Clinical Psychologists' Professional Identity: A Qualitative Investigation and Development of a Pilot Scale

Johannes P. Venter

A Thesis submitted to Auckland University of Technology in partial fulfilment of the requirements for the degree of Doctor of Health Sciences (DHSc)

March 2024

Faculty of Health and Environmental Sciences: School of Clinical Sciences

Acknowledgements

To my spouse, you have been my unwavering support throughout this academic journey, offering encouragement, understanding, and lots of patience. Your support and belief in me sustained me through the challenges and the long road to completion. Thank you!

To my esteemed research supervisors, Dr Kirsten van Kessel and Prof Chris Krägeloh. I am profoundly grateful for your guidance, expertise, and mentorship throughout this research endeavour. Your support, insightful feedback, constructive criticism, and dedication to excellence have shaped not only the outcome of this thesis but also my growth as a scholar. I am indebted to you for your invaluable contributions to this work. Thank you for your wisdom, patience, and unwavering support.

Abstract

Professional identity is an under-investigated construct for clinical psychologists. No profession-specific professional identity measurement scale exists for this professional group. Using an integrative literature review, this thesis investigated clinical psychologists' professional identity construct from a social identity perspective. Following this review, semi-structured interviews were conducted with 11 senior clinical psychologists to further explore clinical psychologists' professional identity. Both qualitative content analysis and interrater agreement measures were employed to generate findings, providing a theoretical framework for a clinical psychologist professional identity prototype. This prototype defined five broad areas as integral to clinical psychology professional identity. This included how clinical psychologists perceive their professional identity, personal attributes seen as integral to professional identity, skills and knowledge central to professional identity, a set of expected behaviours fundamental to being a clinical psychologist, and contexts as being influential to who clinical psychologists are. Using an expert panel of senior clinical psychologists, a pilot scale was developed aimed at early career clinical psychologists to measure their development across the five aspects of professional identity. The overall findings have provided an exploratory perspective on clinical psychologists' professional identity, a pilot scale for further validation, and promote further investigation into this important concept.

Keywords: Professional Identity, Clinical Psychology, Dialectical Pluralism, Social Identity Approach, Mixed Methods, Qualitative Content Analysis, Scale Construction.

Table of Contents

Chapter 1: Introduction……………………………………………………..……………9

The Importance of Professional Identity……………………………..……………9

Professional Identity and Clinical Psychology………………………………………10

The Research Questions…………………………………..……………………14

Thesis Structure……………………………………………………………………14

Conclusion……………………………………………………………………………19

Chapter 2: Dialectical Pluralism………………………..………………………………20

Introduction………………………………..……………………………………20

Paradigm or Worldview? An Issue of Definition………..……………………………20

The Starting Point: Paradigm or Research Question…………………………………22

Considering Compatibility…………………………..………………………23

An Overview of Dialectical Pluralism……………………………….………………26

Conclusion……………………………………………………………………………29

Chapter 3: Social Identity Approach…………………………………………………………30

Introduction…………………..……………………………………………………30

The Many Paths to Defining and Understanding Professional Identity……..………30

An Overview of the Social Identity Approach…………………………….……………36

A Final Definition of Professional Identity…………………………..…………51

Conclusion……………………………………………………………………………52

Chapter 4: Study One - Literature Review……………………..…………………………53

Introduction……………………..……………………………………………53

Literature Review Format……………………………………………………53

Methods………………………………………………………………………55

Results…………..……………………………………………………………60

Discussion……………………………………………………………………77

Limitations……………………………………………………………...……82

Conclusion……………………………………………………………………84

Chapter 5: Study Two – Exploring Clinical Psychologists' Professional Identity……..…...86

Introduction…..………………………………………………………………86

Methods………………………………………………………………………86

Content Analysis Results.……………………………………………...……100

Content Validity Results…...…………...……………………………..………146

Discussion……………………………………………………..………………154

Limitations…………………………………………………………….………166

Future Directions……………………………………………………………168

Chapter 6: Study Three – Constructing a Pilot Scale and Piloting the Scale………………170

Introduction…………………………………………………………………170

Data to be Converted to Scale Items……………..……………………………170

Methods…………………………………..……………………………………171

Sample Scale Items and Interrater Agreement Results…………………………..…178

Qualitative Feedback………..……………………………………………………191

Provisional Scale…………………………………………………………………193

Discussion……………..…………………………………………………………198

Limitations…………….…………………………………………………………203

Future Directions…………………………………………………………………204

Chapter 7: Conclusion…………………………………………………………………206

Introduction………………………………….…...……………………………206

Study One: Integrative Literature Review………………………………….…………206

Study Two: Investigating Professional Identity Qualitatively…...…………………208

Study Three: Constructing a Pilot Scale……………………………………………210

Integration of Results and Discussion………………………………………………211

Reference List………………………………………………………………….……………216

Appendices……………………………………………………………………………….247

Appendix A: Prisma……………………………………………………………...247

Appendix B: Interview Schedule………..…………………………………………251

Appendix C: Chat GPT……………………………………………………….254

Appendix D: Survey……………………………………………………………….259

List of Tables and Figures

Figure 1: Adapted Scale Development Model Proposed by Zhou (2019)………………..….16

Figure 2: Levels of Abstraction……………………………………………………………46

Figure 3: Integrative Literature Review Inclusion/Exclusion Process……………………….57

Figure 4: Example of Category Evaluation Question………………………………………100

Figure 5: Example of Scale Item…………………………………………………………174

Figure 6: Expert Item Rating Example…………………………………………………...176

Figure 7: The Early Career Clinical Psychology Professional Identity Development Scale…………………………………………………………………….....196

Table 1: Process Values of Dialectical Pluralism, adapted from Johnson et al (2014)……....28

Table 2: Papers Included in Integrative Review…………………………………..………62

Table 3: Clinical Psychologists' Professional Identity Themes…………….…………….……67

Table 4: Participant Demographic Information………………….……...…….………………….…89

Table 5: Categories and Subcategories of Professional Identity……...…….…………………...102

Table 6: Modified Kappa Values for Professional Identity Categories…….…………………147

Table 7: Categories and Subcategories Initially Identified…………………………………171

Table 8: k* Values for Sample Items……………………………………………………179

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning

Chapter 1: Introduction

The Importance of Professional Identity

Identity is an important construct, indicating who a person is and what they do (Vignoles et al., 2011). Similarly, professional identity informs the identity and the behaviour of professionals (Cruess & Cruess, 2018; Schubert, Buus, et al., 2023). Consequently, professional identity has been implicated in various professional behaviours, from how professionals behave in organisations to how professionals collaborate (Altopiedi & Lavié, 2006; Lifshitz-Assaf, 2018), how they form judgements in specific situations (Bauer, 2015), and which behaviour they consider ethical (Monson & Hamilton, 2011).

Within the health sciences, Matthews et al. (2019, p.1) noted that professional identity is a crucial component of "safe and effective clinical practice of all health professions". Professional identity has been studied in numerous health-related fields, including pharmacy (Noble et al., 2015; Noble et al., 2014), counselling (Hansen, 2003; Mellin et al., 2011; Prosek & Hurt, 2014), social work (Webb, 2017; Wiles, 2013), nursing (Fagermoen, 1997; Hoeve et al., 2014; Moola, 2017; Worthington et al., 2013), occupational therapy (Ashby et al., 2016; Edwards & Dirette, 2010; Whitcombe, 2013), physiotherapy (Hammond et al., 2016; Lindquist et al., 2006) and medicine (Cruess et al., 2014; Cruess et al., 2016; Lane, 2018).

Additionally, several measurement scales have been developed to measure this latent construct in various health professionals. This included medical doctors (Barbour & Lammers, 2015), dentists (Smith et al., 2023), pharmacists (Obeng-Kusi et al., 2022), counsellors (Woo et al., 2018), nurses (Moola, 2017), and chiropractors (Glucina et al., 2024). Indeed, scales have been described as "critical to much of the work in the health, social, and behavioural sciences" (Boateng et al., 2018, p.149) and have enabled researchers to effectively investigate latent constructs, such as professional identity.

Professional Identity and Clinical Psychology

Even with the importance of professional identity as a construct, it has remained relatively unexplored for clinical psychologists in New Zealand and internationally, and no specific professional identity scale exists for this group. Both these points will be discussed in more detail in the latter literature review in Chapter 4. This absence of literature and research into clinical psychologists' professional identity has potentially significant implications, which will be elaborated on next.

Psychology as a profession developed from a preliminary laboratory-based focus in the late 19th century into the many different expressions of the profession currently seen, including clinical psychology, counselling psychology, social psychology, organisational psychology, and so forth (Llewelyn & Murphy, 2014). Clinical psychology emerged as a separate vocational scope, mainly concerned with mental health, at different times internationally. In the United Kingdom, clinical psychologists were officially recognised in 1952 as having a distinct vocational scope (Llewelyn & Murphy, 2014). In the United States of America, this was achieved much earlier, with the American Association of Clinical Psychology being established in 1917 (Benjamin, 2005).

Within New Zealand, the development of psychology as a profession mirrored that of other countries. Psychology was noted to be an academic and experimental career until the mid-20th century, with applied psychology becoming more common and the first postgraduate program in clinical psychology being established in 1961 (Stanley & Manthei, 2004). In a 1978 newspaper article, it was noted that New Zealand had four clinical psychologists working in the country in 1964, growing to 125 in 1978 (Thomas, 1978), and in the year 2022, 1850 were reportedly registered with the New Zealand College of Clinical Psychologists, a professional body representing many of the clinical psychologists in the country (Lang, 2022). As a registered profession, psychology became enshrined in law through the Psychologists Act in 1981 (Stanley & Manthei, 2004). Within the New Zealand context, as in much of the rest of the world, clinical psychologists are noted to be regulated health professionals, requiring specific qualifications and experience, and are an independent vocational scope, separate from but overlapping with other registered psychological scopes of practice (New Zealand Psychologists Board, 2018a). Therefore, clinical psychology as a profession has continued to grow within the New Zealand context and has developed significantly from its initial laboratory roots. Yet very little structured research or information exists about clinical psychologists' professional identity, irrespective of the number of practitioners noted or the timeframe since the profession's inception. This may suggest a haphazard approach to professional identity formation and maintenance rather than the intentional approach adopted in, for example, medicine (see for example Cruess et al., 2014; Lane, 2018).

Furthermore, psychology, and clinical psychology specifically, has been a recognised profession for over 40 years in the New Zealand context. It is unlikely that clinical psychologists' professional identity has remained immobile since the 1980s. Professional identity is not reported as a static construct over time (Chen & Reay, 2021; Chreim et al., 2007) and is typically presented as evolving based on the requirements of the time and social milieu (Capshew, 1999; Pickren & Rutherford, 2010). An example here would be surgeons, whose professional identity was originally strongly defined and informed by the practice of religion or magic, now embodying a predominantly biomedical professional identity (Friedenberg, 2009). Research is needed to update who clinical psychologists are in the 21st century and within the New Zealand context.

Significant developments in the socio-political environment in which clinical psychologists function have been reported. Given socio-political factors' influence on professional identity, an updated and contemporary description of clinical psychologists' professional identity would be helpful. This factor is noted to be especially relevant given that since the inception of psychology as a subject area, it has been claimed by many other professions (Belar, 2012; Bellamy et al., 2014; Capshew, 1999). This is contrasted with the generally held notion of control over a subject area being a core element in defining a profession (Abbott, 1988; Caza & Creary, 2016; Goode, 1957; Monrouxe & Rees, 2017; Wilensky, 1964; Wilkinson et al., 2016). Determining how clinical psychologists see their identity within a shared subject area would be interesting and important from a differentiation perspective. This is critical given the public's reported difficulty in differentiating between psychologists and other psychological services providers (Hartman et al., 2016) to maintain clinical psychology as an essential provider of psychological services in the future.

Clinical psychology, as has been previously mentioned, is a registered profession in New Zealand and much of the rest of the world, with registration aimed at ensuring appropriate levels of training and practice and, by extension, quality of service and public protection (New Zealand Psychologists Board, 2018a). Yet, scepticism regarding psychological practice is reported (Ferguson, 2015). The roles ascribed to clinical psychologists by professional bodies are often quite diverse, ranging from direct clinical work to other roles, such as research or leadership (see for example Australian Psychology Board, 2020; Health & Care Professions Council, 2021; Health Professions Council of South Africa, 2021; New Zealand Psychologists Board, 2018a). Concerns have, however, been raised that psychologists are often narrowly portrayed as therapists only (Feldman, 2021; Henriques, 2013). This may reflect a very narrow publicly ascribed professional identity for clinical psychologists, contrasted to their skills and knowledge as defined by their respective professional bodies. Given that professional identity is not unilaterally decided by a profession only (Wackerhausen, 2009), understanding how professional identity for this group is currently constructed would be an essential goal, i.e. understanding how contemporary clinical psychologists see their professional identity irrespective of the challenges noted. This, in turn, could be helpful information to review training, public education, and the general visibility of the profession and its roles within society.

The challenges to the milieu in which clinical psychologists function, and by extension, their professional identity, have not been limited to other psychological providers or public perception. Ongoing health and mental health reform (Dobson, 2016; Haarhoff & Williams, 2017; New Zealand Government, 2018; Nordal, 2012; Pilgrim & Carey, 2012), increasing use of interprofessional care models (Belar, 2012; Bellamy et al., 2014), the rapid rise in the use of social media and other technologies (Kolmes, 2012; Maheu et al., 2012; Parsons, 2020), and the emergence of COVID-19 (Jetten et al., 2020; Kazak, 2020) are all factors that have continued to exert pressure on how psychologists function and, consequently, their professional identity. Clinical psychologists must adapt and shift their professional identity alongside these developments to maintain a relevant professional identity.

Maintaining relevance will become increasingly important to psychologists. Some authors have already commented on the negative perceived value of psychologists (Ferguson, 2015; Hartman et al., 2016; Lilienfeld, 2012; MacKay, 2008), the potential of psychologists being replaced by cheaper psychological service providers in traditional practice grounds (Court et al., 2017), psychologists' roles being reduced to those of clinicians only, and psychologists finding it increasingly challenging to partake in leadership roles and roles outside that of the clinician (Bellamy et al., 2014; Du Villier et al., 2015). Others, such as Kenkel et al. (2005) and Belar (2012), have highlighted the changing nature of what psychologists must provide in the future, given the changing health environment. These factors make it critical to understand professional identity in the now to enable an intentional approach to professional identity in the future. This will assist the profession in remaining relevant to serving society.

The Research Questions

As noted in the previous sections, understanding clinical psychologists' professional identity is critical to enable an intentional approach to developing professional identity in the future. To this effect, this thesis was proposed to investigate clinical psychologists' professional identity. Two research questions were posed. The first research question was: "Who are clinical psychologists?"

The second research question investigated in this thesis was: "What is suitable item content for a clinical psychologist professional identity scale?" A scale would provide a potential tool for measuring professional identity development in the group, contributing to a more intentional approach to investigating this construct for this group. As previously noted, no professional-specific identity scale exists for clinical psychologists. While professional identity scales targeted at health professionals more generally do exist, significant concerns have been pointed out regarding the psychometric properties of these scales (Matthews et al., 2019). Concerns have been raised regarding the quality of existing professional identity research given the significant disparity and often absence in definitions and theoretical frameworks used in this research (Cornett et al., 2023). Given the essential role the adequate definition of a construct plays in scale construction (Boateng et al., 2018), combined with the concerns raised, the thesis also investigated the construction of a preliminary or pilot professional identity scale for clinical psychologists based on the results of the first research question.

Thesis Structure

In the previous section, two research goals were highlighted: investigating clinical psychologists' professional identity and developing an initial measurement scale. As the goals of this research were twofold, the two research questions were answered through the embedded steps of scale design. The general steps in scale development have been recognised as incorporating both qualitative and quantitative steps (Boateng et al., 2018; Carpenter, 2018; Furr, 2011; Gilgun, 2004; Kyriazos & Stalikas, 2018) and fit well within the mixed methods research framework (Johnson et al., 2007, p.123). These characteristics enabled the qualitative investigation of the construct of professional identity for clinical psychologists (Research Question 1) and the more quantitative approach to designing an initial professional identity measure for this group (Research Question 2). The scale design process also lent itself to further research in the future through the recursive steps often characteristic of scale design processes.

A mixed methods approach was intentionally chosen, as the approach is noted to enhance scale validity and research conclusions (Onwuegbuzie et al., 2010; Schoonenboom & Johnson, 2017; Zhou, 2019), which has been called into question with some available professional identity scales used in health (Matthews et al., 2019). An equal status mixed method approach (Onwuegbuzie & Combs, 2010) was selected to enable actioning all research questions simultaneously and weighing them equally. The use of mixed method data analysis techniques also aligned well with the paradigmatic focus of dialectical pluralism (discussed in Chapter 2) by allowing dialogue between different points of view/data/theories to illuminate complex realities rather than one unified reality (Johnson & Stefurak, 2013).

Several frameworks for scale development from a mixed method perspective were available. These included models described by Creswell and Clark (2018) and an extensive multimethod scale construction protocol described by Onwuegbuzie et al. (2010). The model proposed by Zhou (2019) was chosen as the basis for this thesis. This framework was selected to balance pragmatic, logistical and validity concerns. The proposed model is more compact than the one offered by Onwuegbuzie et al. (2010), while still maintaining a focus on scale validity.

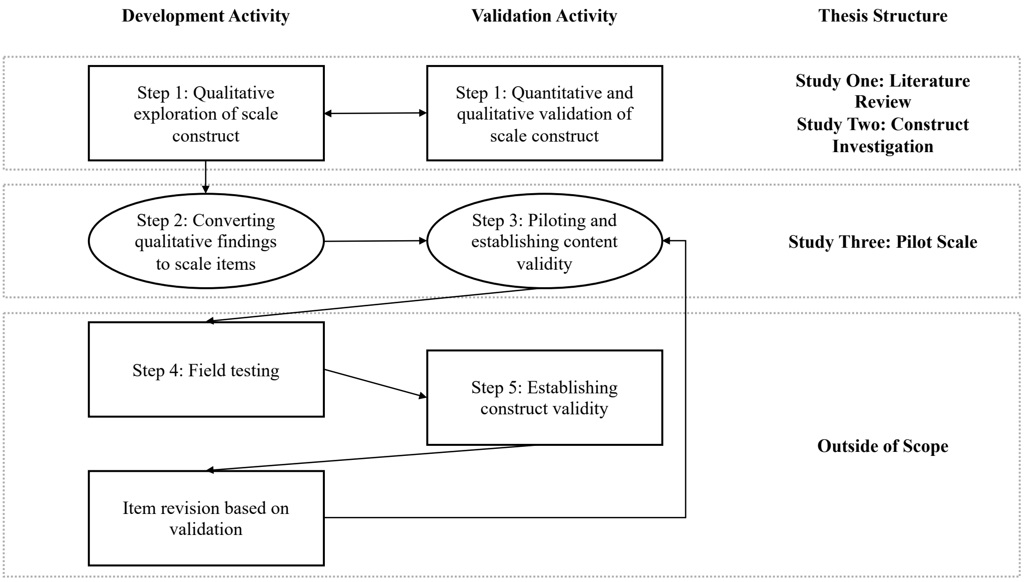
The five-phase scale construction method proposed by Zhou (2019) will be reviewed in the next section. Bazeley (2017) has previously stated that it can be difficult to define or pin down multiple methods. Some adaptation and flexibility in applying the research methods and analysis were therefore necessary during the implementation of the scale design and research approach in general and will be discussed in relevant sections of the thesis.

Zhou Scale Development Model

As noted in the previous section, the scale development model proposed by Zhou (2019) was used to address the research goals of this project. The model implementation relied equally on quantitative and qualitative approaches to scale development. The five phases of the model have been illustrated in Figure 1, adapted from Zhou (2019) to also include the different studies addressed in this thesis.

Figure 1

Adapted Scale Development Model Proposed by Zhou (2019)



To answer the research questions posed, the steps of scale construction were linked with three studies. Study One and Two focused on defining clinical psychologists' professional identity, while Study Three attended to a pilot scale of clinical psychologists' professional identity. Study One investigated clinical psychologist's professional identity through a structured literature review. Study Two examined professional identity using a qualitative study. Study Three utilised qualitative and quantitative techniques to construct a pilot scale. Each of these steps, the associated studies, and their application to investigating the research goals for this project will be discussed briefly in the following sections to provide a high-level overview of the structure of the thesis. A more detailed discussion of the methods used in each step/study, results, discussion of results, limitations and future directions will be presented in separate chapters focused on each study.

Studies One and Two: Qualitative Exploration of the Scale Construct

This first step of the Zhou scale construction process was intimately linked to the first research goal, that of exploring and defining clinical psychologists' professional identity. Boateng et al. (2018) referred to this step as the identification of the domain being studied and allowing for items to be generated effectively. An integrative literature review was conducted as part of this exploration of the construct to be measured. This integrative literature review was presented as Study One in the thesis. The detailed exploration of the approach and methods used in the literature review will be reviewed in Chapter 4.

Zhou (2019) further suggested a qualitative study beyond a literature review to explore the scale construct to deliver the most applicable and detailed information on the scale construct and to inform subsequent item writing. Zhou (2019) did not elaborate on the type of design in their paper, but it was noted that other scale construction protocols often use experts within the field being studied to enable a qualitative exploration of the scale construct (see, for example, Boateng et al., 2018; Onwuegbuzie et al., 2010). Given the nature of the information regarding clinical psychologists' professional identity generated in the integrative literature review and the recommendations from Zhou (2019), a second study was designed to further explore the construct of professional identity in more detail. This was Study Two in the thesis and involved a qualitative study using content analysis to formulate the construct of professional identity for clinical psychologists. The details of the design and implementation of the qualitative study for this step will be discussed in Chapter 5.

Study Three: Converting Qualitative Findings to Scale Items and Piloting the Scale

While the first step of the scale construction process was aimed at understanding the construct to be measured, the second step entailed the construction of initial scale items from the qualitative information generated. The step also involved deciding on the format of scale responses and the visual display of the scale (Zhou, 2019). Zhou (2019, p. 43) described this phase as involving "a mixing strategy that indicates how qualitative and quantitative data are integrated." This step, along with the next step, piloting the scale, would go on to inform Study Three, presented in Chapter 6.

The next step, step three in Zhou's scale development model, focused on reviewing proposed scale items for content-related validity and constructing a pilot scale. Various qualitative, quantitative, and mixed approaches were possible, including reflection, debriefing, panel review, sorting and calculation (Zhou, 2019) to enable the construction of a pilot scale. The methods used in this thesis will be reviewed in the relevant chapter, Chapter 6. Note that both these steps could be repeated several times to ensure good content validity at this level.

Future Studies: Field Testing the Scale and Validation of Content Validity

Both Field Testing and Validation of the Scale Constructs (Phases 4 and 5 of the framework) fell outside the scope of the study. The last two steps of scale development will, therefore, be discussed briefly in theory as they relate to the further development of the professional identity scale and may form part of a future study. After review by an expert panel, scale items are adjusted to satisfaction and the initial scale is administered to the target population, called field testing. Item responses from this step are then subjected to quantitative analysis to further ensure content validity. While the model proposed by Zhou (2019) appeared grounded in a classical test theory approach (although not overtly stated), the option of an item response theory approach could also be considered at this stage. Note again that these steps can be repeated *ad infinitum* until the desired level of content validity.

Conclusion

In this chapter, the importance of understanding clinical psychologists' professional identity was noted. Two research goals, that of investigating a clinical psychologist's professional identity as a concept and the development of a pilot scale to measure this concept, were stated. The overall structure for investigating these two research goals, the scale design structure proposed by Zhou (2019), was noted and linked to the three studies, compromising the body of research aimed at answering these questions. In the next two chapters, the paradigmatic stance and theoretical approach to understanding professional identity will be defined and briefly discussed, as both the paradigm and theory will be important to understand the approach to answering the research questions and the conclusions drawn in Study One, Two and Three.

Chapter 2: Dialectical Pluralism

Introduction

In the previous chapter, the need to investigate clinical psychologists' professional identity was proposed, and the aims of the project were defined. The two aims included exploring and conceptualising clinical psychologists' professional identity and developing an initial professional identity scale. Given the multitude of ways identity could be conceptualised (Vignoles et al., 2011) and the frequent lack of clear definition in professional identity research (Cornett et al., 2023), defining both the philosophical position and theoretical basis of the research was essential, thereby ensuring the way identity was conceptualised and investigated in the thesis being clear. To this purpose, dialectical pluralism was selected as a paradigm, and the social identity approach as a specific identity theory. This chapter starts with an overview of the aspects considered in choosing and defining dialectical pluralism as the framework of the study and moves on to briefly explore the ontological, epistemological, methodological, and axiological aspects of the approach. The next chapter will explore the social identity approach as the theoretical underpinning of identity utilised in the thesis.

Paradigm or Worldview? An Issue of Definition

"Paradigm" and "Worldview" have historically been used interchangeably, but it has also been illustrated that different theorists mean different things when using these terms. Johnson (2011, p. 31) noted in this regard: "The word paradigm has been socially constructed multiple times and it is used in multiple ways by different writers to refer to something they care about." Ghiara (2020) subsequently called for clarity when using these terms and suggested that the word paradigm can reference two perspectives. In the first perspective, paradigm entailed a scholarly framework, or "exemplars" (p.13) of acceptable research practices and methods shared by a scientific community, i.e., the qualitative, quantitative, or mixed methods research community. In essence, this first perspective was reported to hold the paradigm as a tool in the toolbox of that specific community of researchers. The second perspective denoted a scholar's view of the world and the associated ontological, epistemological, axiological, and methodological assumptions. This second perspective, therefore, is more closely aligned to the researcher seeing the world in this specific way exclusively, rather than having different paradigms as tools to choose from.

Johnson (2015), the creator of dialectical pluralism, did not provide a clear indication of the placement of dialectical pluralism in this regard. He noted the placement of mixed methods research as a worldview but also provided principles supporting mixed methods as a paradigm that more widely reflects views held by the community of mixed methods researchers, irrespective of worldview alignment. This community-based approach included respecting, relying on, and combining multiple research approaches and methodologies, as well as non-dogmatism, multiple inquiry goals and purposes, multiple types of reality, dialectics, holism, and so forth (see, for example, Biesta, 2010; Creswell & Clark, 2018; Greene, 2007; Johnson & Gray, 2010; Johnson & Onwuegbuzie, 2004; Johnson et al., 2007; Maxwell, 2011; Schoonenboom & Johnson, 2017; Tashakkori et al., 2012; Teddlie & Tashakkori, 2010).

For the sake of clarity in this thesis, and in accordance with the dialectical nature of dialectical pluralism, I placed myself within the mixed method research community and have therefore been inclined to use paradigmatic frames and methods associated and suitable for mixed methods research, but do not necessarily hold onto only one worldview. The approach in this thesis was, therefore, pragmatically orientated and followed what the research required while still maintaining a paradigmatic view. The term paradigm is therefore favoured in this thesis.

The Starting Point: Paradigm or Research Question

Authors such as Kuhn (1996), Mertens (2012), Schwandt (2015), Davies and Fisher (2018) and more recently, Baker (2021) have noted that all research is conducted within a specific worldview or paradigm as a starting point and that this framework, the researcher and the theoretical orientation adopted are inextricably, recursively, and dynamically linked. Baker (2021, p. 21) stated this beautifully by noting that research does not begin with a research question but rather with the researcher's paradigmatic view and is an attempt to "grapple with truth and to make sense of reality."

From a more pragmatic perspective, however, the research could also be conceptualised as aimed at answering specific questions or aims, which aligned more with the already stated pragmatic approach taken in this research. One aim of this research project involved describing professional identity, which would typically involve a more qualitative approach. Qualitative research methods could provide "rich descriptions of complex phenomena" (Sofaer, 1999, p. 1101) and would, therefore, be suitable for exploring how clinical psychologists perceive their professional identity. The process of scale construction, a second goal in this project, would typically involve both qualitative and quantitative methods and tends to be more reductionist in its outcome (see, for example, Boateng et al., 2018; Carpenter, 2018; Furr, 2011; Gilgun, 2004; Kyriazos & Stalikas, 2018). Both these goals would need to be supported within the paradigmatic approach chosen. Therefore, although it can be said that the paradigm is the starting point for research, a recursive relationship between the goals of the research and the paradigm chosen was envisioned, and these factors influenced one another throughout.

In this project, dialectical pluralism was pragmatically chosen for its ability to account for, converse between, and integrate both qualitative and quantitative information effectively to address the research outcomes. It is important to note that the approach taken to qualitative and quantitative data in this project aligned with the view of Biesta (2010), who noted that qualitative and quantitative denoted different types of data rather than different worldviews or paradigms. Dialectical pluralism provided a structured paradigm to integrate the underlying quantitative and qualitative methods required to meet the goals of the thesis while also providing a philosophically sound (Shan, 2022) paradigm as a base for the research, aligned with the mixed methods community. In the next sections, the compatibility of dialectical pluralism with the research aims, with the scale design process and with the researcher himself will be briefly considered.

Considering Compatibility

Although the position taken in this thesis was one of considering qualitative and quantitative methods as generating data rather than being worldviews in their own right, one cannot ignore the potential for incommensurability (Kuhn, 1996), i.e. whether the data gathered can be integrated and understood in a meaningful way. This debate was, after all, a central factor in the so-called paradigm wars (see, for example, Hall, 2012; Onwuegbuzie & Combs, 2010; Shan, 2022). The potential for incompatibility between methodological approaches taken to the research, given two divergent research aims, needed to be accounted for in the paradigm. Compatibility was therefore considered in reference to the research aims, the scale design process and the researcher himself, and will be discussed in the next sections.

Compatibility with Research Aims

Johnson (2015) noted that dialectical pluralism accounted for the potential of differences between methods used (and indeed other paradigms and theories) by providing a framework for acknowledging, valuing, and synthesising opposing viewpoints using a dialectical approach. Therefore, the dialectic approach accounted for and contained the divergent needs of the two research aims while providing a well-reasoned philosophical framework to support the synthesis of the results. An egalitarian approach is also taken to data collection and synthesis, being labelled as equal status mixed method research (Onwuegbuzie & Combs, 2010). Both qualitative and quantitative methods used were weighed equally in applying the research process. The application of an equal-status mixed research approach has been noted to be especially valued within the dialectic pluralistic tradition (Johnson, 2015) and, from a pragmatic perspective, also held both research goals in equal regard. This ensured both research aims were met within a supporting paradigm compatible with both aims.

Compatibility with Scale Design

Clark-Carter (2010) have previously alluded to the false distinction between qualitative and quantitative data, noting overlap and mutual influence between what would be considered components of each approach. Nowhere has the false distinction between qualitative and quantitative data been more evident than in the process of scale construction. Developing a measurement scale has been observed to require both qualitative and quantitative steps to be successful (see, for example, Boateng et al., 2018; Carpenter, 2018; DeVellis & Thorpe, 2021; Furr, 2011; Gilgun, 2004; Kyriazos & Stalikas, 2018). This multi-step approach fits well with dialectical pluralism's process of "back-and-forth disputation and examination" (Johnson, 2015, p. 2) through dialoguing between the qualitative and quantitative steps as part of the development process. The scale construction process similarly lent itself well to the application of mixed methods research (Johnson et al., 2007), especially given the focus on both qualitative and quantitative steps in the research aims noted. There was, therefore, good alignment noted between the paradigm and nesting the research in the scale design process.

Compatibility with the Researcher

A further factor to consider was the level of separation theorised within the paradigmatic orientations between the researcher and the research. Some paradigms have presented the researcher as an objective observer of a verifiable reality, referred to by John Dewey as a spectator theory approach (Boisvert, 1998). I have not subscribed to this belief of subjective worldviews being completely removed from what you observe. From a neuroscience standpoint, this perspective has been supported by a prevailing neuroscience theory. This theory has postulated the brain as a "probabilistic prediction engine that continually generates predictions of the causal structure of the world" (Nave et al., 2020, p. e1542) based on past learning. Therefore, I did not perceive myself as being able to be an objective observer in the research, and the paradigmatic approach needed to account for this factor.

Another consideration for the paradigmatic frame taken in this thesis was my position regarding different sources of knowledge. Thomas Murner, a German satirist, has been credited with first using the term '*throwing out the baby with the bathwater'* (Murner, 1879), meaning to throw out what is useful alongside what is not. References to the so-called 'paradigm wars' were prolific throughout much of the reading on worldviews and paradigms I did (see, for example, Hall, 2012; Onwuegbuzie & Combs, 2010; Shan, 2022). The use of the word 'war' conjured associations with morality, right and wrong, and, as with war, having just cause to overpower or eliminate an opponent (McMahan, 2008). The paradigm wars, in my view, suggested one approach to being right and truthful beyond all others. In my opinion, this was a restrictive position to knowledge generation, and I was keen to avoid throwing out the metaphorical baby based on a self-limiting approach to understanding a complex phenomenon.

Given the reservations noted regarding objectivity and "true" knowledge, my chosen paradigm needed to reflect a pluralistic approach to the understanding of reality and enable access to this reality through multiple evidence bases and methods. The approach also needed to reflect what Robson and McCartan (2016, p. 16) termed the "scientific attitude", allowing for systematic research, a questioning attitude, and good research ethics. Dialectical pluralism ticked these metaphorical boxes and provided a good fit with both the research questions, research approach, and the researcher.

An Overview of Dialectical Pluralism

The previous sections considered the fit between dialectical pluralism and the research/researcher. The next few sections provide an overview of dialectical pluralism's history, as well as the ontological, epistemological, axiological, and methodological tenets.

A Brief History

Dialectical pluralism could be viewed as a relative newcomer as a paradigm. While initially based on a position of marrying dialectics and pragmatism (Johnson & Gray, 2010), dialectical pluralism was later refined into a paradigmatic approach in its own right (Johnson, 2015; Johnson et al., 2014). While still holding a broadly pragmatic orientation, the approach has now been conceptualised as a "metaparadigm" (Johnson, 2015, p. 156), meaning it is aimed at not only conversing between different methods but also potentially opposing worldviews.

Ontological Assumptions

Dialectical pluralism has been established as perceiving reality as multifaceted. Value is placed on intrapersonal, interpersonal, and objective reality, and these multiple realities are identified as co-existing at the same time (Johnson, 2012, 2015; Johnson & Gray, 2010) and ever-changing (Johnson et al., 2014). Differences and tensions between realities were noted as strengths, with the aim of describing reality comprehensively rather than in a unitary fashion. The aim of the approach was observed to be dialectically engaging with opposing views, leading to a new thesis, antithesis and synthesis, and the cycle repeating due to the differences between realities. Holding this approach to viewing reality ensured a more comprehensive understanding of the subject under study without losing important aspects of the phenomenon being studied.

As previously noted, dialectical pluralism was best described as a metaparadigm, and the core of the ontological framework is seen as pluralism. Dialectical pluralism could, therefore, be conceptualised as valuing different paradigmatic approaches equally and could facilitate discourse between very different perspectives on reality to reach synthesis or a new reality. The approach was reported to encourage empathically working with multiple views or paradigms to uncover a more complex whole (Johnson, 2015; Johnson et al., 2014). The result could be convergent or divergent, the idea being diversity and the combination of viewpoints.

Epistemological Assumptions

Epistemologically, dialectical pluralism was noted to be based on "a dialectical, dialogical, and hermeneutical process for knowledge discovery, construction, and reconstruction" (Johnson et al., 2014, p. 838). The core of the approach's epistemological framework was said to be the dialectical approach to knowing reality (Johnson, 2015), with Johnson et al. (2014, p. 837) having described the approach as both a "philosophical process theory" and "communications theory". As a communications theory, dialectical pluralism encourages dialogue between different worldviews, methodologies, participants and so forth to establish a deeper understanding of the phenomenon being studied. From a process theory perspective, Johnson et al. (2014) proposed several values entranced within the dialectic pluralistic approach, characterising the process adopted within the paradigm to understanding reality. These are represented in Table 1.

Table 1

Process Values of Dialectical Pluralism, adapted from Johnson et al. (2014)

Process Values	Description
Dialectical and both-and logics	Production of new syntheses based on original differences.
Dialogical	Free and open communication and criticism.
Hermeneutical	Every result based on interpretation and may be reinterpreted.
Dynamic and Open	Knowledge continually being formed and reformed.
Holistic	Differences can be combined creatively into larger wholes.
Collaborative	Teamwork, recognises value of others, produces results based on individual strengths operating in combination.
Positive directed	Aims for win-win processes and solutions; vulnerability of researcher/evaluator considered a strength when addressed through trust/openness/power sharing.

Methodological Assumptions

Dialectical pluralism has been conceptualised as pragmatically orientated, using varied methodological approaches and methods based on the needs of each research project. It intentionally mixes very dissimilar methods and methods from potentially different ontological traditions (Johnson et al., 2014). Mixing methodologies could lead to different outcomes, for example, data triangulation or data expansion (Greene, 2007).

Axiological Assumptions

Shan (2022) has reported dialectical pluralism as axiologically orientated rather than ontologically orientated. This orientation meant that the axiological assumptions drove the paradigmatic approach rather than the ontological assumptions. This was based on dialectical pluralism, reportedly drawing from the principles of procedural justice (Johnson et al., 2014;

Johnson & Stefurak, 2013; Rawls, 2001). This approach is noted to value and acknowledge multiple realities as equal, and as such, is also pluralistic regarding ethics and values, as well as sociocultural, political and economic positions (Johnson & Stefurak, 2013). These different perspectives informed reality and were noted to be realities in themselves, and therefore deserving the attention of researchers. The theory was selected based on what was epistemically relevant to the research project, with the practical, applicable theory being valued. This meant that users of dialectical pluralism were encouraged to use the differences and strengths of different points of view to work towards the greater good of humanity.

Conclusion

The investigation of clinical psychologists' professional identity, as well as the construction of a pilot scale, was based on dialectical pluralism as a paradigmatic frame given the ability of this paradigm to integrate both qualitative and quantitative approaches in an equal manner, therefore respecting both research questions and the approach the researcher wants to embody. The overt statement of the paradigmatic approach would also assist those reading the research to judge the overall paradigm used to define and investigate professional identity. While the overt definition of the paradigm has been noted as important in all research, the theoretical framework used to define a construct more narrowly is also important. This theoretical framework, the social identity approach, will be discussed in the next chapter.

Chapter 3: The Social Identity Approach

Introduction

In the previous chapter the paradigmatic frame of the study was explored, being dialectical pluralism. This chapter will focus on the theory that will be used to understand and define identity and professional identity. These were central concepts to the two research goals: the exploration of clinical psychologists' professional identity in New Zealand and the development of a pilot professional identity measurement scale. It has been noted that defining and understanding identity and professional identity is fraught with complexity, given the multitude of frameworks available for this purpose (Vignoles et al., 2011). These frameworks could include sociological (Burke & Stets, 2009), social psychological/group (Tajfel, 1974b) and individual models (Erikson & Erikson, 1998), answering the question "Who are you?" from varying perspectives. Professional identity research, answering "Who are you as a professional?" has also not avoided the pitfalls associated with the complex definitional concerns and has been reported to often lack appropriate theoretical grounding (Cornett et al., 2023). Providing a clear theoretical perspective in the thesis was therefore essential, as this clarity would support how the data is interpreted and reported. This chapter will focus on briefly exploring previous definitions of identity and professional identity and elaborate on the social identity approach as the chosen theory for defining and understanding these constructs. The chapter concludes with a definition of professional identity as used in this thesis, framed in the social identity approach.

The Many Paths to Defining and Understanding Professional Identity

The previous section noted the importance of clearly defining professional identity. This section reviews some of the challenges in defining profession and identity.

Defining Profession

The construct of “profession” has been observed to be a difficult construct to pin down. The Oxford English Dictionary (Oxford English Dictionary, 2000) provided several definitions for the word professional, including being an occupation characterised by holding specific knowledge or being a vocation or career that involves extended training and a formal qualification. More widely, it could mean any work by which someone regularly earns a living. The term was also noted to mean the collection of people engaged in a particular type of work. The breadth of these definitions highlighted what Wilkinson et al. (2016) noted as “course definitional issues” (p. 4) in the use of the word ‘professional’. The word could take on a wide range of meanings, from more task-based definitions, definitions highlighting the role and control of certain areas of knowledge, and how a person acts to definitions that define who a person is in that specific role (see, for example, Abbott, 1988; Caza & Creary, 2016; Goode, 1957; Monrouxe & Rees, 2017; Wilensky, 1964; Wilkinson et al., 2016).

Closely linked to this definitional dilemma were the apparent synonymous meanings of work, occupation and profession. Yadin et al. (2021) provided a potential framework to distinguish between work, occupation, and profession. According to these authors, work was the broadest term, involving any activity requiring effort. Occupation involved work but was narrower in its definition, as it referred to an activity leading to remuneration and was associated with making a living, and therefore placed within the context of an economic activity. A profession, within the Yadin et al. (2021) framework, was viewed as a subcategory of occupations. A profession involves getting paid for expert knowledge and skills that require lengthy, specialised training, some form of credentialing and professional membership, and the work being performed being guided by a professional code aimed at ensuring consistency in the work delivered. Yadin et al. (2021) further highlighted the place of the professional in society, the commitments and responsibilities awarded to the profession within the society, and the generally higher regard enjoyed by professionals within societies as further defining characteristics. Therefore, all professions were considered occupations, but not all occupations were considered professions.

Other, more traditional definitions of professions were noted to have an almost task-based/checklist approach focusing on, for example, having tertiary training, guiding professional bodies and associations, licensing, code of ethics, and so forth (Goode, 1957; Wilensky, 1964). Contemporary definitions, in contrast, appeared to broaden the definition of profession from a noun, i.e. something a person is, to a verb, i.e. something a person does (Caza & Creary, 2016; Wilkinson et al., 2016). As a component of a contemporary definition, control of certain knowledge and skills (being an expert) and the use of these skills would be included in the definition of a professional rather than only educational criteria (Abbott, 1988; Alvesson, 2013).

Another factor complicating the definition of a profession is the underlying purpose and intention of the researcher. Freidson (1970) noted in this regard that definitions can, at times, simply be motivated by one occupation trying to establish superiority over another rather than serving a true analytical purpose.

Given the broad meanings associated with the word professional, a deliberate approach was taken in this study to identify the professional group being studied. This approach involved defining the group using components of the previously discussed definitions, including specifying qualifications, access to and roles within society, and ensuring that participants were also actively engaged (using their skills) in the profession. The legislative framework and regulatory board requirements for psychologists within New Zealand were noted to dictate specific conditions (behavioural, experience, skills and education) to be met to use the term psychologist and clinical psychologist (New Zealand Government, 2012; New Zealand Psychologists Board, 2018a). Given the review of the meaning of profession to this point and the legislative and board requirements noted, clinical psychologists in New Zealand would be considered a specific profession and would be distinguished from similar professions engaged in similar tasks, such as other vocational categories of psychologists, psychiatrists, counsellors, or psychotherapists. These legislative and board requirements also ensured that there was no confusion as to membership of the profession resulting from overlap between the knowledge and skills of clinical psychologists and the practices of other potentially similar professions. Although these professions can, for example, also provide talking therapies or psychotherapy, only a psychologist (and, by implication, clinical psychologist) would be allowed to use the term ‘psychologist’ legally. This study consequently narrowly defined the professional group, clinical psychologists, as currently registered with the New Zealand Psychologist Board within the vocational category of clinical psychology and in current practice.

Defining Identity and Professional Identity

The next term to consider in defining professional identity was the term “identity”. The term identity is reported to have its origin in Latin, *idem et idem*, meaning the same and the same (Gleason, 1983). The focus of this study, being conceptualising professional identity and constructing a measurement scale, relied on finding an appropriate definition of sameness for the group of clinical psychologists. Finding a universally accepted definition for the concept of professional identity, however, has been noted as a challenging prospect (Fitzgerald, 2020).

Identity has been reported to provide a structure for the self, the self in relation to others and the world at large and being pivotal in determining behaviour (Burke, 2004; Hogg & Vaughan, 2018). In short, identity provided an answer to the question “Who are you?” and informed “what you do” as a result. This seemingly simple definition, however, belied a significant amount of complexity. Indeed, Wetherell (2010) made note of a “panoply of concepts" (p.5) in this regard and went on to note three main routes to investigating identity: that of the individual, that of group membership and lastly, the ethical and political route (societal).

While individual, group and social definitions of identity can broadly be identified, there can be further significant differences within these broad categories of definitions in how identity is philosophically and theoretically informed. Both Tajfel (1975) and Jenkins (2014), for example, utilise the term 'social identity' and report identity formation linked to group membership. While similarities are noted, the way these authors understand the term illustrates important philosophical and theoretical differences in the understanding of the concept of identity. Tajfel and other proponents of the social identity approach utilise a positivistic, cognitive and predominantly intrapersonal approach to define a social identity. Jenkins (2014), on the other hand, presents a "collective dialectic of identification" (p.111) based on a social constructivist, intrapersonal and interactional approach based on language to defining social identity. This further highlights the complexity of defining identity clearly.

Professional identity, as a specific "type" of identity, was similarly difficult to universally define. Early seminal professional identity theorists, such as Freidson (1970), reported on this complexity, noting that defining professional identity went beyond simplistically listing specialised knowledge and skills. He noted that professional identity is constructed in negotiation with society interactionally, defining the profession's autonomy, roles, responsibilities and standards.

Fitzgerald (2020, pp. 449-467) further commented on this complexity in her concept analysis of the construct that definitions could vary to include "actions and behaviours", "knowledge and skills", "values, beliefs, and ethics", "context and socialization", and "group and personal identity" and highlighted confusion on structural (i.e.

this is what professional identity ‘is’) versus process (i.e. this is what professional identity ‘does’) definitions.

Wackerhausen (2009) also illustrated the breadth of the construct’s definition by offering an expansive description, noting that professional identity exists on two levels. On a “macro-level” (p.459), professional identity was composed of several factors, including how the profession is officially recognised, how the profession views itself and its competencies, how other professions and the public view it, and how these role-players view the professions competencies, duties, authority and privileges, legal frameworks, etcetera. On the “micro-level” (p.459), a professional identity was defined by what an individual must do to become part of the profession and what they need to keep doing to maintain membership of the profession.

Schubert, Buus, et al. (2023), in turn, provided a very pragmatic definition of professional identity, specifically in the context of clinical psychologists. They simply defined professional identity as the “sense of who we are and how we should behave as professionals” (p.1). This definition reflected the link between who a person/group is and what they do in a very eloquent manner, while the Wackerhausen (2009) and Fitzgerald (2020) definitions allowed for the conceptualisation of the “who and what” on different levels. In this thesis, professional identity was understood as “who” clinical psychologists are, “what” they should do, and “where”, or at what level they are who they are and do what they do. The distinction was not drawn between structural and process components of the definition given that many definitions and identity frameworks, as already discussed, note that “who” you are informs “what” you do. Furthermore, the inclusion of context in the definition highlighted an important component in some identity theories, namely setting or context, being influential in the definition of “who” and “what” a profession does. This contextual component, also present in the social identity approach, the chosen identity theory for this thesis, will be discussed next as the theoretical basis for the chosen definition. Understanding how the definition was viewed in the thesis through the lens of s supporting theory would allow for an understanding of how the identity is formed, and how it functions.

