process, conformability ensures that the findings reflect the views of the participants (Tong & Dew, 2016). Conformability can be achieved through the linking of the findings to raw data by quoting the participants' responses. In this study, confirmability was communicated through the clear descriptions of the manner in which interpretations and conclusions of the research were derived.

### **Conclusion**

The aim of this chapter was to discuss the research design and the methods that were used in this research. Ethical considerations and the trustworthiness of the data were also discussed.

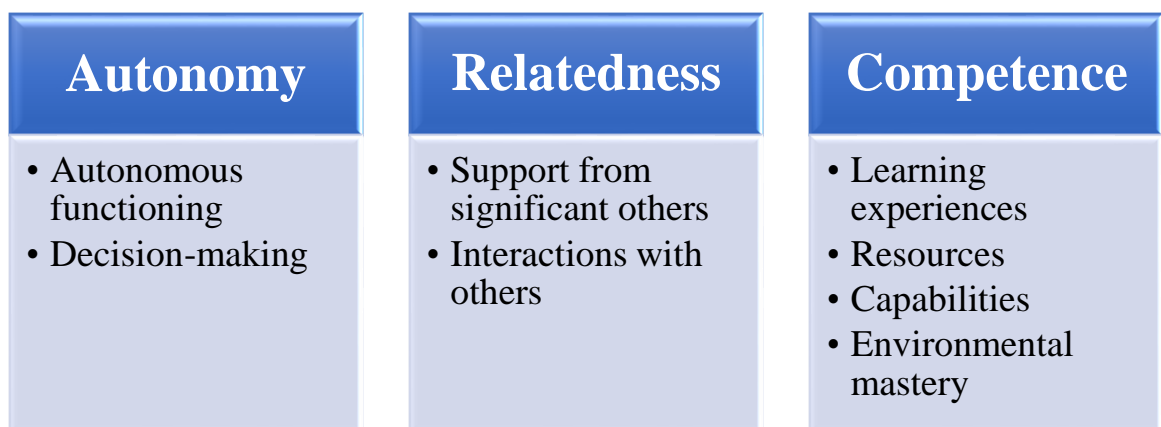
## Chapter 5: Results

### Introduction

The aim of this chapter is to discuss the experiences of community-service clinical psychologists through previously conducted interviews; an integrated discussion of the results follows. Data collection was done through six semi-structured interviews to gain an understanding of the participants' experiences of being community-service clinical psychologists. The evaluation of this data was done through the lens of the SDT of Deci and Ryan (2000). Inductive thematic analysis yielded open codes. Step 3 and Step 4 of the thematic analysis (Braun & Clarke, 2006) resulted in these codes being merged into the following themes: autonomy, relatedness and competence. These themes were considered within the theoretical framework of the SDT. The aim of this study was to explore and describe the experiences of community-service clinical psychologists through a self-deterministic perspective. The original themes as they fit into the three needs for self-determination are presented in Figure 3.

### Figure 3

*Themes of the Study*



**Table 2***Demographics of Participants*

<b>Participant pseudonym</b>	<b>Age</b>	<b>Race</b>	<b>Gender</b>	<b>Community service year</b>	<b>Data collected</b>
<b>Palesa</b>	28	Black	Female	2016	Face-to-face
<b>Sharon</b>	29	White	Female	2017	Face-to-face
<b>Mary</b>	32	White	Female	2014	Face-to-face
<b>Monique</b>	27	White	Female	2017	Skype
<b>Chantelle</b>	33	Coloured	Female	2016	Skype
<b>Kelly</b>	37	White	Female	2020	Skype and telephonic

The ages of the participants ranged from 28 years to 37 years, with a mean age of 31. Of the six participants, one was a black participant (16%), one was a coloured participant (16%) and four were white participants (68%).

**Autonomy***Autonomous Functioning*

Autonomous functioning refers to one's behaviour being a choice rather than being coerced (Deci & Ryan, 2000). Furthermore, autonomous functioning relates to a person feeling that their behaviour is of their own free will, and impeding this results in the feeling of alienation towards the self (Rasskazova et al., 2016; Ten Cate et al., 2011).

Five participants of this study related to autonomous functioning by indicating their ability to adapt to certain situations. "Palesa" declared, "So you had to adapt, learn new things as well. Like I had to learn to do a parole assessment when I was there" (Palesa, p. 4, para. 8). In terms of making choices regarding which workshops she wanted to attend, Palesa again demonstrated autonomous functioning: "So now you're more selective in terms of what you went to in order to be able to get better with your offender population" (Palesa, p. 5,

para. 10). Palesa indicated her ability to adapt to a new environment in her statement:

“[B]ecause it was a different environment but I adapted in a couple of months and I was like, ‘Okay, I can do this’” (Palesa, p. 8, para. 14). According to “Chantelle”, adjusting to a new environment was “quite unstructured, so they kind of throw you into the deep end and you figure things out” (Chantelle, p. 2, para. 6). Chantelle, therefore, felt that she was expected to navigate her way through the new environment by herself.

In terms of language barriers, “Sharon” demonstrated her willingness to adapt to her environment: “I would understand partly some Setswana because I would have to understand the basics” (Sharon, p. 6, para. 11). “Monique” indicated that she also navigated through language barriers with clients:

Some of my colleagues, uhm, that were able to either speak, you know, whatever language it was that I wasn’t able to speak – even though I was the one that was either in the assessment or in the therapy role, they would come in as, uhm, being a translator. So that is also how we tried to assist each other. (Monique, p. 4, para. 8)

This indicated that both Sharon and Monique generated solutions to challenges they faced, and this contributed to their sense of autonomous functioning.

Discovering certain aspects about oneself and further expressing free will in terms of achieving goals set for the community-service year, Palesa expressed this opinion:

I think that, uhm, that comm serve, it’s also a year to learn and also find your own identity because in that year, that’s the last part. Then you need to make a plan to say, What’s next now? Where are you gonna go? Because it’s easy for the first two years. (Palesa, p. 7, para. 13)

Despite a lack of resources, autonomous functioning was still demonstrated by some participants. Sharon expressed, “We would organise if there is something really important that needs to be done” (Sharon, p. 2, para. 4). “Mary” demonstrated this and provided an

example, “If you wanted to work with children, then anything that you will use with children at the hospital, you would need to bring yourself, and it is your own things” (Mary, p. 2, para. 5). She further stated, “We could not do any psychometric assessments and you could not, there was no ... nothing was for the children specifically, was psychologists. So anything you needed, you had to bring yourself” (Mary, p. 4, para. 9). Showing additional free will in her actions, Mary stated that “when I said when I did the talks, if a patient didn’t show up for groups, then I would rather the talk, give the talk to the whole group of patients at the clinic” (Mary, p. 8, para. 14). The information that Mary provided showed that she took the initiative of her own free will to help others. This indicated that the actions carried out by Sharon and Mary were of their own free will so that the best possible service could be rendered to their clients.

Despite feelings of frustration regarding challenges faced during community service, “Monique” still indicated autonomous functioning: “Although it was quite frustrating at times, I myself, am very goal-directed. So if I put my head on something, I figure a way out to get it done” (Monique p. 4, para. 9). Palesa indicated her stance regarding this frustration by saying, “There were challenges but they were not extreme, and I was able to work through them which gave me confidence as well to say, ‘I can do this’” (Palesa, p. 8, para. 14).

### ***Decision-Making***

Autonomy involves a person’s desire to do what they consider useful to them (Ten Cate et al., 2011). This sub-theme includes certain decisions that participants had to make regarding their community-service year. According to Van den Broeck et al. (2016), autonomy does not imply acting independently and completely disregarding the needs of others. Instead, autonomy is when an individual acts out of a sense of choice while complying with others’ wishes.

It was evident in the data set that safety was a major concern for two of the participants; however, despite these concerns, they still managed to do what was required of them. Palesa expressed her concern in providing therapy for dangerous offenders within a prison environment. She recalled,

You had to be more cautious as well in terms of your security; you had to do background checks on your clients before you saw them to assess the potential risk they could be to you as a therapist as well. (Palesa, p. 2, para. 4)

“Kelly” also expressed a safety concern regarding therapy with offenders, stating, “Firstly, sometimes you had to have your door open because of seeing a dangerous individual” (Kelly, p. 3, para. 7). She further expressed her discontentment with therapy within a prison environment because “[i]t’s really not a safe environment to see people for growth purposes” (Kelly, p. 3, para. 7). Contrary to the views of the other participants, Kelly expressed the feeling of being coerced into conducting therapy within this environment, believing that it was not conducive to helping offenders. Rasskazova et al. (2016) state that coercion can lead to feelings of alienation towards the self.

According to Deci and Ryan (2000), studies have indicated that rewards and choice affect intrinsic motivation, which has a further influence on creativity, cognitive flexibility and conceptual learning. Participants made certain decisions relating to their learning and thus, their growth as community-service clinical psychologists. Palesa (p. 5, para. 8) expressed that workshops provided during her community-service placement were not sufficient and declared, “It’s just a workshop on a specific topic, which I felt was not enough”. Bearing this in mind, she took responsibility for her own learning as evidenced by “[b]eing part of workshops that were specific to the environment. So now you’re more selective in terms of what you went to in order to be able to get better with your offender population” (Palesa, p. 5, para. 10).

Furthermore, field studies by Deci et al. (1989) indicate that autonomous support as opposed to control leads to positive outcomes such as increased intrinsic motivation and increased satisfaction and well-being. Regarding her learning, Mary indicated, “If you had interest in going to other opportunities, they were quite willing to try and find time to give to you to be able to go to other training opportunities” (Mary, p. 5, para. 8). Thus, Mary’s supervisors were willing to provide the time off from work that she required to undergo training related to her topics of interest, thus enabling Mary to increase her knowledge base. Mary further indicated the reasons for furthering her learning by saying,

The closer you got to the end of your comm serve where you would realise that after this you have to be on your own. And you have to work on your own. So we all started becoming more involved in training as we go along but it had to be your own responsibility. (Mary, p. 5, para. 9)

Similarly, Monique expressed that autonomous support was beneficial to her:

During my comm serve year, we were allowed to go on various CPD courses and things like that. So they made a lot of room for us with regards to [*sic*] our own professional development, which I also appreciated a lot. (Monique, p. 5, para. 11)

As opposed to the autonomous support that the abovementioned participants experienced, Kelly had a different experience:

Some of the others felt that it was a punitive situation where they would just, you know ... permanent staff telling you to ‘suck it up, this is how it is here. You’re not going to change the situation’ or something like that. So I think that really made it difficult. (Kelly, p. 7, para. 16)

According to Deci and Ryan (2000), strategies used in motivation, namely rewards and threats may have a negative effect on autonomy and lead to hindered creativity, decreased levels of intrinsic motivation and poor problem-solving skills. From this, it is

evident that it may have been difficult for Kelly to be creative at times due to the opinions of permanent staff members.

## **Relatedness**

### ***Support from Significant Others***

This sub-theme relates to an individual's desire to feel connected with other people. When an individual experiences support and care, it may have a positive effect on their intrinsic motivation and overall well-being. According to Ryan and La Guardia (2000), intrinsic motivation tends to increase when an individual experiences a sense of secure relatedness.

Palesa expressed that she felt a sense of support and a natural sense of connection with her fellow community-service colleague:

I had one more person who was at comm serve with me. It was just a mutual thing to gravitate towards one another. But I wouldn't say it was a conscious decision to say, 'I need to stick with her because we are in comm serve year'. It was just a natural thing. And the support was just given freely; I didn't have to ask for it or try to convince them to give that support or anything like that. (Palesa, p. 6, para. 12)

Sharon also expressed the feeling of being supported by her fellow colleagues and described this support as assisting her to cope with her community-service year:

And the other very helpful thing is we had a really nice team that worked with. We had supervisors; that was amazing and you could just fall in. If it was just to vent or let's think of creative ways of helping. Or you know what, you need to let go; you can only do so much. It was very helpful. (Sharon, p. 3, para. 5)

Mary described her feeling of support as one that prevented from her experiencing feelings of isolation. She, therefore, felt connected with her fellow colleagues, which was expressed by the following:

Because we drove together in the same car, so we built quite good relationships and then there was [*sic*] also, for example, community-service doctors that also for them, it is a new experience. They are also there for only one year or a community-service dietician, also there for one year. So it was quite a nice experience, feeling supported by each other because I think it is the group setting of having to drive together so we weren't isolated in that sense socially. (Mary, p. 7, para. 13)

Whereas some participants felt a strong sense of support from their colleagues, others such as Monique and Kelly felt a strong sense of support from their significant others. Monique described that her significant other understood her journey from his own experience and was thus able to provide the necessary support for her. She described this by saying, "And especially with regards to [*sic*] my husband, already being through such a process, it was still easy to connect with him because of his previous experiences" (Monique, p. 3, para. 7). In addition to the fact that she received support from family and friends, Kelly affirmed that the support from her significant other contributed to her resilience, "Friends and family, and I got married so I think I had a lot of other things keeping me busy and also assisting in my resilience to go through that year" (Kelly, p. 7, para. 16).

According to Ten Cate et al. (2011), isolation, exclusion and a lack of support can lead to feelings of disconnection from others. In contrast to feeling supported, this was what Kelly experienced in terms of support from her superiors: "I didn't feel that I had adequate, uhm, support from the, let's call it the, like the, uhm, superior psychologists – permanent staff psychologists" (Kelly, p. 4, para. 8). She added, "[N]ot even peer, peer supervision or peer support was available". Kelly continued,

[I]n terms of peer supervision and working with the senior psychologists, I think at the very end, some people, some of my peers in the same situation as I was felt that it

was worse than I did. And I think maybe because each person to themselves and you need to then find back up resources. (Kelly, p. 7, para. 9)

### *Interactions with Others*

Relatedness is experienced when individuals feel a sense of support and a sense of being cared for by those around them and vice versa. This sense of connectedness applies to both significant others and members of the person's community (Ten Cate et al., 2011).