An Overview of the Social Identity Approach

While providing the definition in the previous section was an important step, this definition does not provide a theoretical description/understanding of the underlying construct and its functioning. This section briefly defines and explores the core aspects necessary for understanding the chosen theoretical framework supporting the definition, being the social identity approach. The social identity approach was chosen pragmatically to support the research questions. Wetherell (2010) and Vignoles et al. (2011) have previously suggested that many different potential avenues for the understanding of identity exist, from the individual to socially informed theories. To account for this variety in research, Vignoles et al. (2011) suggested a pragmatic approach to selecting the guiding theoretical identity perspective. The choice should depend on the question being studied.

The research questions in this thesis were to explore clinical psychologists' professional identity and construct a measurement scale for this construct. The identity theory selected needed to embody a group or social perspective given the focus on understanding the professional identity of clinical psychologists as a group in New Zealand and the focus of measurement scales being measurement across a group of people or situations rather than being focused on a specific individual or small group of individuals.

The social identity approach (Haslam, 2004) was therefore chosen as a framework for this study, given the definition of identity from a group membership perspective. As noted by Reicher et al. (2010, p. 52): "When we self-categorize as members of a particular group, we answer the question 'who am I'? in terms of the characteristics that we share with other group members." The question of identity effectively changed to "Who are we?" which is central to understanding professional identity from a group perspective. By holding group membership as a cornerstone to defining identity, this social identity has been indicated as the major determinant of attitudes, perceptions, and behaviour for an individual under certain circumstances (Hogg, 2006; Tajfel, 1975; Turner et al., 1987). Given the social identity approach's emphasis on identity according to group membership (Tajfel, 1969, 1974b) and a group being defined as "having common characteristics or a common fate" (Tajfel, 1974b ,p.72), involving three or more people, these people identifying and attaching with others in the group in some manner and other groups existing to compare this group to (Hogg, 2018; Tajfel, 1982), the application of a social identity understanding to clinical psychologists' professional identity appeared fitting given the ability to define these professionals as a distinct group.

Investigating professional identity using the social identity approach was further supported by the previous use of the theory to define professional identity by other theorists (Fitzgerald, 2020). Ulfsdotter, Eriksson and Linde (2014) furthermore noted that a profession is a prospective source of knowledge about someone's identity given the multiple levels of information the profession conveys, from knowledge and training to social standing, aligning well with the construct of social identity. The variety of definitions of professional identity in the literature further aligned well with a social identity approach, often noting collective perspectives on who a profession is as a group and within society (See, for example, Caza & Creary, 2016; Hilton & Slotnick, 2005; Lancaster & Smith, 2002). The definition offered by Wackerhausen (2009) could be highlighted here again, as he noted that professional identity exists on a "macro"(p. 495) and "micro" (P.495) level and, by implication, both social and individual levels. Professional identity, therefore could exist on an "individual (personal and social) and collective dimension" (Cardoso et al., 2014, p.83) concurrently and, depending on the perspective taken, be a personal system of beliefs that modulates an individual's workplace behaviour (Caza & Creary, 2016), and modulates what roles professionals have access to and play within society, as well as how professionals behave when fulfilling these roles (Lane, 2018).

While the focus of this thesis is on understanding clinical psychologists' professional identity from a group perspective, it is important to note that there are a range of theoretical approaches that could be utilised in this regard. Some of these theoretical approaches even use similar language but vary significantly in the assumed theoretical process involved in establishing and maintaining this group identity. Jenkins (2014) and Tajfel (1974), for example, both utilised the term social identity. Jenkins acknowledged many commonalities between his perspective and that presented by Tajfel's social identity approach but highlighted predominantly sociological, interactional, post-constructive, discourse/narrative constructs as involved in establishing and maintaining group identity. In contrast, Tajfel and later social identity theorists focus on a post-positivistic, social-psychological, cognitive approach to identity formation and maintenance. The approach taken in this thesis aligned more closely aligned theoretically with that proposed by Tajfel and colleagues.

It is important to note at this point that the term "social identity approach" was used as phrasing during the thesis. The social identity approach, however, was best viewed as an amalgamation of different interrelated theories within the understanding of group/social identity (Haslam, 2004). The approach has been reported to have its roots in social identity theory (Tajfel, 1969, 1974a, 1974b, 1982) and the later self-categorisation theory of Turner et al. (1987). The approach has seen the development of several "compatible and integrated sub-theories" (Hogg & Vaughan, 2018, p. 430) and is referred to as an approach rather than a theory to acknowledge these different components (Hornsey, 2008). These developments included, for example, the original focus on intergroup behaviour (especially in the context of prejudice) by Tajfel and the later emphasis on the social cognitive component, called self-categorisation theory by Turner (Tajfel, 1974b; Turner et al., 1987).

Pursuing an understanding of clinical psychologists' professional identity using the social identity approach appeared reasonable given the pragmatic alignment with the construct in the literature, as well as its previous use within the area of study in other professions. The following sections provide a brief review of some of the core aspects and processes of the social identity approach, including how identity is formed and informed and when a social identity is enacted. The chapter ends with a definition of professional identity informed by the social identity approach.

Multiplicity of Identity

The social identity approach has been noted to view individuals as experiencing themselves subjectively as whole integrated persons but holding multiple, well-defined personal and social identities (Hogg & Vaughan, 2018). Holding a divergent set of identities was considered healthier than holding a smaller number of convergent identities (Hogg, 2018). This meant that, at any given time, an individual would have access to many different social or personal identities. Within this thesis, the research questions were focused on exploring one of these identities, at a group level, being the professional identity of clinical psychologists. Professional identity was therefore not conceptualised as the only identity someone identifying as a clinical psychologist would hold but was the focus of the research, rather than other potential identities.

Social Identity Mechanisms

Understanding, in broad strokes, some of the critical processes involved in forming and maintaining a social identity will be important to understand how the gathered data will be interpreted and reported later in the thesis. This section provides a brief overview of some central aspects informing a social identity from the social identity approach.

Social Categorisation.

The first process noted as important to informing social identity is the individual organising the environment into groups. This first step, social categorisation, was defined as "a process of bringing together social objects or events in groups which are equivalent with regard to an individual's actions, attitudes and systems of beliefs" (Tajfel, 1974b ,p.69). The process represented how individuals simplify and make sense of their social environments through grouping (Hogg, 2018; Stets & Burke, 2000; Tajfel, 1969). Bringing individuals together in this manner required "personalization and simplification" (Tajfel, 1969, p. 93). Through social categorisation, groups were seen as possessing certain distinguishing common factors or characteristics (personalization), and simultaneously, differences were accentuated between groups and members of those groups, as well as similarities within groups (simplification). Therefore, clinical psychologists' professional identity in this framework could be seen as informing differentiation from others based on shared characteristics with the group, these characteristics becoming personalised and similarities between group members being accentuated.

Two loosely defined 'types' of social groups could be formed through the application of personalisation and simplification: similarity-based categorical/common identity groups or interaction-based dynamic/common-bond groups (Hogg, 2018). Clinical psychologists, who have been noted to require completion of specific legislative, training and experience requirements to enter the specific grouping, would be an example of a categorical identity group. Common-bond identity groups, on the other hand, would be bound to the grouping through association. A group of protesters protesting global warming may come from vastly different walks of life but are united in a common bond related to a central issue, the issue becoming the bond for the group. Professional identity, as a social identity, was therefore defined in this thesis as based on categorical group membership, requiring the fulfilment of specific criteria to enter the group rather than just sharing a specific bond.

While these typologies of groups broadly defined the similarity between group members, it is also important to note that group members are not necessarily purported to be completely alike (Hogg, 2018) but rather identify based on commonalities, and this social identity becoming the defining identity under certain conditions and contexts. The identity provided by the group is seen as moving to the fore, and other personal or social identities move to the background based on context. This component links with the previously provided definition of professional identity in this thesis as involving who clinical psychologists are, what they do, but also where they do it.

Social Identification.

Social identification was another critical and related process to social categorisation identified, and informed whether a social identity would be moulded and enacted. Social identification involved the individual not only categorising themselves into a specific group, distinct from other groups, based on social categories, but also identifying with the group through an emotive attachment to this categorisation (Ellemers & Haslam, 2012; Tajfel, 1974b). The social category needed to hold "emotional significance" attached to membership of the group to inform a social identity (Tajfel, 1974b, p. 70) or a social identity would not come to the fore.

Therefore, a clinical psychologist would describe themselves as a member of the larger group of clinical psychologists rather than from an individual perspective only if this social grouping held value to that individual clinical psychologist in that context. In essence, identification meant that the group and group membership needed to be important enough to the person at that time as a mechanism to inform who they are and how they behave. Subsequently, the definition of professional identity in this research also implied identifying as a clinical psychologist through a valued attachment to the identity, and the assumption was held that participants volunteering for the study hold an attachment to their identity as clinical psychologists.

Social Comparison.

Another aspect that helped define whether group membership (social categorisation) would lead to identification with the group was social comparison. As previously noted, attachment to a group, alongside knowing one could be categorized into a group, leads to the formation of a social identity. Attachment is further informed by comparison to other groups. This process, called social comparison, involved comparing the group to other groups and judging the comparative status of the groups (Ellemers & Haslam, 2012; Tajfel, 1969, 1974b). Grouping was not viewed as being created equally, and individuals were, where possible, more likely to embrace, identify with and enact social identities linked to groups with a positive social comparative status (Stets & Burke, 2000). A more positive comparative status was noted as more attractive and, therefore, created more potential attachment to the social identity.

The process of social comparison either added value or devalued the particular social identity, leading to specific behaviours aimed at either strengthening or weakening the social identity attributed to the individual (Tajfel, 1969). The more attached a person was to the identity, the more positively an identity was viewed in a context, and the more likely the person was to behave in a way consistent with that social identity. Therefore, for a clinical psychologist to have viewed and enacted their social identity/professional identity as a clinical psychologist, they needed to view this identity as positive not only related to their individual attachment to the identity but also in comparison to other groups. The assumption in this thesis was, therefore, that participants compared their clinical psychologist group membership positively to other groupings they belong to.

Social Identity Salience and Positive Distinctiveness.

While the previous sections detailed the basic process of categorising and identifying with a specific social identity, it is also important to understand when and how a specific social identity becomes “switched on”. Only one identity (social or personal) would have salience at any given time in any given situation (Hogg, 2018). This process is called social identity salience, also sometimes called psychological salience (Haslam et al., 1999; Hogg, 2018; Hogg & Vaughan, 2018; Tajfel & Billic, 1974). Tajfel and Billic (1974) noted that social categorisation is consistently present to varying degrees in every situation involving others and plays varying roles depending on the context. When a social identity or personal identity is active, behaviour on all levels (intrapersonal, interpersonal, intra-group, intergroup, societal, etc.) was seen to be both underpinned by and enabled by the salience of a personal or social identity (Reicher et al., 2010).

The salience of a social identity was driven by a process called positive distinctiveness, also referred to as psychological distinctiveness or optimal distinctiveness (Haslam, 2004; Hogg, 2018). Psychological distinctiveness referred to the process of an individual or social group engaging in actions to preserve and promote their value over other groups or individuals (Ellemers & Haslam, 2012; Tajfel, 1974b). Individuals were seen as striving to value themselves positively and to be valued positively by others in every context they inhabit. This need to be viewed in a positive manner drove, in a dynamic, contextually informed manner, the individual to adopt or devalue specific social or personal identities. The construct of clinical psychologists’ professional identity was, therefore, likely to also be defined by context, i.e. being a valued social identity in certain contexts under certain circumstances. In approaching the research, the ‘context’ was the focus on professional identity, and it was assumed that this social identity was the prominent identity during the research process rather than a personal identity.

Self-Categorisation Mechanisms

In the previous section we explored how social identities were shaped and activated primarily from traditional social identity theory first suggested by Tajfel (1974b). Turner et al. (1987) further elaborated on how individuals enact or switch on social identities using certain cognitive mechanisms, and these cognitive mechanisms becoming critical in determining the salience of a particular identity. The change in salience was primarily based on alterations in how an individual perceived and categorised themselves (Haslam, 2004). This self-categorisation, meaning perceiving oneself as similar to some class or category and dissimilar to another class or category (Turner et al., 1994), was supported by several interlinked cognitive processes allowing an individual to move from a personal identity to a social identity. These cognitive processes were noted to be depersonalisation, abstraction, meta-contrast, fit and category prototypes and perceiver readiness (Haslam, 2004; Turner, 2010; Turner et al., 1987). These mechanisms were important to understand in the context of the current research, as they informed how professional identity was understood and defined throughout the research process.

Depersonalisation.

Self-categorisation was facilitated through a process called depersonalisation or self-stereotyping (Haslam, 2004; Reicher et al., 2010). Depersonalisation involved creating *sameness*, the individual self being perceived as “categorically interchangeable with other ingroup members” of the same category (Haslam, 2004, p. 30). As an example, on a basic level, one would expect one clinical psychologist to be interchangeable with another clinical psychologist as a professional in terms of behaviours, skills, and so forth. Depersonalisation would be an essential step in moving from a personal identity to a social identity, and involved the individual aligning their self-perception, behaviour and attitudes with the group associated with the social identity (Turner et al., 1994). This meant that personal, unique characteristics move to the background while group characteristics move to the fore. Depersonalisation did not mean losing identity (deindividuation) but rather moving into another identity. Clinical psychologists' professional identity, as understood in this thesis, was therefore informed as "sameness" and being "interchangeable" with the rest of the group. In investigating the construct of professional identity, the focus was on this sameness with the group rather than individual differences.

Abstraction.

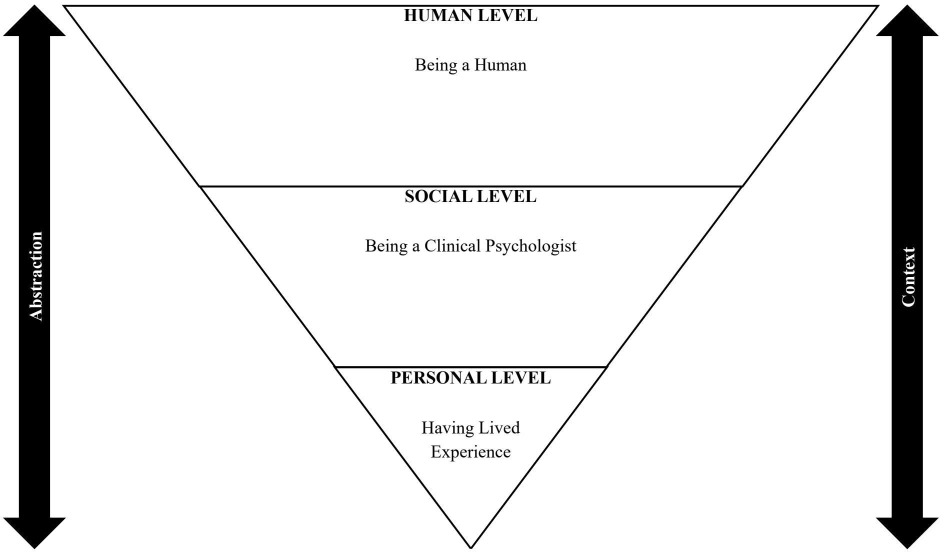
Self-categorisation was further facilitated by the process of abstraction. At any given time, self-categories were noted to exist at different levels of abstraction for the individual, and the individual would have access to categories at high, intermediate, and low levels of abstraction (Haslam, 2004; Turner, 2010). Levels of abstraction referred to the inclusivity of a specific category, with higher levels of abstraction including broader and more diffuse characteristics and requiring more depersonalisation than lower levels of abstraction. Abstraction also facilitated a move from individual identity to group or social identity.

The process of abstraction involved a person being able to define themselves at different levels through social comparison (Reicher et al., 2010). These levels of abstraction could be illustrated by considering clinical psychologists as a group, as illustrated in Figure 2 (adapted from Haslam, 2004). All clinical psychologists are human and would, therefore, share a high level of diverse characteristics with others. Not all humans are clinical psychologists, and clinical psychologists would share several specific characteristics with one another. Not all clinical psychologists have lived experience of mental health issues, and those with lived experience would share an even smaller set of very specific characteristics with one another. Each level represented a lower level of abstraction and was also, therefore, less inclusive and more specific regarding the shared characteristics of the group.

Investigating professional identity was therefore linked to the social level in this thesis, and the characteristics shared at this mid-level of abstraction were investigated in this thesis.

Figure 2

Levels of Abstraction



Meta Contrast.

Self-categorisation also involved meta contrast, with meta contrast providing a context for categorisation through the evaluation of "relative differences" (Haslam, 2004, p. 31). Meta contrast meant individuals grouping stimuli in a specific context based on the degree of similarity or difference between themselves and the stimuli and facilitated self-categorisation by highlighting contrast or similarity to a specific stimulus (Hogg & Vaughan, 2018). If we, for example, consider clinical psychologists being present at a conference for mental health professionals (including psychiatry, social work, occupational therapy, and so forth) versus a conference involving participants from diverse professions such as economics, engineering, marketing, and health, it is likely that the meta contrast principle could lead to different self-categories being enacted by the clinical psychologists in those contexts. In the first scenario, the greatest similarity would likely be between clinical psychologists as a group, leading to self-categorisation with this social identity. In the second scenario, the greatest similarity would likely be between health and other professions, with meta-contrast leading to enacting a wider health professional social identity. Therefore, meta contrast and context were noted as critical in determining which self-category and associated personal or social identity would be active at any given time. Consequently, meta-contrast also informed the understanding of professional identity in this thesis, with the assumption being that during the investigation, clinical psychologists defined the most pertinent aspects of their professional identity as differentiating them from others.

Fit.

The self-category being used at any time is also determined by fit (Haslam, 2004; Turner et al., 1994). Two types of inseparable fit were reported as interplaying with the context and available personal and social categories to determine the self-categorisation that will be displayed in any given situation (Haslam, 2004). Comparative fit referenced the difference between two groups being perceived as bigger than between members of the group (Turner et al., 1994). Comparative fit therefore provided an explanation for the intergroup differences and categorising the self into a specific group and is enabled by meta-contrast (Haslam, 2004; Hogg, 2018; Reicher et al., 2010; Turner et al., 1994).

Normative fit, on the other hand, was more related to the “specific content dimensions” (Turner et al., 1994, p. 6) of comparison. The social category must hold true to what is expected of the category, or the categorisation could happen. A clinical psychologist would not categorize themselves into a group of other clinical psychologists if, for example, the group displayed behaviour significantly different from the norms expected from clinical psychologists. The individual clinical psychologist would, therefore, likely enact a different personal or social identity in that context. The thesis, in exploring clinical psychologists’ professional identity, aimed to identify and define what characteristics clinical psychologists hold dear to enable both comparative and normative fit.

Category Prototypes.

Category prototypes were, in the current research project at least, one of the most useful concepts in understanding how clinical psychologists' professional identity would be understood and could be seen as the information used to inform aspects such as fit and abstraction. Category prototypes referred to a vague set of meaningful qualities attributed to a group that helped to identify similarities within the group and disparities between the group and other groups and functioned to enhance similarities within groups and differences between groups (Hogg, 2018). Prototypes were ideal representations of the group, and group members varied in their level of conformity with the prototype (Hogg & Vaughan, 2018).

These ideal representations would vary based on context. Clinical psychologists would hold a fuzzy set of shared beliefs regarding the general characteristics of being a clinical psychologist, with different members of the group varying in their alignment with these characteristics depending on the specific situation. These characteristics would also shift slightly depending on the context. If the frame of reference or comparison was, for example, based in a treatment centre (context), clinical psychologists showing behaviours and attitudes more characteristic of clinicians may be seen as more representative and prototypical of the category of 'clinical psychologist' than clinical psychologists primarily in academia.

Therefore, multiple prototypes could exist within any given category. The prototype used would depend on the context and be predicted by the meta-contrast principle. In this study, professional identity was defined primarily as a category prototype, with the study aiming to capture the most comprehensive professional identity prototype applicable to the majority, if not all, clinical psychologists.

Social Identity Complexity.

Roccas and Brewer (2002) introduced the concept of social identity complexity. While prototypes are category representations that depict the typical, average characteristics of that specific group, category boundaries would be another way of determining group membership for an individual. In the social identity complexity model this is presented as a way of investigating how individuals perceive their social identity through perceived category boundaries when simultaneously part of several social groups potentially informing identity.

Four strategies were proposed by Roccas and Brewer (2002), arranged on a continuum of cognitive complexity, informing a simplified to a more complex personality structure. Intersection achieves recognition of multiple simultaneous social identities while maintaining a single ingroup categorisation by defining the active social identity based on the intersection between different social identities. A clinical psychologist who is also a male may, therefore, define their social identity as being a male clinical psychologist, creating a multifaceted category. Dominance creates a single social identity by assuming the dominance of one social category while other components are seen as subordinate. Using dominance, a male clinical psychologist may assume clinical psychologist as the primary social identity, while being male is seen as a characteristic of being a psychologist. Compartmentalisation entails the individual differentiating and isolating very distinct social identities based on context. In a work setting, the clinical psychologist may prioritise his identity as a clinical psychologist, while in another setting, his gender may become a primary informant of his identity. The last strategy proposed, merger, involved the blending of multiple social identities to form an inclusive, unified identity. The male clinical psychologist using merger to inform identification would, therefore, identify with all males irrespective of profession and all clinical psychologists irrespective of gender within all contexts.

The current study did not aim to investigate how clinical psychologists deal with the complexity of multiple social identities that are likely present. Instead, the study focused on the average, the prototype suggested by clinical psychologists as representative of a clinical psychologist. Taking this position necessitated the acknowledgement that the clinical psychologist prototype presented would potentially be subject to the same limitations as using an average metric, including supposed homogeneity and decreased sensitivity to outliers. Care was taken to define and interpret data in a manner that was transparent and to a high level of abstraction to mediate this possibility.

Perceiver Readiness.

Perceiver readiness, also sometimes called perceiver accessibility (Haslam, 2004), related to the readiness and willingness of an individual to use a specific self-categorisation and was linked to their own experiences, values, needs, goals and motives (Turner et al., 1994). This process of engaging with a specific self-categorisation was influenced in any given situation by the particular importance and emotional attachment to the category for the individual (Leaper, 2011; Reicher et al., 2010). More important categories were likely to be enacted more frequently should the context allow. Therefore, the social identity of a clinical psychologist might be enacted widely across contexts by an individual attached to this social identity, whereas someone less attached to their social identity as a clinical psychologist may enact more diverse personal and social identities across the same contexts.

The availability of the specific category in the individual's mind at that time would also predict social identity salience. Chronic accessibility referenced more readily available cognitive categories, while situational accessibility referenced cognitive categories being triggered by environmental/situational cues (Hogg, 2018; Hogg & Vaughan, 2018; Turner et al., 1994). An individual who is very attached to their social identity as a clinical psychologist and uses this social identity frequently would likely find this identity more accessible and usable than less frequently enacted identities. A specific context might also cue the availability of a specific social identity, with attachment and regular use of the identity being a less relevant factor for that individual. Being at work for a clinical psychologist would likely be a trigger for enacting the noted professional identity, irrespective of the attachment to the category of clinical psychologist. Again, the study worked on the assumption that participants displayed perceiver readiness in data gathering, leading to results suggesting chronic accessibility of the self-category of clinical psychologists.

A Final Definition of Professional Identity

While it should be clear at this point that professional identity could be viewed as a social identity, the simple definition of professional identity as a social identity was not sufficient for this study. Previous studies on professional identity and professional identity measurement using the social identity approach have often strongly focused on social identification without providing a description of the professional identity (see, for example, Fitzgerald, 2020; Nocerino & Chiarini, 2018; Reinders et al., 2020; Willetts & Garvey, 2020). This might suggest an overreliance on simply identifying with the group rather than embodying who the group is and what they should do. The current study was aimed at conceptualising clinical psychologists' professional identity and providing an initial measurement scale aimed at measuring the level of identification across the constructs identified as forming part of this social identity. It was therefore proposed that the thesis firstly focused on exploring the prototypical professional characteristics of a 'clinical psychologist' as held by the group of clinical psychologists. Professional identity was therefore defined as a category prototype that allowed for maximum identification, differentiation, and fit for most clinical psychologists, as well as the identity they would be most ready to adopt irrespective of context. While the definition of professional identity as "who" clinical psychologists are and "what" they should be doing still rang true, the definition and understanding of professional identity was also driven by the “where”, being the widest context possible.

The second goal of the thesis was to produce a measurement scale measuring the identification of clinical psychologists with these prototypical characteristics. It was, therefore, more accurate to define professional identity in this thesis not only as a social identity but also as based on the category prototype clinical psychologists promote at this time. As illustrated previously, this prototype is highly influential alongside other self-categorisation mechanisms in informing personal and social categorisation, social identification, and social comparison processes inherent to the social identity approach.

Conclusion

This chapter provided an overview of how clinical psychologists’ professional identity would be defined and understood in this thesis. In short, professional identity was defined as who clinical psychologists are and what they should do in the widest context possible. This definition was grounded in the social identity approach and closely aligned with a category prototype, which captured the most critical aspects of what it means to be a clinical psychologist. The next section of this thesis focuses on the exploration of the concept of clinical psychologists’ professional identity through a structured literature review and compromises the first study, Study One, included in the thesis, as per the introduction in Chapter One.

Chapter 4: Study One - Literature Review

Introduction

In Chapters 1 to 3, the stage was set for the thesis, providing information on why the study of clinical psychologists' professional identity was important and how this construct was understood paradigmatically and theoretically. Chapters 4 to 6 focus on reporting the implementation of the research according to the five-phase scale construction framework proposed by Zhou (2019) in Chapter 1 and will present the results of the three associated studies. In this chapter, the first of the three studies addressed the investigation into the professional identity construct using a literature review.

Systematic literature reviews, as concise summaries, have been noted to contribute to policy, future research, and the uptake of evidence-based practice (Grant & Booth, 2009; Leeman et al., 2015). This contribution relied on following a scientific method to reach conclusions, and therefore literature reviews needed to follow the same thorough, methodical design and format as an empirical research study (Cooper, 1998). Literature reviews were also not completely objective endeavours devoid of a researcher's worldview (Onwuegbuzie & Frels, 2015).

This chapter will, therefore, briefly review the chosen literature review format, alignment with dialectical pluralism as the chosen paradigm for this thesis, the methodological frame, and the methods used to review the existing literature. The chapter will conclude with a discussion of the results, limitations of the literature review, and future directions.

Literature Review Format

An integrative literature review format was chosen after consideration was given to the limited direct research into clinical psychologists' professional identity, as will be discussed later in this chapter, as well as the paradigmatic frame, dialectical pluralism. The focus on mixed methods and dialectical pluralism in this thesis required a mixed methods literature review approach (Leeman et al., 2015) to purposefully and systematically provide information on professional identity while still allowing for a degree of interpretation. The literature review approach needed to align with the previously discussed pluralistic ontological view, and dialectical epistemological and methodological perspectives characteristic of dialectical pluralism (Johnson, 2012; Johnson & Gray, 2010; Johnson et al., 2014; Johnson & Stefurak, 2013). Furthermore, the approach needed to be flexible enough to allow for a level of interpretation given the limited direct investigation into professional identity. Integrative literature reviews were noted to be a good fit given the approach's ability to provide "new insights and summarised knowledge" that goes beyond "analysis and synthesis of primary information" (Lubbe et al., 2020, p. 308). While systematic reviews allowed for the exploration of defined research questions in a highly systematic manner focusing on scientific evidence, with the goal of summarising this evidence (Bettany-Saltikov & McSherry, 2016), they were also judged to be highly restrictive given the methods used.

Integrative literature reviews, in contrast, were observed to be aimed at providing an ecumenical understanding of a subject under study, going beyond a strict definition of empirical literature and including other sources of information (Lubbe et al., 2020). Integrative literature reviews achieve this through a systematic, but flexible combination of diverse methods and perspectives, including the broadest review of research and theory possible, in order to critically review and re-envision or expand on the theoretical foundation of the subject under study (Christmals & Gross, 2017; Doolen, 2017; Snyder, 2019; Whittemore & Knafl, 2005). The more forgiving and flexible approach embodied in this type of literature review method was therefore judged as appropriate to generate information on professional identity that could be useful in the qualitative study of clinical psychologists' professional identity. The literature review functioned to explore the current status of the construct, provide an initial overview of the construct, and determine the availability of existing professional identity scales to measure the construct.

Methods

Integrative literature reviews have been reported to include distinct phases, including problem identification (goal of study), literature search, data evaluation, data analysis and presentation phases, respectively (Christmals & Gross, 2017; Doolen, 2017; Whittemore & Knafl, 2005). These five steps were followed to investigate professional identity in the literature and will be elaborated on in the following sections.

The Problem Identification Stage

The problem identification stage in this integrative literature review involved determining the goal of the review, the identification of constructs or variables being addressed and the framework for sampling literature (Whittemore & Knafl, 2005). The current literature search was aimed at identifying, describing, and summarising how clinical psychologists' professional identity was portrayed in the academic literature. The research question was simply "Who" are clinical psychologists in the literature? A second question, related to the first, was whether any specific professional identity measurement scale exists for clinical psychologists. Note that the concept of identity was defined as a social identity and, more specifically, a category prototype, as discussed in Chapter 3. Clinical psychologists were specifically targeted as a population or group, consistent with the discussion in Chapter 3. Professional identity, as a construct, was not strictly defined according to any specific theoretical framework for inclusion, and it was decided that the presence of the term in primary sources was sufficient to potentially include the literature as part of the study parameters.

The Literature Search Stage

The second stage of the integrative literature review involved clearly defining the literature search strategies, the rationale for the search strategy employed, and the inclusion and exclusion criteria used (Whittemore & Knafl, 2005). Google Scholar was initially chosen to ensure the widest possible inclusion of studies. A preliminary literature search on Google Scholar for the terms ‘professional identity’ and ‘clinical psychology’, limited to years 2001 to 2021, was conducted in August 2021 and delivered over 17000 results, often unrelated to professional identity in the target group. Given the number of results and the low quality of these results, the decision was made to follow a more targeted strategy in gathering relevant data for the literature review. Three databases were hence selected (EBSCO host, OVID, and Web of Science), and a narrow search string was applied. The search terms “clinical psycholog*” and “professional identit*” were used across titles, subjects, keywords, and abstracts for English papers between 2001 to 2021. The same search strategy was applied again in November 2023 to update the literature review, extending the year to 2023. Web of Science was no longer available via the University of Auckland Database platform and was excluded from the 2023 update. Search results were combined and checked for repetition, language, year, and clinical vocational scope.

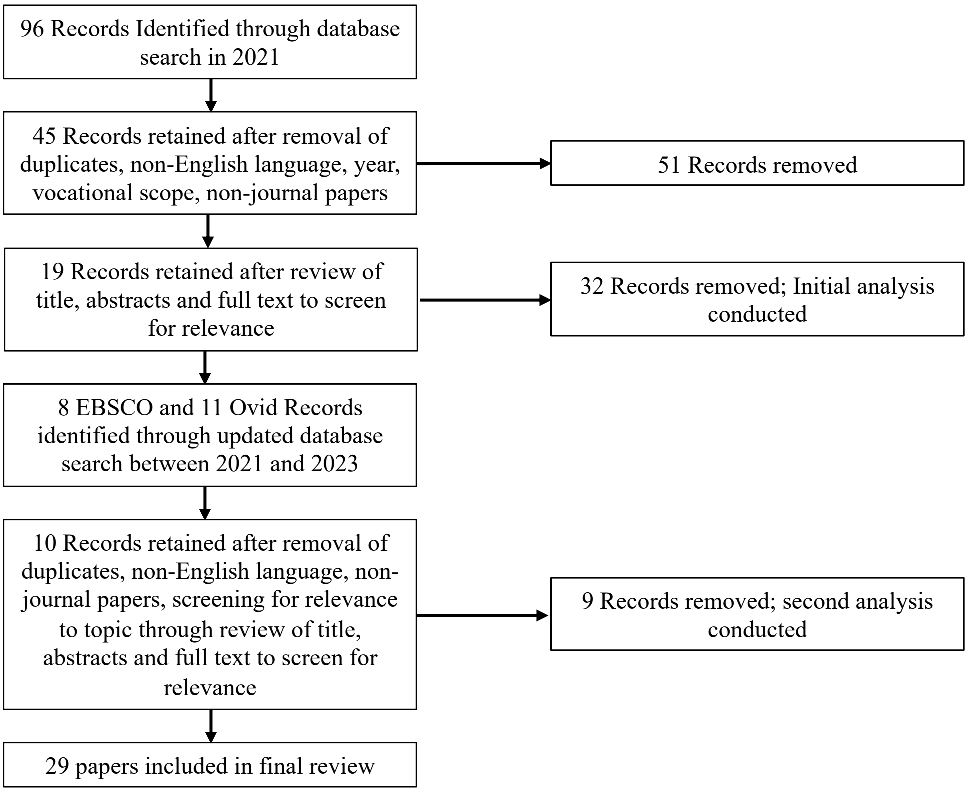
The Data Evaluation Stage

The quality of data or primary sources gathered was evaluated in this next step to determine inclusion in the literature review. A defined quality framework determined inclusion and exclusion criteria. Criteria used were based on reviewing primary sources for repetition, language, year, and clinical vocational scope. The title, keywords, abstracts, and full text of primary sources were also reviewed to ensure professional identity was either investigated or the paper referenced professional identity in relation to clinical psychologists. Papers that did not include direct investigation or reference to the construct were excluded.

The process was conducted twice, once in 2021 and in 2023. The process was conducted by the author of the thesis, working alone and having periodic supervision. The initial investigation led to 19 papers being included in the study for initial analysis, while the 2023 review resulted in 29 papers being included in the study in total. Note that no single study comprehensively investigated the construct of professional identity, and the results were based on references to and inferences about clinical psychology professional identity, as will be discussed in the data analysis stage. The process of refinement is pictured in Figure 3.

Figure 3

Integrative Literature Review Inclusion/Exclusion Process



The Data Analysis Stage

The fourth stage of the integrative literature review involved data reduction, data display, data comparison, and conclusion drawing and verification. To ensure a mixed-method approach to understanding the data, an inductive qualitative content analysis approach was utilised (Bengtsson, 2016; Elo & Kyngäs, 2008; Hsieh & Shannon, 2005) alongside counting (Bazeley, 2017) to generate both qualitative and descriptive quantitative data.

Given the primary sources gathered often did not directly investigate professional identity, an inductive content analysis process was chosen. This choice was based on the inductive content analysis approach being aimed at understanding a phenomenon, compared to a directive, deductive or summative content analysis, which describes a phenomenon based on existing theory (Hsieh & Shannon, 2005). Qualitative content analysis was further selected as it is a flexible qualitative data analysis method, can be used on any type of text, is flexible regarding data collection methods, and is useful to reduce large amounts of texts to meaningful data (Bengtsson, 2016; Mayring, 2022b; Schreier, 2012). The aim of this type of content analysis was to “attain a condensed and broad description of the phenomenon, and the outcome of the analysis is concepts or categories describing the phenomenon” (Elo & Kyngäs, 2008, p. 108). The approach would, therefore, be useful in describing the potentially broad concept of professional identity for clinical psychologists in literature that often did not directly investigate or summarise the phenomenon. The content analysis process will be discussed next.

The Content Analysis Process.

The literature review employed the inductive content analysis procedure suggested by Elo and Kyngäs (2008). Three distinct phases, Preparation, Organising and Reporting, with a total of eight steps, are distinguished in this approach. While appearing linear, the process has been described as recursive, with researchers moving up and down the steps as needed to reach data saturation. The entire content analysis process was repeated in 2021 and 2023 respectively. Each of the three phases, with their accompanying steps, will be discussed in the next sections.

Preparation Phase.

During the preparation phase of content analysis, a research question was defined as the first step. Adaptation and inclusion of this additional step in the original Elo and Kyngäs (2008) approach was based on the recommendations of Mayring (2022b), who suggested that for the purposes of content analysis, a research question needs to be clearly formulated prior to interrogating any text. As already mentioned, the question kept in mind during the analysis of the literature was simply: "Who are clinical psychologists?" and the text was also scrutinised for any indication of a professional identity measure for this group.

The second step was to decide on the unit of analysis. A seme, a clear meaning component in the text (Mayring, 2022b), was considered the smallest interpretable component that could be used to reflect on how professional identity was presented in the text. The meaning units were divided/segmented based on a thematic criterion, described by Schreier (2012) as considering a change of topic at the end of a unit. The decision was also made to interpret latent content (Elo & Kyngäs, 2008). Latent content in this study referred to what was implied as important in the context of professional identity. This decision was necessary given the limited direct investigation of professional identity; the term often being used in context to other constructs being investigated. The third step in the preparation phase involved the researcher immersing themselves in the data to get a sense of the data. This was actioned by reading through the included papers several times in 2021 and again in 2023.

Organising Phase.

After immersion, the researcher moved on to the second phase, as described by Elo and Kyngäs (2008), which focused on organising the data. This phase included five steps. The first step, open coding, involved writing notes and headings in the margins of papers using the chosen unit of meaning (semes) to segment the text and generate specific codes. The material was read through several times, and notes/headings/codes were added as needed in the margins of the included papers. The goal of this process was to describe all aspects of the content related to the research question. The codes were next collected onto coding sheets. Once completed, the codes were grouped into more meaningful units or subcategories followed by the development of generic categories. These generic categories were then grouped under higher-order headings, thereby reducing the number of categories by bringing together data that fits under an overarching main category. These higher-order headings involved interpretation by the researcher, as these categories conveyed meaning and understanding, the process known as abstraction. In considering abstraction, the level of abstraction and interpretation needed to be decided (Graneheim et al., 2017). A high level of abstraction and interpretation was decided on to facilitate the consideration of latent content given the nature of the data and to provide broad categories of the professional identity construct for clinical psychologists.

Reporting Phase.

The last phase of the content analysis process, as defined by Elo and Kyngäs (2008), involved reporting the results obtained, which will be discussed in the next section. Qualitative content analysis results could be represented in either categories or themes (Graneheim et al., 2017). Given the nature of the data, the decision to interpret implied content, and the high level of interpretation, themes were chosen to present the findings, as the identified categories denote a unifying thread running through the literature and required a higher level of interpretation by the researcher.

Results

Twenty-nine papers were included in the review. Just over half (16 papers) included participants with differing levels of education ranging from students, postgraduate students, and fully qualified clinical psychologists. Most papers were focused on student and early career psychologists. Most studies with participants were qualitative studies. Studies often indirectly implied a link to professional identity through investigation or reporting on non-professional identity constructs, with professional identity being embedded in the text in some manner. Most papers were from the United Kingdom and Australia (eight papers respectively), followed by the United States of America (seven papers), while the rest were divided between Italy (three papers), Canada, New Zealand, and South Africa with one each. None of the included papers focused specifically on a comprehensive conceptualisation of professional identity, but either reported on or alluded to aspects of professional identity. The included papers, and associated data are summarised in Table 2. The qualitative content analysis results discussing the outcome of the first literature review research question, who clinical psychologists are in the literature, is discussed after Table 2, as well as the results of research question two, the availability of a specific professional identity scale for clinical psychologists.

Table 2

Papers Included in Integrative Review

Authors and Year	Title	Study Methodology	Study Site	Professional Identity Measure used	Participants
Amodeo et al. (2017)	Group psychodynamic counselling with final-year undergraduates in clinical psychology: A clinical methodology to reinforce academic identity and psychological well-being	Quantitative	Italy	Utrecht-Management of Identity Commitments Scale	49 Stud
Arnett (2001)	Clinical and health psychology: Future directions.	Review	Canada	No	None
Court et al. (2017)	They're NICE and Neat, but Are They Useful? A Grounded Theory of Clinical Psychologists' Beliefs About and Use of NICE Guidelines	Qualitative	United Kingdom	No	11 CP
Di Stefano et al. (2019)	Developing professional identity through group experiential learning: A Group-Analytic experiential training approach for use with postgraduate clinical psychology students	Quantitative	Italy	No	21 PG
Evans (2008)	Steering by Matariki and the Southern Cross: Plotting Clinical Psychology's Course in New Zealand	Commentary	New Zealand	No	None

**CP: Clinical Psychologist*
***GenP: General Psychologist*
****PG: Post Graduate Clinical Psychologist*
*****Psych: Psychiatrist*
******Stud: Clinical Psychology Student*

Papers Included in Integrative Review (Continued)

Authors and Year	Title	Study Methodology	Study Site	Professional Identity Measure used	Participants
Falgares et al. (2017)	Learning Psychology and Becoming Psychologists: Developing Professional Identity through Group Experiential Learning	Quantitative	Italy	No	88 Grad
Foo and Green (2023)	Investigating professional identity formation of postgraduate clinical psychology students.	Quantitative	Australia	Macload Clark Professional Identity Scale	77 PG
Fox et al. (2022)	From the blues to gray matters: Affirming a senior professional identity	Review	USA	No	None
Gill (2012)	An Identity Theory Perspective on How Trainee Clinical Psychologists Experience the Death of a Client by Suicide	Report	United Kingdom	No	None
Gonsalvez et al. (2008)	University psychology clinics in Australia: Their place in professional training	Survey	Australia	No	None
Priest et al. (2011)	Preparing for collaborative working in mental health: an interprofessional education project with clinical psychology trainees and nursing students	Mixed Methods	United Kingdom	No	10 PG 11 mental health nursing students
Hassett et al. (2021)	Motivation to lead in trainee clinical psychologists: service evaluation of a UK doctorate programme.	Mixed Methods	United Kingdom	No	87 Stud 5 CP

**CP: Clinical Psychologist*
***GenP: General Psychologist*
****PG: Post Graduate Clinical Psychologist*
*****Psych: Psychiatrist*
******Stud: Clinical Psychology Student*

Papers Included in Integrative Review (Continued)

Authors and Year	Title	Study Methodology	Study Site	Professional Identity Measure used	Participants
Hogan (2018)	The “Two Cultures” in Clinical Psychology: Constructing Disciplinary Divides in the Management of Mental Retardation	Report	United States of America	No	None
Holttum and Goble (2006)	Factors influencing levels of research activity in clinical psychologists: A new model	Report	United Kingdom	No	None
Hurd (2016)	Claiming Subjectivity: Re-Storying Clinical Psychology and Myself	Qualitative	United States of America	No	1 CP Intern
Jones et al. (2021)	In Faith and Practice: How Christian Doctoral Programs Address Religious Diversity Needs	Report	United States of America	No	None
Kenkel et al. (2005)	A Psychologist by Any Other Name…: Response to Commentary by John L. Arnett	Commentary	United States of America	No	None

**CP: Clinical Psychologist*
***GenP: General Psychologist*
****PG: Post Graduate Clinical Psychologist*
*****Psych: Psychiatrist*
******Stud: Clinical Psychology Student*

Papers Included in Integrative Review (Continued)

Authors and Year	Title	Study Methodology	Study Site	Professional Identity Measure used	Participants
Kottler and Swartz (2004)	Rites of passage: Identity and the Training of Clinical Psychologists in the current South African context	Qualitative	South Africa	No	None
Lancaster and Smith (2002)	What's in a name? The identity of clinical psychology as a specialty	Review	Australia	No	None
Little et al. (2019)	Valued but tenuous? Postgraduate clinical psychology placements for psychology students in rural and remote areas – implications for future directions	Qualitative	Australia	No	8 PG
McKenzie et al. (2013)	Reconciling the professional and student identities of clinical psychology trainees	Quantitative	United Kingdom	No	256 Stud 106 CP
Odusanya et al. (2018)	The Experience of Being a Qualified Female BME Clinical Psychologist in a National Health Service: An Interpretative Phenomenological and Repertory Grid Analysis	Qualitative	United Kingdom	No	6 CP
Ronfeldt and Grossman (2008)	Becoming a Professional: Experimenting with Possible Selves in Professional Preparation	Qualitative	USA	No	29 Stud, 42 student teachers, 15 clergy students

**CP: Clinical Psychologist*
***GenP: General Psychologist*
****PG: Post Graduate Clinical Psychologist*
*****Psych: Psychiatrist*
******Stud: Clinical Psychology Student*

Papers Included in Integrative Review (Continued)

Authors and Year	Title	Study Methodology	Study Site	Professional Identity Measure used	Participants
Salter and Rhodes (2018)	On Becoming a Therapist: A Narrative Inquiry of Personal-Professional Development and the Training of Clinical Psychologists	Qualitative	Australia	No	11 CP
Schubert et al. (2020)	Transformation of professional identity: An exploration of psychologists and psychiatrists implementing open dialogue	Qualitative	Australia	No	3 CP 2 GenP 4 Psych
Schubert, Monrouxe, et al. (2023)	Fragilising clients: A positioning analysis of identity construction during clinical psychology trainees' supervision	Qualitative	Australia	No	4 CP 12 Stud
Schubert, Buus, et al. (2023)	The development of professional identity in clinical psychologists: A scoping review	Literature Review	Australia	No	None
Treichler et al. (2020)	Diversity and Social Justice Training at the Postdoctoral Level: A Scoping Study and Pilot of a Self-Assessment	Literature Review Quantitative	USA	No	16 PG
Woodward et al. (2015)	The buds and shoots of what I've grown to become: the development of reflective practice in Trainee Clinical Psychologists	Qualitative	United Kingdom	No	7 CP

**CP: Clinical Psychologist*
***GenP: General Psychologist*
****PG: Post Graduate Clinical Psychologist*
*****Psych: Psychiatrist*
******Stud: Clinical Psychology Student*

Content Analysis Results

Qualitative content analysis identified nine themes associated with professional identity. The main themes are presented in Table 3 and will be discussed below in more detail under the relevant theme names.

Table 3

Clinical Psychologists' Professional Identity Themes

Theme Name	Description
Specialised	Holding a differentiated and specialised identity separate from other professions.
Dynamic	Professional identity is dynamic and changing.
Ideologically Driven	Professional identity is rooted in and driven by a defined ideology.
Self-referential	The self, i.e. personal identity, is an important and mutually influential component of professional identity.
Setting Based	Who clinical psychologists are is linked to the settings they function in.
Societally Influenced	Professional identity is recognised and influenced via societal structures, public and other professionals' perceptions.
Trained and Socialised	Specific training and socialisation experiences inform professional identity.
Knowledgeable and Skilful	The knowledge, skills and related activities clinical psychologists hold and utilise define who they are.
Acts appropriately	Professional identity is grounded in the way clinical psychologists do what they do.

Specialised.

The first theme identified was that of specialisation or differentiation. Clinical psychologists were described as differentiated from other professions, an independent speciality (Lancaster & Smith, 2002) requiring "specialised ways of working" (Schubert, Buus, et al., 2023, p. 3), suggesting a specialised set of skills and expertise. This differentiation allowed for a sense of belonging, starting as students, and enabled the modelling of professional behaviours (Priest et al., 2011). The differentiation and specialisation appeared based on expert knowledge, a broad psychological knowledge base and the ability to flexibly apply this knowledge in complex treatment-oriented contexts (Court et al., 2017; Lancaster & Smith, 2002). While some overlap in professional identity and similarity with other professions was acknowledged (Priest et al., 2011), this overlap was seen by some as an opportunity for movement towards a “unique and less imitative professional identity”, less confided by “rigid disciplinary boundaries” (Evans, 2008, pp. 5, 7).

Dynamic.

Clinical psychologists’ professional identity was reported to be a dynamic construct (Schubert, Buus, et al., 2023). Professional identity was observed to be established initially as a developmental process in student clinical psychologists (Amodeo et al., 2017), later involving the integration of personal and professional identity (Odusanya et al., 2018) and allowing for a “shift from a reliance on technical expertise to one’s own experience, values and knowledge” (Schubert et al., 2020, p. 145).

Ideologically Driven.

An ideological frame or guiding philosophical stance was noted as informing clinical psychologists’ professional identity. Kenkel et al. (2005, p. 213) described these philosophical stances as the “world views… that define one as a psychologist”, while Schubert et al. (2020, p. 161) referred to "dominant professional paradigms or discourses” in describing clinical psychologists. Descriptions of this ideology were at times very broad, such as referencing being “helping professionals” (Falgares et al., 2017, p. 233), describing clinical psychology as being all about “improving lives” (Woodward et al., 2015, p. 5), or being broadly “humanistic” or “scientific” in orientation (Hogan, 2018). Some descriptions were more specific. Arnett (2001), for example, noted a biopsychosocial underpinning for clinical psychology. More commonly, clinical psychology’s philosophical grounding, and consequently professional identity, was reported to be “enshrined” (Lancaster & Smith, 2002,

p. 48) in the scientist-practitioner approach (Di Stefano et al., 2019; Gonsalvez et al., 2008; Holttum & Goble, 2006; Jones et al., 2021; Salter & Rhodes, 2018). The reflective practitioner model was also noted by select papers as informing professional identity, sometimes in combination with the scientist-practitioner model (Holttum & Goble, 2006). Some authors also called for a more contextually based ideology taking unique cultural-specific concerns into account (Evans, 2008; Kottler & Swartz, 2004).

Setting Based.

Setting was another important determinant of who clinical psychologists were defined as and how they should behave. McKenzie et al. (2013), for example, used social learning theory principles to note that identities, including professional identity, will vary depending on the demands of the specific setting. The setting most linked to clinical psychologists and, consequently, their professional identity was mental health settings, with clinical psychologists described as “highly specialised mental healthcare clinicians within healthcare settings” (Schubert, Buus, et al., 2023, p. 2). It was noted that clinical psychologists “are specifically trained to work in mental health contexts that are unique from other health care settings” (Schubert, Buus, et al., 2023, p. 3). Kenkel et al. (2005, p. 213) referred to a clinical psychologist as “a mental health provider providing testing and therapy to others”, while Court et al. (2017, p. 900) noted that clinical psychologists were “important members of UK mental health services.”

Other authors argued for a broader conceptualisation of the setting, with Arnett (2001, p. 45), for example, noting that “the interests and clinical commitments of clinical psychologists will have to expand considerably beyond the current primary focus on mental health” and that clinical psychologists have “professional responsibilities across the spectrum of health.” Jones et al. (2021, p. 91) echoed this sentiment by noting clinical psychologists have a “health service psychology role”. Another aspect highlighted was knowledge and skill in providing services in diverse cultural/religious contexts (Evans, 2008; Jones et al., 2021; Kottler & Swartz, 2004; Odusanya et al., 2018). This suggested a wider context for clinical psychologists' professional identity than only health or mental health-based settings, and setting characteristics, such as culture, religion, and other social factors, also being influential in defining professional identity.

Self-Referential.

The self, or personal identity, was noted to be in a reciprocal and influential relationship with clinical psychologists' professional identity. Hurd (2016, p. 64) noted in this regard that "clinical work draws on the whole of the clinician". Personal and professional identities were highlighted as being shaped in "parallel" (Amodeo et al., 2017, p. 165) and were interconnected with personal identities (Gill, 2012). This relationship was noted to be an "inextricably linked and interdependent developmental process" (Kottler & Swartz, 2004, p. 487). Clinical psychologists "valued and prioritised integrating personal and professional identities" (Schubert, Buus, et al., 2023, p. 9) and this allowed for both "personal and professional changes" (Woodward et al., 2015, p. 782). The self was noted to inform professional identity, and professional identity became part of the self (Holttum & Goble, 2006).

The integration of self and professional identity involved both formative experiences and personal characteristics being utilised to inform professional identity and to shape behaviours as a professional (Schubert, Buus, et al., 2023; Schubert et al., 2020). Falgares et al. (2017, p. 240) described "'becoming a psychologist'' … (as a) balance between growing (in that it is necessary to gain skills, such as knowledge and competence) and being (it is necessary to be a certain kind of person)." These formative experiences and personal characteristics were indicated as playing a role in the choice of clinical psychology as a profession (Amodeo et al., 2017), providing a disposition to become a psychologist (Falgares et al., 2017, p. 234). Personal characteristics, such as gender, age, motherhood, faith, and ethnicity, could also become tools in being a clinical psychologist and later inform how practice is approached (Fox et al., 2022; Hurd, 2016; Jones et al., 2021; Odusanya et al., 2018). Formative experiences could also provide modelling experiences, for example where a clinical psychologist has received talking therapy (Ronfeldt & Grossman, 2008). Amodeo et al. (2017, p. 165) described this category succinctly, simply noting the self of a clinical psychologist becomes “the main tool of work”.

Societally Driven.

Professional identity was reported to be shaped societally and systemically. Falgares et al. (2017, p. 240) observed this by indicating that “becoming a psychologist can be considered a matter of waiting for social and institutional acknowledgment.” Lancaster and Smith (2002) noted the “training requirements, together with a legislated requirement for registration, increase the status of the profession and distinguish psychology from some health professions”, thereby implicating the role of society and legislative frameworks on the professional identity of clinical psychologists. Gonsalvez et al. (2008, p. 279) emphasised, when discussing clinical psychologists’ professional identity, that “the identity of a profession is in part delineated by … the recognition of the specialist expertise of the profession in society which informs the boundaries of and the contexts a profession can access.” One cannot therefore “be” a clinical psychologist without social recognition and outside of the legislative framework. Social and societal acknowledgement and access to certain roles were noted to be attained through accreditation of training and maintenance of certain standards through professional body memberships (Arnett, 2001).

The societal and systemic components of professional identity were further maintained through the perception of others. Lancaster and Smith (2002) and Arnett (2001) both allude to the influence of public and other professionals’ perceptions on the broader identity of clinical psychologists, either for good or bad. Kenkel et al. (2005) highlighted that "other professionals and the general public generally describe a psychologist as a mental health provider providing testing and therapy to others", thereby placing the conceptualisation of the professional identity of clinical psychologists societally within the mental health care field. Falgares et al. (2017, p. 235) reported the "marked discrepancy between the representation/image of the psychologist as presented by media and the one shared by the scientific and academic community. According to the social representation of psychology given by the media, anyone believed to possess strong empathic, listening and interpretational skills—to be simply strengthened through academic studies—may pursue the career of a psychologist. In contrast with this, within the academic community is a common belief that the university should provide both theoretical and professional skills and tools for personal growth through active involvement in the learning process."

These authors underlined the impact of societal perception on the roles and responsibilities seen as inherent to "who" clinical psychologists are. Court et al. (2017, p. 899) linked these societally driven perceptions to how clinical psychologists express their professional identity, noting that "due to the pressures and dominant discourses within services", clinical psychologists tended to practice in ways inconsistent with their full potential and experienced "fears that their professional identity was threatened", further impacting their behaviour. Societal factors, therefore, played an important role in shaping who clinical psychologists were reported to be and what they believed they should do in the reviewed literature.

Trained and Socialised.

A well-represented theme in the literature regarding professional identity was the completion of specific training and socialisation components, and these components being influential in shaping who clinical psychologists are. Didactic learning and experiential learning were both highlighted as informing professional identity and "being the primary means by which clinicians should be prepared for practice" (Salter & Rhodes, 2018, p. 486). Odusanya et al. (2018) reported "clinical training as a key historical event in professional identity development as a qualified clinical psychologist." To this end, "clinical psychology students are exposed to shared attributes of psychologists through course work, supervision, and practical placements" (Foo & Green, 2023, p. 3), and this exposure became an "identity laboratory" (Amodeo et al., 2017, p. 164).

Didactic learning was noted to provide "some opportunities to grapple with and experiment with… possible selves" (Ronfeldt & Grossman, 2008, p. 56), and to be "the intellectual foundation for practice and hence is central to the identity of a profession" (Lancaster & Smith, 2002, p. 49). Didactic training was an opportunity to acquire psychological knowledge and needed to "ensure that a breadth of exposure to file field of psychology occurs" (Arnett, 2001, p. 43). Experiential learning, in its many forms, was noted as equally important. Amodeo et al. (2017, p. 176) noted that "the learning from experience methodology, which is rooted in the clinical approach, can help to achieve several objectives simultaneously. For instance, one of its main advantages is that it provides an opportunity to acquire an emotional understanding of a technique and is thus undoubtedly more effective than purely cognitive learning. At the same time, this clinical method can allow development of a binocular vision able to pay attention to both identity and well-being dimensions." Little et al. (2019, Discussion, Para 3) further stated: "Professional identity is fundamentally linked to … how they mature through the experiences they encounter".

Several types of experiential learning approaches were highlighted as important components of professional identity development. Falgares et al. (2017, p. 232), for example, highlighted group experiential learning as "particularly useful in changing the basis of social representations and may contribute to the construction of a realistic image of both the profession and the professional identity”. Schubert, Monrouxe, et al. (2023, p. 13) noted the importance of clinical supervision as “an interactional site in which identity work happened.” Ronfeldt and Grossman (2008, p. 52) reported the importance of fieldwork as “having the most influence on professional identity development because of the extensive opportunities to experiment with professional role.” Clinical placements were further noted to be a force for professional socialisation through “viewing leadership, supervisors, MDT (*multi-disciplinary team*) working, supervising others and experiencing service or system change” Hassett et al. (2021, p. 449). Clinical placements offered the opportunity to engage with a “range of psychologist clinical role models and obtain the support of peers and mentors, thus fostering the development of a specialist identity as a psychologist” (Gonsalvez et al., 2008, p. 279). Other experiential components could also include ongoing professional development activities (Schubert et al., 2020), partaking in personal therapy (Kottler & Swartz, 2004) or experiencing certain critical events, for example, client suicide (Gill, 2012).

The training and socialisation process reportedly had a direct impact on the roles clinical psychologists subsequently inhabit. (Holttum & Goble, 2006, p. 344), for example, noted the “formation of professional identity through undergraduate and postgraduate training” and “the degree to which people’s experiences help to create a positive identity as a scientist-practitioner or to alienate them from this identity” as influential in whether the psychologist goes on to secure employment that allows for the embodiment of ‘being’ a scientist-practitioner. Training and socialisation experiences were therefore suggested as important factors in not only developing professional identity but also maintaining and further shaping professional identity throughout a clinical psychologist’s career.

Knowledgeable and Skilful.

The types of knowledge and skills and the associated roles further defined who clinical psychologists were in the reviewed literature. Descriptions of these defining knowledge/competencies/activities varied from broad descriptions such as Jones et al. (2021) referring to specific profession-wide competencies (e.g., evidence-based intervention and assessment) and areas of discipline-specific knowledge (e.g., research methods and lifespan development) to Hassett et al. (2021, p. 442) indicating a “variety of skills necessary for undertaking the role as a qualified clinical psychologist, including professional, clinical and strategic skills.” More condensed descriptions included Schubert, Monrouxe, et al. (2023, p. 2) having noted clinical psychologists’ “primary professional activity” being the provision of talking therapy and the application of clinical skills such as assessment, formulation, and diagnosis to enable this process. This importance of clinical skills was mirrored by Gonsalvez et al. (2008, p. 279), indicating that “Clinical psychology training involves three components: theoretical knowledge, research skills and clinical practice.”

Much of the focus was on clinical psychologists’ role as clinicians and the associated knowledge and skills, suggesting these skills were a critical component of professional identity. Gill (2012, p. 154), for example, described a broad “healer identity” for clinical psychologists, Jones et al. (2021, p. 91) referred to “health service psychology”, while Evans (2008) noted psychologists possess competencies and skills to be generalist providers of mental health and health services. Clinical skills reported included the ability to provide “tools, methods, and techniques which enable … preventive work, make diagnoses, provide psychological support, and deliver rehabilitation programmes” (Amodeo et al., 2017, p. 166), being knowledgeable in multiple treatment modalities (Court et al., 2017; Kottler & Swartz, 2004; Salter & Rhodes, 2018), complex formulation and individualised intervention (Court et al., 2017; Evans, 2008), critical thinking and metacognition (Falgares et al., 2017), and skills necessary to apply specific therapeutic and assessment modalities (see for example Amodeo et al., 2017; Court et al., 2017; Di Stefano et al., 2019; Evans, 2008; Falgares et al., 2017; Priest et al., 2008; Salter & Rhodes, 2018; Woodward et al., 2015).

Indirect clinical and non-clinical/practitioner roles and competencies were highlighted less often in the reviewed literature. These skills/roles included providing supervision (Hassett et al., 2021), leadership (Arnett, 2001; Hassett et al., 2021; Lancaster & Smith, 2002), clinical quality assurance and service development (Court et al., 2017; Hassett et al., 2021), research (Court et al., 2017; Hassett et al., 2021; Holttum & Goble, 2006), consulting and teaching (Court et al., 2017), and socio-political and policy advocacy activities (Arnett, 2001; Hassett et al., 2021; Jones et al., 2021; Lancaster & Smith, 2002; Treichler et al., 2020).

Acts Appropriately.

How clinical psychologists conduct themselves, their professionalism, or in the words of McKenzie et al. (2013, p. 746) "the explicit and tacit rules and practices of the profession", was a further important component of professional identity identified. As part of professionalism, conforming to ethics and professional norms and values was highlighted by several authors (Arnett, 2001; Evans, 2008; Hassett et al., 2021; Jones et al., 2021; McKenzie et al., 2013). Others commented on specific related competencies, including familiarity with the legal aspects of practice (Lancaster & Smith, 2002) or understanding and practising with reference to diversity (Evans, 2008; Hassett et al., 2021; Jones et al., 2021). Certain specific behaviours were also highlighted, including integrity (Hassett et al., 2021), being collaborative and person-centred with both clients and other stakeholders (Arnett, 2001), being congruent, flexible and reflexive (Salter & Rhodes, 2018), being authentic (Hurd, 2016; Schubert et al., 2020), resilient, sensitive, insightful, and emotionally intelligent (Hassett et al., 2021; Schubert, Buus, et al., 2023) and actively contributing to a psychological perspective in setting (Hassett et al., 2021; Kenkel et al., 2005). Specific behaviours were, therefore, a notable component of clinical psychologists' professional identity.

Professional Identity Measure

In the previous sections, the nine identified professional identity constructs were reviewed as suggested by the qualitative content analysis results. This section focuses on the second research question concerned with the availability of a specific professional identity scale for clinical psychologists. Only two studies used an identity scale in the reviewed literature. Amodeo et al. (2017) used the Utrecht-Management of Identity Commitments Scale in reviewing final year undergraduate psychology students' identity development. Foo and Green (2023) employed the Macload Clark Professional Identity Scale in their investigation into professional identity formation in postgraduate psychology students. Neither scale was developed for psychologists specifically, although Foo and Green (2023) highlighted the validity of their chosen scale being reflected in one study involving psychology students in the Australian context.

Discussion

This chapter reviewed the current literature on the construct of professional identity for clinical psychologists using an integrative literature review approach and inductive content analysis method. The review was aimed at providing a description of clinical psychologists' professional identity and reviewing the availability of specific professional identity scales for this group. The literature review identified 29 papers for inclusion. None of the included literature defined or developed a comprehensive description of professional identity for clinical psychologists but commented on professional identity. Most papers were from a Western perspective and, when including participants, focused on student or early-career clinical psychologists. Professional identity was most often commented on or implied in the absence of a thorough investigation into the construct, a specific identity theory or a comprehensive definition being offered.

The literature review provided an attempt to offer a comprehensive overview of “who” clinical psychologists are. The review furthermore provided an overview of the availability and use of professional identity measures for clinical psychologists. The qualitative analysis identified suggested clinical psychologists hold a professional identity conceptualised as being specialised and differentiated from other professions, dynamically developing over time, being driven by an ideological framework, and including and referencing aspects of the self. The identity was strongly shaped and influenced by context or setting, as well as the societal context. The professional identity was further defined by being trained and socialised in a specific manner, holding specific knowledge and skills, and enacting defined, appropriate behaviours. No specific measure for clinical psychologists’ professional identity was identified, and only two studies utilised any developed professional identity measurement. In the next section, important implications of the research are briefly discussed. This includes reference to issues of definition and context when considering clinical psychologists’ professional identity, the lack of targeted research into clinical psychologists’ professional identity, and the lack of developed professional identity scales appropriate for clinical psychologists.

Definition and Context of Professional Identity for Clinical Psychologists

The definition of professional identity and the application of the term appeared highly variable in the reviewed literature. Largely, professional identity appeared to be a loosely defined buzzword with concepts attributed to the construct that may or may not have any relevance. As noted by Vignoles et al. (2011), identity is a complex concept and can be viewed from many different perspectives, ranging from individual developmental (Erikson & Erikson, 1998), social/group (Ellemers & Haslam, 2012) and sociological perspectives (Burke & Stets, 2009). Each of these perspectives provides different answers to “Who are you?” and the given framework is likely to influence the understanding significantly. Cornett et al. (2023) also highlighted these definitional and theoretical difficulties in a scoping review of professional identities in health professions. Although the current literature review was helpful in constructing an understanding of professional identity in clinical psychologists, the quality of the definition in primary literature left the reviewer wondering whether apples were being compared to apples. This is especially relevant given the breadth of identity theories available.

A further point considered was the dynamic and contextual nature of professional identity (Barbour & Lammers, 2015). Both context and time were noted to play an important role in defining professional identity. Consequently, several observed contextual and temporal factors limited the generalisability of the identified professional identity constructs in the New Zealand context. While a perceived alignment between psychological practice in New Zealand and Western perspectives on clinical psychological practice has been noted, there have also been calls for a less iterative identity for psychology within New Zealand (Evans, 2008). It was not clear from the review whether clinical psychologists in New Zealand hold a professional identity aligned with Western values or embody this less iterative identity. No New Zealand-specific study of clinical psychologists' professional identity was identified, and much of the reviewed literature extended over potentially very different international contexts, often first-world and Westernised contexts. The included literature also often relied on early career and student psychologists, not providing an indication of professional identity across the career spectrum of clinical psychologists. Most studies used limited participants or were commentaries or reports, limiting the conclusions that could be generalised as applicable to the group of clinical psychologists in the New Zealand context. The literature reviewed also spanned over 20 years within these different contexts.

These dynamic and contextual nature made it difficult to pin down a full understanding or description of professional identity, especially given the lack of proper definition and theoretical frameworks to support the construct. While the literature review provided a potential framework, contextual factors and time might have a mediating impact on how clinical psychologists' professional identity would be conceptualised in the New Zealand context. Further investigation into the constrict of professional identity in the New Zealand context, therefore, appeared warranted given the lack of well-defined, contextually appropriate and period-appropriate research into the construct.

Research into Professional Identity for Clinical Psychologists

The lack of consistent definition and use of appropriate theoretical frameworks in professional identity research was highlighted in the previous section, as well as the mediating impact of contextual factors. In this section, the lack of research into professional identity as a target construct is highlighted. Within the New Zealand context, no studies could be found that addressed the construct in a holistic manner. Indeed, the literature was sparse internationally, with much of the knowledge presented in this review the product of implied links to professional identity, potentially limiting the validity of the findings. Only one scoping study on professional identity specifically aimed at clinical psychologists was found, this being the paper focused on clinical psychologists' professional identity development by Schubert, Buus, et al. (2023) within the Australian context.

These observations suggested a lack of research attention over the last two decades to professional identity as a construct. While the medical fraternity has long displayed an interest in professional identity and professional identity development (see, for example, Cruess et al., 2014; Lane, 2018), this same intentional approach was lacking for clinical psychologists. As Kenkel et al. (2005, p. 213) noted when discussing psychologists: "Oftentimes professional identity is not deliberately constructed." This may be an untenable position to maintain in future for clinical psychologists given the importance of professional identity as a construct, as highlighted in Chapter 1. While this review was able to propose professional identity structures important to clinical psychologists' professional identity, it was limited by the quality of primary material and certainly does not present an infallible model. Again, further research into the construct was warranted.

Professional Identity Scales for Clinical Psychologists

Linked to the literature review's findings of lacking contextually, temporally, and theoretically sound research on clinical psychologists' professional identity, was the absence of both the use of professional identity scales and specific scales for measuring clinical psychologists' professional identity. In the results, only two studies employed some form of measurement scale in their investigation of professional identity. Although measurement scales have been noted as imperfect (see, for example, Matthews et al., 2019), the application of a measurement scale to research could suggest a theoretical model being applied to professional identity investigation. Scale development has been observed to require the appropriate definition and understanding of the construct being measured to be in place prior to scale construction (Carpenter, 2018; DeVellis & Thorpe, 2021; Furr, 2011; Worthington & Whittaker, 2006), and therefore the scale measurement cannot be separated from the underlying theory supporting the scale. The lack of use of professional identity measurement scales in the research further promoted the perception of the construct being ill-defined or may simply suggest a perceived lack of professional identity scales deemed suitable by researchers for use with clinical psychologists.

Furthermore, the suitability of existing professional identity measures for use with clinical psychologists was dubious. While scales were available to measure professional identity in health professionals, which would include clinical psychologists, and were employed in one study reviewed (Foo & Green, 2023), the psychometric properties of these scales and other 'general' professional identity scales have been questioned. Matthews et al. (2019) conducted one such review and found the validity of commonly used professional identity scales (also in the Foo & Green, 2023 study) problematic. The limited use of professional identity scales again highlighted the need for an appropriately defined and theoretically sound investigation into clinical psychologists' professional identity and the construction of a measurement scale from this information to further support future research into this important concept in New Zealand.

Limitations

While care was applied to minimise the limitations inherent to the literature review of who clinical psychologists are as professionals, some limitations were evident. No existing quality framework for integrative literature reviews could be located. It has been noted that PRISMA guidelines, indicated for use in systematic reviews, can also be used as a guide in this type of literature review (Icahn School of Medicine at Mount Sinai, 2024). The 27-item 2020 PRISMA checklist (Page et al., 2021) was therefore reviewed as part of assessing the design, implementation and reporting of this literature review and is included in Appendix A. Limitations will be briefly discussed next.

Quality Framework

While the PRISMA quality framework was useful as a checklist, it is not specifically designed for Integrative Literature Reviews. While systematic reviews are well-defined in their overall methodology, the absence of an agreed quality framework for integrative reviews may lead to some variation in the understanding and application of the approach.

Paradigm

The chosen paradigm, dialectical pluralism, was clearly stated as a paradigmatic approach for the literature review. It is important to note that dialectical pluralism is often touted to be a meta-paradigm that allows for dialogue between very different paradigmatic approaches and their associated methodologies (Johnson, 2015). The primary dialectical synthesis in this study was from a methods perspective, with the use of counting and the qualitative analysis of primary data. Opposing perspectives on what constitutes professional identity were not analysed, in part due to the lack of a clear or consistent definition of the construct already discussed, as well as the limited available literature. This may have limited the application of the paradigmatic approach, and the potential scope of results generated.

Methodology and Methods

From a methodological perspective, the tension and accompanying potential of synthesis is valued when using a dialectical pluralistic approach, and this was limited to the use of methods as already discussed previously. When evaluating methods, there existed the potential for bias, given the researcher worked alone in both collecting primary resources and analysing primary resources. While supervision by another clinical psychologist and a research psychologist was undertaken, this does not eliminate the potential for bias completely. The researcher is a clinical psychologist himself, has a vested interest in the professional identity and future of the profession and holds specific opinions regarding professional identity. This may have led to increased focus on specific constructs highlighted in the literature, while potentially neglecting others.

Another potential limitation from a methods perspective was the chosen analysis method, qualitative content analysis. Qualitative content analysis has several varied approaches to its implementation (see, for example, Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Mayring, 2022b; Schreier, 2012). While useful to reduce large volumes of text, the way this is done can vary. Given the variation in the agreed implementation of the approach, care was taken to highlight what choices were made during the analysis. This does not, however, preclude another researcher from using qualitative content analysis and potentially coming up with a different framework.

Primary Literature

The primary literature was limited in several aspects, given that not all literature was empirical in nature, nor investigated clinical psychologists' professional identity directly. While judged to be acceptable from a paradigmatic and literature review perspective, this also led to the need for assumptions and interpretation in analysing the data. Primary in these assumptions was that the reviewed literature implied a connection to professional identity by simply stating a connection to professional identity. The second important assumption was that information in the reviewed primary sources reflected directly on who clinical psychologists are and how they should behave based on the opinion of a single or small group of researchers, often unsubstantiated by larger samples of clinical psychologists. These assumptions were useful in the review of the literature and in establishing an exploratory professional identity framework but do not guarantee that this is exactly what primary literature authors believe or to a widely generalisable framework for clinical psychologists' professional identity. This factor is especially important when considering the level of interpretation required to generate the results.

Conclusion

Notwithstanding the limitations noted previously, this study contributed to an initial exploration of the professional identity construct for clinical psychologists. Primary literature sources were analysed using qualitative content analysis to produce an initial framework of clinical psychologists' professional identity. The literature review also investigated whether a measurement scale was available for evaluating professional identity in this group. The literature review findings suggested clinical psychologists hold a professional identity conceptualised as being specialised and differentiated from other professions, dynamically developing over time, being driven by an ideological framework, and including and referencing aspects of the self. The identity was strongly shaped and influenced by context or setting, as well as the societal context. The professional identity was further defined by being trained and socialised in a specific manner, holding specific knowledge and skills, and defined appropriate behaviours. No specific measure for clinical psychologists' professional identity was identified, and only two studies utilised existing professional identity scales.

The findings were limited given the lack of direct investigation into professional identity, primary sources often lacking appropriate definition and theoretical grounding when considering professional identity, and various contextual and temporal factors being identified as potential moderators for professional identity in the New Zealand context, conceivably limiting generalisability of results. These findings laid the framework for further investigation using a larger participant-informed sample in the New Zealand context to establish how professional identity is conceptualised and to develop a pilot scale for measurement of professional identity. The next two chapters will review the two studies developed and executed to achieve the aforementioned.

Chapter 5: Study Two - Exploring Clinical Psychologists' Professional Identity

Introduction

The previous chapter reviewed clinical psychologists' professional identity using an integrative literature review and laid the foundation for further investigation into this important construct in the New Zealand context. A systematic investigation into clinical psychologists' professional identity in New Zealand was consequently designed to further elaborate on the first research goal of the thesis, describing clinical psychologists' professional identity in New Zealand. The following sections lay out the process used and results from this investigation. The chapter will conclude with a discussion of the results, as well as future directions and limitations of the study. The next chapter will cover the construction of a pilot professional identity scale as a further point of research identified in the literature review and inform the second research goal of the thesis.

Methods

Study Design

The study was nested in the scale construction process laid out by Zhou (2019), discussed in Chapter 1. The aims of the study, as nested in the scale construction framework, were to provide a qualitative exploration of the scale construct and clinical psychologists' professional identity and inform the qualitative findings required for constructing scale items as the next phase of the scale construction process. As indicated in Chapter 2, a dialectical pluralistic approach and an equal status mixed method approach were used to paradigmatically inform the study. The social identity approach was used to inform and define the researcher's understanding of professional identity from an identity theory perspective, as was discussed in Chapter 3.

The study involved investigating the construct of clinical psychologists' professional identity using a qualitative content analytic design using a panel of expert clinical psychologists in the field. The results of the qualitative content analysis were thereafter re-presented to the original participants to evaluate the content validity of findings through interrater agreement ratings. The next sections will elaborate on the sampling methods, data gathering, and data analysis used in both quantitative and qualitative components of the study, whereafter the results, discussion, limitations, and future directions are presented.

Sampling Procedure.

Professional identity was explored using an expert panel, with the goal of defining the construct of professional identity. Given the reliance on an expert panel, the literature was explored to define ‘expert’. Shanteau et al. (2003) reported several ways to define ‘expertise’ in a review of this concept’s use in Delphi techniques. This review included consideration of expertise being defined based on knowledge, experience, or influence. In this study, an “expert” was defined in two ways, being relevant knowledge and relevant experience. Given this definition of expertise, a minimum level of required knowledge was obligatory for participants and established by inviting clinical psychologists registered with the New Zealand Psychologist Board to participate. This was possible due to the requirements the New Zealand Psychologist Board requires for registration as a clinical psychologist (see, for example, New Zealand Psychologists Board, 2011, 2012; New Zealand Psychologists Board, 2018a). Expertise in “being” a clinical psychologist was established by introducing a time-based experience requirement. Senior (greater than five years’ experience) and consultant (greater than 10 years’ experience) clinical psychologists were invited to partake in the study. This estimate of seniority was guided by collective agreements in the New Zealand context using these terms to denote level of tenure, and requiring certain levels of skills (APEX, 2016).

To maintain the potential for a wide variety of opinions on professional identity and encourage heterogeneity, a simple random sampling procedure was followed, meaning each member of the population of senior and consultant clinical psychologists had an equal chance of being included in the sample (Bhardwaj, 2019). This decision was informed by the need to define clinical psychologists' professional identity, and not, for example, clinical psychologists' professional identity within a specific health sector or organisation. Given the psychology profession's commitment to biculturalism in New Zealand (New Zealand Psychologists Board, 2011), having Māori and Pasifika clinical psychologists present on the expert panel was set as a sampling goal to promote equitable representation, partnership, and participation in defining professional identity.

Sampling was actioned by inviting participants meeting the knowledge and experience requirements to participate in the research between April 2022 and December 2022. Participants were recruited through advertisements published by the New Zealand College of Clinical Psychologists and Psychological Society of New Zealand in April 2022, and email notifications to the membership of the New Zealand College of Clinical Psychologists, the New Zealand Special Interest Group for Neuropsychology, and the Auckland Regional Interest Group for Neuropsychology in October 2022. The second round of participant invitations was required due to a poor response to the April 2022 requests. Sampling participants identifying as Māori and Pasifika was unsuccessful.

The aim of sampling was to have a panel of 10-20 expert contributors to the study to help ensure the breadth of opinions being represented. Given there is little consistency in the research regarding sample sizes for qualitative research, Mayring (2022b) recommended considering the variability of the phenomenon under study and the research design. He recommended that the more homogenous a phenomenon is, and the more descriptive a study is, the smaller a sample size can be. For heterogeneous phenomena and exploratory studies, a larger sample size was preferable. It is unclear how Mayring defined exploratory and descriptive studies. Elman et al. (2020) provided a definition of exploratory research, noting that exploratory research has a broad (and problematic) definition and functions as an attempt to discover something new about a phenomenon. DeCarlo (2018) provided a more pragmatic definition, noting that exploratory research is associated with the early investigation into a phenomenon and establishing the feasibility of conducting more research into the area, while descriptive research is aimed at describing or defining a particular phenomenon.

The goal of this research was to provide an initial exploration and description of clinical psychologists' professional identity given little focused research in this area and the research was therefore conceptualised as an exploratory study. Given this was an exploratory study where the variability of the phenomenon (professional identity prototype) was unknown, the framework offered by Mayring (2022b) would suggest a larger sample size as preferable. This requirement needed to be balanced against the exploratory nature of the research and the pragmatic concerns of a single researcher sampling a larger volume of participants, as well as the ability to secure a large sample in a relatively small professional group. An initial sample of eleven participants was consequently recruited for both the qualitative phase and quantitative phase of the study. Due to attrition, seven of the original participants provided feedback in the interrater agreement (content validity) phase. The demographic details of the initial sample are presented in Table 4.

Table 4

Participant Demographic Information

Characteristic	n	%
Age		
30 to 40	4	36.36
41 to 50	1	9.09
51 to 60	3	27.27
61 +	3	27.27

Participant Demographic Information (Continued)

Characteristic	n	%
Gender		
Male	1	9.09
Female	10	90.91
Ethnicity		
New Zealand European	4	36.36
Other European	3	27.27
Other	4	36.36
Country of Training		
New Zealand	6	54.55
Other	5	45.45
Other vocational scope registration		
Neuropsychology	5	45.45
Years in Practice		
5-10 Years	3	27.27
11-20 Years	4	36.36
21 – 30 Years	2	18.18
31+ Years	2	18.18
Years in Practice in New Zealand		
1-10 Years	6	54.55
11-20 Years	3	27.27
21 – 30 Years	1	9.09
31+ Years	1	9.09
Sector Experience		
Sector Experience – Client facing work	11	100
Sector Experience – Academia/Teaching	5	45.5
Sector Experience – Supervision	7	63.63
Sector Experience – Leadership/Management	3	27.27

Data Gathering Procedure.

Data was gathered in two discreet phases. The first phase focused on using semi-structured interviews to gather qualitative data on professional identity. The second phase aimed at establishing agreement between participants on the identified professional identity constructs using a primarily quantitative approach. Both data-gathering procedures will be discussed briefly in the following sections.

Qualitative Data Collection.

Data was gathered in the qualitative phase using in-person and video conferencing interviews (Microsoft Teams) in late 2022. Two in-person interviews were conducted, while the remainder utilised video conferencing. Epistolary e-mail-based interviews (as described by Debenham, 2007) were also offered to maximise participant choice, but no participants took up this method as an option. Interviews lasted, on average, 45 minutes to an hour. Semi-structured interview schedules were developed and used during the interviews and captured biographical information and data regarding participants' perceptions of clinical psychologists' professional identity. Semi-structured interviews were used given the ability to formulate questions from the literature review conducted in Chapter 4, and these interviews supported a less structured, dynamic, and flexible conversation, enabling a comprehensive account of a participant's views (Clark-Carter, 2010; Jamshed, 2014). Given little research currently exists in the area of interest, clinical psychologists' professional identity, the use of a less structured interview approach in such circumstances was supported by Streiner (2015, p. 21), who noted that "the less is known about an area under study, the less structured is the interview."

The procedure described by Kallio et al. (2016) was used to generate the semi-structured interview schedule. This procedure included five distinct phases, identifying the necessary conditions for using semi-structured interviews, conducting a review of previous knowledge in the area of study, constructing the prefatory semi-structured interview schedule, pilot testing the schedule, and formulating the complete semi-structured interview guide. As noted already, semi-structured interviews were deemed appropriate. The literature review presented in Chapter 4 informed the set of questions formulated for the interview schedule. The initial semi-structured interview was piloted over several supervision sessions with the research supervisors for this thesis. The final interview schedule was constructed and is presented in Appendix B. The interview schedule was used as a guide in interviewing the 11 participants, and the results of these interviews are presented later in this chapter.

Quantitative Data Collection.

On completion of the analysis of the qualitative results from the semi-structured interviews, the 11 participants were again approached to provide feedback on the results, with seven responding to the request. Data was gathered using the RedCap Online Survey Tool in July 2023. A brief definition and description of the main categories and subcategories derived from the qualitative investigation were provided. Participants were asked to rate how relevant they thought these categories were to clinical psychologists' professional identity.

Ratings were based on a 4-point unipolar Likert scale, the descriptive anchors (Alhassn et al., 2022) being Irrelevant, Somewhat Relevant, Quite Relevant and Very Relevant. A unipolar Likert scale, or scale in which values extend in only one direction, was chosen given the interest being only relevance of the category or subcategory to professional identity (as opposed to how irrelevant the construct may be to professional identity). There was also the opportunity to further comment at the end of the survey and provide additional qualitative information if required. No qualitative feedback relative to the proposed categories and subcategories was noted. The results of the interrater agreement (content validity) phase will be presented later in this chapter.

Data Analysis Procedures.

Two interrelated data analysis procedures were completed using the methods described previously. The first reviewed the qualitative results generated through the semi-structured interviews using qualitative content analysis. The second analysed the data gathered in the survey using quantitative ratings of interrater agreement on the constructs identified previously as central to clinical psychologists' professional identity. These two procedures will be discussed subsequently.

Qualitative Data Analysis.

Interviews were audio-recorded and transcribed using a clean or easy-read transcription method as described by Mayring (2022b). This approach was chosen as the researcher was interested in analysing and interpreting the data as close as possible to the text, rather than focusing on latent content and meaning. The data was also anonymised during transcription, with any identifying particulars removed. Participants were identified by P and an assigned number and any identifying contextual information, e.g. occupation was replaced with REDACTED OCCUPATION. This approach will be evident in quotes that illustrate results later in this chapter.

Data from the semi-structured interviews were analysed using conventional/inductive qualitative content analysis (Bengtsson, 2016; Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). Whereas directive/deductive content analysis was noted to be generally aimed at validating, confirming, or extending theory, conventional/inductive content analysis was observed to be aimed at describing and exploring a phenomenon. This suggested an inductive approach to be best suited to the goal of providing an exploratory review of clinical psychologists' professional identity. Qualitative content analysis was further chosen based on several considerations related to the paradigmatic view taken in the study, the dual goals of describing professional identity and producing a measurement scale, and various pragmatic concerns related to the research questions and the amount of information that would need to be interpreted. These reasons will be discussed briefly.

Using qualitative content analysis appeared fitting, given the good alignment between the method and dialectical pluralism (discussed in more detail in Chapter 2). Ontologically, qualitative content analysis was positioned as being neutral in its assumptions regarding reality (Schreier, 2012), and epistemologically and methodologically linked to the use of dialectics and mixed methods research (Mayring, 2022b). The approach was not aimed at describing all meanings, but ‘a’ meaning, and acknowledged the role of the researcher in developing this meaning (Schreier, 2012). These aspects aligned well with dialectical pluralism as a chosen paradigmatic frame.

From a scale development and systematic research perspective, the approach also illustrated good alignment. The qualitative content analysis approach was described as flexible regarding data collection method and analysis (Bengtsson, 2016; Schreier, 2012), and able to be used with a large amount of material in order to systematically and in a focused manner describe meaning by reducing the material to manageable dimensions (Elo & Kyngäs, 2008; Schreier, 2012). The approach was noted to be systematic and ensured consistency and validity through several processes (Schreier, 2012), something that is not only important from a research perspective but also in the scale development framework Zhou (2019) proposed.

Furthermore, from a pragmatic perspective, the qualitative content analysis process was judged as appropriate. The choice of method required simplicity and practicality given a single researcher conducting the work, large amounts of text generated in data gathering, and the need to reduce this text into meaningful components for later use in item design (this process is described in Chapter 6). Different qualitative content analysis approaches were noted to exist, each with slight variations in methods used and with somewhat differing labour requirements (see, for example, Elo & Kyngäs, 2008; Mayring, 2019; Schreier, 2012). The availability of purpose-built software to help support the process was, therefore, a consideration in the choice of method employed, given the software's ability to help simplify the process, the large amount of text, and a single researcher doing the work. The qualitative content analysis process suggested by Mayring (2022a) was subsequently selected as an approach. The semi-structured interview transcripts were analysed using the QCAmap software developed by Mayring (2022a). Nine steps were followed using the QCAmap software and based on the process described by Philipp Mayring (Mayring, 2014; Mayring, 2022a, 2022b). Note that an additional step, immersion, was added to this process, as suggested by Elo and Kyngäs (2008). These nine steps are described in the following paragraphs.

The first step in analysing the qualitative data gathered was stating a specific research question aligned with the previously discussed theoretical framework, the social identity approach. The research question was "Who are clinical psychologists?" and interrogated in the relevant interview. The professional identity prototype was essentially identified as the main category (Schreier, 2012) used to understand the text.

The second step involved defining the selection criteria for identifying data in the interview transcripts. Criteria selection included defining which analytic approach, category definition, abstraction level, coding unit, coding context and recording unit would be used. Inductive category formation was used as an analytical approach, meaning that categories were developed from the text, rather than based on theoretical considerations (Elo & Kyngäs, 2008; Mayring, 2022b). This inductive process did not require all material to be considered, but only the parts that were relevant to the specific research question and was based on defining a category definition in advance. The approach was noted to be faster and more economical when dealing with large texts, produced categories from the text directly, and was suitable for exploratory research questions. The category definition was defined as any data reflecting a “category prototype” or “the ideal representation of clinical psychologists as a group” or reflecting “what/who clinical psychologists 'should' be”. The coding unit was described next, being the smallest section of the material being analysed that can be assessed to fall into one category. For this project, a seme (a clear meaning component in the text) was considered the smallest interpretable component that can be used to reflect on how professional identity is perceived. A thematic criterion was used to decide on the segmentation of text and was described by Schreier (2012) as considering a change of topic at the end of a unit.

The context unit was outlined next, as well as the recording unit. The context unit is the largest text section that could fall into one category and was defined as an individual interview with an individual participant for this study. The recording unit was the text components that were analysed within a system of categories, and in this study included all the interviews conducted. The abstraction level was established, which referred to how narrow/close or general/distant the category definitions or selection criteria would be and set the stage for interpretation and recontextualization. Abstraction was aimed at establishing the categorised structure of the categories and subcategories, and the level of interpretation that will be maintained when categories and subcategories were generated from the text (Graneheim et al., 2017; Lindgren et al., 2020). Given that the goal of the research was to describe professional identity as closely as possible to participants’ descriptions, the interpretation level needed to maintain closeness to the original material. There was, however, a need for some interpretation, especially given the implied importance regarding certain constructs to professional identity. The complexity of the material and the likelihood of multiple categories being identified, therefore, required the level of abstraction accommodating of this complexity. The abstraction level was consequently defined as maintaining a predominantly descriptive stance while allowing for some interpretation and allowing for a higher level of abstraction.

Consideration was also given to two additional points not described by Mayring (2022b) as components of the second step of qualitative content analysis. The first was whether categories and subcategories could only be coded once. Schreier (2012) recommended that when generating categories, these categories be one-dimensional, mutually exclusive, exhaustive, and enabling saturation. Lindgren et al. (2020) advocated for a more flexible approach and suggested that where a code fits into multiple subcategories, it is assigned as such. The approach by Lindgren et al. (2020) was taken given the overlap noted between certain categories and subcategories and how participants were describing these contextually. This also fitted better with the theoretically fuzzy nature of category prototypes as defined in the social identity approach reviewed in Chapter 3. The second consideration was immersion in the text. Although not specifically noted by Mayring, immersion was added as an additional and calculated third step to the process he described. This process of immersion was described by Elo and Kyngäs (2008) as part of the preparation phase in their content analytic procedure. Immersion ensured a high level of familiarity with the text through repetitive re-reading during the analysis process in 2023.

After immersion, the fourth step of the content analysis process involved generating initial categories from interviews using the selection criteria defined previously in Step 2. Lindgren et al. (2020, p. 4) described this process as an essential step in the de-contextualising of data and noted coding involving: “labelling the condensed meaning unit with a descriptive code… Coding should be done with the study aim in mind.” This was similar to the initial generation of codes and categories described by Elo and Kyngäs (2008) in Chapter 4, with as many codes being generated as possible and these being progressively grouped as the analysis progresses to create higher-order categories.

The fifth step involved the process of coding framework revision, while step six was to apply the finalised coding framework to all text. The coding frame was developed through multiple successive piloting loops (revisions) after 10% to 50% of the material was coded, as described in step four above. The coding definition and the level of abstraction were reviewed to ensure that an appropriate level of categories was established to ensure a balance between being too generalised and too specific. This process formed part of the re-contextualisation of the text by sorting the codes into relevant categories and subcategories (Lindgren et al., 2020). Validity of findings was ensured through this process by tailoring the coding frame to the material being analysed, i.e. the coding frame being adapted to "measure" what it is meant to "measure" (Schreier, 2012); in this case, the professional identity prototype. Final coding, the sixth step in the content analysis process, was conducted after a review of the coding framework. The coding framework generated was applied to all text and codes generated for all material using the selection criteria established. This process informed the final categories to be identified.

Once the final coding was completed, a further analysis of the categories was conducted, and main categories and subcategories were established and further refined as the seventh step in the content analytic process. Note the use of the terms categories and subcategories in this research to reflect the appropriate level of interpretation and abstraction taken in the approach. Qualitative content analysis can represent results in either categories or themes (Graneheim et al., 2017). Categories were described by Graneheim et al. (2017) as codes that share similarities, enabling the description of similarities and differences in the text, as well as hierarchies and are generally represented with a low degree of interpretation and a higher level of abstraction. Themes, in contrast, were described as a unifying thread running through several categories and conveying a central meaning, and conversely involve a higher level of abstraction. (Schreier, 2012, p. 95). Categories, therefore, were judged to provide a more appropriate description of the results generated. Categories were named based on a "concise description of what the category refers to." Categories were defined based on the four-part model described by (Schreier, 2012) to include:

1. a name,
2. a description of what you mean by that name,
3. examples,
4. decision rules (if needed), i.e. how to decide if a code belongs to a certain category/subcategory.

Intra-coder and Inter-coder checks function to assist with reliability and was the eighth step of the content analysis process defined by Mayer (2022a). Reliability is enabled by having different coders check for consistency in material and/or by having the same coder do this at different points in time (Schreier, 2012). The recommended timeframe for rechecking was 10 to 14 days between initial coding and rechecking the codes. No inter-coder process was possible, given the researcher was solely responsible for data interpretation. Intra-coder checks were established several times during the first half of 2023 through successive revisions of the coding framework and generated codes. A further round of rechecking codes was done in late 2023/early 2024 after a review of the survey. This led to further refinements in the codes generated.

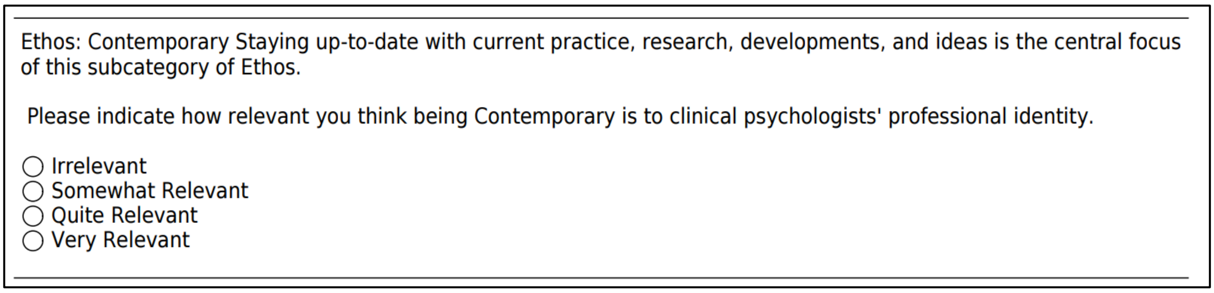
The final step in the content analysis process was to present results. Results were generated after checking inter-coder agreement for the final time. The results of the qualitative content analysis are discussed later in this chapter.

Quantitative Data Analysis.