Palesa experienced a sense of support from a senior psychologist and expressed the following:

The best thing is not to compromise your client. Do what's best for them as well. And you also talk to other psychologists; we also had a director at Head Office who was also a psychologist. He was also quite academic. So you're able to have these discussions with him and work around the issues and find a solution. (Palesa, p. 3, para. 6)

Sharon felt a sense of support from other colleagues:

We were quite lucky; we worked with the community service medical doctor that had a little bit more knowledge and information of psychiatry. We had a psychiatrist that would come in once in a while, and even that was very, very limited. (Sharon, p. 2, para. 4)

She indicated that the support was helpful:

And the other very helpful thing is we had a really nice team that worked with. We had supervisors; that was amazing and you could just fall in. If it was just to vent or let's think of creative ways of helping. Or you know what, you need to let go; you can only do so much. It was very helpful. (Sharon, p. 3, para. 5)

Monique recalls:

As I mentioned earlier, that the team that I worked with, which was very supportive. And when I refer to the team, I don't only mean my colleagues. I mean my supervisors, the, uhm, administrative staff, the doctors that we had to work with, the nurses, even the porters and things like that. It was a very, uhm [sigh] – How can I say it? It was actually light, nice, supportive environment. (Monique, p. 5, para. 10)

Chantelle also expressed that she had debriefing sessions with her fellow colleagues and this contributed to her coping well with her community-service year. She mentioned, I think I had a very good support structure at work but also at home with my family. If it weren't for them, it would've probably been tough. But nothing specific in terms of professional help or anything like that, but a lot of debriefing, a lot of support from family and a lot of down-time. (Chantelle, p. 1, para. 3)

Mary had a different experience regarding support within her working environment because she did not feel part of a team. She expressed this by saying,

I think in any work situation, you want that sense of acceptance working with other people of the team. I think, uhm, what was lacking for me in Thaba Nchu is that we as psychologists didn't sit around as a multiple, multi-professional team. We didn't have team rounds specifically with patients. So the doctors, for example, have their own meetings but we were not included in that. So we were ... you kind of saw your patients on your own and there was no communication really between the different disciplines. (Mary, p. 6, para. 12)

## **Competence**

### ***Learning Experiences***

The SDT defines competence as the need to master one's environment and to develop a new set of skills (Van den Broeck et al., 2016). Mastering one's environment is achieved through learning and that is how this sub-theme relates to competence. Van den Broeck et al.

(2016) add that an individual's need for competence stems from the need to explore one's environment and to seek out challenges actively.

Rodolfa et al. (2005) indicate that competency does not only equate to possessing knowledge but in order for competency to exist, it also requires individuals to use their critical thinking and decision-making skills. A lack thereof may result in the skill being lost or never attained.

Due to working in an environment that she was not necessarily trained in, Palesa expressed that she lost certain skills and learnt new ones. She expressed this as follows:

I think as a person, I lost that skill on conducting assessments. Although we do conduct assessments, but it's different; it's parole assessments. It's specific to the environment, whereas in M1, I was not taught how to do parole assessments. So I had to learn something new, but I lost other skills like your scholastic assessments and other psychometric tests that we used to use in M1. (Palesa, p. 3, para. 7)

Palesa continued, "So there's lots of learning but it's specific to that environment. So a lot of learning and unlearning of other stuff or let me rather say, you don't use some of the other stuff that you gained" (Palesa, p. 4, para. 8). Mary also expressed a gap within her learning due to the lack of psychometric assessments: "We could not do any psychometric assessments and you could not, there was no ... nothing was for the children specifically" (Mary, p. 4, para. 9). Kelly expressed that her learning gap resulted in a lack of exposure to different psychiatric conditions. She expressed concern regarding this because as a community-service clinical psychologist, exposure to different kinds of conditions is important in the workplace. Kelly expressed her concern by saying, "Also you are not really exposed to many different psychiatric conditions. It's mostly substance abuse and psychosis due to substance abuse. And anti-social behaviour" (Kelly, p. 2, para. 4).

Competence includes applying one's knowledge and adequately managing the demands of one's working environment (Winterton et al., 2006). Thus, not receiving adequate exposure to other psychiatric disorders could have possibly led to feelings of incompetence for Kelly.

### ***Resource Availability***

This sub-theme relates to competence because having access to certain resources helps with learning and eventually, environmental mastery. A lack of these resources can lead to challenges in feeling competent. Three participants indicated challenges such as the lack of office space and psychometric assessments. Palesa found the lack of certain physical resources such as office space to be arduous. She explained that she shared an office with other psychologists and, therefore, had to arrange to see clients in other areas. This led to a high level of frustration. She also mentioned the lack of psychometric assessments, which is a necessary tool in her line of work:

In terms of psychometric tests, we didn't have any. So you had to use other means if you wanted to do assessments or anything else. So you had to be creative to work around that. So resources, plus it's a government department, certain things were not in place. (Palesa, p. 2, para. 5)

Sharon also indicated the lack of office space and psychometric tests as a challenge:

I think at some point, in the beginning, there was even just things like office space but that got better. And even if you looked at the clinics that you would give an outreach, there would be limited space. So yes, psychometrics. (Sharon, p. 2, para. 3)

Lastly, Mary shared the following:

I think the facilities at the hospital as well. We didn't have, uhm, when I went there, there was another permanent clinical psychologist and she ... we had to share an office. And then at certain times when we both had patients, we had to, uhm, I used to

use an office that was across, next door. Well, it's not actually an office; it was just with beds and things like that. So you had to put chairs in there. (Mary, p. 2, para. 3)

Another resource that was important to the participants was that of either being able to communicate with clients in their mother tongue or having access to a translator. Whereas Chantelle expressed that she could effectively communicate in her client's language because she had learnt it previously, Sharon expressed certain challenges regarding this issue. As Chantelle commented,

But I also think in terms of population, *ja*, uhm, if you don't speak Tswana, obviously that would be a problem. I had to learn [giggles], but I think because at our hospitals here, your majority of your population are black South Africans so if you can't speak their language, I think it is an issue. And I do think people would prefer to have therapy in their mother tongue; it makes them more comfortable. So in [*sic*] would say you have to at least make an effort to learn their language or to try to help them somehow. (Chantelle, p. 4, para. 7)

According to Sharon, language was an obstacle that affected her therapeutic processes:

I think language was a very big barrier. It was a community that there was very little of English-speaking. There was a lot of Setswana-speaking and a lot of Afrikaans-speaking. You got to a point where you would pick up words. (Sharon, p. 6, para. 11)

Despite other challenges, for Sharon, having access to other medical professionals, for example, psychiatrists, was a valuable resource. She said, "You would have them referred to the psychiatrist and get all the right medication. And you would see that shift, the marks improving and an actual difference that you are able to make" (Sharon, p. 6, para. 10). This

had a positive effect on her therapeutic processes because she had the resources that she needed.

### ***Capabilities***

Capabilities include the ability or knowledge that an individual possesses. The term ‘capabilities’ relates to competence in that it refers to one’s skills and abilities.

The lack of certain resources resulted in Sharon feeling that she could only conduct a limited amount of work with her clients. Despite this, Sharon made use of the skills that she had, and she felt that she had made a difference. She expressed this by saying,

So I think there were cases where you could truly feel that efficacy and that carries you through often. But feeling, ‘I know that I have made a difference and that I have helped someone’ and others where you just know there is nothing you can truly do, you don’t have the resources to help. (Sharon, p. 6, para. 10)

Monique expressed that despite the difficulties she experienced, she still felt capable of helping her clients:

So if I put my head on something, I figure a way out to get it done. So when I got things done, sometimes I felt as if I wasn’t able to do it to the best of my ability due to the lack of resources. But nevertheless, I felt that even if I got a little bit done, compared to doing nothing, [I] was fine with that. (Monique, p. 4, para. 9)

### ***Environmental Mastery***

According to Deci and Ryan (2000), intrinsic motivation is the tendency to seek challenges, to learn, to explore and to gain mastery. In considering the need for competency, environmental mastery is relevant since it contributes to the sense of having control.

Monique felt that she was able to navigate her way through her community-service year and was able to become creative. She said, “So for most of the time, I felt like I knew what was expected of me, yes. But there were some days or some incidents where I just had

to think on my feet” (Monique, p. 6, para. 14). Thorough preparation helped Chantelle feel a sense of mastery over her environment because she knew what to expect and knew the people to contact when requiring assistance. She expressed this by saying,

But I also knew what kind of patients to expect coming in to the department. So you can't really prepare exactly in terms of therapy when you're sitting with that patient but at least it did give me an idea of more or less what was going on, what kind of patients, what kind of environment but also how to work closely with other people in different departments. (Chantelle, p. 6, para. 11)

Palesa eventually started to become comfortable with her role as a community-service clinical psychologist and began to feel a sense of mastery over her environment. She expressed this by saying,

With comm serve, there were challenges but they were not extreme and I was able to work through them, which gave me confidence as well to say: 'I can do this' because it was a different environment. But I adapted in a couple of months, and I was like, 'Okay, I can do this'. Then, I just pushed through it because it was just a matter of months, then you get your qualification. (Palesa, p. 8, para. 14)

Mary also felt a sense of mastery over making presentations. This had previously been a problem for her due to social anxiety. However, she managed to conquer this during her community-service year, as demonstrated by the following:

And I think what actually also helped me personally with was, uhm, social anxiety, being able to speak in front of groups of people and working in clinics and also seeing yourself like that. So that was a personal thing that I, that I ... that I gained. The experience of being there. (Mary, p. 8, para. 15)

**Conclusion**

This chapter reviewed the themes that were generated from the transcribed interviews with the participants. The themes were interpreted within an SDT framework, particularly regarding the three psychological needs of the participants (Deci & Ryan, 2000). The themes were backed by direct quotations from the participants taking part in this study.

## **Chapter 6: Discussion of Results, Implications and Limitations of the Study and Recommendations for Future Research**

### **Introduction**

With the aim of this study in mind, an integrated discussion of the results is presented. Participants reflected on their experiences as community-service clinical psychologists and how they remained motivated to complete the year successfully despite numerous challenges. Their reflections related to the three needs of the SDT, and the main trends within these themes were identified.

Chapter 6 also discusses the implications and limitations of the study and provides recommendations for future research.

### **Main Trends in the Results**

“Personal growth” was a trend across the themes, with participants expressing that they discovered additional qualities about themselves. This discovery stemmed from introspection and the feedback that was received relating to the participants’ environment. Personal growth was evident by the participants’ ability to be creative in situations they deemed challenging. Participants worked through multiple frustrations such as the unavailability of important resources. The effort that participants made regarding their own learning is prominent across the themes and relates to the concept of personal growth. Despite the fact that community-service placements did not provide formal training opportunities, participants took responsibility for their own learning. This effort to learn fostered environmental mastery, further contributing to their motivation.

More specifically, pertaining to the need for relatedness was the importance of “group dynamics with colleagues”. Most participants felt a sense of connection with their colleagues. This connectedness was not only related to their fellow community-service clinical psychologists but also to other professionals. Colleagues provided emotional support such as

debriefing sessions, peer supervision and serving as translators. Because therapy is usually on a one-on-one basis with clients, the support from colleagues helped in reducing feelings of isolation. In recognising the important role of others, the participants mentioned a number of relevant coping strategies. Coping strategies such as spending quality time with friends and family and engaging in activities not related to community service were reported. When feeling unsupported by supervisors in terms of supervision, another coping strategy of participants was to find support outside their work environment. This coping strategy could be said to promote a sense of autonomy since participants took responsibility for their own supervision. Furthermore, this coping strategy contributed to feelings of relatedness to other healthcare and mental healthcare practitioners. Brainstorming solutions to challenges with supervisors and other colleagues assisted in their engagement with others. Furthermore, positive feedback from supervisors led to participants feeling supported and contributed to their personal growth as community-service clinical psychologists.

The last major trend across the themes was “self-awareness”, which can be described as a driver of the participant’s personal growth processes. Lou et al. (2017) and Bahrami et al. (2010) posit that self-awareness allows for the transmission of information used for self-monitoring. Self-monitoring, also known as meta-cognition, assists individuals in consciously controlling their behaviour and adjusting their worldly experiences accordingly. Self-awareness allows individuals to gain a better understanding of their personality, needs, wants, goals and identity (Ziaei et al. 2018).

It can be hypothesised that the self-awareness of the participants was a contributing factor in conducting a realistic needs analysis. With this in mind, some participants were aware of gaps within their learning. Awareness of these self-identified gaps led to steps being taken to attain the necessary knowledge. Awareness of the lack of certain resources led to participants becoming creative. Creative solutions were generated to ensure that they

delivered a good service to their clients and achieved their goals. Making alternative plans to overcome challenges such as the lack of office space or the existence of language barriers provided participants with a sense of environmental mastery. The lack of resources did not hinder the participants from playing their roles. This further contributed to a sense of self-confidence and positive self-talk.

Lastly, Richards et al. (2010) reported that self-awareness has positive consequences because it has a significant positive relationship with self-care. These researchers further stated that self-awareness helps individuals realise what is important (Richards et al., 2010). Therefore, self-awareness may be viewed as the vehicle for the growth that participants experienced in all three themes.

### **Were the Three Psychological Needs Met?**

With the main trends in mind, it is important to discuss how the three psychological needs were (fully or partially) fulfilled. Regarding autonomy, participants felt that they pursued the year mainly through a personal decision and choice because it was a step closer to their goal of qualifying as a clinical psychologist. In terms of relatedness, participants identified social support from family, friends and colleagues as motivation to persevere despite the challenges they faced. Additionally, a sense of relatedness contributed positively to their well-being and enabled further pursuit of their goals. Participants faced challenges such as the lack of certain resources during their community-service year. Despite not having access to these resources, they took the initiative and became creative, and this contributed to their sense of competence.

By satisfying all three needs, the SDT supposes that an individual will be intrinsically motivated (Deci & Ryan, 2000). Kruglanski et al. (2018) view intrinsic motivation as the “relation (or fusion) between any goal and the activity meant to serve it” (p. 167). From this

definition, it can be hypothesised that the goal of becoming a clinical psychologist and the activities meant to serve it (e.g., community-service psychology) are related.

When the participants experienced a sense of security in what they challenged themselves to do, it contributed to their intrinsic motivation. Statements from participants demonstrated that they felt supported from those around them, and this contributed to the sense of relatedness.

It can be hypothesised that the participants of this study had all three of their basic psychological needs partially met. According to Hardre and Reeve (2003), individuals tend to persevere through challenging circumstances due to intrinsic motivation, and it is through having all three psychological needs met that all the participants managed to complete the community-service year successfully.

### **Are There any Other Explanations for Participants' Motivation?**

Human motivation can be viewed through a variety of lenses. It is, therefore, important to explore possible explanations for the successful completion of the community-service year despite partially met psychological needs. According to Lewin's (1939) Field Theory, there are three factors that influence individuals' motivational force to reach their goals. These factors are (a) the magnitude of the need, (b) the properties of the goal object, and (c) the psychological distance the person is from the goal. Despite multiple challenges faced by the participants and the partial fulfilment of the three psychological needs, they remained motivated. According to the Field Theory (1939), it can be hypothesised that the participants' need to fulfil their goals of completing the community-service year was great. This was because the completion of this community-service year was the last step to becoming an independent practitioner. There was a certainty that each participant had, which was the fulfilment of the role as a community-service clinical psychologist for a period of 12 months before fully qualifying as

an independent practitioner. Additionally, the sacrifices made by the participants in their journey to becoming independent practitioners further motivated them to persevere.

Vroom's (1964) Expectancy-Valence Theory also supports the hypothesis that participants persevered and completed their community-service year despite numerous challenges. This theory proposes that individuals act in certain ways because their behaviours may lead to expected results. Porter and Lawler (1968) built on Vroom's (1964) Expectancy-Valence Theory and proposed that environments that consist of both intrinsic and extrinsic rewards lead to higher satisfaction. In this study, intrinsic rewards were described as goal attainment and personal growth, whereas extrinsic rewards were described as the completion of community service and hence qualifying as a clinical psychologist. Therefore, higher satisfaction is relevant to the results of this study since it contributes to the reasons why community-service clinical psychologists managed to complete their community-service year successfully.