After finalising the results from the qualitative content analysis described previously, the results were re-presented to the expert panel for review using a survey, as previously discussed in this chapter. Once the survey was completed, the data was subjected to statistical analysis to provide estimates of content validity through evaluating interrater agreement. Cohen's modified kappa (k*) was chosen to evaluate interrater agreement (Almanasreh et al., 2019; Boateng et al., 2018), enabling the estimation of a shared interpretation of the construct (Stemler, 2004). Note that a detailed exploration of the statistical procedures involved will be provided in the next chapter (Chapter 6), focused on the provisional pilot scale, as the k* measure was primarily developed for scale construction. The reader is directed to this chapter for a review of these procedures. Any domain or category achieving a k* of less than 0.60 was judged to suggest low agreement between participants on the relevancy of the construct to professional identity. Results will be discussed in the subsequent section. The limited qualitative comments provided by participants were reflected on, and no formal analysis was conducted. Note that qualitative feedback was primarily focused on scale item construction, discussed in Chapter 6. An example of the evaluation question is presented in Figure 4, and the full survey can be found in Appendix D.

Figure 4

Example of Category Evaluation Question



Ethos: Contemporary Staying up-to-date with current practice, research, developments, and ideas is the central focus of this subcategory of Ethos.

Please indicate how relevant you think being Contemporary is to clinical psychologists' professional identity.

○ Irrelevant
○ Somewhat Relevant
○ Quite Relevant
○ Very Relevant

Content Analysis Results

Following qualitative content analysis, five main categories of clinical psychologists' professional identity were identified. These were: Professional Identity Perception, Personal Attributes, Skills, Ethos, and Focus. Each category will be discussed in detail in the sections below. Note that participant quotes were used throughout the results section to illustrate the results. Quotes were attributed to participants using P and the participant number. Note also that gender specific pronouns were avoided to ensure participant accounts remain as anonymised as possible. The pronouns they/them were therefore used throughout the text when describing participant contributions. Any personal information that could lead to identification was indicated in capital letters and redacted to maintain context. Where any clarification was provided in a quote, this was done in brackets and in italics within quotes.

Although there were different possible ways of structuring the data, the five categories were chosen to capture professional identity for this group based on the ability to succinctly answer the question “Who are clinical psychologists?” The categories allowed for reflecting on how clinical psychologists *perceive* their identity as a profession, *who* they are *personally* (personal attributes), *what* they know and do (skills) as a group, *how* they to enact this professional identity (ethos), and *where* they enact their professional identity (focus). These components identified were thought to be present not only in client-facing work but permeate all aspects of 'who' clinical psychologists are across the professional contexts they function in. There was likely a mutual influence and complex relationship between the categories envisioned. The focus a clinical psychologist has, for example, would influence what skills and knowledge come to the fore as part of the identity. A clinical psychologist classifying themselves as a paediatric psychologist would likely emphasise clinical skills more readily than, for example, a clinical psychologist working in academia. Therefore, categories were best conceptualised as overlapping, rather than discreet and mutually exclusive.

These identified categories and their subcategories were briefly summarised in Table 4 and will be discussed in detail in the sections following. Note that the choice was made to only present two levels of results, categories, and subcategories. Although it would have been possible to provide even further delineation, this approach was thought to risk excessive detail and losing focus on the “identity prototype”. Indeed, each aspect identified could likely be further explored as a separate research project. Results were reported in a non-hierarchical manner, and order does not imply importance. Also, note that those categories and subcategories marked with an * were present during the initial data analysis in mid-2023. Further refinement of subcategories was delineated in the second round of analysis in late 2023/beginning 2024.

Table 5

Categories and Subcategories of Professional Identity

Category	Subcategory	Brief Description
Professional Identity Perception*	Differentiated* Dynamic Paradigmatic Socially Informed	Professional Identity Perception captured how clinical psychologist ‘see’ their professional identity, this being as differentiated from other professions, paradigmatically based in a guiding philosophy, dynamically changing throughout clinical psychologists’ careers, and socially influenced and constructed by others outside the profession.
Personal Attributes*	Traits Self-Referential	Personal Attributes dealt with distinctive traits, feature or motivators deemed essential for 'being' a clinical psychologist and integration of these personal identity features into practice and professional identity, clinical psychologists therefore becoming self-referential.
Skills*	Business* Clinical* Generalist* Leadership* Reflective-Practitioner* Scientist-Practitioner* Specialist* Supervision* Teaching*	Skills focused on the practical knowledge and included Business, Clinical, Generalist, Leadership, Reflective Practitioner, Scientist Practitioner, Specialist, Supervision and Teaching Skills.
Ethos*	Contemporary* Elucidative* Holistic* Just* Modest* Purposeful* Responsible*	Ethos, or spirit of doing, highlighted how clinical psychologists do what they do and included being contemporary, elucidative, holistic, just, modest, purposeful, and responsible in their daily practice.

* Categories identified after initial analysis in mid 2023.

Categories and Subcategories of Professional Identity (Continued)

Category	Subcategory	Brief Description
Focus*		
	Context* Context-Informed	Focus referenced the specific contexts psychologist inhabit and train in, and how these contexts shape or inform their work.

* Categories identified after initial analysis in mid 2023.

Professional Identity Perception

Participants viewed professional identity as differentiated from other professions. Professional identity was linked to a developmental process, being a dynamic construct developing over a psychologist's career. Throughout the clinical psychologist's career, the identity was entrenched in a guiding paradigm, the scientist-practitioner approach. Broader societal factors, for example, organisations, government, professional boards, or the public, further influenced and shaped the construct of professional identity and the expression of the identity through the availability of roles to clinical psychologists. Each of these four subcategories, being differentiated, dynamic, paradigmatic, and socially informed, will be discussed in more detail below.

Differentiated.

Being differentiated from other professions referred to 'how' clinical psychologists perceive their profession compared to other professions. Participants emphasised clinical psychologists being "a very select group of people" (P11), standing "apart from most of our colleagues" (P10). This differentiation was noted to lead to a "unique identity of clinical psychologists as separate from other disciplines that sound similar" (P2). The differentiation was based on high-level, specialised knowledge and skills, even when compared to potentially similar professions. Terms such as "depth of understanding" (P5), "depth of knowledge" (P10), "a specialized body of knowledge" (P5; P10), being able to "identify *(as)* experts in particular things" (P5) and being more skilled, the "best of all professions … at bringing things together" (P12), were reported by participants to solidify the differentiation from other professions. The specific type of expertise or knowledge used to differentiate was linked to several different factors by participants. These factors were most often related to different specific skills (e.g. formulation skills, application of research). These factors will be discussed in more depth in the sections following, as they further inform the categories and subcategories of professional identity.

Whilst differentiation was highlighted, some participants were at pains to also note that different does not indicate ‘better-than’ (in a status-related manner), but simply different from a skills-based perspective. P6 expressed distaste for “clinical psychologists as ‘other’, ‘up there’, ‘better’” and the title, the “labels *(becoming)* a bit of a barrier” when discussing the differentiation between clinical psychologists and other professions. P1 maintained a position of differentiation based on knowledge but also emphasised that this “doesn't make them *(clinical psychologists)* better… but it makes them different”, later noting: “Better than a counsellor. Better than a psychiatrist. At some things. … I think we're different.”

Participants also acknowledged overlap and sameness in their professional identity with other professions to varying degrees. P2, for example, noted, “Other parts of my role are more specific to (REDACTED HOSPITAL), and these are not necessarily unique to being a clinical psychologist.” P6 stated this overlap more strongly, noting: “the idea, the topic of psychology is collectively owned by people” and “I don’t think anything belongs to clinical phycology. I don't think anything we do is any more special than anybody else and also a lot of psychology is common bloody sense….”. P3 and P5 took a more nuanced approach, describing similarities in what psychologists do to other professions, but also noting: “I don't know if this is necessarily different from some professions, but I think it is from a lot of professions(P3)” and different “from some other professions” (P5). Even where sameness with other professions was more strongly endorsed by a participant, some role differentiation was maintained. P6 stated this well, indicating: “If you're working on a multidisciplinary team, you're taking on a little bit more of the psychological work than the occupational therapists and the physios *(physiotherapists)* and the dietitians and the doctors. We're all doing the same there.” Therefore, while clinical psychologists maintained a differentiated professional identity, there was also a strong sense of overlap and similarity with other professions also present. The differentiation was based on depth of expertise but did not necessarily extend to everything clinical psychologists do daily, or ownership over a specific subject area.

Dynamic.

Professional identity was seen as a dynamic construct, evolving over time, with clinical psychologists “constantly striving to get better and to learn, most of us constantly stretch and push ourselves” (P10). P9 described this dynamic nature of professional identity well, noting: “I think professional identity is not constant. It can fluctuate and change. It's also not a destination it's a journey.” The starting point for professional identity was noted to be initial training at university. Identity was seen as being “constantly under construction” (P5) and a process that “doesn't end for psychologists” (P9). The evolving nature of professional identity, especially the continual striving to improve, was seen by some participants as a distinguishing feature of being a clinical psychologist.

The dynamic nature of professional identity was linked to several diverse areas, including ongoing professional development, the dynamic and evolving nature of people, the integration of professional and personal identities, and having had more life experiences. P6 expressed this dynamism as: “I don't think you really are a clinical psychologist until you've got some years under the belt where you've had some hard knocks, and you've had to learn that actually, you don't know everything.” Experiential learning appeared to be an essential mechanism supporting the dynamic development of professional identity and was noted to start at university through placements and continue into later practice through different work environments, professional development opportunities and personal experiences.

Another component of this dynamism was the expertise or specialisation clinical psychologists hold as malleable over time, and clinicians being able to move into more specialised niche areas. P9 noted, for example, that clinical psychologists can “specialize …focus on a niche”, while P10 noted the ability to become “an expert in an area”, and P3 indicated: “Increasingly I see myself as having become quite an expert in the area of …”. This reflected movement for some clinical psychologist during their careers to becoming more specialised and focused on specific areas of work, and a likely a more narrowly defined professional identity as an expert in a certain area of practice.

The dynamic nature of professional identity also led to some uncertainty in select participants. P1, for example, expressed a change in their professional identity perception over time, and this perception about who they are (as a psychologist) currently: “I was thinking about professional identity. And I was thinking about what my professional identity is. And I used to have a very clear professional identity. And I can tell you what that used to be, but I'm not sure if I have it anymore.” This uncertainty may reflect a normal process of developmental shift based on the stage of career and other factors such as age. P6, being close to retirement age, for example, reflected on whether they would still ‘be’ a clinical psychologist after retirement.

Professional identity was, therefore, seen as a dynamic construct over a psychologist’s career. The dynamism was linked to increasingly integrating experiential learning linked to both personal and professional contexts into the identity. The change, at least for some clinical psychologists, involved becoming specialists or experts in certain areas of practice. While the dynamic nature of professional identity was positively described by most participants, it may also be accompanied by periods of uncertainty and re-evaluation.

Paradigmatic.

In describing who clinical psychologists are, the scientist-practitioner approach was perceived as a foundational philosophical approach shaping professional identity in every area of practice. The scientist-practitioner approach was noted as underlying all clinical psychologists do and influencing all components of their practice. As P7 and P10 noted, respectively, the "scientist-practitioner is one of the central parts of being a psychologist" and "the scientist-practitioner stance, that's the crux of it." The centrality was echoed throughout most participant accounts, either directly naming the approach or referencing a general scientific approach to their work. P1 described "what makes a clinical psychologist" as directly linked to the scientist-practitioner model and often referenced being "scientific" and a "scientist" and a "scientist-practitioner" in their approach to practice. P11 further emphasised "scientific understanding", a "very science-driven approach", and "science-based practitioner perspective" as important. P5 reflected on the timeless influence of the approach when saying: "I think one of the things that's always stuck with me for better or for worse is this idea of the scientist-practitioner model of clinical psychology. That's something I've always held in mind with my own practice."

The scientist-practitioner approach was noted to be "based in the research" (P1) and clinical psychologists should "be able to integrate the scientist-practitioner model (P8) as "an application of a research base" (P1) or "using evidence-based practice, putting the research into practice" (P7). This research base was further noted to be "what you should be doing if you want to use best practice" (P1). This integration into "doing" could also be seen as one of the skills clinical psychologists possess and will be discussed as a further component of professional identity later, as it goes beyond attachment to being a scientist practitioner but involves skilful application of the scientist-practitioner approach.

The scientist-practitioner approach was also used as a differentiating factor between clinical psychologists and other professions, especially when referring to the influence of research on practice compared to other professions. P11 conceptualised this differentiation as “most of us are science-based practitioners. You're trained in science.” P1 noted, when referring to other mental health practitioners, that “they don't have that knowledge of the research” within the psychological realm. P5 provided a slightly different perspective of this differentiation: “I think other allied health and medics definitely got more skilled or they have put more emphasis in their training on research and its understanding and application, but I think we've had that for a much longer period of time as a profession.” P10 was more direct in their stance regarding the scientist-practitioner model as a distinguishing factor, having noted: “The scientist-practitioner stance, I think that that does make us stand out.”

In summary, the scientist-practitioner stance was seen as a central and differentiating factor of clinical psychologists’ professional identity. Endorsing the scientist-practitioner approach meant a professional identity linked to being scientific and evidence-based in approaching the work clinical psychologists do and the ability to engage in research.

Societally Informed.

Professional identity was noted to be societally informed, with professional identity being described as extending beyond what a profession thinks of itself but also being influenced by the way others view and recognise the profession on a broader societal stage and how the profession is regulated. A commonly noted aspect of professional identity in this regard was mandated training, and training being the starting point for professional identity formation. As P8 noted: “I think you can't call yourself one (a clinical psychologist) without the training, and I do think you need the training to start the journey”. P3 also echoed this sentiment, noting, “I did the training, got my ticket”, while P6 stated “, You can call yourself a clinical psychologist when you qualify", both eluding to the compulsory and legally enshrined requirement for training as well as the legally protected status of the title.

Apart from training, several participants also recognised the legal and professional registration and regulation requirements as shaping and informing who clinical psychologists are and what they do. P4 stated this well, noting "what we are permitted to do depends on what scope we are registered under the board", while P6 highlighted "on a group level, it's membership to the New Zealand Psychology Board" that makes a clinical psychologist a clinical psychologist, and P9 indicating "sticking to their scopes of practice as outlined by professional boards throughout the world" as crucial to being a clinical psychologist. These professional registration requirements were noted to have an enduring impact on behaving as a clinical psychologist, described by P8 as "the board expects you to keep your nose clean" and P9 noting "you stay within that scope of practice", and this impacting behaviour professionally and personally. P9 further reported that these vocational scopes and registration criteria are globally influential on clinical psychologists' identity, as "that's standardized in all countries if you're not trained, you are not competent. And you stay within that scope of practice".

While registration with professional boards and the direct legal components related to the registration and role of clinical psychologists were highlighted, the broader legal framework was also emphasised as having an impact on who clinical psychologists are and what they do. Clinical psychologists were noted to require appropriate knowledge of the broader legal framework they function within. This awareness influenced and shaped who clinical psychologists were and what they do within that specific context, for example, the difference between being an assessor in a judicial environment versus being a treating clinician in a mental health context.

Some participants also commented on the restrictive nature of the registration and legal requirements on identity. P6 stated this bluntly, noting, “I think it's tough that you can't call yourself anything unless you pay somebody some money. It's what I do.” P9 noted: “It's easier than to be a life coach on Instagram because you're not answerable to anybody. If you are a psychologist, you have legal and ethical responsibilities, and should you contravene those, you are subject to malpractice issues. So, we are definitely much more regulated in that respect.” P4 noted: “The constraints under which we have to express our professional identity is insane between contracts and acceptable behavioural standards and all the rest of it, which I respect. But we have to work with them because that's how it works.” Participants also commented on legislative and registration requirements sometimes not having the desired impact on professional identity, potentially leading to a more restricted expression of professional identity than what would otherwise be possible. One example offered by P4 was regarding supervision, noting that supervision has become a tick box exercise, “a legal requirement, and that's kind of what it's become over time… it has it has the potential to be so much more.” Other participants simply accepted the regulation as essential and attributed positive outcomes to the regulation. The expectations from a registering body perspective were noted to lead to “probably a slightly higher standards for you as a psychologist” (P8). This expectation was linked to needing to be more effective, as P3 noted: “I think the status that comes with that professional label comes with both a value but also an expectation.”

Another aspect of the socially informed component of professional identity was related to how other people/professions see the profession, and how this shapes access and roles in society and organisations. Different opinions were noted by participants in this regard. Some reported a positive perception by the public and other professions, and this positive perception led to increased access to roles within society. P7, for example, described clinical psychologists as a “generally respected profession that people value”, and P9 noted when commenting on public perception that “we can cover such a broad domain of skills and expertise.” P6 echoed this sentiment, noting that being a clinical psychologist leads to people stopping and listening “because you've got some sort of qualification.”

Other participants reported a perception of negativity and restriction of professional identity when describing the social perception of the profession. P2, for example, expressed frustration in the limited public differentiation (and impact of this non-differentiation) between clinical psychologists and other similar professions, highlighting: “I would love for the public to be able to understand the unique identity of clinical psychologists as separate from other disciplines that sound similar so they would understand why they would go see a clinical psychologist as opposed to a psychotherapist or a counsellor for example.” P2 further expressed frustration with how other professions (in this case, medical doctors) described what clinical psychologists do, noting: “I think that it's important for our identity to be distinct from not “just having a chat”, we're actually assessing and formulating and intervening. Because I think it really undermines the value of what we do.” One participant (P5) also alluded to the specific society or cultural context having a further impact on who clinical psychologists are and what they do. They stated that when engaging with the public, “I think there's something about when someone comes into the room it's like you both mutually agree to buy into this myth”, this myth referencing one person being there to help or heal and the other to receive help/healing. Professional identity was therefore seen as dependent also on how the profession was seen and accepted within the specific social context.

The impact of societal perception was also pronounced in the description of clinical psychologists’ roles in organisations and society, with participants noting clinical psychologists being pigeonholed into the role of therapists. P10 stated in this regard that clinical psychologists “are seen as experts in therapy,” and P6 noted: “On a societal level, I don't think I've ever been seen as a clinical psychologist. I think I'm seen as a therapist.” This impact of societal and organisational perception extended to how clinical psychologists are managed within systems, leading to a narrow definition of what psychologists can do and the roles that can access. P5, for example, reported, “Often as psychologists in bigger health settings, you’re managed by people from other professions who don't really grasp all of the skills that psychologists have and don't place value on research.” P11 also commented on the restrictions imposed by organisations: “… but going higher up they forget that there could be more psychologists could be doing in terms of teaching. Again, research, and all those things we've mentioned.” The restrictive impact of organisational perception was met with frustration, especially given the underutilisation of clinical psychologists’ skills. P1 noted, “Within a hospital setting it's medically controlled, and they don't want psychologists’ (opinions). You're seen as the second-class citizen”, while P10 had a more nuanced comment, indicating: “I think certainly in Te Whatu Ora, it is a medical model, and we are valued, but we are valued in our place” and following this comment up with noting that clinical psychologists are not just “face-to-face therapist”, implying this was the place allocated to clinical psychologists within this specific organisation.

Clinical psychologists’ professional identity was seen as societally and socially informed. This influence extended to the legal and professional aspects of registering and acting as a clinical psychologist, as well as the associated roles and responsibilities associated with the role. The legal and professional requirements were noted to have a broad impact on both personal and professional behaviour and the impact was mostly positively regarded, although also experienced as restrictive in embodying a broader professional identity. Public perception, perception by other professions and organisation perceptions were indicated as further influencing factors on professional identity. Some participants noted a positive association and influence, while others noted these perceptions to be linked to restriction in the extent of professional identity enactment.

Personal Attributes

Personal Attributes deal with distinctive traits deemed essential for "being" a clinical psychologist, as well as the overlap between personal identity and personal identity, and this informs a self-referential aspect of professional identity. Traits included both personality characteristics and elements of personal history informing a vocational calling to becoming and being a clinical psychologist. The self-referential component of personal attributes included how personal attributes, and more broadly personal identity, became integrated with professional identity and how the "self" became a tool of the profession. Both traits and the self-referential aspect will be discussed next.

Traits.

Traits, encompassing specific personal characteristics and personal histories, were diversely commented on by participants, but there was a sense that becoming a clinical psychologist required "a certain person" (P11). Some participants reported specific motivators and drivers that brought them to the profession. P2, for example, reported on specific experiences growing up as being formative in their choice to pursue clinical psychology as a career, while P10 indicated in this regard: "I think many psychologists… many of them come from a family or personal experience of difficulty, and so they want to give back and understand. I came from an intellectual curiosity, a scientist basis, which I think is probably rarer than the other. For me it really is about the outcomes for the service-user, but I think I come with a very scientifically curious stance on it is my primary interest or driver."

Other personal history components included as influential in professional identity were holding a previous occupation, as expressed by three participants. P3 noted, "that's part of my (REDACTED OCCUPATION) background coming through", and P4 stated this well, referring to not finding "professional identity that easy and it's been very smudged by being a (REDACTED PREVIOUS OCCUPATION)" and "I like the professional person I'm becoming even though it's not purist." Of note, the three participants noted previous occupations to be helping professions. Other participants highlighted diverse personal attributes being integrated into who clinical psychologists are as professionals. P3 reported, for example, "A lot of us are very different, sort of so different from me that I think they may hold quite a different set of values, and they may be bringing themselves, but what they're bringing of themselves would be very different from what I bring myself."

Personal attributes described were varied and included, for example, an interest in helping others or impacting others' lives. Others noted curiosity, a passion for learning, personal values, compassion, a commitment to understanding behaviour, openness, empathy, and a capacity to tolerate difficult emotions and uncertainty, having appropriate political views, being open-minded, tolerant, and/or being inclusive as influential attributes. P6 noted, for example: "I'm curious about the people I meet, their needs, their history", while P7 highlighted: "…essential that you wish to help people… They *(clinical psychologists)* want to understand behaviour, what makes people tick" and P8: "It's a capacity to understand and empathize with a range of experiences and emotions, we do hold a lot of uncertainty that maybe other people would prefer not to."

While personal identity aspects were often expressed as specific attributes, such as values or characteristics, other aspects of participants' personal history were also noted to be influential on professional identity and influenced professional identity expression. This included aspects such as adverse experiences highlighted by P6: "So for me it's about life experience. I think it really adds to it." This component also highlighted the role of experiential learning in both the professional and personal lives of clinical psychologists, playing a formative role in the professional identity of this group. In summary, specific traits were reported as components of personal attributes, in turn a component of clinical psychologists' professional identity. Traits included personality traits such as curiosity, holding specific values, or having specific historical experiences, both personally and occupationally. These traits were seen as vocational aspects of professional identity and essential for entering the profession and being in the profession.

Self-Referential.

Personal identity and personal attributes/identity were reported as overlapping with professional identity and influencing the expression of professional identity, and professional identity influencing the expression of personal identity. Professional identity, therefore, referenced personal identity, and personal identity referenced professional identity (hence the term self-referential). P4 commented, for example: "I think that identity of the person that I am has obviously shaped my professional identity." P2 noted "definite overlap" in "being a psychologist *(as)* part of who I am", these aspects being blended "constantly in a holistic way". P3 also reported on the mutually influential nature of personal and professional identity, having noted: "So it's almost like you can't take the clinical psychologist out of me, you know. People say you leave your work at the door, and of course, I try to do that, but it has very much become a part of who I am, part of the way I think and the way I view the world. And … it is sort of embedded."

These personal attributes became part of how clinical psychologists do what they do, or the expression of their professional identity. P3 identified this well, reflecting on an interview they had for a specific position: "I remember in my interview they were quite excited about some of the qualities I was bringing to the job. I would say a lot of them were actually about me as a person rather than what I knew. Things like having a collaborative approach, a non-hierarchical structure on the team, which I value, and the warm, engaging relational style of leadership rather than top-down. I think as clinical psychologists we do bring ourselves whatever that looks like to our practice."

Although the overlap was noted as important, clinical psychologists' professional identity was noted to be one identity held, but not the whole of a person. P2 reported in this regard that "my identity is wider than just being a clinical psychologist. Even though it is what I do day in and day out, it's actually not my first identity." The integration of professional identity into personal identity was furthermore conceptualised as being independent of the title "clinical psychologist". P6 noted, "It is not the title that makes me what I am. It is what I do that makes me what I am. I could be a florist and still do what I do."

The aspects of personal identity were integrated into practice through self-reflection and self-reflective practice, where the self becomes the tool in doing what clinical psychologists do. P3 noted this: "We're hopefully self-reflective, and we use that kind of capacity to inform our practice". Through this process of "understanding yourself and understanding all the different elements of yourself and integrating them, that makes you a better clinical psychologist. If you don't know yourself and you don't explore yourself then again, it becomes very unidimensional" (P6). The ability to integrate these self-referential aspects well could be conceptualised as a skill and will be further explored as one of the skills that define what clinical psychologists do later in this chapter. In conclusion, personal attributes were noted to be a self-referential component of professional identity, with professional identity actively dependent on integrating aspects traditionally associated with personal identity. This integration was reported to lead to the person or self becoming a tool of the profession.

Skills

The third category of the professional identity prototype, professional skills, deals with the knowledge and skills clinical psychologists hold and apply to their work, in other words, what clinical psychologists *do* as professionals. Skills and knowledge were noted to be based on training, both didactic and experiential, as mechanisms informing these components of professional identity. Many participants expressed skills as holding knowledge in a broad sense, or in an undifferentiated manner. P4, for example, reported, "My professional identity comes primarily from (*working with)* my clients but also actual knowledge". P3 further elaborated: "From my perspective, a clinical psychologist is someone who has undertaken a rigorous sort course of training in terms of both academic rigour and professional practice rigger. A clinical psychologist is someone who has a very comprehensive knowledge base."

This level of knowledge and training was noted as a distinguishing factor between psychologists and other professions. P1 noted this: "I think that's what makes a clinical psychologist someone who's trained to a very high level" and later "You should have a knowledge base." Training was seen as a point of differentiation between clinical psychologists and other professions, with P8, for example, highlighting the "different training set" of clinical psychologists and P2 reflecting on the fact that becoming a clinical psychologist "requires more training" compared to many other mental health providers. The nature of the training was also highlighted as important. P9 indicated in this regard, "It's predominantly that training, I think, that makes such a difference. You are devoting five years of academics and an additional two to three years on top of that with supervised experience."

Whilst an undifferentiated or diverse knowledge and skill base were noted as important, participants also identified several more specific skills. These skills are discussed as subcategories in the following sections and include Business Skills, Clinical Skills, Generalist Skills, Leadership Skills, Reflective Practitioner Skills, Scientist Practitioner Skills, Specialist Skills, Supervision Skills, and Teaching Skills.

Business Skills.

Some participants highlighted clinical psychologists' business skills to play a role in informing professional identity, particularly for those working in private practice. P9 linked these business skills directly to psychological training and knowledge, noting, “If you study psychology, you could be good at sales, you could be good at marketing.” Both P9 and P10 described clinical psychologists as businesspeople, with P9 noting the need to evidence “business management skills” and “business acumen” as a clinical psychologist, while P10 highlighted the need to develop a business and networks as part of psychological practice. Endorsement of this subcategory of skills was fairly limited in the participant group.

Clinical Skills.

Clinical psychologists' psychological and clinical knowledge base and skills were widely endorsed by participants as a foundational basis for their professional identity. There was some noted variation between clinicians as to which aspects were highlighted. Overall, however, there was agreement on the centrality of skills related to health and mental health work, especially in direct application to client-facing situations.

Overall, participants highlighted broad foundational psychological knowledge, such as psychological models for the understanding of human behaviour, as important. The application of these models to practice was an important skill. P1 summarised this well in saying, “I think that's what makes a clinical psychologist is … you are trained to a high level in cognitive psychology and behavioural psychology, social psychology, developmental psychology, and you bring all of that to your practice.” P4 later also elaborated on the application of learning, noting the requirement for clinical psychologists to “use the knowledge that we've obtained clinically.”

The application of skills and knowledge were broadly linked to the role of a helping professional. P4 put this simply, describing clinical psychologists as: “We’re in a helping profession”. P1 also contributed a diffuse description of clinical psychologists’ skill set, noting: "…you're sort of a problem solver, or a person who sort of looks at things that aren't going right, and tries to give people some options." P8 also echoed the broad sentiment of clinical psychologists as problem solvers but also noted that the role could simply be as a listener: "…if somebody comes to you, and there's a problem to solve, you could be a problem solver. But if there's somebody who comes to you, and there's no problem to solve, they just need you to listen, then you're a listener" and later goes on to describe clinical psychologists as "you are a person who heals people" and "you are speaking to people with the intent to help and to find a way through."

Participants further provided more succinct descriptions of the clinical knowledge and skills of clinical psychologists, as illustrated by P2: "I think clinical psychologists are involved with individuals who are experiencing some degree of distress or functional impairment in their day-to-day life that's either identified by themselves or someone else. Our role is to explore all the factors that might be underlying that distress or functional impairment... I think our role … is to provide a diagnosis and a treatment plan, and to then offer treatment". P3 stated: "I see our role as assessing and treating people who are in distress of some sort, who may be struggling with different aspects of themselves or their lives."

Specific clinical skills were also highlighted frequently, including clinical skills and services such as assessment, formulation, diagnosis, psychometrics, report writing, and treatment using evidence-based approaches. P4 stressed skills linked to diagnosis and psychopathology as important to the clinical psychologist profession identity. P3 also supported this view, noting "… diagnostics and labelling, and also … treatment" as essential activities clinical psychologists perform. Formulation was another clinical skill often referenced. P4, for example, reported "the ability to formulate…. being able to do that artistic formulation … to bring it all together" as central to who a clinical psychologist was. This was echoed by P11: "I feel as psychologists we have a lot to offer. I think one of our biggest strong points would be formulation.” Another area highlighted was the use of psychometrics. P5 noted in this regard: “One of those other skills we have is psychometrics” as important from a knowledge and skills perspective. P3 noted good report writing as a component of clinical skills. P9 highlighted the interconnected nature of the different clinical skills, noting: “Our impression leads from an assessment, it leads to diagnosis, and following on from that, that's where we come in with our therapeutic skills and interventions.”

The ability to use these clinical skills in complex situations was reflected on as important, with P7 commenting on clinical psychologists as “better trained and better skilled …in complexity and risk… figuring out complexity and understanding risk, and how to assess it, and what to do about it”. Others added to this focus on complexity by also highlighting a focus on psychopathology and the complexity regarding psychopathology as a critical skill area for clinical psychology. This potentially suggested clinical skills were perceived to be at a higher intensity and complexity level compared to some other mental health providers.

There was often a focus on the provision of treatment, and more specifically, talking therapies. P3 stated, for example: “Being a therapist is an important part for me in being a clinical psychologist”, highlighting the critical role being a therapist plays in clinical psychologists’ professional identity. This was echoed by P 5, noting clinical psychologists’ role in the “application of particular therapeutic interventions”. When discussing treatment, there was sometimes a focus on specific models of human behaviour and associated treatment modalities being integral to being a clinical psychologist. P10 noted that clinical psychologists are experts in therapy”. P2 noted “CBT” (cognitive behavioural therapy), while P3 stated: “So that's the other dimension I would just like to add in terms of being clinical psychologist. I would say, in my mind, they should be trained in a sort of psychodynamic psychotherapy. They should be a good therapist, I think”.

Some participants also noted more strengths-based clinical components and approaches, such as promoting overall well-being. Participants often used clinical skills as a differentiating factor from other professions, noting the advanced knowledge of various models, assessment tools, and interventions and the ability to work with complexity and risk as distinguishing them as experts in their field.

In summary, clinical skills were perceived as an important component of clinical psychologists' professional identity. These skills included theoretical and scientific knowledge regarding human behaviour and the application of this knowledge to help people. The application of this skill was achieved through assessment, formulation, diagnosis, and treatment and was seen as a differentiating aspect of "who" clinical psychologists are based on the level of complexity involved in applying these skills.

Generalist Skills.

Participants reported generalist skills as a component of professional identity. These skills refer to the ability and proficiency at transferring a broad range of foundational competencies and abilities across various areas of clinical and non-clinical practice. P9 described clinical psychologists in this regard as "jack of all trades" and having a "plethora of skills that extend from the everyday and ordinary". These generalist skills were reportedly linked to doing what "needed to be done" (P6) within specific contexts and entailed taking skills "into many spaces" (P10). The skills used were based on context and what was required. P2, for example, noted the ability to "work across contexts both in terms of age work contexts and also preferably in terms of diversity of gender ethnicity and socioeconomic status" and elaborated on the "ability to be within a medical system but also step out of that system" inherent to being a clinical psychologist. P8 simply stated that "it depends what people need and what they ask for." While generalist skills generally entailed the ability to move between contexts, one of the generalist skills highlighted as a specialist skill for clinical psychologists overlapped with clinical skills, being the ability to work with more severe psychological conditions and risk. P9 described this as clinical psychologists fulfilling the brief for “when they're *(stakeholders)* wanting something on the more severe end of the spectrum”.

Leadership Skills.

Clinical psychologists' leadership skills were reported as another component of their professional identity. These skills were conceptualised as influencing others directly through consult-liaison or management/direct leadership activities, as well as indirectly through the development, implementation, and evaluation of programs. Clinical psychologists were seen as being capable of effecting change within larger systems. P1, for example, highlighted clinical psychologists’ role in the “provision of advice”, “developing programs”, and serving on committees. P10 stated this enacting of influence well, noting, “I think there's been a shift over the last few years to becoming more aware of the value of psychology as consultants as supporting the other professions to deliver in their roles more effectively.”

P3 highlighted direct management of others as a skill, indicating “leading a really good clinically robust team” as an important component of their identity as a clinical psychologist. P5 also endorsed a wider focus on direct leadership for clinical psychologists, noting a role for clinical psychologists in “managerial and strategic areas of … bigger systems” and informing “service development” and further noting “we should be used in that way like management consultants. We have that ability to change systems larger or small systems, but larger systems as well, and consulted on that rather than just the individual therapeutic work.”

P11 highlighted the need to extend leadership influence onto the macro or societal level, including influencing government policies. Participants expressed the need for greater awareness and promotion of clinical psychologists' leadership skills. This included suggesting that these skills should be incorporated into training programs to enable earlier career professionals to develop leadership skills and for greater recognition of clinical psychologist leadership potential in systems. They believed that clinical psychologists excel in holistic formulation leading to a well-informed understanding of complex issues, which makes them well-suited for driving policy-making and organizational change, the skill therefore being a core aspect of professional identity.

Reflective Practitioner Skills.

As a component of professional identity skills, reflective practitioner skills involve the appropriate and effective application of self-referential personal identity components, essentially the self-becoming tool of professional identity. Where personal attributes were seen as essential to being a clinical psychologist, something a clinical psychologist possesses, this subcategory dealt with the skilful application and integration of the self, or the use of the noted personal attributes, in a work role. P6 noted in this regard that being a clinical psychologist is about "understanding yourself and understanding all the different elements of yourself and integrating them that makes you a better clinical psychologist. If you don't know yourself and you don't explore yourself, then again, it becomes very unidimensional."

Although most participants appeared to support self-reflective skills as important and linked to personal attributes, there was some variation noted between participants in clinical psychologists' ability to apply these personal attributes to practice. P10 reported this ability to be self-reflective as predating formal training, thus being an element of personal attributes and as part of the selection process of clinical psychologists: "They're looking for someone who's showing a high degree of reflective awareness." P1, on the other hand, noted when discussing self-reflection, training to be essential and that "some people just naturally do (it) other people don't", implying a need for the skill to be developed in some clinical psychologists.

This ability to be “self-reflective and … use that kind of capacity to inform … practice” (P3) was noted to be an essential and beneficial element to working with clients in treatment contexts, as P6 explained: “If it is beneficial to the therapy, you would share something because it enables the person to normalize to role model to shift something forward.” The self as a tool being brought to practice was noted to vary between psychologists. P3, for example, highlighted this a few times, reporting, “As clinical psychologists, we do bring ourselves whatever that looks like to our practice” and “What they're *(other clinical psychologists)* bringing of themselves would be very different from what I bring.”

The reflective practitioner skill reported on involved self-reflection, insights into own strengths and limitations, and areas for growth on both a personal and professional level and balancing the integration of self with professional tasks. P8 explained this as “On an individual level, I think it's almost tricky because there's almost this parallel process of you struggling with your own life needs, wants, identities, ups downs, and whatever. And then, you know, deciding how much of that your own experience gets to be part of your work and your space and trying to have appropriate boundaries that serve your client without being totally ridiculous”, while P9 commented on “reflective exercise*(s)”* allowing clinical psychologists to find their “own areas of weakness.”

Experiential learning, both personal and professional, and using this practical wisdom to inform practice, was noted by participants as a mechanism informing the self-reflective skill set. P8 stated this well while discussing using the self in practice, noting: “I think you get shaped as much by your subsequent experience as you did by your training”. While P8 noted that certain self-referential aspects would “just be seen as unacceptable”, they broadly endorsed “a range of things that … are also there to embrace. You struggle with stuff you have tough times or crises of your own. I think that as long as it doesn't impair you, or if it did, you took time out, but those are actually very much acceptable parts to me as a psychologist and that people probably find those parts helpful."

The ability to self-reflect was also noted to help push through difficult components of client-focused work and support resilience. P8 reported: "I guess it's a combination of self-efficacy but also a belief in the research, trusting of the process, knowing that there's some value in what we do. Because it doesn't always feel obviously valuable." The ability to self-reflect and reflect on practice was noted to be a distinguishing feature by some participants, as noted by P7: "I think it's the amount of reflection we do. Not only self-reflection but reflection on, and thinking that we do about our clients", and P10 reported "the culture of self-review of work" as a further point of distinction.

In summary, reflective practitioner skills involve the skilful application of personal identity aspects to the work clinical psychologists do and are a defining aspect of their professional identity. The skill allowed the use of the self as a tool in a flexible manner and informed reflection on the self as a tool, as well as aspects of the self related to clinical practice. Reflective practitioner skills were influenced by experiential learning opportunities, both personal and professional. While the self was used as a tool, this was skillfully done with reference to appropriate limits. The self needed to be useful (a tool), rather than a hindrance.

Scientist-Practitioner Skills.

Scientist-practitioner skills involve the skilful and practical application of the paradigmatic frame previously discussed as part of professional identity perception. The skill involved the competent application of the approach, going beyond aligning oneself with the scientist-practitioner stance and extending across the different contexts clinical psychologists inhabit. P7, for example, noted, "A clinical psychologist can work in management. The role would take into account the literature and the effective models of how to work, what's best practice and ethics, what the latest research says. If you are a manager and you are a psychologist, I would expect that you had looked that up, and that you would be using some of those models. If you were CAMHS (*Child and Adolescent Mental Health Service*) clinician, I would expect you to know the latest ways of assessing children and so forth. I think it's just an application of those ideas to wherever you are."

Integration of evidence-based practice, critical evaluation of research, research competence, and scientifically evaluating outcomes were further examples noted in the application of the scientist-practitioner stance to what clinical psychologists do. This application was actioned in a flexible manner, fitting to the context or person, described as being "flexible but still adhering to the model", being "a bit flexible and really make your best guess based on the research. This seems a reasonable approach" (P1). While scientist-practitioner skills encompassed a broad range of skills, the ability to do and apply research, research-related skills and enacting a general scientific approach to professional activities was especially well endorsed by participants. This ability was seen as a differentiating element between clinical psychologists and other professions, with P5 describing: "The idea of doing research as being embedded as part of your clinical practice is not something that is inherent in other professions." P11 also elaborated on research skills providing differentiation, noting, "I think it's about that knowledge of the literature and being very strong from an academic point of view." Research skills, as a component of scientist-practitioner skills, had a general influence on the work clinical psychologists do. P 11 noted, for example, that "science-driven thinking into human relationships … drives the work that you're doing", and P1 noted: "The fact that you have a research basis (*enables you to*) evaluate things."

Doing actual research within an organization or pursuing research opportunities supporting individual interests was also noted as an important factor in supporting professional identity. P1 indicated in this regard that clinical psychologists “do research within the organization. Definitely. That's what they should be doing. It's one of the skills they have”. P3 described “being able to do some of my own research” as important in supporting their professional identity. Another core role linked to the scientist-practitioner skillset was the ability to disseminate scientific information in teams or organisations. P1 described clinical psychologists as essential to “provide information regarding research best practice” (P1). This skill is, therefore, also closely linked to another category identified as part of skills, teaching, which will be discussed later.

The scientist practitioner stance overall was noted to inform clinical psychologist identity significantly, to the extent of clinical psychologists being able to “be an academic a researcher” (P11) if they chose this as a career path. This reflected a broader emersion and application of the philosophy than a casual knowledge of science as a methodology for generating knowledge. Scientific skills were also seen as important in underlying everyday practice and not specifically linked to doing research. These skills played a background supporting role for other skills, for example applying clinical skills, helping “with that scientific understanding in the background *(to)* flesh it out better” (P10). P3, for example, highlighted “the critical thinking aspect of being a clinical psychologist *(as)* incredibly important”, and P5 reported clinical psychologists’ “understanding around statistics and probabilities” as important factors in practice. This enabled what P5 described as a “much clearer understanding around where things should be applied and when they shouldn't and the limitations of the interventions that we have and also the breadth of interventions which are available for particular issues” and allowed for a scientific approach to practice. While the scientist-practitioner approach was acknowledged as being imperfect, the application of the model based on a “reasonable approach” linked to making “your best guess based on the research” was advocated (P1).

Enacting scientist-practitioner skills was noted as a core component of being a clinical psychologist. While holding a scientist-practitioner stance was previously noted as important, the skilful application or overall scientific stance was noted to be a skill going beyond subscribing to the paradigm. Applying these scientific skills was noted to impact professional identity and related activities broadly, ranging from doing research to applying the approach to clinical and non-clinical tasks.

Specialist Skills.

Closely linked to the perception of professional identity as a dynamic, developmental process was the end-product of holding and enacting specialist skills. While clinical psychologists perceived their identity as being dynamic, and one area this dynamism extends to is developing expert skills, the expert skills in themselves became a defining aspect of their professional identity. Specialist or expert skills referred to a focused set of competencies and expertise developed in a specific area, context or population over time. These skills were usually not part of the clinical psychologist's identity when initially established but rather developed over time. P9 described this process as "clinical psychologists we can specialize in we can focus on a niche", while P10 reported this as "becoming an expert in an area". The area of expertise was noted to be specific to areas of interest or practice. P5 highlighted in this regard: "I feel for myself as a clinical psychologist we can identify that we are experts in particular things. It may be models of therapy or within our knowledge around particular conditions, be they psychological or neuropsychological. We can be expert in those areas. An expert as well in the application of therapeutic strategies and ideas and the implementation of that."

Supervision Skills.

Supervision skills were noted to also play a role in shaping clinical psychologist' professional identity. P3, for example, noted the critical role of providing supervision in their practice and professional identity: “For me, being a supervisor, it is also what maintains my practice because it holds me to keeping ahead of the game and make sure what I'm saying and doing is making some sort of sense.” Supervision served to provide support and guidance, enabling professionalism and was noted to extend beyond formal supervision. Methods for providing supervision were diverse and included the direct provision of supervision to a ‘supervisee’ or to “model good practice and good professional practice” (P6) and “enacting with colleagues” (P7) professional behaviours. Providing both formal and informal supervision was highlighted, with P8, for example, describing “if a colleague comes to you, you're a person who can debrief and listen and hold the space” and providing “collegial for other people's input with their clients.”

The bi-directional relationship of supervision was noted to benefit both the supervisor and the supervisee in developing and maintaining professional identity. Supervision challenged supervisors to stay updated and ensured that both parties’ psychological practices remained effective and responsible. Personal responsibility in utilising supervision effectively was emphasised. P10 consequently commented, “Supervision is what you make of it.” Supervision emerged as a critical aspect of clinical psychologists' professional identity, serving not only as a legal requirement but also as a valuable opportunity for development and growth. Participants recognized the potential for supervision to go beyond a mere formality and become a shaping environment where they receive guidance, adhere to ethical standards, and stay on track in their practice.

Teaching Skills.

Teaching skills were noted as a further central component of professional identity. P2, for example, linked her past developmental experiences as critical in choosing a profession where she could teach. Teaching was described as involving both formal and informal dissemination of knowledge, including through informal discussions within multidisciplinary teams and doing formal training, such as “doing training with the team” (P3), “doing talks” (P8) or “lecturing community psychology” (P8). As discussed previously, dissemination of knowledge was also linked with scientist-practitioner skills, suggesting an overlap between the ability to teach others and the ability to do this in a scientifically supported manner.

The ability to teach as a skill for clinical psychologists was well described by P9, noting that as a clinical psychologist, “you could teach because you understand how to pitch things at different levels that are developmentally appropriate age-appropriate, you could lecture. You've often got sufficient academic skills to allow you to moderate dissertations.” P11 also reflected on psychologists’ inherent skill set enabling them to teach certain information effectively: “I think because as psychologists we understand the biopsychosocial behaviour much better there’s a lot to be learned from that and then how do we manage it as well.” Teaching was noted to involve not only instructing other psychologists but also other disciplines, reflecting an interprofessional component to this skill and also potentially highlighting the collective ownership of psychological information with other professions. Teaching extended to sharing more specialised knowledge in certain areas, or as P10 stated: “becoming an expert in an area and working to share that knowledge or teach”.

Teaching was noted to involve disseminating knowledge, sharing valuable information, insights, and perspectives with others, extending beyond formal lectures, and including the ability to deliver information at different, accessible levels depending on the audience. Clinical psychologists were noted to have the necessary academic skills to moderate dissertations, engage in academic teaching and share expertise in specific areas with others.

Ethos

Ethos encompassed the values, beliefs, and ethical principles that guided clinical psychologists’ professional conduct and the general culture of clinical psychology. This category emphasised *how* clinical psychologists *do what they do*. Ethos was further divided into eight subcategories, including ‘being’ Collaborative, Contemporary, Elucidative, Holistic, Just, Modest, Purposeful, and Responsible, which will be discussed next.

Collaborative.

Being collaborative emphasized the importance of a person-centred and collaborative approach across professional activities and appeared to be central to how clinical psychologists enact their professional identity. P1 described this as bringing “a sort of human touch, trying to treat people with respect and treat them like normal human beings”, while P11 noted, “that human side helps to balance out being too logical and maintaining compassion”. P10 framed this collaboration as being reactive to who is being collaborated with, having noted: “Well, with a psychiatrist, you need to talk the lingo and sound very knowledgeable and professional. And with a service user, you need to adapt your approach in a way that makes sense to them.” In direct client-related work, collaboration was described as working with people towards a shared perspective and for clients to “feel heard and seen and respected. And that their distress is heard and seen and respected” (P3). Collaboration was about working “around and with the relationship component as well. That human side helps to balance out being too logical and maintaining compassion” (P11). Collaboration was further described as non-directive, a process of “working with people rather than doing things to people… to get alongside (*people*)” (P3). Getting alongside was noted to be facilitated by “being curious rather than being an expert” (P5), a sentiment echoed by P6: “I want to walk this walk with the person, so I have curiosity… You're not leading; you're walking alongside. Sometimes, you might have to take a step in front to make a suggestion and other times, you might take a step behind, but it's actually informed by what the client’s needs and wishes are.” Being a clinical psychologist is being “a guide, a person to help people explore for themselves” (P8).