Lastly, the drive to complete the community-service year can be explained with Atkinson's (1964) Theory of Achievement Motivation. This theory proposes that an individual's need for achievement stems from the conflict between striving for success and avoiding failure. The journey to becoming a clinical psychologist has been described as lengthy and challenging and hence, the perseverance for success.

### **Implications for Practice Resulting from this Study**

This study highlighted the experiences of community-service clinical psychologists. The research findings can be used by higher education institutions, community-service institutions and prospective community-service clinical psychologists. The study highlighted the challenges experienced by these psychologists, and relevant institutions should be motivated to address these challenges accordingly.

This study provides prospective community-service clinical psychologists with an idea of the challenges that they may experience and suggests ways to overcome these challenges. Previous community-service clinical psychologists can instil hope and motivate those who plan to become clinical psychologists.

Earlier studies on intrinsic motivation and the current study have shown how valuable it is in the pursuit of attaining certain goals. Intrinsic motivation serves as a valuable source of motivation that can be applied in different contexts.

### **Limitations of the Study**

A number of limitations must be considered. Participants were purposefully sampled, resulting in only two participants willing to participate. The sampling procedure was subsequently changed to snowball sampling, which yielded an additional four participants. Therefore, this study resulted in a small sample size. There was also a lack of male participants in this study. Possible male participants were approached for this study; however, they declined to participate. Although this study was not meant to be sex specific, their input would have contributed to the generalisability of the study to community-service clinical psychologists.

Furthermore, the researcher was a novice in conducting research interviews. The researcher was aware of this and made an effort to read more on conducting research interviews. Despite this effort, the researcher could have probed more to illicit more information from the participants. Lastly, a focus group could have been a beneficial addition to the study since it would have served as a collective voice from community-service clinical psychologists.

### **Recommendations for Future Research**

It is recommended that this research is replicated on larger participant samples across the country and including both genders in order to obtain a more accurate view and

representation of the experiences of community-service clinical psychologists from a self-deterministic perspective. Focus groups could also be used in order to illicit the collective voice for community-service clinical psychologists, and the ways of coping could be explored within these groups.

From the research findings of the study, it would be beneficial to probe deeper into the processes of motivation used by these community-service clinical psychologists in coping with certain challenges. Sharing these processes of motivation could help in adjusting the negative attitudes that some individuals have towards community service. It is also worth exploring the motivation of community-service clinical psychologists when their basic psychological needs have been met.

### **Personal Experiences of the Researcher**

The researcher investigated the personal experiences of community-service clinical psychologists, which was a topic she had never explored before. A number of individuals expressed negative experiences regarding the compulsory introduction of community service in South Africa. The reasons for the successful completion of this compulsory community service, therefore, became an area of interest.

Furthermore, the study led the researcher to individuals who had endured difficulties in the pursuit of becoming a psychologist in South Africa. The researcher could relate to some of the participants' experiences, such as the difficulty of working in an environment far from home and completing one more year of working before qualifying as a psychologist. These experiences served as motivation for the researcher to persevere. This study also assisted the researcher in becoming more self-aware in order to identify her own needs, wants and aspirations regarding her career in psychology.

## **Concluding Remarks**

Chapter 6 focused on the integrated discussion of the results, the implications and the limitations of the study together with recommendations for future studies. The aim of the study was to explore and describe the experiences of community-service clinical psychologists from a self-determination perspective. A qualitative multiple-case design was used to collect data based on the experiences of the participants. Data were collected through semi-structured interviews. Participants' experiences were transcribed by the interviewer and investigated through the lens of the SDT. There was evidence of the three needs, namely autonomy, relatedness and competency (Deci & Ryan, 2000), although the needs were only partially met. By having some of their needs met, participants managed to persevere. Intrinsic motivation, therefore, allows for persistence despite challenges (Hardre & Reeve, 2003).

This study demonstrated that despite the challenges experienced by community-service clinical psychologists, they still managed to complete the year successfully. These research findings, therefore, have important implications for prospective community-service clinical psychologists in persevering despite hardship. The researcher hopes that the findings of this research will contribute knowledge regarding the journey to becoming a clinical psychologist in South Africa. Furthermore, the researcher hopes that more South Africans will pursue psychology degrees in order to provide the much-needed mental health services in the country.

In conclusion, in order to persevere in challenging situations, an individual must have intrinsic motivation. The research participants' successful completion of their community-service year can be used as evidence for this conclusion.

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## Appendices

### Appendix A: E-Mail Advertisement

Research participants

Inbox x



nicollette utloa <nicolletteu20@gmail.com>

Jan 9, 2020, 11:27 AM



[Redacted]

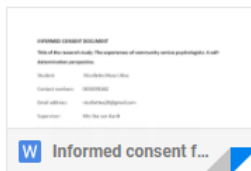
Good day

I am an M1 student at The University of the Free State. I am currently busy with my research study (The experiences of community service psychologists) and in need of research participants. The inclusion criteria is as follows: any clinical psychologist who completed community service between 2015-2017.

The interview is semi-structured in nature and can be conducted via Skype. The approximate length of the interview is 30-45 minutes long. More information is contained in the attached informed consent form.

Kind regards

Mosa Utloa



## Appendix B: Ethical Clearance Letters



Faculty of the Humanities

29-Nov-2018

Dear Miss Utloa

**Ethics Clearance: The experiences of community service psychologists: A self-determination perspective.**

Principal Investigator: Miss Nicollette Utloa

Department: Psychology Department (Bloemfontein Campus)

### APPLICATION APPROVED

With reference to your application for ethical clearance with the Faculty of the Humanities. I am pleased to inform you on behalf of the Research Ethics Committee of the faculty that you have been granted ethical clearance for your research.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2018/1422**

**This ethical clearance number is valid for research conducted from 29-Nov-2018 to 29-Nov-2019.** Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the ethics office to ensure we are kept up to date with your progress and any ethical implications that may arise.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. Asta Rau  
Chair: Research Ethics Committee  
Faculty of the Humanities

Dekanskantoor: Fakulteit Geesteswetenskappe  
Office of the Dean: Faculty of the Humanities  
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**GENERAL/HUMAN RESEARCH ETHICS COMMITTEE (GHREC)**

03-Mar-2020

Dear Miss Utloa, Nicollette NM

**Continuation/Report Approved**

Research Project Title:

**The experiences of community service psychologists: A self-determination perspective.**

Ethical Clearance number:

**UFS-HSD2018/1422/2702**

We are pleased to inform you that the application to extend your ethical clearance has been approved. Your ethical clearance is valid for twelve (12) months from the date of issue. We request that any changes that may take place during the course of your study/research project be submitted to the ethics office to ensure ethical transparency. Furthermore, you are requested to submit the final report of your study/research project to the ethics office. Should you require more time to complete this research, please apply for an extension. Thank you for submitting your proposal for ethical clearance; we wish you the best of luck and success with your research.

Yours sincerely

**Prof Derek Litthauer**

**Chairperson: General/Human Research Ethics Committee**

Digitally signed

by Derek

Litthauer

Date: 2020.03.03

09:30:04 +02'00'

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## Appendix C: Interview Schedule

### Identifying particulars (For researcher only)

- Name and Surname
- Age
- Sex
- University of study
- Internship site and year

### Questions for semi-structured interview

1. Reflect on your community service year
2. Did you experience any challenges during your community service year and what were they?
3. What was positive about your community service year?
4. Were there any training opportunities to improve your skills?
5. Did you feel that you knew what was expected of you during community service?
  - If not, did you do something about it?
  - If you did, what influence did that have on you?
6. Did you have a support structure and what influence did that have on your community service year?
7. Did you feel the need to be accepted by and connected to others during your community service year?
  - Why?
  - Why not?
8. Who did you feel the need to be connected to and why?
9. Which factors influenced you to complete your community service year?

## Appendix D: Consent Form Example

### INFORMED CONSENT DOCUMENT

**Title of the research study:** The experiences of community service psychologists: A self-determination perspective.

**Student:** Nicollette Mosa Utloa

**Contact numbers:** 06558391682

**Email address:** nicolletteu20@gmail.com

**Supervisor:** Dr ~~hooj~~ Nel

**Co-supervisor:** Mrs lise van ~~Asot~~

You are invited to take part in a research study that forms part of my Masters in Counselling Psychology degree. Please take time to read the information presented here, which will explain the details of my study. Please ask me, Nicollette Mosa Utloa, the researcher, any questions about part of this study that you do not fully understand. It is important that you are fully satisfied and that you fully understand what this research is about and how you may be involved. Also, your participation is entirely voluntary and you are free to withdraw at any time.

### What is this research study about?

The objective of this study is to explore and describe the experiences of previous community service psychologists who completed their community service year between 2015 and 2017 through a self-determination perspective. The self-determination theory (SDT) has been widely used in research and it is thus an applicable theoretical model to utilize for this research as it serves as a method of exploring both motivation and coping processes during the community service year of clinical psychologists. Given the rationale, SDT also creates structure for this research as the focus is on the experiences of community psychologists and how they are coping.

### Why have you been invited to participate?

You have been invited to be part of this research because your experiences of your community service year will be of value for others who will also undergo community service. The information obtained from this research study can also be of value to the Department of Health by allowing future clinical psychologists to be better equipped for their community service year. Furthermore, this study will add to research conducted through a SDT approach.

### What will be expected of you?

You will be expected to participate on a one-on-one semi-structured interview, by answering questions which will be asked by the researcher.

### Will you gain anything from participating in this research?

The gain for you in participating in this research is to contribute to a body of research regarding the self-determination theory and the experiences of community service psychologists. Further gains are contributing to the training of future community service psychologists to allow them to be better equipped for their community service year.

### Are there risks involved in you taking part in this research?

The risk to you taking part in this research is possibly expressing negative experiences that you may have encountered during your community service year. However, should you require a debriefing session, a psychologist has been appointed in order to assist. The appointed psychologist for debriefing sessions is Mrs Eloise Venter. Her contact details are as follows:

Telephone number: 051 011 0082

Email address: eloiseventer.therapy@gmail.com

### How will your confidentiality be protected?

Anonymity of your findings will be protected by assigning you with a pseudonym. Your privacy will be protected by conducting the interview in a private office. Only the researcher and her assigned research supervisors will be able to look at your experiences. Experiences will be kept confidential by locking any hard copies as well as electronic data in the researcher's private office. Electronic data will also be password protected. As soon as data has been transcribed it will be deleted from the recorder. Data will be stored for a period of 5 years.

**Will you be paid to take part in this study?**

No, you will not be paid to take part in this study because the research is self-funded and there are therefore no funds for remuneration of participants. Travel expenses will be paid for by the researcher and there will therefore be no costs involved for you as the participant.

You will receive a copy of this informed consent form for your own purposes.

**Declaration by participant**

By signing below, I ..... agree to take part in the research study titled: **The experiences of community service psychologists: A self-determination perspective.**

- I declare that:
- I have read this information.
- The research was clearly explained to me.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to withdraw from the study at any time.

Signed at (place) ..... on (date) ..... 20<sup>th</sup>.....

Signature of participant

Signature of witness

**Declaration by researcher**

I Nicolette Mosa Utlea declare that:

I explained the information in this document to .....

- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them or I was available should he/she want to ask further questions.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.

Signed at (place)..... on (date).....20.....

Signature of researcher

Signature of witness

## Appendix E: Transcribed Interview Excerpts

### Palesa (Participant 1)

R: Good morning participant 1, my name is Mosa.

P1: Good morning.

R: I am going to be transcribing this research myself so I will leave out your name and personal details.

P1: Okay

R: Okay so we can start now. What year did you do your M1?

P1: I did my M1 over a period of two years, in 2013 and 2014.

R: Okay

P1: Because in 2013 I had to stop and then I continued in 2014.

R: Okay and where did you do your M1?

P1: I did it in the University of the Free State.

R: Okay. And your internship placement after that? Was it then in 2015?

P1: Ja, in 2015 at the Three Military Hospital in Bloemfontein.

R: Okay, and where did you do your comm serve?

P1: I did it at Johannesburg Prison.

R: In 2016?

P1: Ja, in 2016.

R: Okay, right and how old are you?

P1: I am 28.

R: Alright, well we can move over to the questions.

P1: Okay.

R: Uhm, so basically these questions are now stemming from uhm your comm serve year. And so the first question would then be: Describe for me the challenges you experienced during your comm serve year.

P1: Okay. First it was the environment, it was totally different to what I was used to because at Three Military Hospital it was more of like a hospital set up, psychiatric ward and all different types of wards that would provide uhm, psychological services too. But now it was a prison environment where your primary clients are offenders. So it's quite a different environment because it's a security environment where you work with, uhm, sometimes with the most dangerous criminals. You have to provide therapy for them and being there. According to policy, you're supposed to have your prison warders outside your therapy room or inside the therapy room depending on the risk. But because of the challenges that they experience themselves...

R: Yes?

P1: It was difficult to implement that. So they would give you an offender and be left with that offender on your own while providing therapy. So you had to adapt to that environment. Certain things were not allowed. You had to be more cautious as well in terms of your security, you had to do background checks on your clients before you saw them to assess the potential risk they could be to you as a therapist as well.

R: Okay. And then did you have any other challenges, for example, language difficulties or you know barriers in terms of the equipment that you would have to use or anything like that? Stationery? Uhm I know that security was often a concern, so that was a challenge. But did you have any other challenges?

P1: Ja, in terms of the resources, they were very limited. In terms of psychometric tests, we didn't have any. So you had to use other means if you wanted to do assessments or anything else. So you had to be creative to work around that. So resources, plus it's a government department, certain things were not in place.

R: Certain things like what?

P1: Certain things like office space, you had to share office space because at the military immediately when you came through, you had your own office. But there, you had to share an office with somebody else, other psychologists as well. And also, being there, because most of them it's not an academic institution so everyone works independently but at least you're able to give each other peer supervision. But basically when you get to your comm serve, you realize that you're on your own. And the environment is quite different in the sense that it is not an academic environment, whereas in your internship, you still had to do academic work. You were involved in academic workshops whereas with them it was more environment specific. Even the workshops they provided, I wouldn't even say it's workshops because we'd have case conferences where they presented different cases from different prisons. Then we would all gather and just work around that case or just to see what happens in other prisons as well.

R: Okay, alright. And then any language barriers that you experienced or not really?

P1: No, I didn't have any language problems.

R: Okay.

P1: And I think also the policy as well because they have their own policy, the Correctional Services Policy versus our policy at times. Now concerning the issue of confidentiality because now if a prison warder or official is to sit in your session then confidentiality is compromised. But then again you have to weigh the options. Do you risk yourself as a person or it has to be confidentiality. So it's those kind of ethical dilemmas that get into place. Ja.

R: And how would you deal with that?

P1: The best thing is not to compromise your client do what's best for them as well. And you also talk to other psychologists, we also had a director at Head Office who was also a psychologist. He was also quite academic. So you're able to have these discussions with him and work around the issues and find a solution.

R: And so basically challenges of having your resources limited, for example, psychometric assessments. You say that you would have to get creative. What kind of creative measures would you take?

P1: You would have to rely on your clinical observations most of the time and you had to see people over a long period of time. You rely on collateral information from officials, families and all those people. So when you work with a client, you don't just rely on what they give you as well, you have to find ways, protective measures. Certain things you will just have to get from whatever you're given in the end to use in that set up.

R: Okay, and do you think there's a gap between newly qualified graduates' skills and the availability of resources to enable them to practice their skills?

P1: Uhm, yes. Because I think as a person I lost that skill on conducting assessments. Although we do conduct assessments but it's different. It's parole assessments, it's specific to the environment, whereas in M1 I was not taught how to do parole assessments. So I had to learn something new but I lost other skills like your scholastic

assessments and other psychometric tests that we used to use in M1. Because in that environment they didn't have the test batteries and ja, it was difficult also securing those as well.

R: In terms of... Because if you had to get them from somebody else, you'd probably have to pay for the tests and stuff? So that was rather a challenge?

P1: Ja. And I think also you had to rely on yourself a lot because when you get to your comm serve, everyone there just assumes that you're independent you're, fully qualified. You can do things yourself and at the time when I went into the prison, we didn't have a principal psychologist. So it was just independent psychologists. You come in there, you're a comm serve, they do their own thing as well. So you had to adapt, learn new things as well. Like I had to learn to do a parole assessment when I was there. How to write forensic reports. That is specific to that environment. So there's lots of learning but it's specific to that environment. So a lot of learning and unlearning of other stuff or let me rather say you don't use some of the other stuff that you gained.

R: And you end up losing that skill?

P1: Yes.

R: So in terms of having to learn new things, who helped you in that process of learning how to write parole reports and uhm, you know, forensic reports. How? Who helped you with that?

P1: Okay, we had one psychologist who was like the longest in the department. She was able to provide us with guidelines to say this is how we do it. But essentially, you had to make some of the calls. But she was always there to provide a supportive role.

R: Okay. And you say that you were sort of provided with training opportunities, uhm but they weren't formal, or did I misunderstand you?

P1: Ja, not really like formal, like training for a specific thing like you would get in M1. Like you would have a week where you are being taught maybe how to do CBT for example. Uhm, with them it was the PsySSA conference that you attend annually. And with the PsySSA conference, it's not really training because you get to sit and listen to someone's research paper and their findings, that sort of thing. Then you'd have your case conferences whereas they'd tell you "this is my client, this is what I did with my client", so it's not really training if I think about it. If you wanted something specific, you had to go register for a specific course to get that skill that you want.

R: And pay for it yourself?

P1: Mostly, because the first year, they paid for Vista Academy in Pretoria where you could go for workshops but even with that, with Vista, I think Vista is a workshop where you sit for like 3 hours or so. So you could narrow on a specific topic. Say for example they are talking about suicide. They give research, what they do, that specific individual, that's it. So it's not like extensive training. Ja, it's just a workshop on a specific topic, which I felt was not enough.

R: Okay, so you would just gain what you gain from it but it wasn't, you know, so enriching as workshops compared to those in M1 for example?

P1: Yes.

R: Okay. Alright. Did you ever take responsibility for your own training opportunities?

P1: Yes, yes definitely. By being part of workshops that were specific to the environment. So now you're more selective in terms of what you went to in order to be able to get better with your offender population. So it was just that being selective in saying "okay, I'll go to this one or this one is specific". And also bringing it up to the attention of the people in charge to say "this would benefit us if we went to this workshop because it speaks to our type of work we do".

R: Okay and did they provide, you know, the resources for you to get to those training opportunities or was it your responsibility?

P1: Sometimes they would but because it's a government department, they would tell you resources are limited or it's not in the budget that was given. Maybe try in another financial year. But in terms of time-off, they never gave us a choice. If you wanted to go away for training, they would allow you.

R: Okay. And what other autonomous acts did you do to ensure that you completed your year successfully?

P1: Uhm, lots of research, going back to your.. to the books that you had in M1. Some of them, like forensic stuff, you had to now go into that field and learn more because in M1 they teach you everything but they don't sit for a very long time, they have to cover other topics. So for a prison environment, now your attention has to be now on the forensic side of things.

R: Okay. And then also when interacting within the community service environment, did you feel a sense of efficacy in producing the desired outcomes?

P1: In the beginning it was difficult, but over time, the more you did something, then you'd feel confident that "okay now I am getting it right". From time to time, give the long-standing psychologist our reports to read through them and provide guidance. Then she would help us through. But towards the end, I felt more confident in the environment because I still work at Correctional Services.

R: Okay. So in the beginning it was just a bit difficult, you didn't feel very confident in what you were doing because you were still adjusting to a new environment?

P1: Yes, but it was only for specific tasks. Not everything because therapy, it was okay with therapy because it's the same everywhere. But in terms of like your assessments. Group programmes, we didn't have lots of group programmes but the ones that were given were like straightforward. We could implement them with ease.

R: Alright. And then also, did you feel the need to be accepted and connected to others during your community service year?

P1: Connected in terms of like uhm M1 or internship?

R: No. Your comm serve. Was there anyone that you like, for example, if you guys were like a group in the comm serve you know, within your institution, did you feel a need to be accepted by your peers or senior psychologists that were in your department or even your own family? Because I can imagine it was such a busy year. So did you feel the need to feel connected to people and who were those people?

P1: Okay, when I first got into correctional services, the treatment, we were like treated the same. Even with the independent psychologist. So there was no hierarchy or anything. So it felt like it was just a good fit because we connected with the people. Then I had one more person who was at comm serve with me. It was just a mutual thing to gravitate towards one another. But I wouldn't say it was a conscious decision to say "I need to stick with her because we are in comm serve year". It was just a natural thing. And the support was just given freely, I didn't have to ask for it or try to convince them to give that support or anything like that, ja. So the environment was, uhm, it allowed me to grow, be my own person without any judgment or anything like that. So I would say comm serve, that's where I found my identity as a therapist as well, where I felt comfortable. It was like more like a break where I could breathe whereas in internship, you constantly had to do things for your supervisor, try to impress them, constantly look "am I doing it right?" and all that. But in comm serve, it was totally different. We were treated as independent psychologists. They trusted our judgment so it was, ja, it was a good year.

R: Alright. And uhm, I think that's about it. Anything that you would like to add? Anything that you would like to help me see because I am a counselling psychologist intern so I'm now doing research on my fellow colleagues and I had no idea on what's happening in comm serve.

P1: 48 Internship, comm serve where you are placed. Then you also encounter a bit of anxiety towards the end to say "what's gonna happen with my career?". "Are they gonna employ me?", "where to?" because it's very difficult finding a job after comm serve. A lot of people find themselves at home for a couple of months. Luckily, I was only at home for like two months, then everything was fine. So uhm, I would say people must be strategic in terms of where they choose their comm serve, so that, say for example, you wanna go into a hospital set-up as an independent psychologist, rather do your comm serve in that set-up so that when you are there, you can make connections and ask them, or plead with them to headhunt you. Or so that they retain you and all that because a lot of comm serves that came after us had the same problem. Securing employment afterwards and

that's towards the end. It interferes with your well-being as well towards the end as well. But comm serve is basically more or less like an independent psychologist already. But when you go there, you don't think in that way. You still have the internship mentality. You think there's going to be guidance, there is going to be supervision.

R: Sort of a safety net?

P1: Ja, but it's like now you're on your own. So I think if people could prepare themselves in that manner to say "okay, I need to work independently now". Obviously you can always ask for supervision but have that in mind as well.

R: So now when we look at all the challenges that you experienced, what pushed you or what drove you to complete the year? Because M1 and internship, I can imagine it wasn't easy, so what pushed you to finish your comm serve because a lot of people just gave up on the way and just never finished. So what was your driving force? What were the factors that drove you to finish?

P1: I think in comm serve all the pieces came together and I was like: "oh, okay. This is the complete picture. Because internship was over. I felt like internship was like [sigh] when it ended. What a difficult part. Whereas with comm serve, there were challenges but they were not extreme and I was able to work through them which gave me confidence as well to say: "I can do this". Because it was a different environment but I adapted in a couple of months and I was like: "okay I can do this". Then I just pushed through it because it was just a matter of months then you get your qualification.

R: And who was your support structure?

P1: Definitely the other comm serve, I was doing comm serve with. Some of the other psychologists that I found there and also my family.

R: Okay. And you felt that with their support you can actually achieve and you did.

P1: Ja, ja definitely.

R: Thank you very much, I think we will end our interview here.

### **Sharon (Participant 2)**

R: Welcome, and thank you for allowing me to come here. I would like to ask you a few questions before get to the actual interview questions. How old are you?

P2: I am 29.

R: Okay. And when did you complete your M1?

P2: Mmmh, actually makes me think now. I did my M1 in 2012. Yes, in 2012.

R: And where did you do your M1?

P2: I did my M1 at Mafikeng, the University of the North West, but the Mafikeng Campus.

R: Okay and then where did you do your internship?

P2: I did my internship at Klerksdorp Tshepang Complex, in Klerksdorp.

R: Alright. And where was your comm serve placement?

P2: Also at Tshepang Hospital Complex.

R: When did you complete comm serve?

P2: So my comm serve I completed in 2017. So I started it in beginning January 2017 and I completed it in December 2017.

R: Thank you very much. So I will the go straight into my research questions. What kind of challenges did you experience during your community service year?

P2: I think there was definitely a lack of certain resources. So we worked in a community that was very poor. And also the hospital services a very big community outside. So we have patients traveling two hours or so to come for psychological services. And any assessments really, I mean I know it has improved in time since I did my internship there. But there is not a lot of assessments, all that must be privately done. Patients have no funds, they struggle to even get transport to the hospital. And we also had to do a bit of outreaches at some of the clinics which is also about an hour away. We mainly did Wolmaranstad. So I mean we're really struggling with a population group that has no resources, that really needs them desperately but struggle to get to it. Any suggestions you make and you think that you are trying to help, it's difficult. And then also you have limited time. You can only see someone for a very short period of time.

R: Approximately how long would you have to assess somebody?

P2: I think it would differ but it's always a balancing act, do I take more time with one patient or do I get to see the patients that are there? So you would sometimes do 12 patients or 15 patients in a day quite easily. So it is obviously easier if it is follow-ups or check-ins, making sure that everything is working well, it's easier to have a short session. But otherwise it's very difficult to do full assessments.

R: Specifically what resources were you missing? You mentioned psychometric assessments, you mentioned resources that the patients themselves have a lack of. Can you specify other resources that you lacked?

P2: I think at some point, in the beginning, there was even just things like office space, but that got better. And even if you looked at the clinics that you would give an outreach, there would be limited space. So yes, psychometrics, patients had actually no money for transport but they also wouldn't have money for food. They'd come there and they don't know how they're going to get back. We'd also be bound by the hospital, so we need to get the file from the hospital, which would also be the hospital's filing systems are also quite chaotic. So a patient would come all the way, would struggle to get a file. You'd have to start from scratch and make a new file that's opened with no other information.

R: No history, no background information?

P2: Ja, and there's a little continuity of course. And then also if you have patients that need to see the doctors, that would also be quite limited. We were quite lucky, we worked with the community service medical doctor that had a little bit more knowledge and information of psychiatry. We had a psychiatrist that would come in once in a while and even that was very, very limited. There was just too many patients, too few psychologists.

R: Ja, that's true. And how did you deal with these challenges that you came across? In terms of not having psychometric assessments, how did you overcome those challenges or knowing that your patient doesn't even have transport to go home or those types of challenges. How did you overcome those?

P2: Well there were a few ways we could. We would sometimes have, find psychometric tests that are maybe not so [inaudible], screening measures that you could get for free or that you could get as part of being a researcher or student that we use quite often. We'd use some of the other psychologists' assessments. We would organize if there is something really important that needs to be done. But you also have to sharpen your skills of assessment and evaluation in a very short period of time. So I think it really was just sharpening your skills as well. And the other part I struggled with quite a bit is you have to have boundaries. I can't take you home. I would want to take you home but I can't take you home. So we would have to work around that. Here, and in private context, I can send a person a link of a Youtube video to watch or I could you know tell them to go do something themselves. Buy a book that would be helpful. There, I would have to take my laptop and play the clip I'd like you to see or I'd have to provide that. I'd have to print it out for you because you might not have any access to a computer you know?

R: Yeah, the necessary resources?

P2: Yeah, but often it's a challenge that you can only overcome so far. And we try to schedule all the appointments on one day. For example, if you have to come see the doctor and the physiotherapist, and the psychologist, we try to make it on the same day. We try to accommodate you in that way. So transport would be once.

R: Okay so you also tried your best as far as you could just to assist the client.

P2: It was a good learning opportunity of where your boundaries lie and how far you can go. And the other very helpful thing is we had a really nice team that worked with. We had supervisors, that was amazing and you could just fall in. If it was just to vent or let's think of creative ways of helping. Or you know what, you need to let go, you can only do so much. It was very helpful.

R: And do you think there's a gap between newly qualified graduates skills and the availability of resources to enable them to practice these skills? So do you think that new graduates, you know, get access to certain resources when they're being trained and then when they're exposed to the real world, do you think there is a gap there?

P2: Well, on the one hand, yes. But I think also, probably yes. You have some access to psychometrics, you have access to immediate supervision, you have access to electronic measures in the Masters Programme. Whereas the moment you go out, you are confronted with the real world. I think, it is good that you do the practicals in Masters where you might also work with some population groups but you already starting to realize this so. So there is a gap, but I think there are ways that they are also trying to bridge that gap with the practical work.

R: So do you think that the practical work helps bridging that gap? So in terms of comm serve, do you think that's where you get to bridge the gap?

P2: I think the comm serve definitely helps with bridging that gap. And also just with skills development. If come from a Masters Programme, into an internship, you are still very "gooey", very unsure. You don't have the resources, you only have limited knowledge. You can't know everything. Little things like basic medical knowledge that you might not have, but need immediate access to in the actual practical. So I do think the comm serve programme is actually very helpful tool in that. I know it's not always everyone's favourite part, but I think it really played a big role for me. I know that where I was in internship for example, and after comm serve was a completely different place.

R: And what do you think got you to that different place?

P2: Partly just being thrown in and having to do it. But the supervisors we had, actually the supervisors in comm serve have been much more valuable to me. I still have contact with both of my supervisors from comm serve actually. We actually have the one who has left for New Zealand, he's leaving. We had a "going away" about two weeks ago so we still have access. They have been incredibly helpful, even going forward from comm serve into the more private set up.

R: So they still give you advice and some sort of peer supervision?