Although this component of ethos was most often discussed in relation to client-based clinical work, participants highlighted a broader collaborative approach with colleagues and other professionals as important as well. P9, for example, highlighted the role of clinical psychologists within organizations and teams as “a huge part of what we do is around interpersonal effectiveness. Not just with our patients but with the interpersonal effectiveness of teams and organizations. Being able to mediate and allow different voices to be heard.” P10 simply described this ability as being able to “promote smooth relationships” within organisations. Collaboration with other professions, especially in the application of psychological technologies, was noted to be important. P5 indicated in this regard “it is helping people think about other aspects of those interventions. For example, if we have a physiotherapist who does mindfulness, just being able to drill down into what the specifics of that intervention are and where is the evidence around its effectiveness in this particular kind of problem. That's where I come in and attempt to try and carve out an identity which I hope is also helpful for my colleagues.” P5 later linked this sharing with other professions as a general sharing of psychological technology, something that differentiates psychologists from, for example, medical professionals. P5 noted, “If you compare us to our medical colleagues, they restrict the technologies that come under their profession. They've been very resistant to having things like nurse practitioners and nurse prescribing rights, whereas we've just said: Oh, CBT (cognitive behaviour therapy) is great. Everybody should know how to do CBT. Maybe that's an important part of our identity as a profession, how generous we have been with that with the knowledge that we have.”

Collaboration was noted to be important in leadership, enabling the clinical psychologist to provide a “warm engaging relational style of leadership” and a “non-hierarchical structure” (P3) within teams. Collaboration was noted to be essential in helping to build teams, as P10 noted: “We're good at the relationship stuff. We're good at building teams.” Collaboration was not associated with being a ‘yes-man’ but rather having the ability “to have a voice of difference or dissent within teams *(in order to)* them more effective overall” (P5). Therefore, collaboration links to another component of ethos that will be discussed later, that of elucidation or bringing an alternative perspective. Being scientific while being collaborative was emphasised by participants, something P11 described as an “overlap between a very science-driven approach and having a very humane component”. Therefore, collaboration was informed by other aspects of professional identity and not simply collaborating for collaboration’s sake. Collaboration was noted by some participants as a distinguishing feature for clinical psychologists. P10 noted, for example: “…as well as bringing in the humanistic aspect of the work we do. I think that makes us stand apart from most of our colleagues.”

Contemporary.

Being contemporary, or staying up to date with current practice, research, developments, and ideas within the profession, was a central focus of clinical psychologists’ conduct. This subcategory captured clinical psychologists’ dedication to “developing through continuing education advanced skills and interventions” (P7), as well as “develop their professionalism” (P3) and being “up to date with the research” (P1) in the field.

A contemporary approach was deemed essential due to the subject area clinical psychologists deal with, being humans and their behaviour. P9 noted, “People just continuously evolve, you know. You can't put them in a pigeonhole and say you are done; it's constantly changing.” This skill was, therefore, closely linked to the dynamic nature of clinical psychologists’ professional identity, as it involved the evolution of knowledge and skills over time. Being contemporary was also strongly linked to the self-referential nature of professional identity. “The ability to have further training as well, whether it be further postgraduate training or conferences and workshops as a way to change or influence identity and just to reflect on that identity as well" (P5). P3 highlighted that being contemporary provides the context for evolving practice, or "not doing something that we were taught two years ago and sticking to that." P4 highlighted the self-reflective component of being contemporary, indicating: "I think we need that regular input to question what we do, how we do it and have the up-to-date facts."

Being contemporary was described as a continuous process of "carrying on learning as you go" (P1). The process held meaning for participants as a way of introducing new ideas to the work clinical psychologists do, a differentiating element between clinical psychologists and "some other professions" (P5), as well as a point of "pride" (P3). "Keeping ahead of the game" and ensuring what is said and practised "is making some sort of sense" (P3) was also emphasised. The process of staying contemporary was noted to be diverse and fitting with the specific context of individual participants. P2, for example, noted, "In terms of continuing education, anytime they offer one-hour webinars where I can get a peek at some updated research or what practice people are engaging in, that's how I try to stay current as well as through attending conferences. I don't necessarily have as much time to read literature as I would like, so I find that the content that's presented web-based is easier for me to engage in." Other participants highlighted the impact of supervision on staying current, "it is a very important part of growth and learning" (P10). The ability to utilise supervision effectively, a specific skill discussed earlier, is therefore also critical in contributing to being collaborative.

The need and willingness to learn, and the associated curiosity were noted as underlying characteristics and linked by some participants to pre-qualification personal attributes. The process was further noted to be maintained "intentionally and continuously" and requires a "cohesive plan" (P8), therefore linking with the dynamic nature of professional identity. While being contemporary was mostly linked to psychological knowledge, both gained through didactic and experiential means, P8 also highlighted the need for ongoing learning and contemporary learning in wider areas beyond psychology as informing professional identity through personal identity. This included changing “jobs regularly to challenge ourselves to stretch ourselves and put ourselves in situations where we don't know the answers. That's where some good learning is. Due to my willingness to learn I've put myself into jobs and areas geographical areas and with different cultural groups of people where I have had to learn. And, of course, what I do is I ask the people; I say I want to understand this. But also, academically pushing myself, learning more, like going off and learning about quantum physics. To me, the more curious you are about the world and what's out there, the better you're going to be as an individual human, let alone as somebody trying to help another human through some difficult time. Otherwise, you just stay ‘that human’, and you still repeat the same things you learned 30 years ago.”

Elucidative.

The word elucidative means to bring to light and aligned with how clinical psychologists provide an alternative perspective, alternative voice, broad understanding, or make difficult psychological concepts plain or intelligible across clinical and non-clinical contexts. The skill referred broadly to sharing clinical psychologists’ “own sort of perspective of how we view people” (P3). The skill was linked mostly to providing “a different viewpoint on mental health and wellbeing” (P10). In client-facing work and within multi-disciplinary teams, the elucidating “voice of a psychologist is just so incredibly important… we think about what has happened to you and how it has impacted your life. And I think that voice is so important when we're talking about patients or clients or anyone really” (P3). The clinical psychologist was seen as a voice for normalizing people’s psychological experience and assisting with relationships where the individual’s psychological experience became “a barrier to interacting with the outside, with the broader world” (P4), as well as putting their experience within a broader context. Providing an alternative voice was also seen as an essential component of working within teams, with P5 noting: “In my own practice, that idea of being an alternative voice is important. It is important for both our clients but it's also important for teams as well because the ability to have a voice of difference or dissent within teams makes them more effective overall.”

Elucidating was further described as a process of moving away from “labels we've *(clinical psychologists)* been trained to use” (P4) and “questioning the model of psychiatry” (P5). The alternative voice was a tool to add to formulation and understanding, “another interpretation of what's going on or an alternative viewpoint … Psychologists are the ‘yes-butters’. We might go: ‘That might be the diagnosis, but this is the formulation,’ and this is the more subtle or nuanced picture” (P7). While presenting an alternative point of view was highlighted as important, the collaborative component of ethos was reported to overlap with being elucidative. As P7 noted: “You have to present an alternative point of view. You also have to hear other points of view mull things over.”

The ability to provide an alternative voice was furthermore noted to be a point of distinction for clinical psychologists. “Psychologists think differently. We think about humans and their behaviour differently from other professions. (P7)” Elucidating was also linked to being able to “offer reflective spaces where we can have multiple voices heard… Being able to mediate and allow different voices to be heard” (P9). Therefore, being elucidative also involved making space for others to have different perspectives to the dominant perspective heard, allowing for a broader conceptualisation of what was happening in a specific context or scenario.

Holistic.

Being holistic captured clinical psychologists’ ability to acknowledge, account for and effectively use historical, cultural, contextual, diversity, and religious variables to understand person(s) or situations holistically, both clinically and non-clinically, or simply “looking at things in a wider way" (P7) and to "to tie it together" (P5). P9 described this process as considering "not just biomedical but biopsychosocial and more importantly cultural and spiritual" information in formulating and understanding, and furthermore "to include the context that I find myself and how that transacts or intersects at these different levels." P6 described this as not putting yourself in a silo as a clinical psychologist but rather having a broad view of "what clinical psychology is" and doing what works for the person.

P11 described several aspects that informed a holistic approach, including "having as holistic a perspective of the client from a mental health perspective *(as possible)*, and including socio-cultural aspects as well", and later broadened the description to include "public systems", including "health", "forensic" and "legal justice" systems to formulation which assisted in guarding against a "piecemeal approach".

Being holistic overlapped with being elucidative; "because as psychologists we tend to say well, on the one hand, the literature says this, but then there's (*these factors*)" (P1). Being elucidative, therefore, helped balance variables not accounted for in the literature and the composed and holistic application of scientific evidence by being able "to tease out societal or cultural components to a certain kind of presentation" (P11). Being holistic also went beyond theory, as P4 noted: "There's a lot of art that comes into understanding the person, the context, how you view the problem, and how you have permission to treat the problem within the constraints of money and budgets." Being holistic considered several variables in the environment and was noted to work towards enacting a comprehensive formulation. P4 exemplified this approach by noting: "The role of the clinical psychologist is to come in with an understanding of the internal life of a person including what diagnostically could be problematic. The clinical scope can link that diagnosis to the social, spiritual, occupational, and family life of the human being, helping them break down barriers and optimize quality of life."

While being holistic focused on contextual factors often associated with a client, it also overlapped with the professional identity categories of being responsible (to be discussed later) and socially informed (discussed previously). Clinical psychologists' holistic approach was reportedly informed by "culture, the legalities as well as my ethical codes. I see myself as somebody who has to sit and integrate four streams of information within a context I occupy. (P9)" Being holistic was further associated with being flexible and specifically adjusting the approach based on contextual factors. Taking "a holistic viewpoint of whatever someone is coming with and try*(ing)* to adapt" (P8) was indicated as important.

A holistic approach was noted as a differentiating factor for clinical psychologists. P8 expressed this sentiment by saying: "I think that psychology has scope to be a bit broader and more holistic in its viewpoint". This perspective was echoed by P10, having noted: "I think bringing a more holistic psychosocial viewpoint is what we do." While being holistic was noted as a key professional identity concept, participants also noted "a long way to go in terms of cultural knowledge and I … cultural humility" (P3), suggesting that being holistic is an ongoing concern and area of learning for the profession.

Just.

Being just, a component of clinical psychologists' ethos, encompassed a focus and approach to clinical and non-clinical work consonant with the principles of equity, righteousness, fairness, the greater good, or simply social justice. Enacting this focus on the 'greater good' was noted to be linked to "talking about the impact of psychological factors important psychological factors. Speaking up" and "should say as a group or as concerned individuals, if they have the energy for it, these are the things that we need to be aware of" (P1). Clinical psychologists were, therefore, envisioned as justice advocates. As P9 noted: "I see that role as a part of being a clinical psychologist, a role as an advocate." This role extended to individual clients, as well as on a systemic or societal level, to enact "values around justice and equity" and for clinical psychologist knowledge, skills and expertise to also be "relevant on meta-level" (P3). This included "doing things like trying to influence health or social policy or people's understanding and awareness and knowledge" (P8).

Participants acknowledged difficulties with social justice representation, with P10 noting, for example, "We haven't had many people that are willing to step up and speak to the media or speak up on government decision-making forums, so I think our visibility at those levels is not what it could be." While a social justice role was advocated for by many participants, it was also noted that "there's layers of us *(clinical psychologists)* needed and there will be the loud ones and the quiet ones. We will have those people who feel confident, and we need to support them and not do what Kiwis do, which is try and chop their legs off even if we don't always agree with everything they say. So yes, I do think the whole system would benefit by psychologists having a bigger voice at the table" (P10).

One barrier identified by participants to be just on a wider level was a focus on one-on-one work and a reluctance to broaden work to group work or provide input in broader organisational, community or societal contexts. This reluctance was further noted to impact the societal perception of the profession, "where we sit, how we're viewed by others, and also how we view ourselves, so how we're valued in society and have that value or lack of it is demonstrated how we give out to a wider world the wider society" (P3), therefore overlapping with societal perception. Being just was also noted to be partly based on personal attributes. P4, for example, elaborated on how their personal opinions on equity and access to psychological services led them to only work for funded organizations where the clients aren't charged for their sessions. They elaborated: "It sits wrong with me to ask people in need for money. And the more distressed they are, the more sessions they need, the more money you've got to ask them for, and that is just something I struggle with. I value the opportunity to not have to do that."

Modest.

Modesty, as a subcategory of ethos, referred to the ability to function as a professional while avoiding extremes of behaviour and acting with humility. This subcategory of ethos was not widely endorsed, and dealt with two opposing aspects of being modest, that of being realistic regarding your own failings/limits and that of being modest due to lack of confidence or systemic pressure. Modesty was noted to be born from an ability to self-reflect and not overvalue abilities. Being modest was further described as maintaining confidence and speaking up without trying to overpower. P10 described the act of being modest well in this regard, noting that “humility doesn't mean being quiet and mousey. I do like the stance of humility, but that doesn't mean being subservient or a lack of strength. Because I think we do, we get the best out of people.”

Maintaining a modest approach was noted to be a necessity for functioning within specific systems. As noted by P10, coming from a position of “you should listen to me because I'm a psychologist” is often met by “them get squashed by the system. I won't tolerate them. Even another psychologist won't tolerate them. I think there's the tall poppy syndrome that New Zealand's known for, but I think there's also the ability to promote smooth relationships. But also, I think we are scared of getting things wrong. I think because we're always looking to grow, we're always worried whether there is something I don't know, is there something, if I put my hand up and say I know quite a bit about that, someone else knows more, and I get shamed.” One participant (P10) also described humility as a barrier, noting “somehow there's this very, and it's partly a kiwi cultural thing, this real humility to us where we don't feel like our opinion is worthy of bigger stages maybe in our own little world maybe in our teams our voice is worthy of being heard but on a bigger level that stops us.” And continuing, “I just think we don't like to show our expertise, or we don't sell ourselves very well.” This may highlight the dualistic nature of this ethos. On the one hand, being modest was linked to not being overconfident and domineering but could also lead to being under-represented or coming across as not confident.

Purposeful.

Holding a position of being purposeful was noted by a few of the participants as being important. This subcategory indicated the ability to have a definite purpose in mind and be resolute in approaching clinical and non-clinical work. The subcategory described being goal-directed in all work done as a clinical psychologist. Participants expressed this focus as “it's always about your ultimate goal and how you best to deliver that” (P10) and being focused on “very clear outcomes” (P10), “clinical goals (P11)” or “recovery goals” (P11).

Responsible.

Participants noted the ability to maintain ethical and professional standards as central to professional identity and the ethos clinical psychologists embody. Being responsible encompassed accountability, reliability, trustworthiness, and sensibleness when embodying the identity of a clinical psychologist. This component of ethos overlapped with professional identity being societally informed, specifically with the professional and legal requirements mandated by professional bodies and the judicial framework clinical psychologists function within. Being responsible was conceptualised as the skilful application of these socially defined frameworks to daily practice as a clinical psychologist.

P1 described the need for clinical psychologists to “behave to a very high standard professionally and ethically”. Throughout the interviews, the application of ethics and the board prescribed professional code was an important component of clinical psychologist identity and shaped how clinical psychologists conducted themselves. Clinical psychologists were noted to have a responsibility to meet the requirements set out in these guidelines. P4 simply stated this as: “I follow the code of ethics what I meant to do within my profession.” P7 broadened this description to include taking “into account the literature and the effective models of how to work what's best practice and ethics" as central components of responsible behaviour, therefore also overlapping with being contemporary, which was discussed earlier as a component of ethos.

The influence of professional standards and ethics was noted to impact not only clinical psychologists' professional lives but also their personal lives, again reflecting the reciprocal relationship between professional identity and personal identity. P2 noted in this regard: "I think in a lot of ways being guided by our ethics contributes to our identity because I think that it goes beyond just when I'm at work. I think those principles guide who I am as a person." While professional standards and ethical behaviour were highlighted as being expected by professional bodies and the profession itself, maintaining a high standard of responsible practice was also noted to be informed by a broader, non-mandated social expectation. P3 reported that the expectation of the public that comes with the "professional label" of a clinical psychologist is "really important … it makes me really aware that I need to deliver, so I need to be on my game. I need to be rigorous and robust and do the best work I can based on my knowledge and expertise" and later continued "there's something about this which doesn't sit comfortably with me about having the label of a clinical psychologist, that somehow makes us an expert on or somehow our work our word or what we say carries more gravitas, carries more weight than when someone else said it and I feel that it makes me really aware of that responsibility that we hold." Being responsible was therefore linked to the earlier subcategory of professional identity perception discussed, that of professional identity being socially informed, also by public perception.

Whereas there was a sense of being monitored by professional boards and bodies to maintain being responsible, clinical psychologists also used other avenues to reinforce this component of their professional identity. Receiving clinical supervision was reported as one such mechanism for maintaining professional and ethical behaviour, with P4 noting:

“checking of ethics' keeping you on track” as a goal of supervision. The integration of professional identity and professional identity appeared as another mechanism for reinforcing being responsible, with the higher standard expected from psychologists extending not only to their behaviour as professionals but also their behaviour in their personal lives. While behavioural standards were often highlighted, some participants also noted concerns regarding whether all clinical psychologists are meeting these standards. P1, for example, acknowledged that just “like mechanics or hairdressers. You get good ones, and you get bad ones” while discussing clinical psychologists’ professional behaviour. Critiques noted by several participants included professional standards being sacrificed in the pursuit of financial reward, being non-compliant or simply not up to date with scientific literature, an attacking attitude to opinions different than their own, and lacking the professional skills required to be effective as a clinical psychologist. These critiques reflected a strong sense of appropriate, responsible behaviour being supported by other aspects of professional identity, such as being contemporary or holding certain personal values (personal attributes).

Overall, participants reported a process of being “constantly accountable” (P9) professionally across the different aspects of professional identity. Not only do clinical psychologists enact specific skills or stay contemporary in their knowledge base, but there was also a perceived moral obligation inherent to enacting these components to the best of their ability and in line with professional standards.

Focus

The fifth and last category, focus, highlighted the important role of “where” clinical psychologists work and the modulating impact this context and its associated activities had on professional identity. The context itself (e.g., a mental health clinic) and characteristics specific to the context (e.g., the management culture of the specific mental health clinic) were noted to inform focus or what clinical psychologists do as part of their professional identity.

Context.

All participants commented on having worked or working in certain contexts as part of the discussion on professional identity. These contexts were mostly health and mental health-focused and included New Zealand organisations such as Te Whatu Ora (public health service), ACC (Accident Compensation Corporation), and Corrections. Historic contexts were also linked to professional identity development and expression and often related to training and practice in other countries and contexts, and these contexts influenced who a participant had become as a clinical psychologist. Again, the link between didactic and experiential learning could be made here, and the modulating role of where and when this learning took place was emphasised.

The contexts supporting professional identity development and expression were noted to sometimes be purposefully chosen to develop professional identity in a certain direction. P2, for example, described: “For me personally, when I trained to become a clinical psychologist, I made a choice early on in my training for it to predominantly be child-focused, so I actually really see myself as a paediatric psychologist. Clinically, I wouldn't feel comfortable working one-on-one with an adult, diagnosing an adult, and treating an adult. That's certainly not part of my identity”. These different contexts, both current and historic, ‘focused’ clinical psychologists’ work through activities associated with different contexts, leading to a different enactment of professional identity based on context. P6 described this process as “I do what's needed to be done, and it's playing the game within contexts like ACC, DHBs *(District Health Boards, more recently referred to as Te Whatu Ora)*”, reflecting the influence of the context on how and what is done by clinical psychologists. This, for example, led to, in more clinically orientated environments, clinical psychologists doing work related to clinical tasks such as assessment and treatment and expressing their professional identity as a clinician or as a therapist. This influenced how clinical psychologists described themselves, with some noting, for example, being a clinical psychologist using more detailed descriptions such as “paediatric psychologist” (P2), “therapist” (p6), or “manager” (P7).

Context-Informed.

The dynamic impact of characteristics associated with specific contexts on professional identity was also noted as important and overlapped with the social perception of the clinical psychologist ‘role’. Certain contexts were characterised by a narrow, societally informed definition of clinical psychologists’ identity. This led to the context informing the focus of a clinical psychologist’s activities and roles, irrespective of the potential of a wider professional identity being available. P5, for example, reflected on clinical psychologists being siloed into mental health work by the settings they work in (and broader societal perception) and not being able to contribute to other areas. This led to clinical psychologists’ other abilities, for example, leadership abilities, “not *(being)* acknowledged in job descriptions” (P5) and roles limited to that clinician or therapist. P11 elaborated on this feeling of restriction while commenting on clinical psychologists’ ability to do research: “The fact is I know we should be doing it *(research)*. Te Whatu Ora probably wouldn't give us the time to do the research, or if you do it, it's jumping through so many hoops when you're already doing so much work.”

Specific settings were also noted to present practical and logistical barriers to what clinical psychologists focus on professionally. P7 highlighted, for example, the lack of leadership representation in this regard: “Some areas of management, for example, clinical psychologists, do not go into because of the rate of pay. It's not worth our while to be some manager in, say, a clinical service like mine because you would have to lose $15000 or more. That has a price in that you're also not having clinical psychologists make decisions. So that's problematic. We do have psychologists who are clinical and service directors, but we don't have operational managers. We don't have psychologists be clinical team leaders. We don't because it's not worth our while. But it's managers, coordinators, and others like that that actually make the decisions about the direction of the service goes.”

Some participants noted the need for an active shift in professional identity, especially as it relates to what clinical psychologists focus on. P5, for example, commented: “As psychologists, I think we need to move away from this idea of working with people individually and thinking on bigger scales on how we can promote ideas of well-being on all sorts of different levels. We shouldn't be restricted to thinking that therapy is in a room with an individual or with a group. It's about how we can apply these ideas and models within other systems.”

Content Validity Results

In the previous section, the results of the qualitative content analysis were presented. The results noted that clinical psychologists’ professional identity was informed by five broad categories, being perception, personal attributes, skills, ethos, and focus. These categories and their subcategories generated in the initial round of qualitative analysis were further subjected to a second round of review by seven of the panellists previously approached for interviews. Participants were asked in mid-2023 to rate the relevance of each domain to professional identity, and interrater agreement was calculated using Cohen’s modified kappa (k*). The results were interpreted using the guidance provided by Polit et al. (2007), noting an interpretative framework for k* as being fair (0.40–0.59), good (0.60–0.74), or excellent (=k > 0.74). Categories scoring less than k* = 0.60 were deemed to not have achieved sufficient interrater agreement to be retained. Note that the interrater agreement was focused on the categories identified in the first round of content analysis performed in 2023. The results are summarised in Table 5, and the findings for each category and subcategory are reviewed briefly.

Table 6

Modified Kappa Values for Professional Identity Categories

Category/Subcategory	k*	k* Interpretation
Professional Identity Perception Category	0.85	Excl.
Personal Attributes Category	0.85	Excl.
Skills Category	0.65	Good
Business Skills Subcategory	-	-
Clinical Skills Subcategory	1.00	Excl.
Generalist Skills Subcategory	0.65	Good
Leadership Skills Subcategory	0.85	Excl.
Reflective Practitioner Skills Subcategory	0.85	Excl.
Scientist Practitioner Skills Subcategory	0.65	Good
Specialist Skills Subcategory	0.65	Good
Supervision Skills Subcategory	0.65	Good
Teaching Skills Subcategory	-	-
Ethos Category	0.65	Good
Collaborative Ethos Subcategory	0.85	Excl.
Contemporary Ethos Subcategory	0.85	Excl.
Elucidative Ethos Subcategory	0.65	Good
Holistic Ethos Subcategory	0.85	Excl.
Just Ethos Subcategory	0.85	Excl.
Modest Ethos Subcategory	-	-
Purposeful Ethos Subcategory	0.65	Good
Responsible Ethos Subcategory	0.65	Good
Focus Category	-	-

k*: Cohen modified kappa
k* Interp: Cohen modified kappa interpretation
Excl.: Excellent

Perception of Professional Identity

Professional identity perception, as a component of clinical psychologists' professional identity, referenced the ability for a clinical psychologist to perceive and embody a differentiated perception of professional identity from other professions. The expert panel endorsed the category highly as a component of professional identity, with a k* of 0.85, suggesting excellent interrater validity. This suggested good agreement among panel members that clinical psychologists hold a view of their professional identity as different from other professions.

Personal Attributes

Personal attributes dealt with distinctive traits, features or motivators deemed essential for 'being' a clinical psychologist and were thought to compromise a distinctive category of clinical psychologists' professional identity. Personal attributes included, for example, an interest in others, an interest in supporting people, an ability to empathise, understand non-verbal cues, being driven and an ability to tolerate ambiguity and difficult situations. Excellent interrater agreement was noted on this construct, with a 0.85 k* score. Personal attributes appeared to be a central aspect of being a clinical psychologist, and this finding may further support the overlap between personal identity and professional identity.

Skills

Another category previously identified as a component of clinical psychologists' professional identity was skills, or the practical knowledge in combination with the ability to 'do' what clinical psychologists 'do', encompassing both knowledge and abilities. Skills included several subcategories, including business skills, clinical skills, generalist skills, leadership skills, reflective practitioner skills, scientist-practitioner skills, specialist skills, supervision skills, and teaching skills. Undifferentiated Knowledge and Skills also fell under this broad category. Panel members endorsed skills in general at a 'good' level, with a k* score of 0.65. Variations in the endorsement of subcategories were noted. The inclusion of the different subcategories in the framing of the survey question may have led to a lower overall endorsement of skills, even when certain subcategories delivered a very high level of inter-rater agreement. The subcategories and interrater agreement achieved for each will be discussed separately in the section that follows.

Business Skills.

Business skills referred to a set of competencies and knowledge related to managing and operating a clinical psychology practice or engaging in entrepreneurial activities within the field. This subcategory was not well-endorsed as a central component of clinical psychologists' professional identity, suggesting that participants did not see business skills as a central and relevant component of professional identity. This was not an unexpected result, given that the construct was put forward by only one participant in the original text.

Clinical Skills.

Clinical skills encompassed a set of abilities, competencies, and proficiencies that clinical psychologists possess and utilise in the clinical setting to provide quality patient/client care. These skills included various aspects, including diagnosis, intervention, psychometric assessment, formulation, report-writing, and intervention. All expert panellists agreed on this component as a central feature of clinical psychologists' professional identity, with a k* score of 1, suggesting a high level of agreement on the centrality of diverse clinical skills such as assessment, formulation, diagnosis, treatment, and so forth to clinical psychologists' professional identity.

Generalist Skills.

Generalist Skills indicated the ability and proficiency at transferring a broad range of foundational competencies and abilities across various areas of clinical and non-clinical practice. There was good agreement in the expert panel as to the relevancy of this construct to professional identity, delivering a k* score of 0.65, suggesting an acceptable level of agreement on this construct as a component of clinical psychologists' professional identity.

Leadership Skills.

Leadership involved the ability to guide and influence others towards a common goal or objective and, therefore, encompasses a variety of activities. In the context of this analysis, Leadership Skills referred to any pursuit or activities that would guide and influence others, usually more than one person, outside the confines of direct client-facing work or in providing clinical supervision. Examples noted were:

- Liaison/consulting,
- Program development and evaluation,
- Direct management.

Participants evidenced excellent interrater agreement, with the k* score at 0.85. This level of agreement implied a high level of agreement on leadership skills being an important component of clinical psychologists' professional identity.

Reflective Practitioner Skills.

This subcategory of skills reflected on knowledge and competent application of reflective practitioner skills, for example:

- Self-reflection, Insights into strengths, limitations, and areas for growth,
- Critical analysis of own practice,
- Integration of experiences (professional and personal) and practical wisdom that informs future practice,
- Authenticity and genuine engagement, using the 'self'.

Expert panel members endorsed this skill highly, with a 0.85 k* score. The interrater agreement achieved inferred reflective practitioner skills as an important component of clinical psychologists' professional identity.

Scientist-Practitioner Skills.

Knowledge and the competent application of the scientist-practitioner model through evidence-based practice, critical evaluation of research, research competence and outcome evaluation were the focus of this subcategory of skills. A good level of interrater agreement on the relevance of this skill to professional identity was recorded, with a k* score of 0.65. Therefore, an adequate interrater agreement was noted to include scientist-practitioner skills as a construct in defining professional identity.

Specialist Skills.

Specialist Skills referred to a focused set of competencies and expertise developed in a specific area, context, or population. Examples could be expertise in forensic settings or in co-occurring disorders. Endorsement of the relevancy for this proposed aspect of professional identity was noted to be good, with a k* score of 0.65, suggesting a satisfactory level of endorsement of specialist skills forming part of professional identity for clinical psychologists.

Supervision Skills.

Supervision skills, or the skilful ability to utilise and influence supervision and provide supervision, were also interrogated as a component of clinical psychologists' professional identity. A k* of 0.65 suggested good inter-rater agreement on this subcategory of skills as relevant to professional identity. Sufficient agreement was noted to include supervision skills as a component of professional identity.

Teaching Skills.

Teaching Skills referred to the ability to relay knowledge to others. This subcategory primarily encompassed the ability to teach others confidently outside of the confines of direct clinical work or clinical supervision. Interrater agreement was low in this skill domain, suggesting this was not a central component of professional identity for clinical psychologists.

Ethos

Ethos embodied 'how clinical psychologists do what they do'; in other words, their overarching spirit, approach, attitudes, aspirations, and philosophy in applying their skills in the contexts in which they work. Ethos was divided into seven subcategories. These were 'being' contemporary, elucidative, holistic, just, modest, purposeful, and responsible. Each subcategory of ethos will be evaluated separately in the section that follows. Participants evidenced a good level of interrater agreement on ethos being a relevant component of professional identity (k* 0.65), suggesting an acceptable level of agreement on ethos being an important component of clinical psychologists' professional identity. Note that some components/subcategories of ethos were better endorsed than others, and the grouping of these together under one main category may have influenced a more variable level of agreement by the expert panel.

Collaborative.

This subcategory of ethos was about working with clients/patients, within teams, and within organisations in a way characterized by collaboration, cooperation, and being person-centred. The panellists reported excellent agreement on the relevancy of this construct to professional identity, with a k* of 0.85, suggesting collaboration was central to enacting professional identity.

Contemporary.

The central focus of this subcategory of ethos was ensuring contemporary practice by staying up to date with practice developments, research, and new ideas. This subcategory received an excellent level of interrater agreement on relevance to professional identity, having recorded a k* of 0.85, implying that being contemporary is crucial to ratifying professional identity.

Elucidative.

As a component of clinical psychologists' professional identity, being elucidative referred to the ability to provide an alternative perspective, alternative voice, broad understanding, or making difficult concepts plain or intelligible across clinical and non-clinical contexts. A k* of 0.65 reflected a good level of inter-rater agreement on the relevance of this construct to clinical psychologists' professional identity. The results suggested an acceptable level of agreement on the centrality of the construct to professional identity.

Holistic.

This subcategory referenced the ability to acknowledge, account for, and effectively use cultural, contextual, diversity, and religious variables to understand person(s) or situations holistically, both clinically and non-clinically. Participants highly agreed that being holistic was relevant (k* 0.85), suggesting that the construct is important to the concept of professional identity for clinical psychologists.

Just.

Being just encompassed a focus and approach to clinical and non-clinical work consonant with the principles of social justice. The construct's relevancy as a component of professional identity was noted to be excellent, with a k* of 0.85. Being just was, therefore, likely an important component of professional identity for clinical psychologists.

Modest.

Modesty as a subcategory of ethos referred to the ability to function as a behaviourally well-balanced professional, avoiding harsh or domineering behaviour. Participants did not agree on the centrality of this construct to professional identity, achieving a k* score below the cutoff.

Purposeful.

This subcategory indicated the ability to have a definite purpose in mind and be resolute in approaching clinical and non-clinical work, i.e., being goal-directed in all work done as a clinical psychologist. The panellist noted a good level of agreement as to the relevancy of this construct (k* 0.65), reflecting adequate agreement to include the construct in conceptualising professional identity.

Responsible.

The ability to maintain ethical and professional standards was central to this subcategory of ethos. This included accountability, reliability, trustworthiness, and sensibleness when embodying the identity of a clinical psychologist. The expert panel noted good agreement on the construct's relevancy, reporting a k* of 0.65. Being responsible was, therefore, sufficiently supported for inclusion as a professional identity construct.

Focus

This category of professional identity referenced inhabiting specific contexts or working with specific populations typically associated with being a clinical psychologist, and this focus helping to define professional identity for the group. Participants evidenced varying agreement on this construct as relevant to professional identity. A below cut-off k* value was recorded. This was an unexpected result given the high level of endorsement of context as important in the interviews and possibly reflected a limitation of the study (in this case, likely the wording of the survey question).

Discussion

In the previous section the results of the qualitative content analysis investigation into clinical psychologists' professional identity were discussed, as well as the review of the identified categories by the expert panel to ensure content validity. Investigating clinical psychologists' professional identity through content analysis suggested clinical psychologist perceive their professional identity as being differentiated from other professions, dynamic, informed by a guiding philosophy of practice, and influenced and shaped socially through regulation and others' perceptions. Professional identity was linked to personal attributes, and integration between personal and professional identity was highlighted. The skills and knowledge clinical psychologists hold, as well as the way they conduct themselves, were important aspects of professional identity. Finally, the focus or context clinical psychologists work in, as well as the influence of this context itself, was noted to be informative of professional identity. Upon further review by the expert panel, further refinement in the supported categories was noted, with certain subcategories being discarded, for example, business skills as a component of the knowledge and skills clinical psychologists hold. The original findings were, however, broadly supported. Note that some categories and subcategories identified in a later review of the data were not subjected to this additional scrutiny by the expert panel.

The findings identified were important, as they allowed for an updated perspective on clinical psychologists' professional identity, something largely absent from the literature. Furthermore, the findings provided a framework to link clinical psychologists' professional identity with the broader professional identity literature. The findings also highlighted the contextually bound and somewhat fuzzy nature of clinical psychologists' professional identity, with the concept unlikely to be present at the same level in any one individual. The results also delivered a practitioner-based perspective on professional identity, allowing for reflection on adoption and alignment with the 'legislated' professional identity prescribed by the New Zealand Psychologist Board. Lastly, the results allowed for consideration of future challenges to the identified professional identity, as well as recommendations. Each of these aspects will next be discussed in more detail. The chapter will conclude with an overview of the limitations of this component of the research.

Clinical Psychology in the 21st Century

The study provided an exploratory overview of clinical psychologists' professional identity in the 21st century. Given that professional identity is a dynamic construct (Chen & Reay, 2021; Chreim et al., 2007) and typically shifts based on the requirements of the time and social milieu, often triggered by significant changes within society (Capshew, 1999; Pickren & Rutherford, 2010), it is unlikely that "who" clinical psychologists are now has remained the same since the inception of the profession. While the profession emerged from philosophy in the late 1800s (Kelly & Kelly, 2007), it was primarily a laboratory-based profession until the mid-1900s (Benjamin, 2008; Capshew, 1999), realigning itself as predominantly an applied helping profession with a mental health focus (Goodwin, 2008; Schubert, Buus, et al., 2023). While the applied focus on mental health is still evident, results suggest an overall shift in clinical psychologists' professional identity. Contemporary clinical psychology was reported to hold a broad professional identity, straddling both a social scientific and health science perspective, and appeared willing to enter many different settings. The profession still linked itself broadly with the Boulder model (Frank, 1984), referred to in this thesis as the scientist-practitioner model. This model advocates for scientific and evidence-based practice, and results suggest this approach to be a valued component of who clinical psychologists perceive themselves to be.

Although the identification with mental health was still strongly presented in the results, it appeared as if there is a broadening of focus to other areas of health and wellbeing and from individual to broader systemic intervention. The broadening of professional identity was linked to not only a focus on clinical aspects of work but also on providing leadership and enacting social justice causes. This aligned with calls from authors such as Dobson (2016) to consider a wider and more inclusive role for psychology given the changing demands of society and the benefit psychologists can have at different levels. The broadening of focus to other areas may also lessen some historic concerns of clinical psychology limiting itself to the therapy room (Du Villier et al., 2015). Recent calls have also been made for a broader social justice agenda for psychologists (Carr et al., 2023). It is encouraging to see that these broader perspectives have entered the collective view of "who" a clinical psychologist should be. It is, however, not clear how widely this view is enacted, as the sample size was small, and the project likely attracted participants interested in professional identity.

Within health systems, clinical psychologists were reported to embody an elucidative role, providing an alternative voice to often dominant medical models. While certainly not a new concept for clinical psychologists (see, for example, Guerney et al., 1971), the emphasis on being an alternative voice, or as one participant put it, a "yes-butt" person, was an important perspective, as was working from a holistic, person-centred approach to practice. This positioned clinical psychologists as important disruptors within health and other systems, potentially allowing for growth and change where required while still maintaining a collaborative approach. This may help clinical psychologists position themselves effectively within the arena of interprofessional practice.

Clinical psychologists continued to differentiate themselves from other professions using psychological technologies, such as talking therapy. While acknowledging overlap with other professions, clinical psychologists achieved differentiation through their level of training, knowledge, and skills and the application of these skills in high-level intervention. This echoed the position taken by Stewart et al. (2014), with the value of psychologists (as opposed to other psychological providers) being linked to the provision of complex mental health services.

While results supported the evolution of a broader professional identity, there was still a sense of being tethered to the role of an 'individual mental health therapist'. While participants valued this component of identity, and for some, this was a primary component of identity, many also reported a sense of being restricted within organisations, and indeed society, to this role. This restriction, in turn, limited access to other valued roles, including research and leadership roles and embodying a broader professional identity. This aligned well with previous discussions on the imposed restrictions on the role of psychology (see, for example, Du Villier et al., 2015; Holttum & Goble, 2006) and possibly reflected a mismatch between societal perspectives on who clinical psychologists are and how clinical psychologists perceive themselves.

In summary, clinical psychologists within the 21st century embodied a perceived distinct professional identity characterised by providing mental health and health services with a high level of complexity. Professional identity has broadened beyond historic laboratory-based or mental health-based conceptualisations of the profession to also include broader systemically focused approaches through the provision of leadership and focus on social justice initiatives. Clinical psychologists maintained a strong position within the scientist-practitioner model but have also incorporated other approaches, such as being reflective practitioners. Clinical psychologists' identities are noted to be moving beyond the therapy room into more diverse roles.

Clinical Psychologists' Professional Identity and Professional Identity Theory

The difficulty with defining identity, and subsequently professional identity, has previously been discussed (see Chapter 3), and the varying definitions referenced. While a simplified definition of identity noted was simply "who" clinical psychologists are and what they "do" (Schubert, Buus, et al., 2023), the question could still be answered in many ways. This potential for a very broad definition of clinical psychologists' professional identity was also observed in the results, with participants identifying wide-ranging and diverse constructs related to professional identity and not being in full agreement on most constructs found. This may suggest that professional identity is a broad construct that answers the question "Who are you?" in a variety of interconnected ways, ranging from identity perception, personal and professional identity overlap, skills, and acceptable behaviours to where clinical psychologists focus their work. How the question is answered by an individual clinical psychologist may simply depend on the context and emphasis of the question at the time.

The findings of this study aligned well with previous definitions and theories promoting this broad conceptualisation of professional identity. Wackerhausen (2009, p. 459) offered such a broad definition of professional identity, highlighting the "macro-level" and "micro-level" of professional identity. The macro level captured identity as dynamically residing in the profession's recognition and regulation within society, societal perception of the profession, the profession's promoted identity, and the subsequent roles, authority and privilege associated with these roles. The micro level encapsulated the abilities that define membership of a profession at the level of an individual professional, including training, level of knowledge and skills, as well as acceptable behaviour. Both macro and micro-level constructs were present in the findings discussed and informed professional identity in the current study. This again supported the complex definition of professional identity and the varied sources of information clinical psychologists draw from to define who they are as professionals.

Fitzgerald (2020) recently provided a concept analysis and theoretical exploration of the professional identity construct. While she also highlighted this inconsistency in the definition of professional identity, she concluded that professional identity could be defined through the actions and behaviours of a professional group, the knowledge and skills they hold, their values, beliefs and ethics, belonging to a professional group and the associated group socialization itself, and the associated integration of professional identity with personal identity. These findings again highlighted the multiplicity of professional identity constructs that could be drawn from to inform who a clinical psychologist is at any time. These aspects were also well represented in the different categories of clinical psychologists' professional identity identified in the study, again illustrating good alignment with the findings of other investigators and highlighting the complexity of the phenomenon.

While having illustrated good alignment with the complex definitions and theories supporting professional identity conceptualisation by other theorists, one aspect of professional identity should be further considered. Existing professional identity definitions often highlighted the notion of control over a subject area as being a core defining element of a profession and its identity (Abbott, 1988; Caza & Creary, 2016; Goode, 1957; Monrouxe & Rees, 2017; Wilensky, 1964; Wilkinson et al., 2016). While participants did claim a high level of expertise in psychology, the overlap between the roles of clinical psychologists and other professions was also readily acknowledged. Shared ownership of psychological technologies was further highlighted. The findings may suggest a more nuanced approach to professional identity definition being required, at least in this group. Professional identity was not defined based on perceived ownership of a subject area but rather the depth of knowledge.

In summary, clinical psychologists' professional identity aligned well with other definitions and theoretical constructs of professional identity in this study, suggesting good alignment with the current understanding of the construct of professional identity generally and allowing for a more specific understanding of clinical psychologists' identity when thinking about these definitions/theories.

The Fuzzy Nature of Clinical Psychologists' Professional Identity

While the results suggested good alignment with the broader understanding of professional identity as a construct, they also highlighted the variance in agreement between different participants on what constitutes "who" clinical psychologists are. Except for the subcategory of clinical skills, no category or subcategory identified received a perfect endorsement when the content validity was reviewed.

The lack of consistent agreement supported the conceptualisation of a professional identity prototype, or a category prototype, as a fuzzy construct. This aligned with the conceptualisation of identity (and subsequently professional identity) within the social identity approach. Hogg (2018) defined category prototypes as a vague set of ideal qualities attributed to a group that help to identify group members. The results suggested good, but not perfect, agreement on most of the different constructs identified as central to clinical psychology's identity. The results, therefore, also supported the observation of variation in ideal prototype representations within the group and varying levels of conformity with the prototype depending on context (Hogg & Vaughan, 2018). Clinical psychologists are likely to hold a core set of characteristics as defining “who” a clinical psychologist is, but there is unlikely to be perfect agreement on this stereotypical clinical psychologist, with different aspects of this prototype being in focus at different times. This would be an important factor to consider in further research into this area, as perfect agreement between clinical psychologists would be rare.

One reason for the variation noted in the social identity approach was the role of context. The social identity approach holds that social identity, and the social identity prototype will vary based on context (Tajfel, 1974b; Turner, 2010), in part informing the fuzzy nature of this construct. Interestingly, the category of context or “focus” was not well supported as a defining aspect of professional identity in the quantitative construct validation review. Qualitatively, the role of context and setting was common, being embedded as formative and influential in professional identity formation and expression. The lack of endorsement of setting/context is thought to be of wording of the review.

In summary, while perfect agreement on the different categories and subcategories of professional identity was not achieved in most identified categories and subcategories, this result is not unexpected. Given the understanding of identity perception being supported by category prototypes and these category prototypes being context-dependent, it is unlikely a perfect clinical psychologist professional identity prototype would be identified. The study did contribute to a ‘good-enough’ understanding of core aspects of professional identity and aligned well with the social identity approach’s theoretical framework from the category prototype perspective.

Clinical psychologists’ Professional Identity and Professional Regulation

The study provided a practitioner-informed review of the professional identity construct. Given that clinical psychology is a regulated profession requiring professional registration within New Zealand, it could be argued that the professional identity held by clinical psychologists should closely mirror what is required by the professional board.

The New Zealand Psychologist Board (NZPB) defines a psychologist as someone who offers psychological services through the application of psychological knowledge to individuals and larger groups to understand, predict and influence human behaviour at its various levels (New Zealand Psychologists Board, 2018b). A clinical psychologist is one of the different scopes of psychologists registered in New Zealand and requires a master's degree or higher in psychology from an accredited educational organisation, a Postgraduate Diploma in Clinical Psychology or equivalent qualification, and completion of a NZBP-approved practicum or internship involving 1500 hours of supervised practice.

NZPB also promotes several core competencies for all psychologists (New Zealand Psychologists Board, 2018a). These include holding an adequate knowledge of empirical theoretical and scientific psychological models, research principles and methods, cultural and diversity competence, legal and ethical knowledge and application of psychological practice, reflective practice, the ability to effectively organise, plan, implement and evaluate systematic psychological assessment and intervention, evaluation and problem-solving, communicate effectively with other professions and the public, establishing and maintaining effective relationships with stakeholders, being able to provide effective consultation, and the ability to collaborate effectively, being able to provide effective supervision.

Clinical psychologists need to demonstrate these foundational skills and must demonstrate additional competencies related to their scope, broadly related to mental health and mental illness across the lifespan of an individual and including consideration of brain behaviour, developmental factors, and cultural factors within the mental health context (New Zealand Psychologists Board, 2018a). The application of this knowledge, in combination with skilful assessment and formulation, is then used to implement effective, evidence-based intervention.

The results suggested good overall alignment with the NZPB core competencies as defining characteristics of who clinical psychologists are as a group. While the aspects considered as important by the NZPB were included in participant's evaluation of professional identity, the level of agreement on what is central to being a clinical psychologist varied somewhat, suggesting some difference in understanding of the concepts linked to core competencies and what is central to the professional identity of that specific clinical psychologist at that time. An example would be the identified subcategories of scientist-practitioner skills or being elucidative. While there was enough agreement to include these concepts in the final construct of professional identity, participants did not fully agree on the centrality or relevance of professional identity.

While the NZPB core competencies were broadly supported, there were also aspects of professional identity that fell outside of the prescription of the board. One example was personal attributes. Participants endorsed specific personal characteristics and the integration of these characteristics and personal identities into being a clinical psychologist. While the NZPB references self-reflective practice as important to all psychologists, it stops short of referencing personal attributes defining who clinical psychologists are or the integration of personal identity into professional identity. Speculatively, this may be an aspect held by universities as a component of the highly competitive selection process for entry into postgraduate training programs.

In summary, the results suggested good alignment of core aspects of professional identity as presented by practitioners when compared to legislated aspects required from clinical psychologists. This suggested a good integration of these mandated competencies in professional practice and may reflect on training (both initial and ongoing) being effective in installing and maintaining these factors as central to professional identity. Of note was that there was not perfect agreement on each component, which may reflect some variation in understanding the NZPB requirements or the category/subcategory as identified in the research. This may also reflect that these competencies are promoted as important in isolation rather than being components of a mandated professional identity for the profession. This may reflect the need to bring these competencies intentionally under the umbrella of professional identity, this term being largely absent from board documentation. Also important is the wider professional identity endorsed by participants, for example, in providing leadership, which was not as definitively defined in board documentation. This may reflect a need to broaden board competencies to what is also perceived as important at the coalface of practice.

Future Challenges to Clinical Psychologists' Professional Identity

As already noted, professional identity is an evolving concept. Within the medical fraternity, there has been a focus on intentionally instilling and teaching professional identity (Cruess et al., 2014). This intentional focus on professional identity will become increasingly important for clinical psychologists, both in the training and development of new clinical psychologists and in the societal perception of the profession's identity. This focus is required given the continually evolving context in which clinical psychologists find themselves. Some of these contextual challenges are briefly discussed.