P2: Yes, and I think also in terms of the group in comm serve that we were. We also still have quite a bit of contact with each other. We still have a Whatsapp group together, we still check in with each other whenever we are in the same vicinity so I think having that group has really been, having those people has been the best part of it. Also people who know you and can tell you "You're going off line, you need to look at this a little bit", they bring you back in line if it is necessary.

R: So just onto that, do you feel or did you feel a need to be accepted and connected to other people during your comm serve year?

P2: I think definitely yes, it was an incredibly important part. I think work-wise, you work at a pace that you're not used to. You work with so much emotional contents that you work with on a daily basis, it is so overwhelming. And there is so much helplessness where you know that I can only do this much and that's how far it is going to go. Having that connectedness in that group, that support is probably what brought me through the comm serve period in a positive way instead of a negative way. It could have been anxiety inducing and depressing where instead it became strengthening and building.

R: And did you have any other support apart from your comm serve group?

P2: I think I have very good family support, they are all very supportive. I also have other family members that are in the psychiatric community which has been very helpful because there is an understanding in a way that others don't have. A very supportive partner and supportive friends so I think having that group of people around you has made a big difference.

R: And in terms of training opportunities or workshop opportunities, were you provided with those?

P2: I think it is still something that is developing a lot, I think that the comm serve programme I did; actually the first interns they had was in 2013. So it was quite a new programme still. But we did have, every two weeks, a meeting where it would either be a journal club or a presentation about a topic. One would present about the Rorschach the other one would come and present about new research on ADHD. So we would have that opportunity. And then if you had interest in going to other opportunities, they were quite willing to try and find time to give to you to be able to go to other training opportunities,

R: And would they sponsor those other trainings or was that completely your responsibility?

P2: No, it was completely your responsibility. The hospital wasn't quite willing to sponsor those.

R: Did you also find yourself taking responsibility for your own training opportunities?

P2: Yes, I think that all of us, I could say with me and the rest; especially the closer you got to the end of your comm serve where you would realize that after this you have to be on your own. And you have to work on your own. So we all started becoming more involved in training as we go along but it had to be your own responsibility unfortunately.

R: And what other autonomous acts did you do to ensure that you completed the year successfully? Did you ever find yourself, for example, buying your own psychometric instruments or if the institution, the hospital, could not provide what other acts did you do to just make sure that okay "my year is successful"?

P2: I think that did sort of happen. You would often do your own printing if there wasn't any paper or ink available. You would go and do your own printing to have basic screenings or to have things to do with patient. You might buy your own colouring pencils and especially because I sometimes worked with kids I'd have sort of little basic things that I buy, your own clay, your own few toys. Just things to take with to deal with all that. So it was not necessarily big expenses but it was all the little things or there would not always be tissues so you would buy your own tissue. Sometimes there would be difficulty with water so you would buy your own bottle of water to also be able to give to a patient water because they can't go to the bathroom and get some water.

R: So there were times where you would just have to take responsibility for how things run in your practice?

P2: Yes, definitely.

R: And when interacting within the community service environment, did you feel a sense of efficacy in producing the desired outcomes? So did you feel like you were on the right track? Did you feel confident in your skills and what you were actually doing?

P2: I think that is quite a difficult question. In some cases yes, you had places where you would really feel confident. You would go for supervision, have a discussion with your peers. You would identify what is truly going on with this patient. You would have them referred to the psychiatrist and get all the right medication. And you would see that shift, the marks improving and an actual difference that you are able to make. But I think the frustrating thing in this sort of set-up was limited resources and very bad follow ups from patients. That there is a lot of patients that you know fall through the gaps, where you feel very ineffective. And you know there is so little that I can do in this case. So I think there were cases where you could truly feel that efficacy and that carries you through often. But feeling "I know that I have made a difference and that I have helped someone" and others where you just know there is nothing you can truly do, you don't have the resources to help.

R: Did you have any other challenges?

P2: I think language was a very big barrier. It was a community that, there was very little of English-speaking. There was a lot of Setswana-speaking and a lot of Afrikaans-speaking. You got to a point where you would pick up words. I would understand partly some Setswana because I would have to understand the basics. Especially when you work with the very young and very old, they would... Actually strangely enough, the older population was not a difficult population. Most of them spoke Afrikaans as well. But there were cases where you wouldn't have someone that could truly translate and then you sit in a situation where you can either help someone and get the care worker to translate which is not actually accurate. Or you could get the spouse to translate but that contains confidentiality issues. So there were cases where, I am glad you mentioned that, was an incredible big boundary. But then we would have to sit with "is it possible to wait for someone who could speak the language"? Some cases we would, the others it was just not available. So we had to make do with translation and sometimes with even drawings or ticking. Especially when you are in the clinics.

R: Now looking at all these challenges that people face within comm serve like language barriers, lack of resources and so forth, what pushed you to finish? What drove you to the finish line? Because I am quite interested as to.. you probably hear your friends or previous people that have gone through the same journey speak about these challenges. What gets you to that finish line?

P2: There is a few things I think. It is a journey that you have been working on for such a long time that reaching the end is truly that goal post. But I think with me it was probably the few cases where you know you could truly make a difference. And the supportive group that we worked with, that really helped you to get to that point. I think I got frustrated at certain points in the journey. And I mean internships have some of the same frustrations. But having a mind shift about the incredible training that you receive. And I know that I have often in my own practice used skills and knowledge that I gained from that part of my life. So I think to me in general it was more positive than negative. But it was a certain mindset that you had to have.

R: Okay we have reached the end of our interview. Thank you very much, I appreciate your time.

### **Mary (Participant 3)**

R: Okay welcome participant 3.

P3: Thank you.

R: Uhm, I'm just going to start off with uhm questions about your age and date of completion in everything. Uhm, how old are you?

P3: 32.

R: You're 32, and when did you complete comm serve?

P3: It was... 2014, when I completed it, yes.

R: And you're female. Which province are you from?

P3: Free State.

R: From the Free State. Okay and uhm which university did you get your training?

P3: University of the Free State.

R: Okay. And what year was that?

P3: I completed it in 2012.

R: Okay.

P3: And then I did my internship at FSPC. So that was 2013 and then my community service year was in 2014.

R: 2014? Okay, alright. So you were placed at FSPC?

P3: Yes.

R: Internship and comm serve?

P3: No, the internship was for a year at the Free State Psychiatric Complex and then after that I was placed at Dr J.S Moroka Hospital.

R: Okay in Thaba Nchu?

P3: Yes.

R: Okay, got it.

P3: For my community service year \*clears throat\*

R: Uhm, can you please describe the challenges you experienced during your community service year?

P3: Okay so we are starting with the challenges?

R: Yes.

P3: I think, uhm, the distance. That was quite the biggest thing for me because uhm, in Thaba Nchu, it is quite a drive down there. It takes about 45 minutes each day so maybe to start off with the basics, it was the distance that we had to drive because previously the hospital did provide transport for us to get there and then they took that away. So we had to drive ourselves every day. But there was a group of people, other professionals where we drove together.

R: Okay.

P3: So we went there. Uhm, that was a challenge. Then also I think the facilities at the hospital as well. We didn't have, uhm, when I went there, there was another permanent clinical psychologist and she.. we had to share an office. And then at certain times when we both had patients, we had to, uhm, I used to use an office that was across, next door. Well it's not actually an office, it was just with beds and things like that. So you had to put chairs in there. So that was a challenge as well. Also, we went to uhm, different clinics. So getting to the clinics, you had to drive with doctors because you didn't go with your own car every time. So you had to use transport with other doctors to get to the clinic. But they would not always go on the day that you wanted to go. And the facilities at the small clinics surrounding the hospital was also problematic because there was also limited office space.

R: Mmh...

P3: So ja, I think other challenges now, specifically with the patients, uhm, we tried to ... in a certain sense I wanted to make like groups where they come for group participation... But then it's difficult if you work with a low socio-economic uhm, group of patients. So they would usually go to the clinics if they want to get their medication. But being able to get a group of patients with the same, for example, diagnosis together to come on a certain day and you can do groups was quite difficult. Uhm, ja, we wanted to start that but then we saw but they do not participate as we expected.

R: Okay.

P3: Uhm...

R: Resource wise?

P3: Mmh... I think, yes, we didn't have any psychometric assessments that we could do there.

R: Mmh

P3: I think... Ja, there is limitations, for example, if anything that you want to use with your patients, you would have to provide it yourself. For example, if you wanted to work with children, then anything that you will use with children at the hospital, you would need to bring yourself and it is your own things. Uhm.. There wasn't anything that was provided for us. We did receive, for example, your patient folders and where you can write your patient notes and things like that. Uhm, any other resources that you were looking for specifically?

R: Uhhh... Stationery, phones?

P3: Uhm... we did have access to phones with the hospital that you can phone your patients. You didn't have to use your own cellphone

R: Okay.

P3: Uhm, we did... I'm not exactly sure if the hospital were supposed to provide your stationery but we took our own things.

R: Okay.

P3: But the office was equipped with the basic stationery that you would need for example, a stapler, a pens and things like that. And if you wanted to take something extra you could.

R: Okay. And computers?

P3: Uhm... there was a computer in the office but it was only used for example, if you had to now formally type something. The process notes were also done by hand.

R: Okay.

P3: Uhm, ja.

R: Did you experience any language barriers with the clients?

P3: Yes, definitely. I think it is difficult because my language which is only Afrikaans and English,. And in Thaba Nchu it is mostly Sotho-speaking patients then as well. So luckily for me at a certain stage when the other permanent clinical psychologist, she could speak Sotho, so I would mostly see patients that could speak English, that could understand English or Afrikaans. We had some Afrikaans patients as well. And then she saw, for example, if it was small children that cannot... if they can only speak in Sotho and so forth. Uhm, at the clinics I remember one day when that was actually a difficulty because when I would go to the clinics I would give talks, for example, on different topics when I went there. Uhm, if there weren't any patients booked for me or things like that then I would give a talk, for example, in English and then I actually had patients that raised their hands and ask if I won't be able to \*clears throat\* they cannot understand me. So then sometimes if one of those, uhm, volunteers were available, I would stand in front of the group and they would translate for me as I am talking. But they weren't always available.

R: Okay, so there were some solutions that you would find to, you know, work around these challenges?

P3: Yes.

R: Okay.

P3: There was a certain stage where it was very difficult because the other clinical psychologist, she went on maternity leave. Uhm, so then I was the only psychologist there. And then it is difficult to manage. And then if you ask, for example, a nurse to translate for you, that's difficult because they are not trained in translating for you. But there were no translators that is trained in translating available to assist.

R: At all?

P3: At all.

R: And do you think there is a gap between newly qualified graduate skills and the availability of resources to enable them to practice these skills? So do you think there is a gap between what we learn, maybe in M1, and the resources that you would then be given when you are put in, for example, uhm, comm serve?

P3: Uhm... Excluding now the internship year?

R: Yes.

P3: Uhm, yes. I think in your M1, what I have also seen... after you have finished with your M1 I think that therapeutically, the practical application, for example, applying your therapy is quite limited. You know the theory but practical implication of it I think that is sometimes where you feel that you have a gap in that sense.

R: Okay.

P3: During your internship year, you do get a lot of practice with that but I think, uhm, more exposure to brief psychological interventions is a lot of times needed at your community. Because it might be that you only see your patient once or for a second time. And then you have not been I think, uhm, in those brief therapeutic approaches like Solution Focused Therapy and things like that to be able to implement that. You asked about resources, what do you mean with that?

R: Yes, basically things like the psychometry you know, like play therapy equipment.

P3: Yes, so like I mentioned that was really lacking. We could not do any psychometric assessments and you could not, there was no... nothing was for the children specifically, was psychologists. So anything you needed you had to bring yourself.

R: Okay. And in terms of the psychometry, I just want to go back to that. When you did need to do a psychometric assessment, what would happen there? Would you just not do it at all?

P3: I think you would just not do it at all or you would refer. For example, if it was now, let's say a child where you want to do a full psychometric assessment then you did have the opportunity to... but it depends on what the reason for referral is. For example, if it is for school placement, you would refer to the Department of Inclusive Education. If it is for something that's... if you have a complicated case with co-morbidities, you might refer them to a tertiary institution like FSPC for those people, but there was a lack. We did use freely available scales that is not necessarily a psychometric test.

R: Ja. Like a battery?

P3: Ja, because the concern is also at that level. For example, at the hospital, the places where the psychometric assessments will be kept and regulated and things like that, they weren't available. And I think that would have also been a problem.

R: Okay. That makes sense. And were you provided with training or workshop opportunities during comm serve? Or was it just in internship?

P3: It was just internship. And then when you went to community service, uhm, they did for example, at FSPC where you can consult with one of the consultants there about difficult cases or things like that. But you didn't have any opportunities for any extra workshops during that time.

R: During comm serve?

P3: Ja, if you didn't initiate it on yourself, it is something outside. Nothing was provided for you.

R: Okay, and did you take responsibility then for looking at outside training programmes or do you feel that that it was something you didn't do at the time?

P3: I didn't do it at the time.

R: What was the reason for that?

P3: I think maybe it's not maybe known or advertised so you're not really, uhm, you do not have that knowledge during that stage of where you can find opportunities to go and look for something \*clears throat\* or a workshop that is available that you can go and attend.

R: Okay, right. And what other autonomous acts did you do to ensure that you completed your year successfully? For example, buying own psychometric material to use in, you know, in assessments if the comm serve institution could not provide for it. So you mentioned that you would download freely available material.

P3: But that is only the scales.

R: Only the scales? Yes, yes.

P3: But with psychometric assessments in itself nothing really.

R: Okay. And then also you say that if you saw a child patient you would buy your own, uhm..

P3: Material...

R: Uhm, toys...

P3: Material that you would use with them and ja, that was out of your own pocket.

R: Okay, alright. Uhm, when interacting within the community service environment did you feel a sense of efficacy in producing the desired outcomes? So did you feel like you were doing what was expected of you? Did you feel like, okay, so I am providing a service and did you feel like you are well equipped to provide that service?

P3: Yes, I think there was a great need with a lot of patients. It was, uhm, you are quite busy at your community service so I think, uhm, and you could consult with, if you have a colleague you can consult. So I think it was a sense of that you did do good interventions with your patients.

R: So you didn't feel like you didn't receive enough training or anything like that? Where you confident in what you were doing?

P3: Ja, I think you tend to... it is a good opportunity to self-study as well at the community service wherever you are placed. I don't know now if it specifically with me, but going out at the place, you cannot go anywhere else. You're at your office. So if you don't have a patient that's a time where you can really sit and develop your skills in for example, reading up on diagnoses and develop your skills in how to conduct first interviews efficiently and certain therapeutic approaches. So I think that is the place where you learn for the first time, you know, what works, what doesn't work. So, but I do feel that, except now for the groups, being able to do group therapy and getting people together in groups. That was something that I really wanted to do but I struggled with logistics with patients being able to attend.