Similar Professions.

Psychology as a subject area has been claimed by a proliferation of other professions (Belar, 2012; Bellamy et al., 2014; Capshew, 1999). Additionally, the public has been reported to have difficulty differentiating between psychologists and other psychological service providers (Hartman et al., 2016), and there is noted scepticism regarding psychological practice (Ferguson, 2015). Psychologists are also often narrowly portrayed as clinicians only (Feldman, 2021; Henriques, 2013). This contrasts with the broad identity endorsed by participants in this study, as well as the professional identity ascribed to psychologists by professional bodies (see, for example, Australian Psychology Board, 2020; Health & Care Professions Council, 2021; Health Professions Council of South Africa, 2021; New Zealand Psychologists Board, 2018a). Clinical psychologists will need to find a way to differentiate themselves from others effectively, both individually and societally, or risk amalgamation into the role of 'therapist'. Regulating board training providers will need to take this broader professional identity conceptualisation to heart and provide support for the differentiation to maintain clinical psychology as a relevant and viable profession.

Interprofessional Practice.

While identity is often about differentiation (Tajfel, 1974b), interprofessional care and the overlap between roles have become increasingly important in health settings (Wackerhausen, 2009). Clinical psychologists will, therefore, not only need to be able to differentiate themselves but also embrace sameness and overlap. This becomes important when thinking about similar professions being increasingly able to access employment contexts traditionally reserved for clinical psychologists, as well as the noted frustration of participants in certain contexts associated with how they are perceived within those contexts. Intentionally focusing on managing this overlap, but also maintaining positive differentiation will become increasingly important in employment and health systems that are increasingly becoming more accessible to a wider spectrum of psychological providers. Again, this has important implications for the regulation of the profession and for training future clinical psychologists.

The Changing Face of Practice.

Technological development in healthcare is progressing at a rapid pace. One area, for example, has been the integration of artificial intelligence (Gado et al., 2022). Artificial intelligence has been touted as an adjunct tool for traditional areas of psychological practice Within the field of psychology, and subsequently psychological practice (De Mello & de Souza, 2019) but has also been positioned as a potential threat to what psychologists traditionally do (Fiske et al., 2019). Clinical psychologists will need to intentionally focus on who they are to develop with these advancements, rather than being left behind in 'traditional' constructions of this is who a clinical psychologist is, and this is what they do.

Limitations

As previously discussed, the research was nested within a mixed methods scale design, and the results and discussion in the previous sections present the first phase of investigation based on the structure proposed by Zhou (2019), an investigation into the construct identified for measurement. To evaluate the limitations and quality of this phase, the choice was made not to use a mixed methods quality assessment approach, such as suggested by Hirose and Creswell (2023), but to focus on a qualitative quality framework, as reviewed by Yadav (2022). This choice was based on the limited scope of the thesis. The review from a mixed methods perspective was thought to be more appropriate at the end of scale construction, with a review from a qualitative framework enabling more detailed reflection on the current phase. The next sections will highlight some limitations of this phase of the research based on this review of the quality criteria.

Paradigm

As previously stated, dialectical pluralism is often touted as a meta-paradigm that allows for dialoguing between very different paradigmatic approaches and their associated methodologies (Johnson, 2015). The primary dialectical synthesis in this study was from a methods perspective, combining qualitative content analysis with a quantitative measure of interrater agreement on the generated categories. This approach was in line with the goal of constructing scale items and the associated reduction of information but did limit the potential for dialectic tension by utilising two different paradigms in the process.

Methodology and Methods

From a methodological perspective, the tension and accompanying potential of synthesis is valued when using a dialectical pluralistic approach, and this was limited to the use of methods as already discussed. When evaluating methods, several potential limitations were noted. These will be discussed briefly.

The semi-structured interviews were constructed from the previously discussed literature review in Study One. Given the limitations of the literature review, the possibility of an interview schedule not adequately capturing all aspects that require exploration is a possibility. More research is required to confirm the current results.

The sample of participants was noted to have several potential pitfalls that could affect the validity and reliability of the results. The sampling of participants resulted in a comparatively small sample. The sample did not include any indigenous culture representation and consisted of a large proportion of overseas-qualified psychologists. The sample also had a significant proportion of the participants being dually vocationally registered as neuropsychologists. The sampling process was also highly cumbersome, with repeated rounds required and difficulty in achieving a workable number of participants. These sampling concerns may lead to a skewing of data and over-presentation of perspectives from a Westernized, neuropsychological, and overseas-trained perspective.

Data analysis and reporting were progressed by a single researcher. Although possible, it is not the ideal implementation of content analysis. Consequently, no interrater agreement process in the data analysis process was conducted. While the process of evaluating and re-evaluating the categories was repeated several times, this still involved one individual researcher drawing conclusions. While supervision by another clinical psychologist and a research psychologist was undertaken, this does not eliminate the potential for bias. The possibility of bias due to a single researcher being involved was somewhat mediated by gathering interrater agreement data after the initial categories and subcategories were generated. It should be noted, however, that these measures were predominantly developed for agreement on scale items, and their use in this context was a somewhat "off-label" use of the method.

As previously noted in Study One, content analysis has several varied approaches to its implementation (see, for example, Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Mayring, 2022b; Schreier, 2012). This suggests the possibility of another researcher using qualitative content analysis potentially coming up with a different framework given some of the differences in approaches. Furthermore, scale construction is a cyclical endeavour, with the steps being ideally repeated as required. The inability to repeat steps in this project is a limiting factor. Ideally, the results, as analysed the second time in late 2023/early 2023, would have again been subjected to participant review, given some concerns regarding wording and explanation of some constructs noted, as well as the addition of categories in the second round of analysis.

Future Directions

The presented study provided an exploratory perspective on the category prototype of clinical psychologists' professional identity. While having provided a framework that defined clinical psychologists' professional identity based on how clinical psychologists perceive their identity, who they are as people and the integration of these selves into practice, what they know and do, how they do what they do, and the contexts in which they do what they do, there is still significant research needed in this area. The study was exploratory, used a small sample, and certain sample characteristics may limit the generalisability of findings. A larger study focused on further defining professional identity, using multiple researchers, would be useful. Given significant difficulties in sampling within the New Zealand context, it could be worthwhile to extend the sampling to Australia, providing the potential for (at least in part) a shared professional identity. This will ensure a larger pool of clinical psychologists to draw from and increase the focus on core aspects of the identity.

Chapter 6: Study Three - Constructing a Pilot Scale and Piloting the Scale

Introduction

The previous two chapters/studies focused on the results of phase 1 of the scale construction process, the investigation into the construct being measured. These two studies involved an integrative literature review and a qualitative content analysis to define the professional identity prototype constructs, and further validation of the defined constructs using a measure of interrater agreement. This chapter describes the use of the qualitative results to construct scale items, as well as the refinement of scale items into an initial or pilot professional identity scale. The steps involved in the process of providing an initial measurement scale will be discussed in detail in subsequent sections. For the sake of clarity, initial items developed for review were termed sample items, and the initial scale presented for review by the expert panel was the provisional scale. From this, a final pilot scale was developed with pilot items. The terms were chosen to reflect the fact that the scale would not be field tested and would require further piloting, as will be discussed later in this chapter.

Data to be Converted to Scale Items

Prior to exploring how scale items were constructed and the evaluation of these scale items, it is important to reflect on the data that was used to construct these scale items. As will be discussed later, following the qualitative exploration in Study One and Two, seven of the original participants from Study Two provided anonymised feedback on the categories identified, as well as the scale items. The process of obtaining interrater agreement on identified categories, therefore, coincided with the review of sample scale items and was actioned in this manner from a pragmatic perspective. Therefore, the sample scale items were based on the initial categories identified after the content analysis in mid-2023, prior to interrater agreement on these categories and subcategories being gathered. These initial categories and subcategories are presented in Table 6. This sequence of events had important implications for the inclusion of scale items into the provisional scale, which will be discussed later in this chapter.

Table 7

Categories and Subcategories Initially Identified

Category	Subcategory	
Professional Identity Perception		
Personal Attributes	Traits	
Skills	Business	Scientist Practitioner
	Clinical	Specialist
	Generalist	Supervision
	Leadership	Teaching
	Reflective Practitioner	
Ethos	Contemporary	Modest
	Elucidative	Purposeful
	Holistic	Responsible
	Just	
Focus		

Methods

This next section provides an overview of the methods used in constructing and reviewing sample scale items with an expert panel.

Converting Qualitative Data to Scale Items

This section reviews the process used to construct sample scale items. Prior to items being converted into scale items, a decision had to be made on more narrowly defining what was to be measured. While the qualitative exploration previously discussed informed a description of the clinical psychologist prototype, the dynamic nature of professional identity was also highlighted as a characteristic of clinical psychologists' professional identity. This finding aligned with the varying nature of professional identity across different stages broadly reported in the literature (Bebeau & Monson, 2012). The focus of the scale had to consequently be more narrowly defined to account for this dynamism. It was unlikely that a student psychologist and experienced clinical psychologist would endorse or measure similarly on all components of the identified professional identity prototype.

The decision was made to focus item (and scale) development on the core prototypical professional identity aspects that trainee and new graduate clinical psychologists would likely be required to develop. Items developed were therefore focused on aspects of professional identity assumed to be of critical importance in the first five years of practice. It was further presumed that trainee and new graduate clinical psychologists would score differently on these aspects as they progress from trainee to new graduate and beyond. In other words, clinical psychologists' professional identity development was considered a latent variable that could be measured due to the variation of the construct's magnitude over time, an essential component of constructing a measurement scale (DeVellis & Thorpe, 2021).

Sample scale items were developed based on an inductive approach using the results in Study Two (Chapter 5). Inductive item development has been described as being based on an initial exploration of the construct or domain to be measured, while deductive item generation was noted to occur when there is relevant information available on the scale domain under investigation in the literature or in other existing scales tapping into this domain (Boateng et al., 2018). Constructing sample scale items involved two analogous processes: item generation and response format specification (Boateng et al., 2018; Kyriazos & Stalikas, 2018). Item generation required consideration of the number of scale items and the wording of scale items. It was recommended that two to four times as many scale items as envisioned in the final scale be included for review (Boateng et al., 2018; Kyriazos & Stalikas, 2018; Worthington & Whittaker, 2006). A final scale no longer than 20 items was envisioned. Consequently, 56 sample items were developed and included for review, averaging 2.8 items per included category/subcategory identified in the first phase. Note that there was some variation, with some categories only having two included items. The inclusion of more items was judged to be excessively burdensome on the review panel.

Several considerations were included in formulating the wording of sample scale items. These considerations included writing items in a clear, concise, readable, distinct manner that reflects the scale's purpose (Worthington & Whittaker, 2006). Items were kept unsophisticated, forthright, and engaging the participant as if in normal conversation (Boateng et al., 2018). Items were written in under 20 words, in the present tense, targeting a single concept, worded to avoid double-negatives, absolutes, or several interpretations, and in a manner abating items likely to be endorsed by everybody (McCoach et al., 2013). Personalized and strongly worded items were used as recommended by Kyriazos and Stalikas (2018) to ensure that items were not overly agreeable. Items were worded in a single direction, i.e. items were rated only positively. This choice was made given the benefits of balancing a measure with both positively and negatively worded being previously questioned as unsatisfactory (DeVellis & Thorpe, 2021).

The response format for sample items was considered based on the recommendations compiled by Kyriazos and Stalikas (2018). This included considering the format of response options, number of response options, response option labels, and response midpoint. A visual analogue scale was selected with 10 equal increments (100mm). The two limits of the scale would measure the two limits of the measured construct, in this case, 1 being 'not developed' at all and 10 indicating 'fully developed'. The response labels were selected to maintain the respondent's focus on rating their own development on the specific construct being evaluated. The choice was made to label all response options, which deviates somewhat from other visual analogue scales. This choice was based on labelling being noted to produce measures with better psychometric qualities (Streiner, 2015). A unipolar response option was selected given that the measure is designed to evaluate core prototypical characteristics associated with being a clinical psychologist, and these factors are postulated to be present to some degree to consider yourself a clinical psychologist in any given situation. Items were, therefore, set in the present tense to indicate the current moment of measurement. An example of a sample scale item is presented in Figure 5 below.

Figure 5

Example of Scale Item

I am skilled at handling complex and risky cases

Not Developed ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Fully Developed**

To provide an extensive list of sample scale items, ChatGPT 3.5 was utilised (OpenAI, 2023). The platform was provided with a definition of each category and subcategory previously defined. The platform was then asked to generate scale items based on the provided definition. A second approach was also utilised, where ChatGPT 3.5 was asked to provide alternative ways to formulate scale items already constructed. From the results, and based on the criteria already noted, scale items were selected and simplified for use in piloting. An example of the two approaches used with ChatGPT 3.5 is provided in Appendix C.

Piloting the Sample Scale

The next step was to pilot the chosen sample items (Zhou, 2019). Panel review, or expert review, was chosen to inform content validity (Boateng et al., 2018; Burton & Mazerolle, 2011; Kyriazos & Stalikas, 2018; Worthington & Whittaker, 2006). Expert reviews are conducted by presenting the proposed scale items to a panel of experts to the content validity of each item. DeVellis and Thorpe (2021) also suggested that the expert panel review each item based on the clarity and conciseness of each item. Other authors included additional recommendations; for example, Worthington and Whittaker (2006) suggested comments on face validity, overlooked components in scale development, and providing qualitative comments on each item.

Additionally, two factors were considered as part of the expert review process. The first being the number of expert reviewers, and the second the potential burden of the review. While Zamanzadeh et al. (2015) noted that determining the number of experts is always somewhat arbitrary, both Zamanzadeh et al. (2015) and Yusoff (2019) agreed larger expert panels would ensure sufficient control over the chance agreement. Yusoff (2019) recommended using between 6 to 10 experts to review the items in this regard. The aim was, therefore, to have at least 6 reviewers in this study. A pragmatic decision informed the review length and, consequently, the included scale items for review to lessen the burden on reviewers. Longer surveys have been reported to be more time-consuming, prone to missing data, and higher refusal rates (Stanton et al., 2002). The number of items to review was therefore limited to an approximate timeframe of 30 minutes to complete, based on a suggested framework for this calculation proposed by Versta Research (2011).

The expert panel was made up of participants from Study Two, who were asked to complete a survey using the RedCap Online Survey Tool in July 2023, as presented in Appendix D of the thesis. A brief definition and description of the main categories and subcategories were provided from Study Two, and participants were asked to rate how relevant they thought these categories were to clinical psychologists’ professional identity. These results were described in Study Two already and won’t be repeated here. Participants were next asked to evaluate the sample professional identity prototype rating scale items developed. As per the recommendations provided by Yusoff (2019), each domain was defined, and the related items were demarcated. Participants were also provided with relevant background regarding the proposed scale, including scope, instructions, and so forth. Scale items were rated based on content validity and clarity. Only content and clarity were evaluated, given the additional time and burden requirement additional questions would have posed to the panel. Ratings were based on a 4-point unipolar Likert scale, the descriptive anchors (Alhassn et al., 2022) being ‘not at all’, ‘somewhat’, ‘quite’, and ‘very’ as the points of measurement. A unipolar Likert scale, or scale in which values extend in only one direction, was chosen given the interest being only the relevance of the category or subcategory to professional identity. Participants were also allowed to provide any additional information they wanted at the end of the survey. The Likert scaling used is depicted in Figure 6 below, and the survey can be found in Appendix D of the thesis.

Figure 6

Expert Item Rating Example

1. Item (e.g. I am skilled at handling complex and risky cases).				
	Not at All	Somewhat	Quite	Very
Is the item relevant to evaluating the Item Domain (i.e. Clinical Skills in this example)?	◎	◎	◎	◎
Is the Item easily understandable?	◎	◎	◎	◎

Analysing Interrater Agreement

Once the survey was completed, the data was subjected to statistical analysis to provide estimates of content validity through interrater agreement. Boateng et al. (2018) and Almanasreh et al. (2019) noted several possible statistical procedures to that could be applied to the data gathered in this way. This included the content validity ratio (CVR), content validity index (CVI), Cohen’s coefficient kappa (k), modified kappa (k*), or general agreement estimates for measuring inter-rater or expert agreement. Stemler (2004) highlighted that these indexes enabled the estimation of a shared interpretation of the construct.

Given that multiple expert panellists were used, a preference for the ratings to be more nuanced than nominal rating (agree/disagree), and measurements accounting for chance agreement, the statistical procedure selected was the k* statistic (Almanasreh et al., 2019). While different CVI calculations were noted as possible, the k* relied on I-CVI (Item CVI) calculation and reportedly adjusts this measure for chance. The formula for calculating I-CVI was noted in Equation (1). Note that for Equation (1), Nr = number of experts voting ‘Quite’ or ‘Very’ and N = total number of recruited experts.

$$\text{I-CVI (R)} = Nr/N \tag{1}$$

The formula for the k* calculation was noted in Equation (2.1) and Equation (2.2.). Equation (2.1) calculated the probability of chance of agreement. Equation (2.2) calculated the k*. In Equation (2.1), N = the number of experts and A = the number agreeing on good relevance. In Equation (2.2), I-CVI was the item content validity index for that specific item. Note that the table provided by Polit et al. (2007) was used in this study, as this provided the appropriate k* value based on the value of the I-CVI without having to calculate the values manually.

$$p_c=(N! \div A\,!(NA)!).5^{N} \tag{2.1}$$

$$k^*=\text{I-CVI}-p_c/1-p_c \tag{2.2}$$

The results were interpreted using the guidance provided by Polit et al. (2007), noting an interpretative framework for k* as being fair (0.40–0.59), good (0.60–0.74), or excellent (=k > 0.74). Any sample scale item achieving a k* of less than 0.60 on relevance was excluded. Items receiving a k* score of less than 0.60 on simplicity were targeted for review. Items linked to a specific domain were also excluded if the domain was not endorsed (using the same criteria noted) as discussed in Study Two. As an example, business skills were not endorsed by participants as a core component of professional identity, and items related to this construct were excluded from the final pilot scale. The following sections review the provisional scale items used in piloting the scale, and the interrater agreement findings for each category and subcategory briefly. Following this, the final pilot scale will be presented.

Sample Scale Items and Interrater Agreement Results

The sample items were presented to the expert panel for review and the data subsequently analysed. All items, and their associated interrater agreement on content validity/relevance and simplicity were summarised in Table 7. Each domain, and the interrater agreement on the sample items for that domain will be discussed in the next sections.

Table 8

k Values for Sample Items*

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Professional Identity Perception	I understand the unique aspects of clinical psychology compared to other professions.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	The difference between clinical psychology and other professions is clear to me.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Personal Attributes	I have a deep interest in working with and supporting people.	k* Relevance	-	
		k* Simplicity	0.85	Excellent
	My sensitivity to non-verbal cues and ability to interpret them is highly developed.	k* Relevance	0.65	Good
		k* Simplicity	0.85	Excellent
	I understand and empathise keenly with others.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I am very driven to succeed in my career.	k* Relevance	-	
		k* Simplicity	0.85	Excellent
	I am comfortable with uncertainty and tolerate difficult emotions well as part of my work.	k* Relevance	0.65	Good
		k* Simplicity	0.85	Excellent
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Business Skills	I possess the business skills to run a successful private practice.	k* Relevance	-	
		k* Simplicity	0.85	Excellent
	I have a good understanding of clinical psychologist' business practices.	k* Relevance	-	
		k* Simplicity	-	

k Values for Sample Items (continued)*

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Clinical Skills	I am confident in my clinical ability in both direct clinical work and other professional contexts.	k* Relevance	0.65	Good
		k* Simplicity	-	
	My skills in assessment, psychometrics, diagnosis, formulation, and intervention are well-developed.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I am skilled at handling complex and risky cases.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I write excellent reports.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Generalist Skills	I utilise my professional skills in diverse settings.	k* Relevance	0.65	Good
		k* Simplicity	0.65	Good
	I work in different environments and with diverse populations.	k* Relevance	0.65	Good
		k* Simplicity	0.85	Excellent
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Leadership Skills	I design effective programs and initiatives.	k* Relevance	-	
		k* Simplicity	0.65	Good
	I influence others outside the confines of direct clinical work.	k* Relevance	0.65	Good
		k* Simplicity	-	
	I provide professional consultation in various contexts.	k* Relevance	0.85	Excellent
		k* Simplicity	0.65	Good
	I contribute to policy-making processes.	k* Relevance	-	
		k* Simplicity	0.85	Excellent

k Values for Sample Items (continued)*

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Reflective Practitioner Skills	I regularly and critically reflect on my client facing and non-client facing practice.	k* Relevance	0.65	Good
		k* Simplicity	0.65	Good
	I reflect on and integrate personal qualities in my professional practice when appropriate.	k* Relevance	0.65	Good
		k* Simplicity	-	
	My personal and professional identities are well integrated.	k* Relevance	0.65	Good
		k* Simplicity	0.65	Good
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Scientist Practitioner Skills	I skilfully evaluate and integrate research findings into direct client work and other professional contexts.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I use my scientific training to inform and enhance my work across all professional settings.	k* Relevance	0.65	Good
		k* Simplicity	0.85	Excellent
	I skilfully adjust my approach based on evidence-based practices in everything I do as a clinical psychologist.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I am skilled at research activities.	k* Relevance	0.65	Good
		k* Simplicity	0.85	Excellent
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Supervision Skills	I use supervision skilfully and effectively across clinical and non-clinical contexts.	k* Relevance	0.85	Excellent
		k* Simplicity	0.65	Good
	I have a good understanding of how to use and apply clinical supervision across various professional settings.	k* Relevance	0.65	Good
		k* Simplicity	0.65	Good

k Values for Sample Items (continued)*

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Teaching Skills	I engage others in teaching or training activities.	k* Relevance	0.65	Good
		k* Simplicity	-	
	I skilfully share insights and perspectives when training others.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Collaborative Ethos	I 'walk alongside' both clients and others I work with.	k* Relevance	0.65	Good
		k* Simplicity	0.85	Excellent
	I am non-hierarchical and collaborative in all aspects of my work.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I am person-centred in all I do as a clinical psychologist.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Contemporary Ethos	I stay abreast with developments in the field.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I stay well-informed in my professional practice.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I frequently challenge myself to grow professionally.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent

k Values for Sample Items (continued)*

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Elucidative Ethos	I regularly provide alternative perspectives across various professional contexts.	k* Relevance	0.65	Good
		k* Simplicity	-	
	As a clinical psychologist, I frequently elicit, validate and provide multiple perspectives in clinical and non-clinical work.	k* Relevance	0.85	Excellent
		k* Simplicity	-	
	I question traditional labels and explore alternative psychological models of understanding in both clinical and non-clinical work.	k* Relevance	0.65	Good
		k* Simplicity	-	

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Holistic Ethos	I consider and integrate multiple factors holistically in my work across contexts.	k* Relevance	0.65	Good
		k* Simplicity	-	
	I am knowledgeable regarding diversity and can apply this knowledge well across all I do as a clinical psychologist.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	My cultural knowledge and cultural humility are evident across client and non-client related work.	k* Relevance	0.85	Excellent
		k* Simplicity	0.65	Good

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Just Ethos	I advocate for people I work with professionally in everything I do as a clinical psychologist.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	Promoting justice and equity is central to what I do daily and across work contexts.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	Societal change for the betterment of humanity is a central value in my work, both in direct client work and in other professional contexts.	k* Relevance	0.65	Good
		k* Simplicity	0.65	Good

k Values for Sample Items (continued)*

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Modesty Ethos	I balance my professional opinion with humility in everything I do as a clinical psychologist.	k* Relevance	-	
		k* Simplicity	0.65	Good
	I provide professional opinions while maintaining a willingness to learn or acknowledge when I am wrong in all professional interactions.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Purposeful Ethos	I constantly hold a goal directed approach in mind in what I do professionally across clinical and non-clinical contexts.	k* Relevance	0.65	Good
		k* Simplicity	0.65	Good
	I prioritise delivering clear and meaningful outcomes in both my clinical and non-clinical work.	k* Relevance	0.65	Good
		k* Simplicity	0.65	Good
	I am purposeful in all my work as a clinical psychologist.	k* Relevance	0.65	Good
		k* Simplicity	0.65	Good
Domain	Item	Relevance and Simplicity Score		Score Interpretation
Responsible Ethos	I am confident in my ability to apply professional and ethical standards in all contexts.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	I have a solid understanding and can apply the professional and ethical principles and general philosophy that guide clinical psychologists in everything they do.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent
	As a clinical psychologist, I hold myself accountable and I expect, and value, being held accountable by others in all aspects of my work.	k* Relevance	0.85	Excellent
		k* Simplicity	0.65	Good

k Values for Sample Items (continued)*

Domain	Item	Relevance and Simplicity Score		Score Interpretation
Focus	I am confident to move into multiple settings associated with clinical psychologists.	k* Relevance	0.65	Good
		k* Simplicity	-	
	I am confident to work with multiple client presentations typically associated with the work clinical psychologists do.	k* Relevance	0.85	Excellent
		k* Simplicity	0.65	Good
	I use multiple treatment approaches, i.e. individual, group, family, with ease.	k* Relevance	0.85	Excellent
		k* Simplicity	0.85	Excellent

Professional Identity Perception

Participants were asked to evaluate two items designed to evaluate Professional Identity Perception development for junior clinical psychologists. These items were:

1. I understand the unique aspects of clinical psychology compared to other professions.
2. The difference between clinical psychology and other professions is clear to me.

Both items received excellent k* interrater agreement scores on relevance (0.85) and simplicity (0.85) and were retained.

Personal Attributes

Five items designed to tap into Personal Attributes were offered for review by the expert panel. These items were:

1. I have a deep interest in working with and supporting people.
2. My sensitivity to non-verbal cues and ability to interpret them is highly developed.
3. I understand and empathise keenly with others.
4. I am very driven to succeed in my career.
5. I am comfortable with uncertainty and tolerate difficult emotions well as part of my work.

Items one and four were not supported as relevant by the expert panel, receiving k* scores below the cut-off, and therefore excluded. Item three received an excellent level of agreement in both relevance and simplicity (0.85). Items two and five were rated as ‘good’ when reflecting on relevance (0.65), and ‘excellent’ on simplicity (0.85).

Skills

Items were not developed to tap into skills as an overarching category but rather to tap into the more specific skills linked to the subcategories. The following sections report the interrater agreement on relevancy and simplicity for the sample items constructed for each subcategory.

Business Skills.

The two items designed to tap into *Business Skill* development for junior clinical psychologists were not well endorsed for k* relevancy, consistent with the endorsement of this construct's relevancy for professional identity overall in Study Two, and henceforth excluded from the pilot scale. The sample items were:

1. I possess the business skills to run a successful private practice.
2. I have a good understanding of clinical psychologists' business practices.

Clinical Skills.

Three out of the four items designed to tap into *Clinical Skills* development for junior clinical psychologists received an excellent k* interrater agreement score (0.85) for both relevance and simplicity. Item one received a good k* interrater agreement score (0.65), but the item's simplicity was rated poorly and henceforth reviewed. Items were:

1. I am confident in my clinical ability in both direct clinical work and other professional contexts.
2. My skills in assessment, psychometrics, diagnosis, formulation, and intervention are well-developed.
3. I am skilled at handling complex and risky cases.
4. I write excellent reports.

Generalist Skills.

Both items designed to tap into *Generalist Skill* development for junior clinical psychologists received good k* relevancy ratings (0.65). Item one had a good simplicity rating, while item 2 had an excellent simplicity rating. Items were:

1. I utilise my professional skills in diverse settings.

2. I work in different environments and with diverse populations.

Leadership Skills.

Four items were designed to tap into *Leadership Skill* development for junior clinical psychologists. Item three performed the best from a k* relevancy perspective, being rated as excellent (0.85) by participants. Item two was rated good (0.65) when considering k*relevancy, and items one and 4 received poor ratings for relevancy. Items two and three both received a good rating for simplicity (0.65). Items were:

1. I design effective programs and initiatives.
2. I influence others outside the confines of direct clinical work.
3. I provide professional consultation in various contexts.
4. I contribute to policy-making processes.

Reflective Practitioner Skills.

All three items designed to tap into *Reflective Practitioner Skill* development for junior clinical psychologists received a good level of k* interrater agreement on relevancy (0.65). Items one and three performed better compared to items two and four when simplicity was evaluated (0.65), both receiving a k* score reflecting good agreement. Items were:

1. I regularly and critically reflect on my client-facing and non-client-facing practice.
2. I reflect on and integrate personal qualities in my professional practice when appropriate.
3. My personal and professional identities are well integrated.

Scientist-Practitioner Skills.

Four items were constructed and reviewed for Scientist Practitioner Skill development for junior clinical psychologists. Items one and three received excellent k* ratings (0.85), and items two and four had good k* ratings for relevancy (0.65). All items received excellent k* ratings for simplicity (0.85). Items were:

1. I skilfully evaluate and integrate research findings into direct client work and other professional contexts.
2. I use my scientific training to inform and enhance my work across all professional settings.
3. I skilfully adjust my approach based on evidence-based practices in everything I do as a clinical psychologist.
4. I am skilled at research activities.

Supervision Skills.

Two items designed to tap into *Supervision Skill* development for junior clinical psychologists were reviewed. Item one had excellent k* agreement on relevancy (0.85), while item two had good k* agreement on relevancy (0.65). All items achieved a good rating on simplicity (0.65). Items were:

1. I use supervision skilfully and effectively across clinical and non-clinical contexts.
2. I have a good understanding of how to use and apply clinical supervision across various professional settings.

Teaching Skills.

The two items designed to tap into *Teaching Skill* development for junior clinical psychologists had an excellent k* rating for relevance and simplicity for item two (0.85), and a good k*rating for relevance (0.65), but a poor rating for simplicity for item one was noted. Note that this item was reported to not be as relevant to clinical psychologists' professional identity in Study Two. The items were:

1. I engage others in teaching or training activities.
2. I skilfully share insights and perspectives when training others.

Ethos

As with skills, items were not developed to tap into ethos as a main category. Items were developed to tap into the specific components of ethos, or ‘being’ a clinical psychologist. The results are noted for each ethos subcategory in the sections that follow.

Collaborative.

Three items were designed to tap into being *Collaborative* development for junior clinical psychologists. Item one scored less positively (0.65; 0.85 on relevance and simplicity) than items two to four, all receiving excellent k* agreement on simplicity and relevancy (0.85). Items were:

1. I 'walk alongside' both clients and others I work with.
2. I am non-hierarchical and collaborative in all aspects of my work.
3. I am person-centred in all I do as a clinical psychologist.

Contemporary.

The three items designed to tap into being *Contemporary* development for junior clinical psychologists all evidenced excellent k* interrater agreement on relevance and simplicity (0.85). Items were.

1. I stay abreast with developments in the field.
2. I stay well-informed in my professional practice.
3. I frequently challenge myself to grow professionally.

Elucidative.

Three items designed to measure being elucidative were proposed and are noted below. Item 2 received the best k* interrater agreement on relevance (0.85), but did not achieve a good score on simplicity. All items were rated good on relevance (0.65), but poorly on simplicity.

1. I regularly provide alternative perspectives across various professional contexts.

2. As a clinical psychologist, I frequently elicit, validate and provide multiple perspectives in clinical and non-clinical work.
3. I question traditional labels and explore alternative psychological models of understanding in both clinical and non-clinical work.

Holistic.

Three items were designed to tap into being *Holistic* development for junior clinical psychologists. All received good (item one) to excellent k* ratings (all other items) on relevance, with items two and three performing the best. Item two's simplicity was rated as excellent (0.85), while item 3 was rated as good (0.65) and item one received a poor rating on simplicity. Items were:

1. I consider and integrate multiple factors holistically in my work across contexts.
2. I am knowledgeable regarding diversity and can apply this knowledge well across all I do as a clinical psychologist.
3. My cultural knowledge and cultural humility are evident across client and non-client related work.

Just.

Two of the three items designed to tap into being *Just* development for junior clinical psychologists received excellent k* ratings for relevance (0.85) and simplicity (0.85) by the expert panel, while item three was rated as good on both counts (0.65). Items are highlighted below:

1. I advocate for people I work with professionally in everything I do as a clinical psychologist.
2. Promoting justice and equity is central to what I do daily and across work contexts.
3. Societal change for the betterment of humanity is a central value in my work, both in direct client work and in other professional contexts.

Modest.

Relevance for item one of two (noted below) designed to tap into being Modest development for junior clinical psychologists was poor. Item two received an excellent k*rating for both simplicity and relevance (0.85). The items were:

1. I balance my professional opinion with humility in everything I do as a clinical psychologist.
2. I provide professional opinions while maintaining a willingness to learn or acknowledge when I am wrong in all professional interactions.

Purposeful.

All items designed to tap into being *Purposeful* development for junior clinical psychologists received good k* ratings for relevance and simplicity (0.65). Sample items developed are noted below:

1. I constantly hold a goal directed approach in mind in what I do professionally across clinical and non-clinical contexts.
2. I prioritise delivering clear and meaningful outcomes in both my clinical and non-clinical work.
3. I am purposeful in all my work as a clinical psychologist.

Responsible.

The three items designed to tap into being *Responsible* development for junior clinical psychologists all delivered k* excellent agreement on relevance (0.85). Item four had good k* agreement on simplicity (0.65), while the other items had excellent k* agreement on simplicity (0.85). Items were:

1. I am confident in my ability to apply professional and ethical standards in all contexts.
2. I have a solid understanding and can apply the professional and ethical principles and general philosophy that guide clinical psychologists in everything they do.

3. As a clinical psychologist, I hold myself accountable and I expect, and value, being held accountable by others in all aspects of my work.

Focus

Focus was not well endorsed as a category in the review of professional identity components previously in Study Two. Three items designed to tap into *Focus* development for junior clinical psychologists delivered good k* agreement on items one and two regarding relevance (0.65) and excellent k* agreement on item three (0.85). Simplicity of item one was poor. Items were:

1. I am confident to move into multiple settings associated with clinical psychologists.
2. I am confident to work with multiple client presentations typically associated with the work clinical psychologists do.
3. I use multiple treatment approaches, i.e. individual, group, family, with ease.

Qualitative Feedback

The survey provided to the expert panel requested brief qualitative feedback at the end of the survey. The categories, subcategories and proposed items were summarised, and participants were requested to provide any additional comments on the domains or items and to note the domain and question they were commenting on. Limited further feedback was reported by participants and focused primarily on the structure of items. One participant provided extensive feedback on items. They noted Item 2 of the clinical skills subcategory, “My skills in assessment, psychometrics, diagnosis, formulation, and intervention are well-developed”, would potentially benefit from being divided into several different questions. Concern was noted with the wording of a leadership skills question, reading “I influence others outside the confines of direct clinical work”. The word “influence” was not favoured. Examples were suggested to help clarify the item, “I reflect on and integrate personal qualities in my professional practice when appropriate”, a component of self-reflective skills.

The two elements of the elucidative subcategory item “I question traditional labels and explore alternative psychological models of understanding in both clinical and non-clinical work” were noted to seem unrelated and not well suited to a one-question format. The joint aspects of questions were also highlighted as a potential pitfall, with these components making questions difficult to answer. The example provided was an item of the holistic subcategory: “My cultural knowledge and cultural humility are evident across client and non-client related work.”

Another participant commented on the elucidative item: “I question traditional labels and explore alternative psychological models of understanding in both clinical and non-clinical work." They indicated concern regarding potential misunderstanding of the item, with “alternative” potentially being interpreted as questioning mainstream psychological models rather than possibly questioning medical models.

Personal attributes, and more specifically, the ability to interpret non-verbal cues, were reported by a panel member as developmentally based rather than a personal attribute existing prior to training. They also shared a concern that business skills were over-emphasised, not a core component of clinical psychologist identity, and could rather be seen as an “adjunct to an adjunct to Clinical Psychology skills, a bit like running a household, parenting, or driving a car.”

One panel member commented on the lack of training available in undergraduate and graduate psychology courses for some of the domains highlighted as components of clinical psychologists’ professional identity. They expressed concerns regarding this lack of training and the influence of certain environments on the development of these domains, e.g. going “into a role with no mentorship and forceful team leads i.e. psychiatrist”.

Provisional Scale

Based on the results from the piloting investigation into the scale item validity, a provisional scale was constructed. The relevance of the construct was considered, as well as the relevance, simplicity, and qualitative feedback regarding scale items. Given the 'fuzzy' nature of identity and professional identity, a high standard was set for the retention of scale items. Therefore, the comparatively high k* cut-off was previously noted. This was done to ensure that core components of professional identity were included in the scale as measures for professional identity development. An item was retained if it met the following conditions:

- The category or subcategory should have achieved a good or excellent interrater agreement score (k*>0.60).
- A good or excellent rating on relevancy was required (k*>0.60).
- All items with a good or excellent relevancy rating were only retained if an excellent or good score on simplicity was noted. Items not achieving this score were reviewed or discarded.

The scale name (provisional), instructions and revised scale items are presented in the sections below.

Scale Name

The scale was provisionally named the Early Career Clinical Psychology Professional Identity Development Scale. At this early stage, the name is still provisional.

Scale Description

The scale is noted to be a self-assessment tool aimed at measuring the growth, progress, and evolution of an individual's clinical psychologist's professional identity over time when evaluated against the core components of professional identity. The scale is aimed at intern clinical psychologists and clinical psychologists in their first 5 years of practice.

Scale Instruction

The provisional scale instruction was noted as follows: “Please rate how well each statement describes you as a clinical psychologist, with 1 indicating not at all and 10 indicating the statement describing you perfectly. The revision of scale instructions and measurement points from the sample scale was actioned to more strongly align the pilot scale with identity rather than development.

Scale Scoring

The scoring is based on adding scores across different domains of professional identity. A higher score on a domain would reflect better perceived identification in the specific domain, and the total score could reflect overall professional identity development. The full score is obtained by summing the item responses.

Scale Items

The revised scale items are presented in Table 8 based on the domains or categories/subcategories generated previously.

Figure 7

The Early Career Clinical Psychology Professional Identity Development Scale

Provisional Professional Identity Scale Items
Professional Identity Perception
1. I understand the unique aspects of clinical psychology compared to other professions.
2. The difference between clinical psychology and other professions is clear to me.
Personal Attributes
3. My sensitivity to non-verbal have developed much since I trained and started practicing.
4. I understand and empathise keenly with others.
5. I am very driven to succeed in my career.

The Early Career Clinical Psychology Professional Identity Development Scale (Continued)

Skills

Clinical Skills

6. My assessment skills are well developed.
7. My ability to apply psychometrics is at an advanced level.
8. I provide accurate diagnoses.
9. Providing complex and holistic formulations is a strength for me.
10. I know how to plan and intervene with most of my clients.
11. I am skilled at handling complex and risky cases.
12. I write excellent reports.

Generalist Skills

13. I utilise my professional skills in diverse settings.
14. I work in different environments and with diverse populations.

Leadership Skills

15. I provide leadership to others outside the confines of direct clinical work.
16. I provide professional consultation in various contexts.

Reflective Practitioner Skills

17. I regularly and critically reflect on my client facing and non-client facing practice.
18. My personal and professional identities are well integrated.

Scientist Practitioner Skills

19. I skilfully evaluate and integrate research findings into direct client work.
20. I use my scientific training to inform and enhance my work across all professional settings.
21. I skilfully adjust my approach based on evidence-based practices in everything I do as a clinical psychologist.
22. I am skilled at research activities.

Supervision Skills

23. I use supervision skilfully and effectively across clinical and non-clinical contexts.
24. I have a good understanding of how to use and apply clinical supervision across various professional settings.

Ethos

Collaborative

25. I 'walk alongside' both clients and others I work with.
26. I am non-hierarchical and collaborative in all aspects of my work.
27. I am person-centred in all I do as a clinical psychologist.

Contemporary

28. I stay abreast with developments in the field.
29. I stay well-informed in my professional practice.
30. I frequently challenge myself to grow professionally.

Elucidative

31. I provide well-informed alternative perspectives on people and their functioning in professional contexts.
32. My ability to provide an alternative viewpoint in a professional situation is well established.
33. I regularly confront stereotypical or incomplete assumptions about people an their functioning.

The Early Career Clinical Psychology Professional Identity Development Scale (Continued)

Holistic

34. I am knowledgeable regarding diversity.
35. I can adapt well to diversity in all I do as a clinical psychologist.
36. My cultural humility is evident across client and non-client related work.

Just

37. I advocate for people I work with professionally in everything I do as a clinical psychologist.
38. Promoting justice and equity is central to what I do in all contexts.
39. Societal change for the betterment of humanity is a central, evident value in my work.

Purposeful

40. I constantly hold a goal directed approach in mind in what I do professionally across clinical and non-clinical contexts.
41. I prioritise delivering clear and meaningful outcomes in both my clinical and non-clinical work.
42. I am purposeful in all my work as a clinical psychologist.

Responsible

43. I am confident in my ability to apply professional and ethical standards in all contexts.
44. I can effectively apply the professional and ethical principles and general philosophy that guide clinical psychologists in everything they do.
45. As a clinical psychologist, I hold myself accountable and I expect, and value, being held accountable by others in all aspects of my work.

Discussion

In the previous section, a 45-item provisional pilot scale measuring professional identity development was presented. The pilot scale was constructed to present the professional identity development of early career along several aspects of professional identity. The provisional scale represented several important implications. The scale diverted from the established tradition when using the social identity approach of measuring professional identity as a process of social identification but rather focused on identification with an identity prototype. The scale was the first to have focused on clinical psychologists as a group and challenges the assumption of a shared professional identity among health professionals. The scale construction process was also a departure in professional identity scale construction by using additional steps in constructing the scale to this point. Each of these points will be discussed in more detail in the subsequent sections. The chapter will conclude with a review of the study's limitations and future directions.

Professional Identity Prototype as Measurement of Professional Identity

As has been discussed exhaustively, several different theoretical frameworks exist to define and understand identity, and professional identity has potentially many different definitions (Fitzgerald, 2020; Vignoles et al., 2011). The use of an identified theory in professional identity research, however, appeared to be limited overall. In a recent scoping review, Cornett et al. (2023) reviewed 160 papers on professional identity. They found only 35% explicitly stated the use of a theory or framework of identity. Of this, nine papers used the social identity approach. The scoping review illustrated the general limitations in professional identity research and the likely liberal use of a term that can mean many different things depending on the theoretical approach taken.

Professional identity scale development was also found to not be immune to this lack of theoretical clarity. While some scale construction and validation literature took great care to define the theoretical framework used (see, for example, Hanna et al., 2020; Tagawa, 2019), this is not always the case, potentially leading to a very loose use of the term professional identity. Gracia et al. (2021) and Tan et al. (2017) both constructed professional identity measures targeted at teachers and students, respectively. While Tan et al. (2017) provided a definition of professional identity, neither provided an indication of whether a sociological, group or individual theoretical framework was used for professional identity.

The presented provisional scale for clinical psychologists was clearly situated within a theoretical identity approach, the social identity approach. Furthermore, the definition of professional identity within this theory was also clearly linked to a construct within the framework, that of a category prototype (Hogg, 2018), as has been previously defined in Chapter 2 and again in Chapter 5. Items were therefore constructed with this in mind, and the validation of items was conducted also with this in mind, providing an identified theoretical framework to the scale. This intentional approach ensured meticulous clarification and operationalization of scale items (Barbour & Lammers, 2015) that contribute to an understanding of professional identity in clinical psychologists. Using the category prototype also presented a unique contribution to the field of professional identity measurement. Professional identity and professional identity development can be measured in a variety of ways. Buck et al. (2019), for example, highlighted the use of impactful educational experiences, clinical and cultural identity formation, and identification with the group of professionals as previously used measures of professional identity development in medical professionals. While other scales have used the social identity approach (Reinders et al., 2020), their focus has often been on social identification and sense of belonging rather than exploring the construct directly. This general approach is thought to reflect the essential role of belonging to a group, alongside attachment to the identity, and holding similar beliefs that have been implicated as important constructs in defining professional identity (Barbour & Lammers, 2015). The approach, however, neglected the "content" of professional identity, focusing instead on attachment to the identity.

Garza et al. (2021) have promoted a different perspective, highlighting the need to clearly define critical features professionals need to possess as essential in measuring professional identity. This proposed approach aligned more closely with the professional identity formation model proposed by Cruess et al. (2016) and summarized by Garza et al. (2021, p. 147) as "knows, knows how, shows how, and does" as well as "is". The five levels cover knowledge, competence, performance, action and expected behaviours as defining characteristics of professional identity rather than focusing on identification with a role. The categories generated in Study Two and associated scale items in this study aligned well with the approach of measuring professional identity in a more pragmatic manner, as suggested by these studies. The findings in studies One, Two and Three reflected not only on identification, but "how" clinical psychologists see their professional identity, "who" clinical psychologists are as individuals, “what they know and do”, “how they do” what they do, and “where” they do what they do.

A Professional Identity Scale for Clinical Psychologists

As far as the researcher is aware, the identity scale presented was the first scale, albeit at a pilot level, for clinical psychologists as a professional group. Overall, the scale also contributed to the representation of clinical psychology in the professional identity literature. While Akmane et al. (2020), for example, conducted a review of professional identity scales for psychological providers, none of these scales were developed with psychologists in mind. While these authors were able to identify 15 content items of professional identity across individual identity, relational identity and collective identity domains, the research is somewhat contentious given the very broad definition of ‘psychological provider’ and including diverse professions, bringing into question the applicability to clinical psychologists.

Scale Construction Method

The provisional scale developed used a mixed methods approach based on the framework provided by (Zhou, 2019). While requiring further validation, the scale was constructed with care to ensure good content validity from the point of definition of the construct under investigation through to the construction of the initial 43 items previously presented. There is a proliferation of different professional identity measures, and these measures have been criticized as having poor psychometric properties. Matthews et al. (2019) systematically reviewed the psychometric properties of several professional identity scales by comparing the psychometric evidence for the scales to Consensus-based standards for the Selection of Health Measurement Instruments (COSMIN). They concluded that the psychometric properties of these measures “provides insufficient evidence for researchers to utilize any of these measures without interpreting findings with caution” (p.9). An earlier study by Cowin et al. (2013) also raised concerns regarding the validity of five professional identity scales commonly used in research.

One potential issue in professional identity scale construction approaches used is the lack of definition and agreement on the construct being measured, leading to scales professing to measure the same construct measuring different aspects of the same construct or different constructs altogether. Buck et al. (2019) illustrated this problem regarding construct validity (based on agreement on the construct) when they investigated two physician professional identity measures, concluding that the measures only weakly correlated with one another, suggesting they may measure different aspects of professional identity. This leads to the potential of poor convergent content validity between different professional identity measures.