R: Okay. And did you feel the need to be accepted and connected to others during your community service year? So in terms of maybe your family, or fellow colleagues. Did you feel the need to feel like you are part of a group? The need for acceptance.

P3: Definitely. I think in any work situation, you want that sense of acceptance working with other people of the team. I think, uhm, what was lacking for me in Thaba Nchu is that we as psychologists didn't sit around as a multiple, multi-professional team. We didn't have team rounds specifically with patients. So the doctors, for example, have their own meetings but we were not included in that. So we were.. you kind of saw your patients on your own and there was no communication really between the different disciplines. Except now if you went specifically to a consultant. But you do feel... I'm not really sure what you mean with being accepted by family?

R: No like did you, you know, feel connected to others because sometimes you tend to find that a person, uhm, doesn't have family support. So did you have that? That sense of connection with your family to support you and also from your colleagues as well.

P3: Yes, I really, uhm, have a very good support structure at home, good family support. And the team that we worked with there was also supportive personally can I say maybe?

R: Yes.

P3: Because we drove together in the same car so we built quite good relationships and then there was also, for example, community service doctors that also for them, it is a new experience. They are also there for only one year or a community service dietician also there for one year. So it was quite a nice experience, feeling supported by each other because I think it is the group setting of having to drive together so we weren't isolated in that sense, socially.

R: Okay. And uhm... Just the last question. What are the factors that influenced you to finish comm serve because you mentioned all these challenges, you know, logistics, lack of office space. Things like that can

actually affect a person's motivation levels. So what helped you to get to a point where you actually completed comm serve successfully?

P3: Well it is a requirement for me to become a clinical psychologist \*laughs\* so definitely, uhm, if I had a choice to stay on at the hospital, I wouldn't do it. So I think all the, the the, uhm, the aspects such as those logistic aspects lack of things really do influence you. I think if your permanently appointed there that will be very difficult. But I think because you had that timeframe in your mind, that you do this for a year and you complete it for a year then it makes it more manageable. Also because you were able to provide a service for patients at rural clinics which they might not have found at other places so that is also a motivation if you see your patients and they are improving and you see them on a regular basis and things like that where they wouldn't have received that. They might not be able to get to certain services or be able to afford it so that patient progress also motivated you to continue with being there, making a difference and working there.

R: So just, you you, felt like you're really making changes in people's lives who wouldn't be able to afford such a service.

P3: Because we had a lot of, for example, patients after they have tried to commit suicide, then you immediately get a referral. You have to see in-patients or if a mother lost their baby then psychology would be also be referred immediately as an in-patient. So you really had an opportunity to practice also certain skills, for example, how to do a proper suicide risk assessment and evaluation. So it was patients that improved but also being in a place where you can improve your own skills, uhm, with the patients being more independent.

R: And do you think you learned a lot because you had to do without certain things? So do you think that developed something within you? Some sort of resilience?

P3: Yes, definitely. Being able to do certain things independently and also being creative of how you can do it. For example, when I said when I did the talks, if a patient didn't show up for groups, then I would rather the talk, give the talk to the whole group of patients at the clinic. Uhm, I also did a community project where for example, I went to one of the schools and then it was with substance abuse. But all those things I also paid out of pocket, for example, it was hundred students so everybody go a bag with forms that they could complete to teach them about substance abuse, a pen and sweets and things like that. So there was also a project that I implemented.

R: Okay.

P3: Also because I identified the need in the community of substance abuse, it is really a big big thing. That was their number one thing that they indicated that's a problem in in there. So being able to do a big presentation. And I think what actually also helped me personally with was uhm, social anxiety, being able to speak in front of groups of people and working in clinics and also seeing yourself like that so that was a personal thing that I, that I... that I gained. The experience of being there.

R: Alright, that is all from me. So thank you very much, I appreciate it.

P3: Okay \*laughs\*

#### **Monique (Participant 4)**

R: Welcome. Please say your name and your surname.

P4: Anonymous.

R: Okay, I am sorry for saying your name incorrectly.

P4: No, it is not a problem.

R: And your age?

P4: I am 27 years old.

R: And where did you study your M1 and in which year was it?

P4: I studied my M1 at the North-West University, the Potchefstroom campus and I completed it in 2015.

R: Okay.

P4: Yes.

R: And in terms of your internship, where was your internship site and which year was your internship?

P4: My internship started in January 2016, and I did my internship at Sterkfontein Psychiatric Hospital, that is in Krugerdorp.

R: Okay. I am going to start with a very general question, (uhm), please answer it in whichever way is suitable for you.

P4: Okay.

R: And then we will take it from there. Okay- Please reflect on your community service year.

\*Short pause\*

P4: Okay. Well I completed my community service year at the Tshepong Klerksdorp Hospital Complex. \*sigh\*. So I worked both at Tshepong hospital and Klerksdorp Hospital and... at Tshepong Hospital I only saw adults... and adolescents. And at Klerksdorp Hospital, I saw a lot of children. \*Pause\* So if I were to reflect on my entire community service year, I would say that it was a year of getting to experience, or not really experience- to encounter a lot of diverse (uhm) people, diverse (uhm) problems and (uhm) how else can I put it? \*Pause\* (sigh). And also, (uhm) not only diversity but the amount-wise of how many people we saw on a daily basis, was quite vast. So the two main words that pops out for me was "diversity" and also the amount of people that I encountered on a daily basis.

R: Okay. (Uhm), So in terms of diversity, what was diverse for you?

P4: The specific population that I worked with, (uhm), the- with regards to... I, I got exposed to working with children from the age 2, 3 years old, up until at Tshepong where I saw people of the age of, in their 80s of 90s. So when I say diversity, I mean, especially with regards to the age of the population and then also specifically with regards to race. (Uhm), It was so diverse \*slight stutter\* I can't say it was predominantly this race or that race. It was a blend of- it was a blend of your typical multicultural-type South African population that I got to work with.

R: Okay, alright. And were there any challenges that you experienced during your comm serve year?

P4: \*Sigh\* There was, yes. (Uhm) I think one of the main challenges was a language barrier, especially when I got... I had to work with a patient that can only speak their home language that was different from mine. So if I can give an example: If I had to see someone that can only speak Zulu, or Tswana or Xhosa...

R: Yes?

P4: I can't speak, well any of the African languages \*slight pause\* So that was a bit difficult if I had to see someone, do an assessment or you know, try to conduct therapy or to contain a person and we can't even speak the same language. And that just, you know, speaking in English, where we had to get an interpreter (uhm), to, to join the session. So that was, I think, the most difficult part of my comm serve year- it is just to work around the language barrier.

R: Okay, so... \*Interruption from P4\*

P4: Sorry, something else- (uhm) I think that also was quite difficult was with regards to \*pause\* the amount of staff that we were at the time, compared to the need that there was within the community and the surroundings. Klerksdorp- at Tshepong Hospital, they are kind of central of the psychiatric (uhm) or not even psychiatric, but state psychology, you know, institution where people go for assistance. So we would see people from Wolmaranstad, from Leeudoringstad, from even Potchefstroom. And we were a small group of psychologists but we had to serve a large number of patients.

R: Okay.

P4: That was also quite difficult because there was some days where you had to see 11, 12, 13 patients, sometimes even 14 patients in one day. Then it's really difficult to, you know, fully get to a patient within the given time that you are allowed to spend with them.

R: Alright. In terms of seeing so many clients in a day, how did you cope with that?

\*Pause\*

P4: I coped with that by debriefing on a regular, almost on a daily basis with my colleagues. We were a... Luckily, I worked in a very supportive environment, where everyone was very supportive of one another. We can chat to each other on a regular basis, throughout the day, before the day starts, at the end of the day. So I coped a lot by spending time with colleagues or discussing difficult patients or cases with colleagues. Then after work (uhm), I worked far from home. So I had to drive an hour in and an hour out every day. So one way I also coped with regards to the day's work is (uhm)... in the beginning of the morning, I kind of had my own me-time in the car. Where, you know, I would get my head in the right space. And at the end of the day when I had to drive an hour home, then I also had time for myself to reflect and to resolve some of the difficult things that I was confronted with on that day. And (uhm), I think something that helped also a lot, within my personal life- is that my husband is also a psychologist so I had that support network, especially, or that support structure or system where he already went through most of these things. So it was easy for him to relate. And also, easy for him to support me in that sense- knowing where I came from, the things I had to deal with, and things like that. So even just talking to him helped me a lot just to cope.

R: Okay, so he was part of that support system that you used through that year?

P4: Definitely, and I remained very good friends with some of my \*pause\*, M1 colleagues. I wouldn't call them colleagues, actually, I would call them friends. So even though our routes splitted, when we did internships, we always made a point of at least one month, once a month, meeting up with each other. And just checking in- also debriefing, making use of each other's shoulders, you know. And I also did that in comm serve year where we would frequently also get together at least once a month... our group where we sat and spoke about things surrounding work, personal life, ja everything of that sort.

R: Okay, so did you feel a sense of connection to those around you?

\*Pause\*

P4: I must say that I did feel quite connected. I think because I went within the same time period, a lot of time processes that some of my friends that were also psychologists went through. So we were able to connect with each other in that way. And especially with regards to my husband, already being through such a process, it was still easy to connect with him because of his previous experiences. And I can even say, for out of the psychology realm, with regards to friends, well friends outside of psychology and also family, I had a very supportive system where we would frequently still check-in with each other. So I didn't, I did not really, at any time, felt disconnected either from my family or actually from my friends.

R: Okay, so despite that year being very busy for you, you still managed to maintain social relationships?

P: Yes!

R: Alright. Just going back to some challenges that you mentioned regarding language- language difficulties and language barriers, you mentioned that you would have to (uhm) get a translator, was it always possible to get a translator?

P4: No it wasn't. Sometimes, you know what they say- what is on paper is not always how it plays out in real life. Like there were protocols with regards to the hospital, you can phone the switchboard to ask for a translator. They were not always available. And then we had to make a plan amongst ourselves to get the job done, with or without the translator.

R: Okay. Can you please talk to me about those plans, sounds interesting?

P4: Yes. Some of my colleagues (uhm), that were able to either speak you know whatever language it was, that I wasn't able to speak- even though I was the one that was either in the assessment or in the therapy role, they would come in as (uhm) being a translator. So that is also how we tried to assist each other.

R: Okay, so your fellow colleagues would come in, step in basically to help you?

P4: Yes. There was also in some instances, especially with the children, where we- if there were no translator available, we sometimes also got in family members to help with the translation.

R: Okay. And because you made these plans, how did you feel about yourself and your abilities? How did that influence you as a comm serve psychologist?

P4: \*Sigh\* You know, although it was quite frustrating at times, I myself, am very goal-directed. So if I put my head on something, I figure a way out to get it done. So when I got things done, sometimes I felt as if I wasn't able to do it to the best of my ability due to the lack of resources. But nevertheless, I felt that even if I got a little bit done, compared to doing nothing, was fine with that.

R: Okay. So you made peace with doing what you could?

P4: Yes, exactly.

R: Okay. And what do you think influenced that outlook that you had?

\*Pause\*

P4: I think my upbringing played a big role with regards to that. (Uhm) also just my general (uhm) outlook on life, outlook on situations. I feel wherever there is life, there is a solution. So it's just about finding the solution.

R: Okay.

P4: Ja.

R: Alright. (Uhm) any positive moments about your comm serve?

P4: Oh definitely! As I mentioned earlier, that the team that I worked with, which was very supportive. And when I refer to the team, I don't only mean my colleagues. I mean my supervisors, the (uhm) administrative staff, the doctors that we had to work with, the nurses, even the porters and things like that. It was a very (uhm) \*sigh\* How can I say it? It was actually light, nice, supportive environment.

R: Yes?

P4: So that was definitely a highlight for me because that is not always something you find in a workplace. So, so that was nice. Also, we had a lot of humour in the office, so it would make things a bit easier and to get through the day. And obviously, I think the best part for me was when I had to work with a patient and even though things looked very (uhm) \*sigh\* the outcome didn't look great, if I managed to make even the smallest of changes, that was something that I felt happy with and felt that in some way or another, I was privileged enough to make a difference in someone else's life, no matter how small. So just working as well, working with the people was a highlight for me.

R: Okay. Any other highlights that you can recall?

\*Pause\*

P4: (Uhm). Yes, I think that also the learning opportunity. During my comm serve year, we were allowed to go on various CPD courses and things like that. So they made a lot of room for us with regards to our own professional development, which I also appreciated a lot. So for instance, if I wanted to go to a CPD on let's say, Art Therapy, then they were quite lenient with regards to leave, taking the day off for going on a CPD course. So that was also very nice because the environment was also very conducive towards learning and also encouraging us to (uhm) further our own professional development.

R: So in terms of furthering your own professional development, did you find these courses by yourself or did the institution recommend certain courses? What was your selection criteria or how did it come about?

P4: (Uhm) the institution didn't recommend any of the courses. It was our own responsibility that if we wanted to go on courses, that we had to go do our research to see what it is that we want to go and attend, because we all had different interests as well. And what was nice about the environment is they gave us the opportunity to go and invest more within our own interests. So I was able to go onto the websites to go look for CDPs being presented and they were quite lenient with regards to if it is a CPD-accredited course, then we were allowed to go. We just had to pay for it ourselves.

R: In terms of your training, you had to take responsibility to (uhm) pay for those trainings or workshops and to arrange them yourself. However, the hospital gave you leeway to do what you needed to do to uplift your own skills?

P4: Yes.

R: Did you also feel that you knew what was expected of you during comm serve or did you feel like you were just expected to know your job and how to do it?

P4: (Uhm), \*sigh\* well you know, I think that will depend a lot on the institution. Where I was, with regards to my own experience, is we did, or I did receive orientation as to what was expected of me and within my role. So that was kind of clearly set out. I knew what was expected of me, what I had to do and things like that. However, there was some days where (uhm) I also had to, you know, just think on my feet. There wasn't necessarily specific protocols or... I got confronted with a situation that I had to take control of. (Uhm) \*Sigh\* you know, where I had to take my own initiative to try and sort things out or figure things out. But it was always done in the light of, you know, improving or assisting the bigger picture of the institution or the hospital.

R: Alright. And \*P4 interrupts\*

P4: (uhm)

R: Sorry?

P4: No, sorry. So for most of the time, I felt like I knew what was expected of me, yes. But there were some days or some incidents where I just had to think on my feet.

R: And on those days that you had to think on your feet and take initiative, how did you feel after those experiences? How did you feel about what you had done?

P4: Okay. Well after such experiences, I normally go and first reflect on myself. Just to go look at what was the process and how it played out. [I] think of if there was something I could have done differently, could have done better, and could've maybe approached in a different way. If I am done with my reflection, then I normally also either go to a colleague or I went to my supervisor to also speak to them about what it is that they hear or how they would've handled it. Or (uhm) do they agree with the way it was handled or do they have any inputs should something like that happen in the future- how I can maybe approach it then.

R: Okay. And generally, what type of feedback would your supervisors give you about the actions or steps that you took?