By investigating and establishing a clear theoretical construct for clinical psychologists' professional identity, as well as using an expert panel to review the construct and the items themselves, the validity of the construct being measured was addressed from the beginning of the project. While some measures are well developed in this regard (see, for example, Woo & Henfield, 2015; Woo et al., 2018), this has not always been the case with other measures of professional identity across disciplines. Professional identity scales reviewed were often based on items generated after a literature review and sometimes without an expert panel review (see, for example, Li & Lou, 2022; Tagawa, 2019; Wong & Liu, 2024). While the definition of a construct and the associated construction of items to assess the construct has been reported as being possible a priori (Boateng et al., 2018), this required an established framework or theory for the construct (and arguably consensus on what constitutes the construct), thus enabling the use of a literature review to construct the items. Given the complexity in defining identity and professional identity (Fitzgerald, 2020; Vignoles et al., 2011), lacklustre definition of professional identity as a construct (Cornett et al., 2023), and poor psychometric properties of existing professional identity measures (Matthews et al., 2019), establishing an agreed on construct for measurement based simply on a review of the literature and without using expert panel reviews, as has been reported as best practice (Boateng et al., 2018) seems indefensible.

Limitations

Study Three has several limitations that could affect the validity and reliability of the results. These are discussed in the following sections, with reference to best practices for developing measurement instruments as reviewed by Boateng et al. (2018).

Sampling

Two primary limitations are noted involving sampling. The expert panel used to evaluate the construct remains small, possibly influencing generalisability of results. The use of the same participants in the qualitative study (Study Two) and the expert panel for the current study is not ideal, as this may introduce bias or preference specific to the original (small) sample group being maintained throughout the scale construction process.

Item Construction

Generating items was conducted by a solo researcher, potentially limiting the thought-of items given one perspective. This limitation is somewhat addressed using supervision and ChatGPT, as discussed in the methods section.

Item construction was based on a visual analogue scale. Like Likert-type scaling this assumes equal distribution between points, which may not be the case for development of the identity category prototype targeted by the scale.

The items were also based on certain assumptions. This included the assumption that all aspects identified develop over the first years of practice, and that there will be a measurable difference between intern psychologists versus psychologists in practice for longer. These factors are usually addressed in further analysis that falls outside the scope of this thesis.

Item Evaluation

Certain constructs were eliminated through the process of interrater agreement. One example is Focus as a category. The items generated in this reported round of evaluation were potentially poorly worded to effectively reflect context as a defining factor in professional identity. This is especially relevant given the noted importance of context and setting in the social identity approach, and indications in both Study One and Study Two. A second round to generate more items in this domain and evaluate these items would have been useful.

Scale Construction Process

Related to all limitations discussed thus far, is the fact that effective scale construction is an iterative process requiring several cycles. The current project is pragmatically linked to one cycle and the completion of the first, but not only, phases in scale design. Therefore, while a pilot scale was generated, this scale is limited. The scale construction process chosen was potentially limited (although more pragmatic). Other scale construction frameworks contain more checks and steps (Boateng et al., 2018).

Future Directions

While the thesis was able to provide an initial scale for measuring development of early career psychologists' professional identity along the category prototype for this construct, this remains a pilot scale, unvalidated through further investigation. The scale is therefore best seen as a potential tool for further research.

Given the difficulties previously reported in professional identity scales and their psychometric properties (Matthews et al., 2019) and within professional identity research itself (Cornett et al., 2023), further research to confirm the constructs for professional identity, and for measurement in scale, appears imperative.

Given a provisional pilot scale has been developed, it could be useful to further action the scale development process as suggested by (Zhou, 2019). This would include two additional steps, field testing the measure and confirming the psychometric properties of the measure. When completed, all required steps could be repeated.

Chapter 7: Conclusion

Introduction

This last chapter provides a high-level overview and discussion of the thesis and the three studies covered in the previous chapters. The thesis investigated clinical psychologists' professional identity and provided a pilot scale for this construct in early career psychologists. The research was rooted in a scale construction approach, conducted from a dialectical pluralistic paradigmatic perspective, and utilised the social identity approach as a guiding theory to understand identity. The first study involved an integrative literature review examining professional identity as presented in the academic literature between 2001 and 2023. The literature review was followed by the second study, which was a qualitative investigation using content analysis into the professional identity construct involving experienced clinical psychologists as participants. The third study involved the construction of a pilot professional identity development scale aimed at early career psychologists using an expert panel of experienced clinical psychologists. Each of these studies will be summarised in this chapter. Following the summaries of Studies One, Two and Three, the rest of the chapter reviews some of the important contributions and conclusions that can be drawn from these three studies, and an integrative discussion will be presented.

Study One: Integrative Literature Review

The integrative literature review, as the first study in the thesis, contributed to understanding the extent of existing research into professional identity for clinical psychologists and the availability of professional identity scales for clinical psychologists and provided a vehicle for constructing an initial understanding of the construct in the literature. While direct examination of professional identity in the literature was extremely limited, the construct appeared to play an important explanatory role, being frequently mentioned in studies as being involved or related to a construct under investigation. Based on this, an inductive content analysis was conducted to elaborate on the implied construct of professional identity for clinical psychologists, and an initial professional identity prototype (category prototype) was identified.

The professional identity prototype identified in Study One noted that clinical psychologists hold a professional identity that is specialised and differentiated from other professions. Clinical psychologists' professional identity was perceived as dynamic and changing over the career of a clinical psychologist. The professional identity was ideologically driven, being rooted in being a helping profession and within the scientist-practitioner approach. Professional identity was self-referential, including aspects of the self and integrating personal and professional identity. Settings were noted to be influential in clinical psychologists' professional identity, influencing who they are based on where they are. Professional identity was influenced by society, shaping how the profession is seen and recognised and the roles clinical psychologists can access. Clinical psychologists were further characterised and distinguished by having specific training and socialisation experiences formative of their professional identity. Specific knowledge and skills were acquired from this training and socialisation, leading to a further aspect differentiating clinical psychologists. Lastly, clinical psychologists were noted to act appropriately or according to specified behavioural standards as a component of their professional identity.

The literature review also identified the dearth of valid and reliable professional identity scales available for use with clinical psychologists. While professional identity scales have been developed for other health professionals, the psychometric properties of these scales have been pulled into question. The often-casual use of the term professional identity and lack of overt use of theoretical frameworks in professional identity research further contributed to concerns regarding the existing scales being able to measure professional identity more generically.

Study Two: Investigating Professional Identity Qualitatively

The second study investigated the professional identity prototype construct using qualitative content analysis and involved 11 senior clinical psychologists as participants. This investigation allowed for a more granular exploration of professional identity and resulted in five main categories of professional identity being identified, each with several subcategories. The first category identified suggested that clinical psychologists perceive their professional identity in a specific manner, this being differentiated and specialised compared to other professions, dynamic and changing over time, paradigmatically driven by ideology, and socially informed by public perception and the societal framework they function in.

Professional identity was furthermore conceptualised as being informed by personal attributes and becomes increasingly self-referential, incorporating personal attributes and personal identity as a part of professional identity. Skills and knowledge held by clinical psychologists were noted as a defining aspect of professional identity. These skills included business skills linked to running a private practice, clinical skills in delivering health-related services, generalist skills that could be used across various contexts, and leadership skills aimed at influencing systems and managing people. Also included under skills and knowledge were reflective practitioner skills, involving the reflective practice and skilful application of personal attributes. Scientist-practitioner skills were also noted, including conducting research and applying research and associated skills to practice. Other skill areas included developing specialist skills or distinguishing expertise in a specific area of practice, skills in the provision of supervision, and the ability to teach or transfer skills to others.

Holding a specific ethos was further noted as informative of clinical psychologists' professional identity and included acting collaboratively with all those clinical psychologists engage with, staying up to date or contemporary with evidence-based practice, bringing to light complex psychological subject matter (being elucidative), and being holistic in approaching practice. Embodying a just approach focused on social justice causes, being modest in delivering psychological services, always holding a purposeful approach, and being responsible by adhering to ethical and legal standards expected from clinical psychologists were also noted as important components of ethos.

The last category identified focus as an important factor in this group's professional identity. Focus referred to ‘where’ clinical psychologists ‘do what they do’, and this ‘where’ shaping and defining professional identity. The context in which clinical psychologists work allowed for access to different roles and tasks, and these contexts and roles further inform professional identity, with the clinical psychologist identifying as, for example, a therapist, an assessor or an academic, depending on the context. Context also informed practice in other ways beyond access to roles. This influence was often linked to how professional identity is actively shaped by the environment and the environment being integrated into professional identity. An example here would be describing professional identity as linked to where the psychologist trained, i.e. I am a UK-trained clinical psychologist.

The second study also involved a second phase. Identified categories were scrutinised using interrater agreement procedures originally developed for scale design. The results from this phase supported four of the five main categories previously discussed. These categories were a differentiated perception of professional identity, personal attributes, skills and knowledge, and acting appropriately. Focus, the fifth category, was not well supported, and this was potentially due to poor wording utilised in the survey. Teaching skills (a skills subcategory) and being modest (an ethos or appropriate behaviour subcategory) were also not well supported by participants. Perfect interrater agreement was achieved for clinical skills, suggesting a core component of the professional identity prototype. Note that some subcategories that were identified during a later revision of the initial results were excluded from this additional validation process. This included the dynamic, paradigmatic, and socially informed subcategories of Professional Identity Perception, the self-referential subcategory of the Personal Attributes category, and the context-informed subcategory of Focus.

Study Three: Constructing a Pilot Scale

The third study in the thesis involved using the results from the second study to construct sample scale items and testing these items with an expert panel consisting of the clinical psychologists previously interviewed. The results were used to construct a pilot scale. Given the dynamism of professional identity over the career of a clinical psychologist, the scale was developed for early-career clinical psychologists in practice for less than five years. Participants were asked to review and rate each sample scale item based on relevance to investigating the underlying construct and to rate the simplicity of the item. Additionally, participants were asked to provide any qualitative feedback on items they deemed necessary. The results were subjected to analysis using interrater agreements based on modified Cohen's kappa (k*) scores. Items with an acceptable rating on both simplicity and relevance to the construct were retained, with some rewording based on qualitative feedback. Based on the results, a 45-item pilot scale was constructed that can be subjected to further validation in future studies, which falls beyond the scope of this thesis.

Note that this study was conducted in tandem with the process of gathering interrater agreement for Study Two categories. This process, therefore, did not include items generated to evaluate the Dynamic, Paradigmatic, and Socially Informed subcategories of Professional Identity Perception, the Self-Referential subcategory of the Personal Attributes category, and the Context-Informed subcategory of Focus. Given pragmatic considerations, this was also the end of the studies linked to the thesis. An additional review of the categories and subcategories, as well as items generated to evaluate these categories and subcategories, would be an important next step prior to field testing the scale and continuing with other scale validation procedures.

Integration of Results and Discussion

The focus of the research was to answer the question of who clinical psychologists are professionally and to provide an initial professional identity measurement scale for this group. The thesis offered the first comprehensive but exploratory investigation into clinical psychologists' professional identity. While the term professional identity was commonly used in the review of the literature, no comprehensive investigation into the construct could be identified. The term was often loosely defined in studies, if at all, and often not linked to a guiding theory, reflecting a longstanding issue in identity research (Cornett et al., 2023; Matthews et al., 2019). This created a perception of professional identity being a throw-away term that could be used indiscriminately. No specific measurement scale for clinical psychologists' professional identity was reported in the literature. The current thesis added to a more scientific understanding of the construct of professional identity by providing a qualitative investigation into the construct and a pilot scale for this construct in early career clinical psychologists.

Several potential different perspectives on professional identity were also offered in this thesis. Exploring professional identity using a scale construction approach from a dialectical pluralistic perspective using mixed methods facilitated a more thorough conceptualisation of the construct by allowing (and indeed encouraging) multiple perspectives from multiple methods. This included integrating perspectives from the literature, perspectives from experienced clinical psychologists, and a recursive feedback process checking agreement on results, helping to support the validity of the findings. This comprehensive approach aligned with the positions taken in the dialectic pluralistic paradigmatic approach, mixed methods research and integrative literature review methods overall (see, for example, Creswell & Clark, 2018; Elo & Kyngäs, 2008; Johnson, 2015; Johnson & Onwuegbuzie, 2004)

The thesis further approached the theoretical underpinning of professional identity from a novel perspective. While the use of the social identity approach in investigating professional identity is not new, previous studies tended to define professional identity as a social identity and focus on the level of identification with the social identity when measuring professional identity (see, for example, Cardoso et al., 2014; Moola, 2017; Willetts & Clarke, 2014). In the current study, the approach to using the social identity approach was different. While professional identity was still defined as a social identity held by a group of clinical psychologists, the definition was further refined to focus on a category prototype. This category prototype was defined as a fuzzy set of core characteristics (Hogg, 2018) that someone would need to possess to identify as a clinical psychologist. This facilitated an investigation into the 'content' of the professional identity and allowed for the identification of prototypical aspects of clinical psychologists' professional identity. Embodying a different theoretical approach helped to answer the question of "who are clinical psychologists, and what should they do?" more concretely.

Identity has further been proposed to function as a method to distinguish one individual/group from another and to similarly inform belonging (Tajfel, 1974b; Vignoles et al., 2011). Category stereotypes, as defined in the social identity approach (Leonardelli & Toh, 2015), could help investigate, at a more granular level, which different aspects of professional identity would be emphasised at different times in different contexts, influencing differentiation and belonging. Having access to these more 'concrete' characteristics for clinical psychologists, as informed by this thesis, could further help inform a broader understanding of this group's behaviour, for example, within organisations and other contexts to address, for example, difficulties with staff retention.

While the thesis provided some novel perspectives on clinical psychologists' professional identity, the distinguishing constructs identified as part of the qualitative investigation into professional identity aligned well when compared with existing theoretical models of professional identity. Fitzgerald (2020), for example, highlighted that professional identity can be defined through the actions and behaviours of a professional group, the knowledge and skills they hold, their values, beliefs and ethics, belonging to a professional group membership and the associated group socialization itself, and the associated integration of professional identity with personal identity. Buck et al. (2019) further reported impactful educational experiences, clinical and cultural identity formation, and identification with the group of professionals as potential components of professional identity, while Cruess et al. (2016) and Garza et al. (2021) differentiated between knowledge, competence, performance, action and expected behaviours as defining characteristics of professional identity.

The mediating role of context/setting in professional identification was also noted in the thesis, evidencing alignment with the role of setting in determining identity expression as identified in the social identity approach (Ellemers & Haslam, 2012; Hogg, 2018). This may suggest that, while the construct is often ill-defined in the literature, there is good, albeit unintentional, alignment in the understanding of the construct for clinical psychologists. This is further reflected in the apparent alignment between the New Zealand Psychologist Board (New Zealand Psychologists Board, 2018a) required proficiencies and professional identity components identified for clinical psychologists in this thesis.

While good alignment was noted with some other theoretical models, it is also worthwhile to consider the potentially broader professional identity conception noted in this study compared to what is reflected in board competencies and the availability of roles to meet the broader professional identity within society. One example here is the availability of leadership roles to clinical psychologists. Challenges were noted when enacting other aspects of professional identity outside that of the role of clinician, and often therapist, in many professional environments, as has been evident in previous reflections on clinical psychologists’ roles (Bellamy et al., 2014; Du Villier et al., 2015). These challenges may reflect either a lack of confidence in psychologists to enter these arenas or extend beyond clinical roles, or limited understanding of the breadth of professional identity of this group in society, or both. Earlier socialisation during training to roles extending beyond that of clinician and therapist to ensure these ‘non-clinical’ aspects of clinical psychologists’ professional identities become well integrated into professional identity may be required. Education focused on public, organisational and other key role players would need to be addressed to ensure these professional identity aspects are more broadly understood and presented, and roles become available for clinical psychologists to extend their reach beyond that of the therapy room. This approach is especially important given the longstanding problems with how psychology is perceived publicly (Ferguson, 2015) and the potential flow-on impact on role availability. Having a well-established, intentional, and clear professional identity framework is essential to this purpose.

Differentiating clinical psychologists from other professions may become more challenging and important in the future. Participants were in full agreement on the need for clinical skills as characteristic of clinical psychologists. This included frequent references to the role of ‘therapist’. Therapists, and indeed any provider of psychological services (especially talking therapies), have become more challenging to distinguish without specialist knowledge (Court et al., 2017). Therefore, being able to both answer and educate others on the role of clinical psychologists and what distinguishes them from other ‘therapists’ requires an intentional focus on professional identity in this group, both internally and externally, as constructed in society. Of note in this thesis, was that clinical psychologists did not appear to necessarily differentiate themselves form other psychological providers in terms of ownership or control of a specific subject area, this being a core defining element a profession and its identity traditionally (Abbott, 1988; Caza & Creary, 2016; Goode, 1957; Monrouxe & Rees, 2017; Wilensky, 1964; Wilkinson et al., 2016). Rather, depth of knowledge and complexity of work was noted to be a differentiating factor for clinical psychologists' professional identity.

At the same time, while differentiation was noted as important, and this differentiation has historically been linked as a core component of identity, it bears reminding that clinical psychologists work as part of a larger health and social system and are one piece of a single puzzle. Each puzzle piece is important and differentiated, but still would be needed to inform a whole. Understanding the impact of professional identity and the more traditional role of identity as a construct of differentiation in a health system that has been increasingly focused on interprofessional integration and collaboration, will be important (Joynes, 2018). Therefore, investigating professional identity overlaps with understanding integration, or interprofessional work, and will become increasingly important in helping clinical psychologists to remain a piece of the puzzle.

Given the points mentioned, future research into professional identity, and a more intentional focus on professional identity development and maintenance throughout a clinical psychologist's career appears imperative. An intentional focus would require a well-validated definition of professional identity for this group, something this study has just begun to explore. The addition of a scale to measure the construct will also ensure that an intentional focus can be afforded within training contexts, as well is in later career clinical psychologists. While the pilot scale is an important start and contributes to the potential understanding and measurement of professional development in early career clinical psychologists, the scale requires further validation and research. Having a more well-developed professional identity prototype can also be used to look at other aspects later in a clinical psychologist's career and develop appropriate measurements for these.

Reference List

Abbott, A. (1988). *The system of professions: an essay on the division of expert labor*. University of Chicago Press. https://doi.org/http://dx.doi.org/10.7208/chicago/9780226189666.001.0001

Akmane, E., Mārtinsone, K., & Krieķe, Z. (2020). Instruments for measuring the professional identity of psychological help providers: Rapid literature review. *Education. Innovation. Diversity.*, *1*(1), 6-15. https://doi.org/http://dx.doi.org/10.17770/eid2020.1.5335

Alhassn, I., Asiamah, N., Opuni, F., & Alhassan, A. (2022). The likert scale: exploring the unknowns and their potential to mislead the world. *UDS International Journal of Development*, *9*(2), 867-880. https://doi.org/https://doi.org/10.47740/586.UDSIJD6i

Almanasreh, E., Moles, R., & Chen, T. F. (2019). Evaluation of methods used for estimating content validity. *RESEARCH IN SOCIAL & ADMINISTRATIVE PHARMACY*, *15*(2), 214-221. https://doi.org/10.1016/j.sapharm.2018.03.066

Altopiedi, M., & Lavié, J. M. (2006). Narratives of change and collaboration: The role of professional and organizational identities in shaping school improvement plans. *Intervention Research*, *2*(1/2), 3-18.

Alvesson, M. (2013). *The triumph of emptiness: Consumption, higher education, and work organization*. OUP Oxford. https://doi.org/http://dx.doi.org/10.1093/oso/9780199660940.001.0001

Amodeo, A. L., Picariello, S., Valerio, P., Bochicchio, V., & Scandurra, C. (2017). Group psychodynamic counselling with final-year undergraduates in clinical psychology: A clinical methodology to reinforce academic identity and psychological well-being. *Psychodynamic Practice*, *23*(2), 161-180. https://doi.org/10.1080/14753634.2017.1308834

APEX. (2016). *Psychologists Multi Employer Collective Agreement (MECA)*. https://apex.org.nz/wp-content/uploads/2019/07/Psychologists-MECA-1-June-2016-28-February-2019.pdf

Arnett, J. L. (2001). Clinical and health psychology: Future directions. *Canadian Psychology-Psychologie Canadienne*, *42*(1), 38-48. https://doi.org/10.1037/h0086878

Ashby, S. E., Adler, J., & Herbert, L. (2016). An exploratory international study into occupational therapy students' perceptions of professional identity. *Australian Occupational Therapy Journal*, *63*(4), 233-243. https://onlinelibrary.wiley.com/doi/abs/10.1111/1440-1630.12271

Australian Psychology Board. (2020). *Pathways to Endorsement*. https://www.psychologyboard.gov.au/Endorsement/Pathways-to-endorsement.aspx

Baker, E. B. A. (2021). *Crafting Qualitative Research Questions: A Prequel to Design*. SAGE Publications. https://doi.org/http://dx.doi.org/10.4135/9781071938935

Barbour, J. B., & Lammers, J. C. (2015). Measuring professional identity: A review of the literature and a multilevel confirmatory factor analysis of professional identity constructs. *Journal of Professions and Organization*, *2*(1), 38-60.

Bauer, T. D. (2015). The effects of client identity strength and professional identity salience on auditor judgments. *The Accounting Review*, *90*(1), 95-114. https://doi.org/10.2308/accr-50863

Bazeley, P. (2017). *Integrating analyses in mixed methods research*. SAGE Publications. https://doi.org/https://dx.doi.org/10.4135/9781526417190

Bebeau, M. J., & Monson, V. E. (2012). Professional identity formation and transformation across the life span. In A. Mc Kee & M. Eraut (Eds.), *Learning trajectories, innovation and identity for professional development* (pp. 135-162). Springer Netherlands. https://doi.org/10.1007/978-94-007-1724-4_7

Belar, C. D. (2012). Reflections on the Future: Psychology as a Health Profession. *Professional Psychology: Research and Practice*(6), 545-550. https://doi.org/https://doi.org/10.1037/a0029633

Bellamy, A., Feather, J., Gibson, K., Howard, F., & Lambrecht, I. (2014). Psychology in Aotearoa - where are we going? *Psychology Aotearoa*, *6*(1), 15-18.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open*, *2*, 8-14. https://doi.org/10.1016/j.npls.2016.01.001

Benjamin, L. T. (2008). Psychology before 1900. In S. F. Davis & W. Buskist (Eds.), *21st Century Psychology: A Reference Handbook* (Vol. 1). Sage. https://doi.org/http://dx.doi.org/10.4135/9781412956321

Benjamin, L. T., Jr. (2005). A history of clinical psychology as a profession in America (and a glimpse at its future). *Annual review of clinical psychology*, *1*, 1-30. https://doi.org/https://doi.org/10.1146/annurev.clinpsy.1.102803.143758

Bettany-Saltikov, J., & McSherry, R. (2016). *How to do a systematic literature review in nursing : a step-by-step guide* (Second edition. ed.). Open University Press.

Bhardwaj, P. (2019). Types of sampling in research. *Journal of Primary Care Specialties*, *5*(3), 157-163. https://doi.org/http://dx.doi.org/10.4103/jpcs.jpcs_62_19

Biesta, G. (2010). Pragmatism and the philosophical foundations of mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social and behavioral research* (Vol. 2, pp. 95-118). Sage Publications Inc. https://doi.org/https://doi.org/10.4135/9781506335193

Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quinonez, H. R., & Young, S. L. (2018). Best Practices for Developing and Validating Scales for Health,Social, and Behavioral Research: A Primer. *Frontiers in Public Health*, *6*(149). https://doi.org/10.3389/fpubh.2018.00149

Boisvert, R. D. (1998). *John Dewey: Rethinking our time*. SUNY Press.

Buck, E., West, C., Graham, L., Frye, A. W., & Teal, C. R. (2019). Challenges to assessing professional identity in medical students: a tale of two measures. *Medical education online*, *24*(1), 1649571. https://doi.org/http://dx.doi.org/10.1080/10872981.2019.1649571

Burke, P. J. (2004). Identities and social structure: The 2003 Cooley-Mead award address. *Social psychology quarterly*, *67*(1), 5-15. https://doi.org/http://dx.doi.org/10.1177/019027250406700103

Burke, P. J., & Stets, J. E. (2009). *Identity theory*. Oxford University Press. https://doi.org/http://dx.doi.org/10.1093/acprof:oso/9780195388275.001.0001

Burton, L. J., & Mazerolle, S. M. (2011). Survey instrument validity part I: Principles of survey instrument development and validation in athletic training education research. *Athletic Training Education Journal*, *6*(1), 27-35. https://doi.org/http://dx.doi.org/10.4085/1947-380X-6.1.27

Capshew, J. H. (1999). *Psychologists on the march: science, practice, and professional identity in America, 1929-1969*. Cambridge University Press. https://doi.org/https://doi.org/10.1017/CBO9780511572944

Cardoso, I., Batista, P., & Graça, A. (2014). Professional identity in analysis: A systematic review of the literature [Review]. *Open Sports Sciences Journal*, *7*, 83-97. https://doi.org/https://doi.org/10.2174/1875399X01407010083

Carpenter, S. (2018). Ten Steps in Scale Development and Reporting: A Guide for Researchers [Article]. *Communication Methods and Measures*, *12*(1), 25-44. https://doi.org/10.1080/19312458.2017.1396583

Carr, E. R., Davenport, K. M., Murakami-Brundage, J. L., Robertson, S., Miller, R., & Snyder, J. (2023). From the medical model to the recovery model: Psychologists engaging in advocacy and social justice action agendas in public mental health. *American Journal of Orthopsychiatry*. https://doi.org/https://doi.org/10.1037/ort0000656

Caza, B. B., & Creary, S. (2016). The construction of professional identity. In A. Wilkinson, D. Hislop, & C. Coupland (Eds.), *Perspectives on Contemporary Professional Work* (pp. 259-285). Edward Elgar Publishing. https://doi.org/http://dx.doi.org/10.4337/9781783475582

Chen, Y., & Reay, T. (2021). Responding to imposed job redesign: The evolving dynamics of work and identity in restructuring professional identity. *Human Relations*, *74*(10), 1541-1571. https://doi.org/https://doi.org/10.1177/0018726720906437

Chreim, S., Williams, B. E., & Hinings, C. R. (2007). Interlevel Influences on the reconstruction of professional role identity. *The Academy of Management Journal*, *50*(6), 1515-1539. https://doi.org/https://doi.org/10.2307/20159487

Christmals, C. D., & Gross, J. J. (2017). An integrative literature review framework for postgraduate nursing research reviews. *European Journal of Research in Medical Sciences Vol*, *5*(1), 7-15.

Clark-Carter, D. (2010). Quantitative psychological research: The complete student's companion.

Cornett, M., Palermo, C., & Ash, S. (2023). Professional identity research in the health professions—a scoping review. *Advances in Health Sciences Education*, *28*(2), 589-642. https://doi.org/http://dx.doi.org/10.1007/s10459-022-10171-1

Court, A. J., Cooke, A., & Scrivener, A. (2017). They're NICE and neat, but are they useful? A grounded theory of clinical psychologists' beliefs about and use of NICE guidelines. *Clinical Psychology & Psychotherapy*, *24*(4), 899-910. https://doi.org/https://doi.org/10.1002/cpp.2054

Cowin, L. S., Johnson, M., Wilson, I., & Borgese, K. (2013). The psychometric properties of five Professional Identity measures in a sample of nursing students. *Nurse education today*, *33*(6), 608-613. https://doi.org/http://dx.doi.org/10.1016/j.nedt.2012.07.008

Creswell, J. W., & Clark, V. L. P. (2018). *Designing and conducting mixed methods research* (Third Edition ed.). Sage publications.

Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L., & Steinert, Y. (2014). Reframing medical education to support professional identity formation. *Academic Medicine*, *89*(11), 1446-1451. https://doi.org/http://dx.doi.org/10.1097/ACM.0000000000000427

Cruess, R. L., Cruess, S. R., & Steinert, Y. (2016). Amending Miller's pyramid to include professional identity formation. *Academic Medicine*, *91*(2), 180-185. https://doi.org/http://dx.doi.org/10.1097/ACM.0000000000000913

Cruess, S. R., & Cruess, R. L. (2018). The Development of Professional Identity. In T. Swanwick, F. K., & B. C. O'Brien (Eds.), *Understanding Medical Education: Evidence, Theory, and Practice* (3 ed.). John Wiley & Sons, Ltd. https://doi.org/http://dx.doi.org/10.1002/9781119373780

Davies, C., & Fisher, M. (2018). Understanding research paradigms. *Journal of the Australasian Rehabilitation Nurses' Association (JARNA)*, *21*(3), 21-25.

De Mello, F. L., & de Souza, S. A. (2019). Psychotherapy and artificial intelligence: A proposal for alignment. *Frontiers in Psychology*, *10*, 263. https://doi.org/http://dx.doi.org/10.3389/fpsyg.2019.00263

Debenham, M. (2007). Epistolary Interviews On-line: A Novel Addition to the Researcher's Palette. *JISC TechDis*, 1-7.

DeCarlo, M. (2018). *Scientific inquiry in social work*. Open social work education.

DeVellis, R. F., & Thorpe, C. T. (2021). *Scale development: Theory and applications*. Sage publications.

Di Stefano, G., Ruvolo, G., & Lo Mauro, V. (2019). Developing professional identity through group experiential learning: A Group-Analytic experiential training approach for use with postgraduate clinical psychology students. *Psychodynamic Practice*, *25*(2), 133-143. https://doi.org/https://doi.org/10.1080/14753634.2019.1603809

Dobson, K. S. (2016). Clinical psychology in Canada: Challenges and opportunities. *Canadian Psychology/Psychologie canadienne*, *57*, 211-219. https://doi.org/https://doi.org/10.1037/cap0000061

Doolen, J. (2017). Meta-analysis, systematic, and integrative reviews: an overview. *Clinical Simulation in Nursing*, *13*(1), 28-30. https://doi.org/10.1016/j.ecns.2016.10.003

Du Villier, T., Earl, T., Feather, J., Howard, F., Lambrecht, I., Soldatovic, M., ... & Verhoven, M. (2015). Strengthening the future of psychology in Aotearoa: A call to action. *Psychology Aotearoa*, *7*(2), 94-97.

Edwards, H., & Dirette, D. (2010). The relationship between professional identity and burnout among occupational therapists. *Occupational Therapy in Health Care*, *24*(2), 119-129. https://doi.org/http://dx.doi.org/10.3109/07380570903329610

Ellemers, N., & Haslam, S. A. (Eds.). (2012). *Social identity theory* (Vol. 2). https://doi.org/http://dx.doi.org/10.4135/9781446249222.n45.

Elman, C., Gerring, J., & Mahoney, J. (2020). *The production of knowledge: Enhancing progress in social science*. Cambridge University Press. https://doi.org/http://dx.doi.org/10.1017/9781108762519

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1), 107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Erikson, E. H., & Erikson, J. M. (1998). *The life cycle completed (extended version)*. WW Norton & Company.

Evans, I. M. (2008). Steering by Matariki and the Southern Cross: Plotting Clinical Psychology's Course in New Zealand. *New Zealand Journal of Psychology*, *37*(3), 5-14.

Fagermoen, M. S. (1997). Professional identity: values embedded in meaningful nursing practice. *Journal of Advanced Nursing*, *25*(3), 434-441. https://doi.org/http://dx.doi.org/10.1046/j.1365-2648.1997.1997025434.x

Falgares, G., Venza, G., & Guarnaccia, C. (2017). Learning psychology and becoming psychologists: Developing professional identity through group experiential learning. *Psychology Learning and Teaching-Plat*, *16*(2), 232-247. https://doi.org/https://doi.org/10.1177/1475725717695148

Feldman, D. B. (2021). 3 Things that aggravate psychologists. *Psychology Today*. https://www.psychologytoday.com/us/blog/supersurvivors/202106/3-things-people-say-aggravate-psychologists

Ferguson, C. J. (2015). "Everybody knows psychology is not a real science": Public perceptions of psychology and how we can improve our relationship with policymakers, the scientific community, and the general public [Article]. *American Psychologist*, *70*(6), 527-542. https://doi.org/https://doi.org/10.1037/a0039405

Fiske, A., Henningsen, P., & Buyx, A. (2019). Your robot therapist will see you now: ethical implications of embodied artificial intelligence in psychiatry, psychology, and psychotherapy. *Journal of medical Internet research*, *21*(5), e13216. https://doi.org/http://dx.doi.org/10.2196/13216

Fitzgerald, A. (2020). Professional identity: A concept analysis. *Nursing Forum*, *55*(3), 447-472-472. https://doi.org/10.1111/nuf.12450

Foo, R. B., & Green, H. J. (2023). Investigating professional identity formation of postgraduate clinical psychology students. *Australian Psychologist*, *58*(3), 198-208. https://doi.org/http://dx.doi.org/10.1080/00050067.2022.2095891

Fox, J., Karson, M., & Erickson Cornish, J. (2022). From the blues to gray matters: Affirming a senior professional identity. *Professional Psychology: Research and Practice*, *53*(5), 523. https://doi.org/http://dx.doi.org/10.1037/pro0000379

Frank, G. (1984). The Boulder model: History, rationale, and critique. *Professional Psychology: Research and Practice*, *15*(3), 417. https://doi.org/http://dx.doi.org/10.1037/0735-7028.15.3.417

Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge.* Dodd, Mead & Company.

Friedenberg, Z. B. (2009). *Surgery Over the Centuries*. Janus Publishing Co.

Furr, R. M. (2011). *Scale construction and psychometrics for social and personality psychology*. SAGE. https://doi.org/http://dx.doi.org/10.4135/9781446287866

Gado, S., Kempen, R., Lingelbach, K., & Bipp, T. (2022). Artificial intelligence in psychology: How can we enable psychology students to accept and use artificial intelligence? *Psychology Learning & Teaching*, *21*(1), 37-56. https://doi.org/http://dx.doi.org/10.1177/14757257211037149

Garza, K. B., Moseley, L. E., & Ford, C. (2021). Assessment of professional identity formation: Challenges and opportunities. *New directions for teaching and learning*. https://doi.org/http://dx.doi.org/10.1002/tl.20476

Ghiara, V. (2020). Disambiguating the role of paradigms in mixed methods research. *Journal of Mixed Methods Research*, *14*(1), 11-25. https://doi.org/http://dx.doi.org/10.1177/1558689818819928

Gilgun, J. F. (2004). Qualitative methods and the development of clinical assessment tools. *Qualitative health research*, *14*(7), 1008-1019. https://doi.org/http://dx.doi.org/10.1177/1049732304266819

Gill, I. J. (2012). An identity theory perspective on how trainee clinical psychologists experience the death of a client by suicide. *Training and Education in Professional Psychology*, *6*(3), 151-159. https://doi.org/https://doi.org/10.1037/a0029666

Gleason, P. (1983). Identifying identity: A semantic history. *The journal of American history*, *69*(4), 910-931. https://doi.org/http://dx.doi.org/10.2307/1901196

Glucina, T. T., Krägeloh, C. U., Spencer, K., & Holt, K. (2024). Development and validation of the chiropractic professional identity Embodiment scale (CPIES). *Complementary therapies in clinical practice*, 101840. https://doi.org/http://dx.doi.org/10.1016/j.ctcp.2024.101840

Gonsalvez, C., Hyde, J., Lancaster, S., & Barrington, J. (2008). University psychology clinics in Australia: Their place in professional training. *Australian Psychologist*, *43*(4), 278-285. https://doi.org/https://doi.org/10.1080/00050060802413529

Goode, W. J. (1957). Community within a community: The professions. *American sociological review*, *22*(2), 194-200. https://doi.org/http://dx.doi.org/10.2307/2088857

Goodwin, J. G. (2008). Psychology in the 20th Century. In S. F. Davis & W. Buskist (Eds.), *21st century psychology: a reference handbook* (Vol. 1). Sage. https://doi.org/http://dx.doi.org/10.4135/9781412956321

Gracia, E. P., Rodríguez, R. S., Pedrajas, A. P., & Carpio, A. J. (2021). Teachers' professional identity: Validation of an assessment instrument for preservice teachers. *Heliyon*, *7*(9). https://doi.org/http://dx.doi.org/10.1016/j.heliyon.2021.e08049

Graneheim, U. H., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse education today*, *56*, 29-34. https://doi.org/http://dx.doi.org/10.1016/j.nedt.2017.06.002

Greene, J. C. (2007). *Mixed methods in social inquiry* (Vol. 9). John Wiley & Sons.

Guerney, B., Stollak, G., & Guerney, L. (1971). The practicing psychologist as educator: An alternative to the medical practitioner model. *Professional Psychology*, *2*(3), 276. https://doi.org/http://dx.doi.org/10.1037/h0031716

Haarhoff, B., & Williams, M. W. (2017). Low intensity psychological interventions in Aotearoa: What can we learn from IAPT? *New Zealand Journal of Psychology*, *46*(2).

Hall, R. (2012). Mixed methods: In search of a paradigm. In T. Le & Q. Lê (Eds.), *Conducting Research in a Changing and Challenging World*. Nova Science Publishers.

Hammond, R., Cross, V., & Moore, A. (2016). The construction of professional identity by physiotherapists: a qualitative study. *Physiotherapy*, *102*(1), 71-77. https://doi.org/http://dx.doi.org/10.1016/j.physio.2015.04.002

Hanna, F., Oostdam, R., Severiens, S. E., & Zijlstra, B. J. (2020). Assessing the professional identity of primary student teachers: Design and validation of the Teacher Identity Measurement Scale. *Studies in Educational Evaluation*, *64*, 100822. https://doi.org/http://dx.doi.org/10.1016/j.stueduc.2019.100822

Hansen, J. T. (2003). Including diagnostic training in counseling curricula: Implications for professional identity development. *Counselor Education and Supervision*, *43*(2), 96-107. https://doi.org/http://dx.doi.org/10.1002/j.1556-6978.2003.tb01834.x

Hartman, L. I., Fergus, K. D., & Reid, D. W. (2016). Psychology's Gordian Knot: Problems of identity and relevance. *Canadian Psychology/Psychologie canadienne*, *57*(3), 149-159. https://doi.org/10.1037/cap0000060

Haslam, S. A. (2004). *Psychology in organizations: The social idenity approach*. Sage Publications Ltd.

Haslam, S. A., Oakes, P. J., Reynolds, K. J., & Turner, J. C. (1999). Social identity salience and the emergence of stereotype consensus. *Personality and Social Psychology Bulletin*, *25*(7), 809-818. https://doi.org/http://dx.doi.org/10.1177/0146167299025007004

Hassett, C. L., Gresswell, D. M., & Wilde, S. V. (2021). Motivation to lead in trainee clinical psychologists: service evaluation of a UK doctorate programme. *The Journal of Mental Health Training, Education and Practice*, *16*(6), 442-453. https://doi.org/http://dx.doi.org/10.1108/JMHTEP-10-2020-0075

Health & Care Professions Council. (2021). *Practitioner psychologists - The standards of profienciency for practitioner psychologists*. https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/

Health Professions Council of South Africa. (2021). *Psychology - Overview*. https://www.hpcsa.co.za/?contentId=0&menuSubId=52&actionName=Professional%20Boards

Henriques, G. (2013). The battle for the identity of clinical psychology. *Psychology Today*. https://www.psychologytoday.com/us/blog/theory-knowledge/201312/the-battle-the-identity-clinical-psychology

Hilton, S. R., & Slotnick, H. B. (2005). Proto-professionalism: how professionalisation occurs across the continuum of medical education. *Medical Education*, *39*(1), 58-65. https://doi.org/http://dx.doi.org/10.1111/j.1365-2929.2004.02033.x

Hirose, M., & Creswell, J. W. (2023). Applying Core Quality Criteria of Mixed Methods Research to an Empirical Study. *Journal of Mixed Methods Research*, *17*(1), 12. https://doi.org/http://dx.doi.org/10.1177/15586898221086346

Hoeve, Y. t., Jansen, G., & Roodbol, P. (2014). The nursing profession: public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing*, *70*(2), 295-309. https://doi.org/http://dx.doi.org/10.1111/jan.12177

Hogan, A. J. (2018). The "Two Cultures" in Clinical Psychology: Constructing Disciplinary Divides in the Management of Mental Retardation. *Isis*, *109*(4), 695-719. https://doi.org/https://doi.org/10.1086/701062

Hogg, M. A. (2006). Social Identity Theory. In P. J. Burke (Ed.), *Contemporary social psychological theories* (pp. 111-136). Stanford University Press. https://doi.org/http://dx.doi.org/10.1515/9780804768047

Hogg, M. A. (2018). Social identity theory. In P. J. Burke (Ed.), *Contemporary social psychological theories* (Second ed., pp. 81-111). Stanford University Press. https://doi.org/http://dx.doi.org/10.1515/9781503605626

Hogg, M. A., & Vaughan, G. M. (2018). *Social psychology* (Eight ed.). Pearson Education Limited.

Holttum, S., & Goble, L. (2006). Factors influencing levels of research activity in clinical psychologists: A new model. *Clinical Psychology & Psychotherapy*, *13*(5), 339-351. https://doi.org/10.1002/cpp.501

Hornsey, M. J. (2008). Social identity theory and self-categorization theory: A historical review. *Social and Personality Psychology Compass*, *2*(1), 204-222. https://doi.org/http://dx.doi.org/10.1111/j.1751-9004.2007.00066.x

Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative health research*, *15*(9), 1277-1288. https://doi.org/10.1177/1049732305276687

Hurd, T. L. (2016). Claiming subjectivity: Re-storying clinical psychology and myself. *Women & Therapy*, *39*(1-2), 56-68. https://doi.org/http://dx.doi.org/10.1080/02703149.2016.1116313

Icahn School of Medicine at Mount Sinai. (2024). *Levy Library Research Synthesis and Systematic Review Services: Integrative Reviews*. Retrieved 08/03/2024 from https://libguides.mssm.edu/sysrev/intrev

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of basic and clinical pharmacy*, *5*(4), 87. https://doi.org/http://dx.doi.org/10.4103/0976-0105.141942

Jenkins, Richard. *Social Identity*. (4th Edition). Taylor & Francis Group, 2014. http://dx.doi.org/10.4324/9781315887104

Jetten, J., Reicher, S. D., Haslam, S. A., & Cruwys, T. (2020). *Together apart: The psychology of COVID-19*. Sage. https://doi.org/http://dx.doi.org/10.4135/9781529751680

Johnson, R. B. (2011). Do we need paradigms? A mixed methods perspective. *Mid-Western Educational Researcher*, *24*(2), 31-40.

Johnson, R. B. (2012). Dialectical pluralism and mixed research. *American Behavioral Scientist*, *56*(6), 751-754. https://doi.org/https://doi.org/10.1177/0002764212442494

Johnson, R. B. (2015). Dialectical pluralism: A metaparadigm whose time has come. *Journal of Mixed Methods Research*, *11*(2), 156-173. https://doi.org/10.1177/1558689815607692

Johnson, R. B., & Gray, R. (2010). A history of philosophical and theoretical issues for mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social and behavioral research* (Vol. 2, pp. 69-94). https://doi.org/http://dx.doi.org/10.4135/9781506335193

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational researcher*, *33*(7), 14-26. https://doi.org/http://dx.doi.org/10.3102/0013189X033007014

Johnson, R. B., Onwuegbuzie, A. J., Tucker, S., & Icenogle, M. L. (2014). Conducting mixed methods research using dialectical pluralism and social psychological strategies. In P. Leavy (Ed.), *The Oxford handbook of qualitative research* (pp. 557-578). Oxford University Press. https://doi.org/http://dx.doi.org/10.1093/oxfordhb/9780199811755.001.0001

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, *1*(2), 112-133. https://doi.org/http://dx.doi.org/10.1177/1558689806298224

Johnson, R. B., & Stefurak, T. (2013). Considering the evidence-and-credibility discussion in evaluation Through the lens of dialectical pluralism. In D. M. Mertens & S. Hesse-Biber (Eds.), *Mixed methods and credibility of evidence in evaluation. New Directions for Evaluation* (Vol. 2013, pp. 37-48). https://doi.org/10.1002/ev.20056

Jones, H. C., Rowan, A., Stephens, R. L., & Brauch, J. A. (2021). In faith and practice: How Christian doctoral programs address religious diversity needs. *Christian Higher Education*, *20*(1-2), 87-103. https://doi.org/http://dx.doi.org/10.1080/15363759.2020.1851814

Joynes, V. (2018). Defining and understanding the relationship between professional identity and interprofessional responsibility: implications for educating health and social care students. *Advances in Health Sciences Education*, *23*(1), 133-149. https://doi.org/http://dx.doi.org/10.1007/s10459-017-9778-x

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, *72*(12), 2954-2965. https://doi.org/http://dx.doi.org/10.1111/jan.13031

Kazak, A. E. (2020). Psychology is an essential science: American Psychologist highlights the role of psychology in understanding and addressing COVID-19. *American Psychologist*, *75*(5), 605. https://doi.org/10.1037/amp0000682

Kelly, E. F., & Kelly, E. W. (2007). *Irreducible mind: Toward a psychology for the 21st century*. Rowman & Littlefield.

Kenkel, M. B., DeLeon, P. H., Mantell, E. O., & Steep, A. E. (2005). A psychologist by any other name...: Response to commentary by John L. Arnett. *Canadian Psychology*, *46*(4), 212-214. https://doi.org/10.1037/h0087028

Kolmes, K. (2012). Social media in the future of professional psychology. *Professional Psychology: Research and Practice*, *43*(6), 606. https://doi.org/10.1037/a0028678

Kottler, A., & Swartz, S. (2004). Rites of passage: Identity and the training of clinical psychologists in the current south african context. *South African Journal of Psychology*, *34*(1), 55-71. https://doi.org/10.1177/008124630403400103

Kuhn, T. S. (1996). *The structure of scientific revolutions* (Third edition. ed.). University of Chicago Press. https://doi.org/http://dx.doi.org/10.7208/chicago/9780226458106.001.0001

Kyriazos, T. A., & Stalikas, A. (2018). Applied psychometrics: The steps of scale development and standardization process. *Psychology*, *9*(11), 2531-2560. https://doi.org/http://dx.doi.org/10.4236/psych.2018.911145

Lancaster, S., & Smith, D. I. (2002). What's in a name? The identity of clinical psychology as a specialty. *Australian Psychologist*, *37*(1), 48-51. https://doi.org/10.1080/00050060210001706666

Lane, S. (2018). Professionalism and professional identity: what are they, and what are they to you? *Australian Medical Student Journal*, *8*(2). http://www.amsj.org/archives/issues/amsj_v8_i2

Lang, S. (2022). The troubling therapist shortage in NZ - why we can't find help. *Stuff*. https://www.stuff.co.nz/life-style/wellbeing/300564423/the-troubling-therapist-shortage-in-nz--why-we-cant-find-help#:~:text=Psychologists%20(there%20are%201850%20registered,therapy%20for%20deep%2Drooted%20issues.