P4: \*Sigh\* I can't really recall that there was times where they disagreed. Most of the times they actually agreed and encouraged (uhm), whatever it is that I did. But they would like, perhaps, give input by saying; "just make a small adjustment" but the gist of it was that it was done correctly.

R: Alright. And (uhm) I think we have answered a lot of the questions that I had written down. But in terms of factors that influenced you to complete your comm serve year, what are those factors? You mentioned some challenges like seeing many clients. What influenced you to finish that year, to complete what you had started?

\*Short pause\*

P4: If I can maybe answer it in psychological terms- I would definitely root to my internal locus of control. As I said earlier, if I put my mind to something, then I make sure I complete it to the best of my abilities or as I can. So I knew even though I had difficult days or there were some days were I really felt tired or things like that, I knew I had a goal to work towards and my goal was always to- to complete whatever it is that I started, including comm serve year. And also, obviously, comm serve year is almost like jumping the last hurdles to register as an independent practitioner.

R: Okay.

P4: So I knew that even though it is difficult, it is something worth doing because (uhm), there was also something in it for me- in the sense that in the end of my comm serve year I will be able to register as an independent practitioner.

R: Okay. So, that was your end goal?

P4: Yes, that's correct.

R: Alright. Any other factors that influenced you to keep going throughout the year?

\*Short pause\*

P4: I think it's like the encouragement of my friends and family, obviously my husband also. It assisted me along the way and also motivated me to continue on this journey and to see it through. Something else is that I have never doubted (uhm), the profession or that I wanted to become a psychologist. So I think that made it easier for me in the sense that I knew that this was what I wanted to do for the rest of my life. And I still feel this about the profession. So I think just also having that complete sense of knowing what my purpose is. That also helped me to get through my goal.

R: Alright. Thank you so much for your time, we are finished with our interview. I appreciate your willingness to assist me.

P4: Pleasure.

### **Chantelle (Participant 5)**

R: Can you please state your full name and your surname?

P5: Anonymous. \*Chantelle\*

R: Okay. Your age?

P5: 33.

R: Where did you study your M1 and which year was that?

P5: University of the Free State, Bloem, and it was in 2014.

R: Okay. Where did you do your internship?

P5: So my internship was split in two. (Uhm) It was, the first six months it was in Klerksdorp at Klerksdorp Hospital and Tshepong Hospital- so three months each. And the last six months was at the university in Potch, at the Centre of Psychology and Wellbeing.

R: In terms of your comm serve, where did you do your comm serve and which year was it?

P5: Comm serve was 2016 and I did that at Klerksdorp Hospital.

R: So the focus of our interview is going to be regarding your experience at Klerksdorp Hospital.

R: Can you please provide a general reflection on your comm serve year? What comes to mind when you think of your comm serve year?

P5: (Mmh) It was hard work (giggles), but very rewarding. Fruitful, I learnt a lot, especially with regards to children because the focus at Klerksdorp Hospital was on children under the age of 14. So I'd really say that ja, it was a year filled with knowledge, overwhelming at times, but very rewarding.

R: Okay. How did you cope when you felt so overwhelmed? You mentioned that it was hard work and overwhelming at times. What did you do to cope?

P5: Okay so what helped is I worked with a very good group of comm serves. We knew each other from internship, so that helped. Some of them I studied with, I did M1 with. So we would almost debrief each other if I could use that word. But I think I had a very good support structure at work but also at home- with my family. If it weren't for them, it would've probably been tough. But nothing specific in terms of professional help or anything like that, but a lot of debriefing, a lot of support from family and a lot of down-time. Especially after internship and having finished my research. A lot of down-time (giggles).

R: And, so in terms of support from your colleagues, you said that you would debrief with each other, and that helped you cope a lot. What else did you do that you felt contributed to what you felt is support from them?

P5: Okay so I had a really amazing supervisor as well, whom I still actually friends with. I still work closely with her, and she was, I think, the biggest help if anything, in terms of colleagues. She really had an open-door policy where if you were struggling with patients, you could go bounce anything off of her at any time. She really still gave us really good supervision even in comm serve. Not as strict as in internship, but very like- ja I think it was more unscheduled and unplanned. But supervision was still a big thing for her in comm serve. And ja, I think she was probably the biggest help in terms of support from colleagues. Because I think your supervisor could either make or break you, you know. And I think ja, if I had to attribute anything work wise, I'd say she was probably the biggest help, so that's that.

R: Okay. And in terms of your family? Support from your family? What kind of support did you receive from them?

P5: Okay, so it was quite an adjustment for me because I moved from Bloem to the North West. So I didn't really have family here. But they called me all the time. (uhm) They checked on me all the time. Once a month, I went home and I think like that was the weekend I would look forward to most. Because I knew that when I go home that would be like my peace. I would sort of replenish all my reserve energy and I'd be fine again. So once a month would be sort of that weekend that would just set me for the next month to come again, ja, my family, even though they were far, they really really helped a lot whenever they could. But ja, once a month, I made the drive to Bloem and that helped so...

R: Okay so that also helped you in terms of coping. Any challenges that you faced whilst you were at Klerksdorp Hospital?

P5: Okay, so at Klerksdorp Hospital, I'd say (pause) it's not very (uhm), strict, for lack of a better word. It's not as strict as maybe other institutions. It's quite unstructured, so they kind of throw you into the deep end and you figure things out. But having been there from internship, that prepared me. So I knew what the environment was like and having had the experience of working with those people. I knew, going into comm serve, what to expect. Also in terms of, I think, working with workload, (uhm) ja that might've been a challenge because you know, there's no like sort of, scheduled appointments unless you have outpatients. But in terms of inpatients, you would maybe have a quiet hour and then a stream of patients coming in all at the same time. So if you aren't used to the unpredictability you more used to a structured environment, that could be challenging for you. But I think, you know, it can also be a good thing because it does help you to work under pressure and it helps you prepare for the unexpected. So I think, it just might be a challenge if you really have a Type A personality and you want everything in order- then it can be challenging.

R: Alright. Any other challenges that you can think of?

P5: I think in terms of the hospital itself, I think it's still a challenge at certain general hospitals- referring was quite a challenge. (Uhm) I don't think, especially in terms of doctors, don't always know what kind of problems to refer to psychology. So sometimes the referrals weren't really psychology related. Doctors expect psychologists to do their dirty work, (uhm) so break news to patients they don't want to break news to. So that was quite a challenge and you have to put your boundaries in place from the onset regardless whether it's an intern doctor or a prof... professor or whoever it is. So I think doctors don't always know proper referrals. I think also another challenge in terms of referrals was, because at Klerksorp Hospital, they had the maternity ward, (uhm) so there would be a lot of patients referred who had miscarriages, but maybe like nine-ten miscarriages, you know? So at what point does a doctor tell a patient to stop trying or the possibility of falling pregnant or carrying a baby full-term is not going to happen. So a lot of cases like that where you sat with having to intervene with other professionals at the hospital to try and find a plan as to what's going to happen with regard to referrals. So I think that was quite a challenge, (uhm)... But I also think in terms of population, ja (uhm), if you don't speak Tswana, obviously that would be a problem. I had to learn (giggles), but I think because at our hospitals here, your majority of your population are black South Africans so if you can't speak their language, I think it is an issue and I do think people would prefer to have therapy in their mother tongue, it makes them more comfortable. So in would say you have to at least make an effort to learn their language or to try to help them somehow. You must at least be able to understand what is going on do that might be a problem if you are an intern or comm serve coming into an area where the language is foreign to you. I think that is maybe two of the main challenges that I can think of.

R: And in terms of language, did you find yourself in a situation where you really couldn't communicate with a patient?

P5: Okay so, fortunately when I was a comm serve, there, well they always try to have at least, a large representative sample almost, of people from different races. So although I think it is quite, it's challenging because I do think most people, you probably would know, doing masters- if you look at your class, it's majority white students and then maybe one or two black students. So it's, it's the same. It was the same also in comm serve. I think we had one comm serve who could speak Tswana but you also can't rely on that person every time to see all the Tswana speaking people. So at Klerksdorp Hospital, we did have someone, like a translator who would help in extreme cases. Because I also feel like sometimes the message gets lost if you do use a translator and you know therapy, it is compromised a bit. But if you really did need it, we did have someone who could assist in such cases. But we always tried to (uhm) even if someone wouldn't really speak English fluently and you could understand at least, they could at least articulate themselves in their mother tongue. And they could understand English, you could then express yourself. So we tried to make plans where we could but there was a translator in case you needed one.

R: Okay. Anything that you would say was positive about your comm serve? I remember right at the beginning you said it was a fruitful experience. Any other positive aspects that you can identify about your comm serve year?

P5: (Uhm), yeah well, I didn't have research to deal with- number one (giggles), and I think that really takes the load off of you because I think in internship, you are very very new to this profession and you are also stressed about finishing your research so I think going into comm serve, you are able to almost take in more without too many distractions. (Uhm), I wrote my board exam very early on, I think it was in February of my comm serve so I got that out the way like very early in the year. And I could really just spend the rest of the year learning. So I literally was just a sponge and I took in everything that I possibly could. I think I also learnt a lot about how challenging it could be working with children. We had a children's clinic that I really felt was very useful. It would be on a Wednesday that you would sit in with a psychiatrist and she would see almost all the difficult cases. So your Autism Spectrum Disorders, your ADHD, your Conduct kids, (uhm) and as much as she would focus on medication, she would also teach a lot in terms of, you know, how these disorders could overlap, how they present but also psycho-educating parents. So I found that very useful because if a parent comes in and they're feeling helpless, and they don't know how to deal with their child, and you are able to help them in that manner, it really literally changes their everyday life, you know. So (uhm) that, I found particularly useful. And I think I also just found the value in how important it is to educate parents. Because sometimes we take for granted that they know these things, but they don't always know these things. For us, it's common sense, but not everybody studied psychology. And even if you are a parent, and you have this natural, God-given talent or gift, some things aren't always as common as we think it is. So that I think I found particularly effective and, and helpful. (Uhm) but I think also having worked with a lot of, well- my supervisor at the time, she specializes-

she's been doing her PhD for personality disorders so I think I learnt a lot as well about personality disorders in general that year, but also personality disorder. So my PhD will also now be on Anti-social Personality Disorder in females, so I think I learnt a lot. Why? I'm not sure why I love personality disorders, it might say something about myself (laughs) but that was for me was also very very (uhm) useful and I think I found my interest there. So ja, I really just... But I think I like to just take in as much as I can in my comm serve without any other distractions.

R: Okay. Any training opportunities that you had to improve your therapeutic skills? That were provided by the hospital or did you go out and find your own training opportunities?

P5: Okay so in government, you will see it is quite challenging to do that because they'll tell you that there's no funds. So what we would do is we all took turns- we had like a training schedule for the whole year and (uhm) the interns would also present mostly on their research- but each one of us would have a topic that we would have to research and then present on. (Uhm) we did get CPD points for that but (uhm) you had to put a lot of effort into it. But also our supervisors also obviously did training so in that aspect I think it was really for learning and for growth. If you wanted to do training on your own, you could do that but it was your own costs and all of that. Most of the training I did receive in my comm serve was provided by my department at the hospital. Therapeutic modalities, personality disorders, supportive therapy, whatever it is that you're interested in was- we each could present on that. But that's all I did in my comm serve year in terms of training. But of which I feel was sufficient because it was a wide variety of things and they didn't limit you to anything. Because some people come in to comm serve and they say "well I want to work from a CBT perspective" or whatever and that I think some people, like me, went into internship and comm serve not knowing what the hell I wanted to work from (giggles), so I was just really open to learning a lot of things and I think you also learn a lot in that way. So yeah, that was all in terms of training.

R: Okay, but the gist of what you said is that the hospital did give you some sort of training that was in-house?

P5: Yes.

R: And my next question was going to be did you feel you know what was expected of you during comm serve? And I think you already answered the question earlier on when you said you already knew your way around because of having done your internship at the hospital. So because you knew what was expected of you, what influence did that have on you?

P5: (Uhm) I like being prepared. So, I think it helped me in the sense that I was prepared for what was to come. I was prepared even for the unexpected. I knew that some days there would be crazy, busy days and some days it would be quiet. Or some days would be challenging and some days not so much. But I also knew what kind of patients to expect coming in to the department. So you can't really prepare exactly in terms of therapy when you're sitting with that patient but at least it did give me an idea of more or less what was going on, what kind of patients, what kind of environment. But also how to work closely with other people in different departments. So I think it helped me in that regard. And as much as it wasn't really as structured as maybe other places were, it also helped me in that regard- that not everything is always gonna go the way you want it to go. Or you can't plan everything to the T. but, ja, I think it that answers your question but I think it helped with that regard.

R: Did you feel the need to be accepted by and connected to others during your comm serve year?

P5: (Sigh) (Giggles) (Uhm), that is quite a personal question in the sense that (uhm), yes I did. Only because of my experience as a Masters student. So, I had quite a, not really tough, but I had a- I don't know. If you're a coloured female, the only coloured female in a class and you're quite out there and (uhm) you have tattoos all over, and your hair is the way it is and all of that, I think people see you in a certain light. (Uhm) They judge you by what they see and I don't think people- most classmates and lecturers really expected much if I can put it that way? Which I think put me at an advantage because I like proving people wrong. But in my Masters year I didn't really see it that way. I only saw it afterwards. I was very insecure in my Masters year and I felt like I had to prove myself all the time. And I think going into internship, I was scared as hell because I wasn't sure if I would be accepted because this is me. I am not ashamed of who I am. But I was worried. Working with, I think especially in Potch the last six months, working with predominantly white Afrikaans people, and having had a comment in my masters year of (uhm) you know my lecturer wasn't sure how white, middle-aged Afrikaans would (uhm) respond to me in therapy, so I did feel like I wanted to be accepted. Definitely in internship. But

for comm serve, not so much. But in internship I think I was more expecting of, you know, other people's opinions not to differ from mine. But I did feel the need to be accepted. It is what it is.

R: I understand. (Uhm) What factors influenced you to complete your comm serve year?

P5: (Mmh) (Sigh) I really just (giggles), I couldn't wait in all honesty, to be on my own. So well I think in hindsight, that was it. But in comm serve, all I really wanted to do was psychiatry. Working in a general hospital, I wasn't really exposed to a lot of psychosis, or a lot of psychiatry. So I think the driving factor was I wanted to finish my comm serve and I need to get to a place where I can focus on what I really love. So it did work out for me in the sense that I ended up working at a psychiatric hospital for three years after that. And then, ja, I was like I've seen this now and I still want to do it. But I want to venture out on my own now. I think the biggest thing that motivated me to finish my comm serve was just like seeing psychosis. I don't know why I am like that (laughs), but I love psychosis. I think it is very interesting and I didn't see much of that at a general hospital. It was all medical-related things in terms of referrals, so I think that was the biggest thing for me. And really just being a proper psychologist. Not having an intern before that or a comm serve before the term. Just being a clinical psychologist. And people taking you serious because as an intern and as a comm serve, they still see you as a baby and they don't take you serious. And just not being at the bottom of the food chain anymore because of the hierarchy (laughs). Ja, so being a clinical psychologist, I was like, I need to get there you know, and I don't want to be at the bottom of the food chain.