Leaper, C. (2011). Chapter 9 - More Similarities than Differences in contemporary Theories of social development?: A plea for theory bridging. In J. B. Benson (Ed.), *Advances in Child Development and Behavior* (Vol. 40, pp. 337-378). JAI. https://doi.org/https://doi.org/10.1016/B978-0-12-386491-8.00009-8

Leeman, J., Voils, C. I., & Sandelowski, M. (2015). Conducting Mixed Methods Literature Reviews. In S. N. Hesse-Biber & R. B. Johnson (Eds.), *The Oxford Handbook of Multimethod and Mixed Methods Research Inquiry* (pp. 167-184). Oxford University Press. https://doi.org/http://dx.doi.org/10.1093/oxfordhb/9780199933624.001.0001

Leonardelli, G. J., & Toh, S. M. (2015). Social categorization in intergroup contexts: Three kinds of self-categorization. *Social and Personality Psychology Compass*, *9*(2), 69-87. https://doi.org/http://dx.doi.org/10.1111/spc3.12150

Li, R., & Lou, J. (2022). Professional identity scale for male nursing students using the Rasch model and latent regression on gender and background variables. *Healthcare*, *10*(7), 1317. https://doi.org/http://dx.doi.org/10.3390/healthcare10071317

Lifshitz-Assaf, H. (2018). Dismantling knowledge boundaries at NASA: The critical role of professional identity in open innovation. *Administrative science quarterly*, *63*(4), 746-782. https://doi.org/http://dx.doi.org/10.1177/0001839217747876

Lilienfeld, S. O. (2012). Public skepticism of psychology: why many people perceive the study of human behavior as unscientific. *American Psychologist*, *67*(2), 111-129. https://doi.org/10.1037/a0023963

Lindgren, B.-M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *INTERNATIONAL JOURNAL OF NURSING STUDIES*, *108*, UNSP 103632. https://doi.org/10.1016/j.ijnurstu.2020.103632

Lindquist, I., Engardt, M., Garnham, L., Poland, F., & Richardson, B. (2006). Physiotherapy students' professional identity on the edge of working life. *Medical teacher*, *28*(3), 270-276. https://doi.org/http://dx.doi.org/10.1080/01421590600605272

Little, F., Croker, A., & Carey, T. A. (2019). Valued but tenuous? Postgraduate clinical psychology placements for psychology students in rural and remote areas - implications for future directions. *Rural and remote health*, *19*(3), 4621. https://doi.org/10.22605/RRH4621

Llewelyn, S., & Murphy, D. (2014). *What is clinical psychology?* OUP Oxford.

Lubbe, W., Ham-Baloyi, W. t., & Smit, K. (2020). The integrative literature review as a research method: A demonstration review of research on neurodevelopmental supportive care in preterm infants. *Journal of Neonatal Nursing*, *26*(6), 308-315. https://doi.org/https://doi.org/10.1016/j.jnn.2020.04.006

MacKay, T. (2008). Can psychology change the world? *The Psychologist*, *21*(11), 928-931.

Maheu, M. M., Pulier, M. L., McMenamin, J. P., & Posen, L. (2012). Future of telepsychology, telehealth, and various technologies in psychological research and practice. *Professional Psychology: Research and Practice*, *43*(6), 613. https://doi.org/10.1037/a0029458

Matthews, J., Bialocerkowski, A., & Molineux, M. (2019). Professional identity measures for student health professionals–a systematic review of psychometric properties. *BMC medical education*, *19*(1), 308. https://doi.org/http://dx.doi.org/10.1186/s12909-019-1660-5

Maxwell, J. A. (2011). Paradigms or toolkits? Philosophical and methodological positions as heuristics for mixed methods research. *Mid-Western Educational Researcher*, *24*(2), 27-30.

Mayring, P. (2014). *Qualitative content analysis: theoretical foundation, basic procedures and software solution*. https://nbn-resolving.org/urn:nbn:de:0168-ssoar-395173

Mayring, P. (2019). Qualitative content analysis: Demarcation, varieties, developments. *Forum: Qualitative Social Research*, *20*(3). https://doi.org/https://doi.org/10.17169/fqs-20.3.3343

Mayring, P. (2022a). *QCAmap. A Software for Qualitative Content Analysis*. https://www.qcamap.org/ui/en/home

Mayring, P. (2022b). *Qualitative content analysis: A step-by-step guide*. Sage.

McCoach, D. B., Gable, R. K., & Madura, J. P. (2013). *Instrument development in the affective domain: School and corporate applications* (third ed.). Springer.

McKenzie, K., Cossar, J. A., Fawns, T., & Murray, A. L. (2013). Reconciling the professional and student identities of clinical psychology trainees. *Advances in Health Sciences Education*, *18*(4), 745-754. https://doi.org/10.1007/s10459-012-9412-x

McMahan, J. (2008). The morality of war and the law of war. In D. Rodin & H. Shue (Eds.), *Just and unjust warriors: The moral and legal status of soldiers* (Vol. 19, pp. 19-43). Oxford University Press.

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of*

Counseling & Development, *89*(2), 140-147. https://doi.org/https://doi.org/10.1002/j.1556-6678.2011.tb00071.x

Mertens, D. M. (2012). What comes first? The paradigm or the approach? *Journal of Mixed Methods Research*, *6*(4), 255-257. https://doi.org/https://doi.org/10.1177/1558689812461574

Monrouxe, L. V., & Rees, C. E. (2017). *Healthcare professionalism: improving practice through reflections on workplace dilemmas*. John Wiley & Sons. https://doi.org/https://doi.org/10.1002/9781119044475

Monson, V. E., & Hamilton, N. W. (2011). Entering law students' conceptions of an ethical professional identity and the role of the lawyer in society. *Journal of the Legal Profession*, *35*(1), 385-413. https://doi.org/http://dx.doi.org/10.2139/ssrn.1581528

Moola, S. (2017). Crafting, Constructing and Developing a Nurses' Professional Identity Scale (NPIS). *Global Journal of Health Science*, *9*(8), 21-33. https://doi.org/http://dx.doi.org/10.5539/gjhs.v9n8p21

Murner, T. (1879). *Die Narrenbeschwörung* (Vol. 11). Brockhaus.

Nave, K., Deane, G., Miller, M., & Clark, A. (2020). Wilding the predictive brain. *Wiley Interdisciplinary Reviews: Cognitive Science*, *11*(6), e1542. https://doi.org/http://dx.doi.org/10.1002/wcs.1542

New Zealand Government. (2012). *Health Practitioners Competence Assurance Act 2003*. Retrieved from http://www.legislation.govt.nz/act/public/2003/0048/latest/096be8ed818de835.pdf

New Zealand Government. (2018). *He Ara Oranga : Report of the Government Inquiry into Mental Health and Addiction*. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

New Zealand Psychologists Board. (2011). *Cultural Competencies For Psychologists Registered Under The Health Practitioners Competence Assurance Act (2003) And Those Seeking To Become Registered* http://www.psychologistsboard.org.nz/cms_show_download.php?id=211

New Zealand Psychologists Board. (2012). *Code of Ethics for Psychologists working in Aotearoa/New Zealand.* http://www.psychologistsboard.org.nz/cms_show_download.php?id=235

New Zealand Psychologists Board. (2018a). *Core Competencies for the Practice of Psychology in Aotearoa New Zealand.* http://www.psychologistsboard.org.nz/cms_show_download.php?id=533

New Zealand Psychologists Board. (2018b). *Scopes of Practice and Qualifications*. Retrieved 02.03.2024 from https://psychologistsboard.org.nz/wp-content/uploads/2023/08/Scopes_of_Practice.pdf

Noble, C., Coombes, I., Nissen, L., Shaw, P. N., & Clavarino, A. (2015). Making the transition from pharmacy student to pharmacist: Australian interns' perceptions of professional identity formation. *International Journal of Pharmacy Practice*, *23*(4), 292-304. https://doi.org/http://dx.doi.org/10.1111/ijpp.12155

Noble, C., O’Brien, M., Coombes, I., Shaw, P. N., Nissen, L., & Clavarino, A. (2014). Becoming a pharmacist: Students’ perceptions of their curricular experience and professional identity formation. *Currents in Pharmacy Teaching and Learning*, *6*(3), 327-339. https://doi.org/http://dx.doi.org/10.1016/j.cptl.2014.02.010

Nocerino, R., & Chiarini, M. (2018). The concept of professional identity in nursing students and practitioners: a research protocol of a cross-sectional study. *Senses and Sciences*, *5*(4).

Nordal, K. C. (2012). Healthcare reform: Implications for independent practice. *Professional Psychology: Research and Practice*, *43*(6), 535. https://doi.org/10.1037/a0029603

Obeng-Kusi, M., Choi, B. M., Axon, D. R., Cooley, J., & Warholak, T. (2022). Improving and validating a rating scale to assess student pharmacists' perception of professional identity. *Journal of the American Pharmacists Association*, *62*(5), 1623-1630. e1622. https://doi.org/http://dx.doi.org/10.1016/j.japh.2022.05.006

Odusanya, S. O. E., Winter, D., Nolte, L., & Shah, S. (2018). The Experience of Being a Qualified Female BME Clinical Psychologist in a National Health Service: An Interpretative Phenomenological and Repertory Grid Analysis. *Journal of Constructivist Psychology*, *31*(3), 273-291. https://doi.org/10.1080/10720537.2017.1304301

Onwuegbuzie, A. J., Bustamante, R. M., & Nelson, J. A. (2010). Mixed research as a tool for developing quantitative instruments. *Journal of Mixed Methods Research*, *4*(1), 56-78. https://doi.org/https://doi.org/10.1177/1558689809355805

Onwuegbuzie, A. J., & Combs, J. P. (2010). Emergent data analysis techniques in mixed methods research: A synthesis. In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social and behavioral research* (2 ed., Vol. 2, pp. 397-430). Sage Publications. https://doi.org/https://doi.org/10.4135/9781506335193

OpenAI. (2023). *ChatGPT3.5*. https://chat.openai.com/

Oxford English Dictionary. (2000). *Profession*. Oxford University Press. https://www.oed.com/?tl=true

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., & Brennan, S. E. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International* *journal of surgery*, *88*, 105906. https://doi.org/http://dx.doi.org/10.1016/j.ijsu.2021.105906

Parsons, T. (2020). Ethics in technology for clinical psychology. In *Reference Module in Neuroscience and Biobehavioural Psychology*. https://doi.org/10.1016/B978-0-12-818697-8.00007-8

Pickren, W., & Rutherford, A. (2010). *A history of modern psychology in context*. John Wiley & Sons.

Pilgrim, D., & Carey, T. (2012). Improving access to psychological therapies: An account of recent policy aspirations in the UK and Australia. *Advances in Mental Health*, *10*(2), 117-126. https://doi.org/10.3316/informit.447926238280880

Polit, D. F., Beck, C. T., & Owen, S. V. (2007). Focus on research methods: Is the CVI an acceptable indicator of content validity? Appraisal and recommendations [Article]. *Research in Nursing and Health*, *30*(4), 459-467-467. https://doi.org/10.1002/nur.20199

Priest, H., Roberts, P., Dent, H., Hunt, T., Weston, D., Chell, A., Blincoe, C., & Armstrong, C. (2011). Preparing for collaborative working in mental health: an interprofessional education project with clinical psychology trainees and nursing students. *The Journal of Mental Health Training, Education and Practice*, *6*(1), 47-57. https://doi.org/10.1108/17556221111136161

Priest, H. M., Roberts, P., Dent, H., Blincoe, C., Lawton, D., & Armstrong, C. (2008). Interprofessional education and working in mental health: in search of the evidence base. *Journal of Nursing Management*(4), 474. https://doi.org/10.1111/j.1365-2834.2008.00867.x

Prosek, E. A., & Hurt, K. M. (2014). Measuring professional identity development among counselor trainees. *Counselor Education and Supervision*, *53*(4), 284-293. https://doi.org/http://dx.doi.org/10.1002/j.1556-6978.2014.00063.x

Rawls, J. (2001). *Justice as fairness: A restatement* (E. Kelly, Ed.). Harvard University Press. https://doi.org/http://dx.doi.org/10.2307/j.ctv31xf5v0

Reicher, S., Spears, R., & Haslam, S. A. (2010). The Social Identity Approach in Social Psychology. In M. Wetherell & C. T. Mohanty (Eds.), *The SAGE Handbook of Identities*. SAGE Publications, Limited. https://doi.org/http://dx.doi.org/10.4135/9781446200889

Reinders, J. J., Lycklama À Nijeholt, M., Van Der Schans, C. P., & Krijnen, W. P. (2020). The development and psychometric evaluation of an interprofessional identity measure: Extended Professional Identity Scale (EPIS). *Journal of Interprofessional Care*, 1-13.

Robson, C., & McCartan, K. (2016). *Real world research* (Fourth ed.). John Wiley & Sons.

Roccas, S., & Brewer, M. B. (2002). Social Identity Complexity. *Personality & Social Psychology Review (Lawrence Erlbaum Associates), 6*(2), 88-106. https://doi.org/10.1207/S15327957PSPR0602_01

Ronfeldt, M., & Grossman, P. (2008). Becoming a professional: Experimenting with possible selves in professional preparation. *Teacher Education Quarterly*, *35*(3), 41-60. http://www.jstor.org/stable/23478980

Salter, M., & Rhodes, P. (2018). On becoming a therapist: A narrative inquiry of personal-professional development and the training of clinical psychologists. *Australian Psychologist*, *53*(6), 486-492. https://doi.org/10.1111/ap.12344

Schoonenboom, J., & Johnson, R. B. (2017). How to construct a mixed methods research design [Article]. *Kolner Zeitschrift fur Soziologie und Sozialpsychologie*, *69*, 107-131. https://doi.org/10.1007/s11577-017-0454-1

Schreier, M. (2012). *Qualitative content analysis in practice*. Sage Publications. http://dx.doi.org/10.4135/9781529682571

Schubert, S., Buus, N., Monrouxe, L. V., & Hunt, C. (2023). The development of professional identity in clinical psychologists: A scoping review. *Medical Education*, 612-626. https://doi.org/http://dx.doi.org/10.1111/medu.15082

Schubert, S., Monrouxe, L. V., Buus, N., & Hunt, C. (2023). Fragilising clients: A positioning analysis of identity construction during clinical psychology trainees' supervision. *Medical Education*, 338-353. https://doi.org/http://dx.doi.org/10.1111/medu.15200

Schubert, S., Rhodes, P., & Buus, N. (2020). Transformation of professional identity: An exploration of psychologists and psychiatrists implementing open dialogue. *Journal of Family Therapy*, 143-164. https://doi.org/10.1111/1467-6427.12289

Schwandt, T. A. (2015). *The Sage dictionary of qualitative inquiry*. Sage publications. https://doi.org/http://dx.doi.org/10.4135/9781483398969

Shan, Y. (2022). Philosophical foundations of mixed methods research. *Philosophy Compass*, *17*(1), e12804. https://doi.org/http://dx.doi.org/10.1111/phc3.12804

Shanteau, J., Weiss, D. J., Thomas, R. P., Pounds, J., & Hall, B. (2003). How can you tell if someone is an expert? Empirical assessment of expertise. *Emerging perspectives on judgment and decision research*, 620-641. https://api.semanticscholar.org/CorpusID:16834351

Smith, C. S., Stilianoudakis, S. C., & Carrico, C. K. (2023). Professionalism and professional identity formation in dental students: Revisiting the professional role orientation inventory (PROI). *Journal of Dental Education*, *87*(5), 646-653. https://doi.org/http://dx.doi.org/10.1002/jdd.13159

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. *Journal of business research*, *104*, 333-339. https://doi.org/10.1016/j.jbusres.2019.07.039

Sofaer, S. (1999). Qualitative methods: what are they and why use them? *Health services research*, *34*(5 Pt 2), 1101.

Stanley, P., & Manthei, R. (2004). Counselling psychology in New Zealand: the quest for identity and recognition. *Counselling Psychology Quarterly*, *17*(3), 301-315. https://doi.org/http://dx.doi.org/10.1080/09515070412331317594

Stanton, J. M., Sinar, E. F., Balzer, W. K., & Smith, P. C. (2002). Issues and strategies for reducing the length of self-report scales. *Personnel Psychology*, *55*(1), 167-194. https://doi.org/http://dx.doi.org/10.1111/j.1744-6570.2002.tb00108.x

Stemler, S. E. (2004). A comparison of consensus, consistency, and measurement approaches to estimating interrater reliability. *Practical Assessment, Research, and Evaluation*, *9*(1), 4.

Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social psychology quarterly*, 224-237. https://doi.org/http://dx.doi.org/10.2307/2695870

Stewart, M., Bushnell, J., Hauraki, J., & Roberts, M. (2014). Evidence and wisdom: The role and value of psychologists in healthcare. *Journal of the New Zealand College of Clinical Psychologists*, *24*(1), 3-14.

Streiner, D. (2015). *Health measurement scales : a practical guide to their development and use* (Fifth edition. ed.). Oxford University Press. https://doi.org/http://dx.doi.org/10.1093/med/9780192869487.001.0001

Tagawa, M. (2019). Development of a scale to evaluate medical professional identity formation. *BMC medical education*, *19*(1), 1-9. https://doi.org/http://dx.doi.org/10.1186/s12909-019-1499-9

Tajfel, H. (1969). Cognitive aspects of prejudice. *Journal of biosocial science*, *1*(S1), 173-191. https://doi.org/http://dx.doi.org/10.1017/S0021932000023336

Tajfel, H. (1974a). Integroup behaviour, social comparison and social change. *Katz-Newcomb Lectures*.

Tajfel, H. (1974b). Social identity and intergroup behaviour. *Social Science Information*, *13*(2), 65-93. https://doi.org/http://dx.doi.org/10.1177/053901847401300204

Tajfel, H. (1975). The exit of social mobility and the voice of social change: Notes on the social psychology of intergroup relations. *Information (International Social Science Council)*, *14*(2), 101-118. https://doi.org/http://dx.doi.org/10.1177/053901847501400204

Tajfel, H. (1982). Social psychology of intergroup relations [Article]. *Annual Review of Psychology*, *33*(1), 1. https://doi.org/10.1146/annurev.ps.33.020182.000245

Tajfel, H., & Billic, M. (1974). Familiarity and categorization in intergroup behavior. *Journal of experimental social psychology*, *10*(2), 159-170. https://doi.org/http://dx.doi.org/10.1016/0022-1031(74)90064-X

Tan, C. P., Van der Molen, H., & Schmidt, H. (2017). A measure of professional identity development for professional education. *Studies in Higher Education*, *42*(8), 1504-1519. https://doi.org/10.1080/03075079.2015.1111322

Tashakkori, A., Teddlie, C., & Sines, M. C. (2012). Utilizing mixed methods in psychological research. In J. A. Schinka, W. F. Velicer, & I. B. Weiner (Eds.), *Handbook of psychology* (Vol. 2, pp. 428-450). https://doi.org/https://doi.org/10.1002/9781118133880.hop202015

Teddlie, C., & Tashakkori, A. (2010). Overview of contemporary issues in mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (Vol. 2, pp. 1-41). https://doi.org/http://dx.doi.org/10.4135/9781506335193.n1

Thomas, T. (1978). Plea for greater recognition of psychology profession. *Press*. https://paperspast.natlib.govt.nz/newspapers/CHP19780818.2.53.4

Treichler, E. B. H., Crawford, J. N., Higdon, A., & Backhaus, A. L. (2020). Diversity and social justice training at the postdoctoral level: A scoping study and pilot of a self-assessment. *Training & Education in Professional Psychology*, *14*(2), 126-137. https://doi.org/10.1037/tep0000281

Turner, J. C. (2010). Social categorization and the self-concept: a social cognitive theory of group behavior. In T. Postmes & B. N. R. (Eds.), *Rediscovering social identity* (pp. 243–272). Psychology Press.

Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the social group: A self-categorization theory*. Basil Blackwell.

Turner, J. C., Oakes, P. J., Haslam, S. A., & McGarty, C. (1994). Self and collective: Cognition and social context. *Personality and Social Psychology Bulletin*, *20*(5), 454-463. https://doi.org/10.1177/0146167294205002

Ulfsdotter Eriksson, Y., & Linde, M. (2014). "Being" or "Doing" a profession: Work as a matter of social identity. *The International Journal of Interdisciplinary Cultural Studies*, *8*, 33-43. https://doi.org/10.18848/2327-008X/CGP/v08i01/53186

Versta Research. (2011). *How to estimate the legth of a survey*. https://verstaresearch.com/newsletters/how-to-estimate-the-length-of-a-survey/

Vignoles, V. L., Schwartz, S. J., & Luyckx, K. (2011). Introduction: Toward an integrative view of identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 1-27). Springer. https://doi.org/https://doi.org/10.1007/978-1-4419-7988-9

Wackerhausen, S. (2009). Collaboration, professional identity and reflection across boundaries. *Journal of Interprofessional Care*, *23*(5), 455-473. https://doi.org/10.1080/13561820902921720

Webb, S. A. (2017). *Professional identity and social work* (S. A. Webb, Ed.). Routledge. https://doi.org/http://dx.doi.org/10.4324/9781315306957

Wetherell, M. (2010). The field of identity studies. In M. Wetherell & C. T. Mohanty (Eds.), *The SAGE Handbook of Identities*. SAGE Publications, Limited. https://doi.org/http://dx.doi.org/10.4135/9781446200889

Whitcombe, S. W. (2013). Problem-based learning students' perceptions of knowledge and professional identity: occupational therapists as ‘knowers’. *British Journal of Occupational Therapy*, *76*(1), 37-42. https://doi.org/http://dx.doi.org/10.4276/030802213X13576469254739

Whittemore, R., & Knafl, K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing*, *52*(5), 546-553. https://doi.org/http://dx.doi.org/10.1111/j.1365-2648.2005.03621.x

Wilensky, H. L. (1964). The professionalization of everyone? *American journal of sociology*, *70*(2), 137-158. https://doi.org/http://dx.doi.org/10.1086/223790

Wiles, F. (2013). ‘Not easily put into a box’: Constructing professional identity. *Social Work Education*, *32*(7), 854-866. https://doi.org/10.1080/02615479.2012.705273

Wilkinson, A., Hislop, D., & Coupland, C. (2016). The changing world of professions and professional workers. In A. Wilkinson (Ed.), *Perspectives on Contemporary Professional Work* (pp. 3–15). Edward Elgar Publishing. https://doi.org/http://dx.doi.org/10.4337/9781783475582.00009

Willetts, G., & Clarke, D. (2014). Constructing nurses' professional identity through social identity theory. *International journal of nursing practice*, *20*(2), 164-169. https://doi.org/http://dx.doi.org/10.1111/ijn.12108

Willetts, G., & Garvey, L. (2020). Constructing nurses' professional identity through group performance. *International journal of nursing practice*, *26*(6), e12849. https://doi.org/10.1111/ijn.12849

Wong, C. Y. E., & Liu, W. C. (2024). Evaluating the teacher professional identity of student teachers: Development and validation of the Teacher Professional Identity Scale. *Journal of Education for Teaching*, *204*(1), 131-144. https://doi.org/https://doi.org/10.1177/00220574221101375

Woo, H., & Henfield, M. S. (2015). Professional identity scale in counseling (PISC): Instrument development and validation. *Journal of Counselor Leadership and Advocacy*, *2*(2), 93-112. https://doi.org/http://dx.doi.org/10.1080/2326716X.2015.1040557

Woo, H., Lu, J., & Bang, N. (2018). Professional Identity Scale in Counseling (PISC): Revision of factor structure and psychometrics. *Journal of Counselor Leadership and Advocacy*, *5*(2), 137-152. https://doi.org/10.1080/2326716X.2018.1452078

Woodward, N. S., Keville, S., & Conlan, L. M. (2015). The buds and shoots of what I've grown to become: the development of reflective practice in Trainee Clinical Psychologists. *Reflective Practice*, *16*(6), 777-789. https://doi.org/10.1080/14623943.2015.1095728

Worthington, M., Salamonson, Y., Weaver, R., & Cleary, M. (2013). Predictive validity of the Macleod Clark Professional Identity Scale for undergraduate nursing students. *Nurse education today*, *33*(3), 187-191. https://doi.org/10.1016/j.nedt.2012.01.012

Worthington, R. L., & Whittaker, T. A. (2006). Scale development research: A content analysis and recommendations for best practices [Article]. *The Counseling Psychologist*, *34*(6), 806-838-838. https://doi.org/10.1177/0011000006288127

Yadav, D. (2022). Criteria for good qualitative research: A comprehensive review. *The Asia-Pacific Education Researcher*, *31*(6), 679-689. https://doi.org/http://dx.doi.org/10.1007/s40299-021-00619-0

Yadin, D., Calil, S., Pallikarakis, N., Poluta, M., Bergamasco, S., Clark, D., Judd, T., Wear, J., Fukuta, K., & Mullally, S. (2021). Is Clinical Engineering an occupation or profession? *Global Clinical Engineering Journal*, *4*(2), 26-35. https://doi.org/http://dx.doi.org/10.31354/globalce.v4i2.131

Yusoff, M. S. B. (2019). ABC of content validation and content validity index calculation. *Education in Medicine Journal*, *11*(2), 49-54. https://doi.org/http://dx.doi.org/10.21315/eimj2019.11.2.6

Zamanzadeh, V., Ghahramanian, A., Rassouli, M., Abbaszadeh, A., Alavi-Majd, H., & Nikanfar, A. R. (2015). Design and implementation content validity study: Development of an instrument for measuring Patient-Centered Communication. *J Caring Sci*, *4*(2), 165-178. https://doi.org/10.15171/jcs.2015.017

Zhou, Y. (2019). A mixed methods model of scale development and validation analysis. *Measurement: Interdisciplinary Research and Perspectives*, *17*(1), 38-47. https://doi.org/http://dx.doi.org/10.1080/15366367.2018.1479088

Appendices

Appendix A: Prisma Checklist

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Identified as Integrative Literature Review in Literature Revie Format Section
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	N/A
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Yes
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Yes, in Problem Identification section
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Yes, in Literature Search and and Data Evaluation stages
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Yes, in Literature Search and and Data Evaluation stages
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Yes, in Literature Search and and Data Evaluation stages
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Yes, in Literature Search and and Data Evaluation stages
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Yes, in Literature Search and and Data Evaluation stages

Section and Topic	Item #	Checklist item	Location where item is reported
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	N/A
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	N/A
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	N/A
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Yes, in Literature Search and and Data Evaluation stages
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Yes, in Data Analysis Stage
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Yes, in Data Analysis Stage
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Yes, in Data Analysis Stage
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A

Section and Topic	Item #	Checklist item	Location where item is reported
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Yes, in Results section
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	N/A
Study characteristics	17	Cite each included study and present its characteristics.	Yes, in Results section
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	N/A
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	N/A
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Yes, in Results section and Discussion section
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Yes, in Results, Discussion, Limitation section
	23b	Discuss any limitations of the evidence included in the review.	Yes, in Results, Discussion, Limitation section
	23c	Discuss any limitations of the review processes used.	Yes, in Results, Discussion, Limitation section

Section and Topic	Item #	Checklist item	Location where item is reported
	23d	Discuss implications of the results for practice, policy, and future research.	Yes, in Results, Discussion, Limitation section
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	N/A
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	N/A
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	N/A
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

**From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Appendix B: Semi-Structured Interview Schedule

Biographical details gathered

Name: Age:

Gender: Ethnicity:

- Additional Vocational Registration in Aotearoa/New Zealand?:
- Vocational registration in any other country (all scopes):
- Years in Practice since graduation/completing internship:
- In which country did you qualify as a clinical psychologist?
- Have you worked in any other country? If yes, please specify which country and how long?
- How long have you worked in Aotearoa/New Zealand?

In which sector do you primarily work

- Primary health (DHB)
- Secondary health (DHB)
- Tertiary health (DHB)
- Rehabilitation (including ACC)
- Corrections
- Academia
- Private Practice
- Other (please specify)
- A combination (please specify ratio)

Does your work primarily include

- Direct client/patient contact

- Academia/Teaching
- Supervision
- Leadership/Management
- A combination (please specify ratio, e.g. 10% academia, 20% supervision, 50% client contact, 20% leadership)
- Other (please specify)

Questions

Question 1

In your opinion, what makes a clinical psychologist a clinical psychologist and who are you as a clinical psychologist?

Question 2

In your opinion, what makes a clinical psychologist different from other professions? How do you see yourself as a clinical psychologist as different from other professions?

Question 3

What shapes, maintains, and influences clinical psychologists in general, and who you are as clinical psychologist?

Question 4

What makes a clinical psychologist on a societal, group, organisational and/or individual level? What makes you a clinical psychologist on these levels?

Question 5

How do you see the role of a clinical psychologist and your role as a clinical psychologist?

Question 6

Anything else about professional identity that you think is important?

3. Next steps:

Appendix C: ChatGPT Examples

Example of ChatGPT Prompts and Response

Item Generation

Input.

Being responsible was identified as a component of ethos using qualitative content analysis to investigate the clinical psychologists' professional identity prototype. If I give you examples of participant responses for this category, could you generate scale items from these examples for a clinical psychologist early career development scale?

Output.

Certainly! I'd be happy to help you generate scale items based on the examples of participant responses related to the category of responsibility. Please provide me with the examples, and I'll do my best to create scale items for a clinical psychologist early career development scale.

Input.

You have a certain standard

Behave appropriately

There's an ideal value that you should behave to, a very high standard professionally and ethically

I think in a lot of ways being guided by our ethics contributes to our identity because I think that it goes beyond just when I'm at work I think those principles guide who I am as a person.

I think the status that comes with that professional label comes with both a value but also an expectation.

makes me really aware that I need to deliver so I need to be on my game need to be rigorous

and robust

do the best work I can based on my knowledge and expertise.

it makes me really aware of that responsibility that we hold

in our code of ethics

most of us hold those values

important values

in our code of ethics

what we are permitted to do depends on what scope we are registered under the board

a definition under the board

constraints under which we have to express our professional identity

acceptable behavioural standards

I follow the code of ethics and what I meant to do within my profession.

I view supervision as a legal requirement

Checking of ethics' keeping you on track

the code of ethics

it is about you know doing the job and being effective

Doing an effective job

ethics

“boundaried” type of relationship

boundaries and this is how it will be and that is the way that things should go

slightly higher standards for you as a psychologist, the board expects you to keep your nose clean. I would never consider I mean you know it's not much of a departure from how I am anyway but I would never considered driving drunk or doing anything dodgy it would impact your credibility and your role

the legalities as well as my ethical codes

sticking to their scopes of practice as outlined by professional boards throughout the world.

stay within that scope of practice

constantly accountable

oversight by governing bodies the regulation

answerable

legal and ethical responsibilities

more regulated

legalities around you

Output.

Based on the provided examples, here are some refined scale items focusing on responsibility for a clinical psychologist early career development scale:

I adhere to a certain standard of behaviour expected of a professional psychologist.

I recognize the ideal value of maintaining a high standard of professionalism and ethics in my practice.

My professional identity is guided by ethical principles that extend beyond the workplace and shape who I am as a person.

The status associated with being a clinical psychologist carries both value and the expectation of delivering high-quality services.

I feel a strong responsibility to consistently deliver the best possible work based on my knowledge and expertise.

I understand the importance of being rigorous and robust in my approach to clinical practice.

Adherence to ethical codes and standards is integral to my professional identity and practice.

I prioritize staying within the scope of practice outlined by professional boards and regulatory bodies.

I view supervision as an opportunity to ensure I am maintaining ethical standards and staying on track in my practice.

I recognize the legal and ethical responsibilities that come with being a psychologist and strive to uphold them in my work.

These scale items aim to capture the essence of responsibility as described in the participant responses, highlighting the importance of ethical behaviour, adherence to professional standards, and accountability in clinical practice.

Item alternatives

Input.

Alternatives for: I am knowledgeable about the theoretical models and evidence-based practices in clinical psychology

Output.

1. I possess a comprehensive understanding of the theoretical frameworks and evidence-based practices utilized in clinical psychology.

2. I have extensive knowledge of the theoretical models and evidence-based approaches that form the foundation of clinical psychology.

3. I am well-versed in the theoretical models and evidence-based interventions that are employed within the field of clinical psychology.

4. I possess a deep understanding of the theoretical underpinnings and evidence-based practices that guide clinical psychologists in their work.

5. I have a thorough knowledge of the theoretical models and evidence-based strategies commonly utilized in clinical psychology.

6. I am highly knowledgeable about the theoretical frameworks and evidence-based interventions that are prevalent in the field of clinical psychology.

7. I possess a solid understanding of the theoretical models and evidence-based practices that are fundamental to the practice of clinical psychology.

8. I have an in-depth knowledge of the theoretical underpinnings and evidence-based approaches that inform clinical psychology as a discipline.

9. I am well-acquainted with the theoretical models and evidence-based techniques that are central to the work of clinical psychologists.

10. I possess a comprehensive understanding of the theoretical foundations and evidence-based methodologies utilized within clinical psychology.

Appendix D: Survey

Consent

Thank you for taking part in the first phase of research on clinical psychologists' professional identity. You are now being approached to take part in phase two via this survey, which is aimed at:

Reviewing the constructs or domains informing professional identity for clinical psychologists as suggested in the results from phase one. Reviewing potential items for a clinical psychologists' professional identity scale constructed from the results from phase one. The survey will take approximately 20 to 30 minutes to complete. The survey has three sections. Section one involves reviewing the results from the qualitative interviews following qualitative content analysis. Section two deals with reviewing potential scale items and Section 3 with any comments or suggestions you may have.

By clicking yes, you consent to taking part in this second phase investigating clinical psychologists' professional identity. Note that all responses received are anonymous. You are welcome to withdraw at any time without prejudice.

Introduction

The first phase of the research focused on determining the core aspects of clinical psychologists' professional identity in Aotearoa/New Zealand. The results are based on semi-structured interviews with 11 senior and consultant level clinical psychologists.

After qualitative content analysis, 5 main categories of clinical psychologists' professional identity were identified. These are:

Professional Identity Perception Personal Attributes Skills Ethos Focus These components are present not only in client facing work, but permeate all aspects of 'who' a clinical psychologist is across the professional contexts they function in. These categories (and their subcategories where applicable) are briefly discussed and presented for review.

Review of Constructs

Perception of Professional Identity

Professional Identity Perception, as a component of Clinical psychologists' professional identity, references the ability for a clinical psychologist to perceive and embody a differentiated perception of professional identity from other professions. In other words, this category deals with clinical psychologists seeing themselves as divergent compared to other professions.

Please indicate how relevant you think Professional Identity Perception is to clinical psychologists' professional identity.

Personal Attributes

Personal Attributes deal with distinctive traits, feature or motivators deemed essential for 'being' a clinical psychologist and are thought to compromise a distinctive category of Clinical psychologists' professional identity. Personal Attributes include, for example, an interest in others, an interest in supporting people, an ability to empathise, understand non-verbal cues, being driven and an ability to tolerate ambiguity and difficult situations.

Please indicate how relevant you think Personal Attributes are to clinical psychologists' professional identity.

Skills

Another category identified in phase one as a component of Clinical psychologists' professional identity is Skills. Skills broadly focus on the practical knowledge in combination with ability to 'do' what clinical psychologists 'do'.

Several subcategories were identified for this category including Business Skills, Clinical Skills, Generalist Skills, Leadership Skills, Reflective Practitioner Skills, Scientist Practitioner Skills, Specialist Skills, Supervision Skills, and Teaching Skills. Undifferentiated Knowledge and Skills also fall under this broad category. The subcategories will be evaluated separately.

Please indicate how relevant you think Skills are to clinical psychologists' professional identity.

Skills: Business Skills.

Business skills refer to a set of competencies and knowledge related to managing and operating a clinical psychology practice or engaging in entrepreneurial activities within the field. Business Skills is the first subcategory of the Skills domain previously discussed.

Please indicate how relevant you think Business Skills are to clinical psychologists' professional identity.

Skills: Clinical Skills.

Clinical Skills refer to a set of abilities, competencies, and proficiencies that clinical psychologists possess and utilise in the clinical setting to provide quality patient/client care. These skills encompass various aspects including diagnosis, intervention, psychometric assessment, formulation, report-writing, and intervention.

Please indicate how relevant you think Clinical Skills are to clinical psychologists' professional identity.

Skills: Generalist Skills.

Generalist Skills refer to the ability and proficiency at transferring a broad range of foundational competencies and abilities across various areas of clinical and non-clinical practice.

Please indicate how relevant you think Generalist Skills are to clinical psychologists' professional identity.

Skills: Leadership Skills.

Leadership involves the ability to guide and influence others towards a common goal or objective and therefore encompasses a variety of activities. In the context of this analysis, Leadership Skills refer to any pursuit or activities that would guide and influence others, usually more than one person, outside the confines of direct client facing work or in providing clinical supervision. Examples are:

Liasson/consulting Program development and evaluation Direct management Please indicate how relevant you think Leadership Skills are to clinical psychologists' professional identity.

Skills: Reflective Practitioner Skills.

This subcategory of Skills reflects on knowledge and competent application of reflective practitioner skills, for example:

Self-Reflection, Insights into strengths, limitations, and areas for growth Critical analysis of own practice Integration of experiences (professional and personal) and practical wisdom that informs future practice Authenticity and genuine engagement, using the 'self' Please indicate how relevant you think Reflective Practitioner Skills are to clinical psychologists' professional identity.

Skills: Scientist Practitioner Skills.

This subcategory involves knowledge and competent application of the scientist practitioner model through:

Evidence-Based Practice Critical Evaluation of Research Research Competence Outcome Evaluation Please indicate how relevant you think Scientist Practitioner Skills are to clinical psychologists' professional identity.

Skills: Specialist Skills.

Specialist Skills refer to a focused set of competencies and expertise developed in a specific area, context or population. An example could be expertise in forensic settings, or in co-occurring disorders.

Please indicate how relevant you think Specialist Skills are to clinical psychologists' professional identity.

Skills: Supervision Skills.

This subcategory focuses on both the skilful ability to utilise and influence supervision, and provide supervision.

Please indicate how relevant you think Supervision Skills are to clinical psychologists' professional identity.

Skills: Teaching Skills.

Teaching Skills refer to the ability to relay knowledge to others. This subcategory primarily encompasses the ability to confidently teach others outside of the confines of direct clinical work or clinical supervision.

Please indicate how relevant you think this Teaching Skills are to clinical psychologists' professional identity.

Ethos

This construct embodies 'how clinical psychologists do what they do', in other words their overarching spirit, approach, attitudes, aspirations, and philosophy in applying their skills in the contexts they work. Ethos can be divided into 7 subcategories. These are being contemporary, elucidative, holistic, just, modest, purposeful, and responsible. Each subcategory of ethos will be evaluated separately.

Please indicate how relevant you think Ethos is to clinical psychologists' professional identity.

Ethos: Collaborative.

This subcategory is about working with clients/patients, within teams, and within organisations in a way characterized by collaboration, co-operation and being person-centred.

Please indicate how relevant you think being Collaborative is to clinical psychologists' professional identity.

Ethos: Contemporary.

Staying up-to-date with current practice, research, developments, and ideas is the central focus of this subcategory of Ethos.

Please indicate how relevant you think being Contemporary is to clinical psychologists' professional identity.

Ethos: Elucidative.

The word means 'to bring to light'. This construct aligns with this concept of 'enlightening' and refers to the ability to provide an alternative perspective, alternative voice, broad understanding, or making difficult concepts plain or intelligible across clinical and non-clinical contexts.

Please indicate how relevant you think being Elucidative is to clinical psychologists' professional identity.

Ethos: Holistic.

This subcategory references the ability to acknowledge, account for and effectively use cultural, contextual, diversity, and religious variables to understand person(s) or situations holistically, both clinically and non-clinically.

Please indicate how relevant you think being Holistic is to clinical psychologists' professional identity.

Ethos: Just.

Being Just encompasses a focus and approach to clinical and non-clinical work consonant with the principles of equity; righteousness; fairness; the greater good; social justice.

Please indicate how relevant you think being Just is to clinical psychologists' professional identity.

Ethos: Modest.

Modesty as a subcategory refers to the ability to function as a professional while avoiding extremes of behaviour; being well-conducted, temperate; not harsh or domineering;

and acting with humility. Modesty is about being able to, for example, provide an opinion without coming across as self-important or being closed off to further conversation.

Please indicate how relevant you think being Modest is to clinical psychologists' professional identity.

Ethos: Purposeful.

This subcategory indicates the ability to have a definite purpose in mind and being resolute in approaching clinical and non-clinical work. The subcategory is about being goal-directed in all work done as a clinical psychologist.

Please indicate how relevant you think being purposeful is to clinical psychologists' professional identity.

Ethos: Responsible.

The ability to maintain ethical and professional standards is central to this subcategory. This includes accountability, reliability, being trustworthy, and being sensible at all times when embodying the identity of a clinical psychologist.

Please indicate how relevant you think being Responsible is to clinical psychologists' professional identity.

Focus

This category references inhabiting specific contexts or working with specific populations typically associated with being a clinical psychologist. This domain is about 'who psychologists work with'.

Please indicate how relevant you think Focus is to clinical psychologists' professional identity.

Item Validation

Based on the results from phase 1, items were developed for an early career self-assessment tool aimed at measuring professional identity development across the domains identified. The scale is aimed at intern clinical psychologists and clinical psychologists in their first 5 years of practice. The instruction for the scale will read: "The scale is aimed at measuring your professional identity development as a clinical psychologist. Please rate your current development against each statement between 1 and 10, with 1 being not developed at all and 10 indicating full development.". A higher score indicates better perceived development in the specific domain, and the total score can be used as a reflection on overall professional identity development. Development is measured not only in context to direct client-facing work, but also referencing professional identity development across professional contexts.

Please evaluate the following items for this proposed scale, all designed to tap into the constructs discussed in the previous section. You will be asked to rate the relevance of the item to evaluate the domain (content validity), and clarity (easily understandable) of each item. When evaluating item relevancy, please reflect on both the items' ability to tap into the domain being evaluated, as well as the ability to discriminate between less developed and more developed clinical psychologists.

Note that Specialist Skills are excluded, and Supervision Skills items are focused only on the ability to utilise supervision effectively due to the measure's focus on junior psychologists.

Professional Identity Perception

Please evaluate the following 2 items designed to tap into Professional Identity Perception development for junior clinical psychologists.

- I understand the unique aspects of clinical psychology compared to other professions.

- The difference between clinical psychology and other professions is clear to me.

Personal Attributes

Please evaluate the following 5 items designed to tap into Personal Attributes development for junior clinical psychologists.

- I have a deep interest in working with and supporting people.
- My sensitivity to non-verbal cues and ability to interpret them is highly developed.
- I understand and empathise keenly with others.
- I am very driven to succeed in my career.
- I am comfortable with uncertainty and tolerate difficult emotions well as part of my work.

Skills

Skills: Business Skills.

Please evaluate the following 2 items designed to tap into Business Skill development for junior clinical psychologists.

- I possess the business skills to run a successful private practice.
- I have a good understanding of clinical psychologist' business practices.

Skills: Clinical Skills.

Please evaluate the following 4 items designed to tap into Clinical Skill development for junior clinical psychologists.

- I am confident in my clinical ability in both direct clinical work and other professional contexts.
- My skills in assessment, psychometrics, diagnosis, formulation, and intervention are well-developed.

- I am skilled at handling complex and risky cases.
- I write excellent reports.

Skills: Generalist Skills.

Please evaluate the following 2 items designed to tap into Generalist Skill development for junior clinical psychologists.

- I utilise my professional skills in diverse settings.
- I work in different environments and with diverse populations.

Skills: Leadership Skills.

Please evaluate the following 4 items designed to tap into Leadership Skill development for junior clinical psychologists.

- I design effective programs and initiatives.
- I influence others outside the confines of direct clinical work.
- I provide professional consultation in various contexts.
- I contribute to policy-making processes.

Skills: Reflective Practitioner Skills.

Please evaluate the following 3 items designed to tap into Reflective Practitioner Skill development for junior clinical psychologists.

- I regularly and critically reflect on my client facing and non-client facing practice.
- I reflect on and integrate personal qualities in my professional practice when appropriate.
- My personal and professional identities are well integrated.

Skills: Scientist Practitioner Skills.

Please evaluate the following 4 items designed to tap into Scientist Practitioner Skill development for junior clinical psychologists.

- I skilfully evaluate and integrate research findings into direct client work and other professional contexts.
- I use my scientific training to inform and enhance my work across all professional settings.
- I skilfully adjust my approach based on evidence-based practices in everything I do as a clinical psychologist.
- I am skilled at research activities.

Skills: Supervision Skills.

Please evaluate the following 2 items designed to tap into Supervision Skill development for junior clinical psychologists.

- I use supervision skilfully and effectively across clinical and non-clinical contexts.
- I have a good understanding of how to use and apply clinical supervision across various professional settings.

Skills: Teaching.

Skills Please evaluate the following 2 items designed to tap into Teaching Skill development for junior clinical psychologists.

- I engage others in teaching or training activities.
- I skilfully share insights and perspectives when training others.

Ethos

Ethos: Collaborative.

Please evaluate the following 3 items designed to tap into being Collaborative development for junior clinical psychologists.

- I 'walk alongside' both clients and others I work with.
- I am non-hierarchical and collaborative in all aspects of my work.
- I am person-centred in all I do as a clinical psychologist.

Ethos: Contemporary.

Please evaluate the following 3 items designed to tap into being Contemporary development for junior clinical psychologists.

- I stay abreast with developments in the field.
- I stay well-informed in my professional practice.
- I frequently challenge myself to grow professionally.

Ethos: Elucidative.

Please evaluate the following 3 items designed to tap into being Elucidative development for junior clinical psychologists.

- I regularly provide alternative perspectives across various professional contexts.
- As a clinical psychologist, I frequently elicit, validate and provide multiple perspectives in clinical and non-clinical work.
- I question traditional labels and explore alternative psychological models of understanding in both clinical and non-clinical work.

Ethos: Holistic.

Please evaluate the following 3 items designed to tap into being Holistic development for junior clinical psychologists.

- I consider and integrate multiple factors holistically in my work across contexts.

- I am knowledgeable regarding diversity and can apply this knowledge well across all I do as a clinical psychologist.
- My cultural knowledge and cultural humility are evident across client and non-client related work.

Ethos: Just.

Please evaluate the following 3 items designed to tap into being Just development for junior clinical psychologists.

- I advocate for people I work with professionally in everything I do as a clinical psychologist.
- Promoting justice and equity is central to what I do daily and across work contexts.
- Societal change for the betterment of humanity is a central value in my work, both in direct client work and in other professional contexts.

Ethos: Modest.

Please evaluate the following 2 items designed to tap into being Modest development for junior clinical psychologists.

- I balance my professional opinion with humility in everything I do as a clinical psychologist.
- I provide professional opinions while maintaining a willingness to learn or acknowledge when I am wrong in all professional interactions.

Ethos: Purposeful.

Please evaluate the following 3 items designed to tap into being Purposeful development for junior clinical psychologists.

- I constantly hold a goal directed approach in mind in what I do professionally across clinical and non-clinical contexts.
- I prioritise delivering clear and meaningful outcomes in both my clinical and non-clinical work.

Ethos: Responsible.

Please evaluate the following 3 items designed to tap into being Responsible development for junior clinical psychologists.

- I constantly hold a goal directed approach in mind in what I do professionally across clinical and non-clinical contexts.
- I prioritise delivering clear and meaningful outcomes in both my clinical and non-clinical work.
- I am purposeful in all my work as a clinical psychologist.

Focus: Settings and Populations

Please evaluate the following 3 items designed to tap into Focus development for junior clinical psychologists.

- I am confident to move into multiple settings associated with clinical psychologists.
- I am confident to work with multiple client presentations typically associated with the work clinical psychologists do.
- I use multiple treatment approaches, i.e. individual, group, family, with ease.

Additional Comments

Please note any additional comments on the domains or items. As a reminder, all domains and questions are listed below. Please note the domain and question you are commenting on.