R: Thank you so much for your time, you've answered some of the questions I was going to ask. I really appreciate your time and your willingness to help me.

### **Kelly (Participant 6)**

R: Please provide your full name and surname.

P6: Anonymous. \*Kelly\*

R: Okay, and your age?

P6: Uhm... What am I now? Thirty-seven years old.

R: Alright and where did you study your M1?

P6: My M1 I did at UW- No, sorry (giggles). I did it at NWU- North West University.

R: Okay and which year was that?

P6: That was in 2017.

R: Okay, 2017?

P6: Yes.

R: Your internship site? Where was that?

P6: I was placed in three locations in the Western Cape. It was Valkenburg Psychiatric Hospital, and Groote Schuur Hospital, as well as Alexandra Hospital, for the disabled.

R: Okay. Which year was that?

P6: 2018

R: Alright. In terms of your comm serve, where did you do your comm serve?

P6: So I did my comm serve in Porterville, in the Western Cape at Voorberg Correctional Facility. It is a prison facility.

R: Alright. And you did that in which year?

P6: So I did that in 2019. Only started in Feb 2019 and then continued and ended January 2020.

R: Alright. Can you please reflect on your community service year?

P6: (Sigh). Long question. And long answer.

(Pause)

P6: From my opinion, I knew it was something that had to be done. I actually looked forward to it and [I] was excited. When we applied, we only... I mean availability at prison facilities were much larger than hospital facilities or psychiatric institutions. So obviously also depending on your location, the sacrifices you've already made... You actually want to be closer to your area- where you stay. Or that's what I- in the phase of my life where I was. So prison was the closest so I had to do that.

R: Okay...

P6: And thinking back of the year that has gone by, I don't think a prison facility is the best place to do community service year for clinical psychologists.

R: Okay. What is your reason for that?

(Pause)

P6: My reasons- I think it felt like everyone and your... and your... internship year becomes very focused. You learn about a lot. You, you really exposed to a lot. Many different mental health issues, that's what we do when we are psychologists. And in a prison setting, firstly, I think the problem with (uhm), depending on how rural you are also- the very limited resources and support. Like psychiatrists, mental health (inaudible). You didn't really have to do work with the (inaudible)...

R: (Interrupts participant) Sorry Linda..

P6: Yes?

R: I apologize for interrupting you. The connection went bad so I didn't really quite get your reasoning. I am sorry about that.

P6: Oh okay. Can hear me now?

R: Yes I can.

P6: Okay let's try again or else I will have to go to another place. Okay?

P6: Did you get nothing of the reason?

R: No. Just the lack of psychiatrists and then the connection went bad.

P6: Okay the psychiatric support- the people are suicidal or at high risk of (inaudible). There's just no psychiatric support.

R: Okay.

P6: The hospitals also don't take- well at that time- I was at the rural place where I worked at. The hospital also didn't accommodate these people. So other than that, (uhm).. so that was the one main reason.

R: Okay.

P6: Also you are not really exposed to many different psychiatric conditions. Its mostly substance abuse, and psychosis due to substance abuse. And anti-social behavior.

R: Okay.

P6: So, that was the three things- or that was the two reasons why I felt, you know, that... You are not really rendering a therapeutic service because of many confidentiality issues. Together with (uhm...), I think,

problems relating to sending people back into gang environments basically. So the whole setup was really bad for therapy.

(inaudible) I think if they want us in correctional facilities to rather have in GEMKOR, like when people are on parole, to actually help them during that phase of their lives.

R: Alright. Linda, I just want to suggest something. Can we rather do a telephonic interview because the connection just keeps going bad and then it goes back again.

P6: Aaaw, I am sorry about that.

R: No, I understand. Do you mind if I then do the whole telephonic interview?

P6: Yes, if you're okay with that, it's fine with me. Sorry about this. Otherwise, I will go over to the other place. I can drive over there if you want.

R: No please don't worry about it. You can stay put, I will phone you.

P6: Okay let's try that.

R: I will phone you in two minutes.

(Interview ends)

(Interview resumes after two minutes)

R: Welcome back.

P6: Let's start where you couldn't hear me anymore.

R: Okay so you said that there were confidentiality issues. You felt like you were not engaging in therapy.

P6: Yes. I couldn't engage in therapy that well because of confidentiality issues. I mean firstly, sometimes you had to have your door open because of seeing a dangerous individual.

R: Okay.

P6: And a ward[en] would stand outside your door. And the next person would call the next person because the staff would be too busy or uncooperative to get the next person.

R: Okay so like an inmate would have to call the other one for therapy?

P6: Yes, yes, yes. I mean just think about all of those things put into one. It's really not a safe environment to see people for growth purposes. For containment, maybe. But that's it.

R: Okay.

P6: And that's why I said that to me it felt like- okay, you don't have resources, basically to help you. Uh you don't have the offer of confidentiality. And those two are very important to be actually able to help people in mental health. So for me, those were the two most important things that stood out and made it difficult.

R: Okay in terms of resources, can I please just clarify with you. You spoke about psychiatric support as being one of them, am I correct?

P6: Ja.

R: What other resources did you feel like you did not have and that you needed?

P6: Uhm... In my case, and that's why this should probably stay anonymous, is that I didn't feel that I had adequate (uhm) support from the, let's call it the, like the uhm, superior psychologists- permanent staff psychologists. And we would differ on very important ethical aspects. We actually differed (uhm) where I was

asked to just proceed and continue seeing the person without reporting. And I felt that I desperately had to report the matter. So things like that. So it basically felt very much, you know- each to themselves.

R: Okay.

P6: (Uhm...) and not even peer, peer supervision or peer support was available.

R: Alright. Talk to me about that. How did that feel for you? Dealing with senior psychologists whom you felt weren't very supportive and also not having peer support.

P6: Ja, okay so, I actually dealt with it, I think, how to contain myself and find other resources. I would like phone some of my colleagues outside of DCS. DCS- the Department of Correctional Services and anonymously, without identifying particulars, then explain the case to them for maybe what they think or reflect about the matter. (Uhm), so that was one way of dealing with that. But specifically, in terms of peer supervision and working with the senior psychologists, I think at the very end- some people, some of my peers in the same situation as I was felt that it was worse than I did. And I think maybe because each person to themselves and you need to then find back up resources.

R: Okay.

P6: So I accepted very soon and easily that this is not a place where I can actually do this type of peer supervision. And for that reason, (uhm), accepted and didn't really request it any longer.

R: Okay, so in one word, how would you describe your comm serve year?

P6: (sigh)

R: Or a sentence?

P6: (Laughs)

P6: (Uhm)... (Pause). Let's say (pause).. Well, pros and cons. But much more cons.

R: Alright.

P6: Ja. If that's what I can say.

R: Okay. What were the pros?

P6: Sorry?

R: What were the pros? What did you find to be the pros?

P6: (Uhm) to learn about risk assessment, I think that's one thing. And maybe just to add, that this was the first. In Masters, we never got to learn about risk assessment. So having a responsibility to actually say whether someone is a risk to society or not. And doing that in your first year without real good (uhm) guidance or training, I think that's a massive risk to put a comm serve in such a position. And to put society in such a position. So to me that would definitely... So the pro was to be able to learn more about risk assessment and to be able to learn more about anti-social behavior and substance abuse.

R: Yes?

P6: I think that was the most important.

R: Alright. Any other positives that you could identify about your community service year?

P6: Any other positives?

R: Yes?

P6: (Uhm), Ja... I think also a broad understanding of crime in South Africa. And (uhm), why crime happens in South Africa and how it happens in South Africa, that was something that stood out for me.

R: Alright. Were there any training opportunities to improve your therapeutic skills, that was offered by DCS?

P6: None, for the first mmmh let's say 7 months. And then they offer the opportunity to go to PsySSA- that annual conference, congress. Ja, PsySSA. Uhm, and all expenses paid and in that, you get your CPD points, the whole year basically- your ethical points and you get to do, Ja, get the experience of PsySSA.

R: Okay.

P6: No specific training pertaining to working with criminals in DCS, or relevant themes- none of that. But we had the PsySSA Week.

R: Did you take it upon yourself to improve on your own skills?

P6: Yes. I made time to read if I could and to Google, you know if I see someone and I liked to get some- read more about it. I would get some standardized articles to read. Unfortunately, I didn't have access to internet at the facility. So I had to do those things after-hours, at home. It was quite bad. But ja, so that and basically, I think I did one short course (uhm), on my own to actually do something in between. But because of the PsySSA, I didn't really... and because you have to take your own leave if you want to do a different course of training. So you have to take leave. And for that reason, you basically decide not to.

R: Alright. Did you feel that you knew what was expected of you during comm serve?

P6: (Sigh). I guess that also depends pretty much on your supervisor. (Uhm). And it took a few months for me to really orientate myself and if I was a senior supervisor or psychologist, I probably would've been a bit more organized and structured in that regard, for the new person coming and not knowing this institution at all. So yes, I think to answer your question, not specifically.

R: Did you do something about it?

P6: Maybe just repeat your question?

R: I asked did you feel that you knew what was expected of you during comm serve?

P6: Ja... Yes, I was so... So did I do something about it? So I think I would just continue to ask if I wasn't sure. And I would ask different people if I wasn't sure. And also being mindful that with any other job, you probably won't always know what's expected of you. There is a document that specifies what is expected of you. So you follow that document, but in real life it's a whole different experience than what is being said on that document.

R: Okay I understand. Earlier on, you spoke about consulting your colleagues outside DCS, in terms of supervision. Did you have any other support structure during your comm serve year?

P6: Ja, we, in Western Cape, which wasn't the case in Gauteng- one of my colleagues said, that we had a two weekly, or two monthly sorry, group. Like a peer group supervision something, they called it (giggles).

R: Yes?

P6: That's what they call it and basically what happens are that the permanent staff as well as all the comm serves come together at one location. For instance, someone like in George would be very far from Cape Town, so they usually didn't make it. But then we would get together for half a day and usually there would be some form of formality where there are two case presentations on any topic and then a comm serve would have to- there were like names in a list- and comm serves would have the opportunity to also present a difficult case, for instance.

R: Okay...

P6: So what would happen during those meetings were that many comm serves did not really feel that it was a supportive peer group supervision situation. I didn't necessarily have that with myself. I presented, I had mostly found that people were able to answer me or give advice for that difficult situation. But some of the others felt

that it was a punitive situation where they would just, you know... permanent staff telling you to “suck it up, this is how it is here. You’re not going to change the situation” or something like that. So I think that really made it difficult. And some people disliked going.

R: Alright. And.. (Interrupted by P6)

P6: But I felt it was supportive. I felt that also seeing my colleagues also doing comm serve already had a form of support in it.

R: Okay any other support structure outside of work?

P6: Ja... Friends and family, and I got married so I think I had a lot of other things keeping me busy and also assisting in my resilience to go through that year. So I think my advice would really be to have enough other good things in life to assist you while going through comm serve, for someone that might be feeling a bit powerless and uhm, ja, not giving you a lot of satisfaction.

R: Okay. And in terms of, you know, we spoke earlier about not really being able to speak to senior psychologists or rather speaking to them and not really getting the support that you need. Did you feel the need to be accepted then by your other comm serve colleagues perhaps?

P6: (Sigh). Uhm... In my regard... I don’t really think so. (Uhm)... I don’t think that it fits in with part of my aims or needs basically in doing that year. I felt very content with the support that I have and the things that I put in place for myself not to really take that too seriously.

R: Okay. Did you feel connected to other people?

P6: Yes. Like, like all other groups I think one has people that you connect with immediately and then others you remain (uhm) superficial... People that you just get to say “hello” and “goodbye” to. And I saw the dynamic of that also in the group- that some people are very close and (uhm) we enjoyed each other’s company and we would check-in with each other via Whatsapp to ask how one is doing at your place or their place or facility. And then ja, everyone had their little... I think most people had their sort of support in their smaller groups. Let me put it that way.

R: And how did that make you feel? Knowing that there are people that check-in with you from time-to-time?

P6: I think it was helpful to know, to normalize feelings and to normalize the situation. And ja, definitely helpful.

R: Okay. Last question: we spoke about the pros and the many cons of your comm serve year. So what factors influenced you to complete your comm serve year despite everything that was going on?

P6: (Laughs). Just thinking of getting it done to get the certificate and compliances just feels that this is another small sacrifice, the last sacrifice to do to be able to get the certificate and to be able to practice in private sector and public sector. Where you feel more (uhm), ja of help.

R: You spoke of sacrifices that you made. I just want to backtrack a little bit. You spoke about sacrifices almost in the beginning of the interview. What type of sacrifices did you make?

P6: I think when you apply for a Masters in Psychology, the sacrifices are a part of that. So you need to, I, I- in my case, I come from the Western Cape and I had to move to a different province for a year. Financial sacrifices to study again. You sacrifice your relationships and prioritize your studies. So for three years, it feels like, you that, this course is like a baby, twins or something. And you need to prioritize it to get it done. So when you get to your comm serve and you have to have more sacrifice. I think it’s really... if it, if it was the first sacrifice then it would’ve been different but it’s not the first time you’re sacrificing something and you’ve come a long way. And I think being mindful of that is important.

R: Alright, understood. I just wanted to clarify that. Anything else that you’d like to add?

P6: (Mmmh), I think maybe your research will also help in future to get a place, and I’ve often thought about this- but to get a place for comm serve (uhm) service providers where they are needed most. And beneficial for

both society and also for themselves, both ways. I think it is a reciprocal thing. And if psychiatric hospitals or clinics or GEMKOR which is where the parole people go to- it is those places that are more, I mean, more suitable to render therapeutic services and psychological services. For sure, that should be considered before sending someone to a correctional facility.

R: So thank you very much Kelly\*, I really appreciate your willingness to share time and experience with me.

The end.

## Appendix F: Turnitin Report

Mini-dissertation			
ORIGINALITY REPORT			
9%	4%	3%	6%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS
PRIMARY SOURCES			
1	Submitted to University of the Free State Student Paper		3%
2	<a href="http://scholar.ufs.ac.za:8080">scholar.ufs.ac.za:8080</a> Internet Source		1%
3	Rohleder, P., M. Miller, and R. Smith. "Doing Time: Clinical Psychologists' Experience of Community Service in a Prison Placement", South African Journal of Psychology, 2006. Publication		<1%
4	<a href="http://scholar.ufs.ac.za">scholar.ufs.ac.za</a> Internet Source		<1%
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6	Pillay, A. L., and B. M. Harvey. "The Experiences of the First South African Community Service Clinical Psychologists", South African Journal of Psychology, 2006. Publication		<1%
7	<a href="http://www.magonlinelibrary.com">www.magonlinelibrary.com</a>		