AN EXPLORATION INTO THE SUBJECTIVE EMOTIONAL EXPERIENCES OF THE MSC1-CLINICAL PSYCHOLOGY TRAINEES AT THE UNIVERSITY OF LIMPOPO (MEDUNSA CAMPUS) DURING THEIR FIRST BLOCK OF TRAINING

by

REALEBOHA MHAMBI

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SUPERVISOR: K. Thobejane

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DECLARATION

I declare that the dissertation hereby submitted to the University of Limpopo (Medunsa Campus), for the degree of Msc Clinical Psychology has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

_____ _____

R. Mhambi (Mrs) **Date**

Student Number: 200816691

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DEDICATION

I dedicate this dissertation to all trainees in clinical psychology at the University of Limpopo (Medunsa Campus). I hope this piece of work will strengthen you during difficult times.

ABSTRACT

The Clinical Psychology training programme at the University of Limpopo (Medunsa Campus) is contextualized within the theoretical paradigm of the General Systems Theory. The main focus during the first block of training is on equipping trainees with a person-centered stance and the necessary skills that go with it such as empathy, unconditional positive regard and congruence and also to develop a frame of reference in the trainees which is suitable to form a basis as a therapist. Thus training within this context is experiential.

The aim of this study was to explore the subjective emotional experiences of the Msc1-Clinical Psychology trainees at the University of Limpopo (Medunsa Campus) during their first block of training. The research was conducted through qualitative interviews with the trainees shortly after being exposed to the first block of training. The sample size consisted of five trainees of the 2011 Masters in Clinical Psychology training programme at Medunsa Campus. Interviews were analysed in accordance with qualitative methodology through thematic analysis. Finally, an attempt was made to discuss and integrate the research findings into which the strengths and limitations of the study and future recommendations were made.

Results from this study indicated that trainees during their first block of training experienced different challenges which are not only emotional but mental as well as academic in nature. Moreover, it became evident that trainees further experienced challenges in their social contexts such as families and relationships outside the training context.

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CHAPTER ONE

INTRODUCTION

Inspiring words by Wordsworth form axis of the journey a trainee in psychotherapy undertakes, he postulates: “life ought to be a daring adventure, where fears are faced and goals are continually reached and replaced with wilder dreams. Every mountain holds a riveting rock to climb, while waters taunt you to tip your canoe and crashing waves dare you to step inside the barrel. When you listen to your instincts, they guide you away from the hum of traffic, to a place that will invigorate your senses and quench your spirit” (Wordsworth, 1985:26).

My journey on becoming a psychotherapist had different expressions for me. It has been a journey filled with mixed and conflicting emotions, from feeling extremely excited on one hand to being completely out of control and overwhelmed on the other. What gave me the strength to survive the ordeals of training was motivated and inspired by the risks I took and the challenges I faced before my admission into the Masters program.

Tracing back to where my passion for psychology began, my mind took me back to my first year at university. Around that time during a psychology lecture, I was mostly fascinated by Freud’s theories and since then I knew I wanted to become a clinical psychologist. I can vividly recall with the little knowledge I acquired in class then how I would diagnose certain individuals with different personality disorders and at times render their IQ as low, average or high. This really made me feel “smart”! After being exposed to psychology during those years, soon my childhood dream to become a food technologist disappeared. I was convinced that studying human behaviour was more intriguing than any other career one could ever think of.

Having majored in psychology on my undergraduate, I had an opportunity to continue with an Honours degree, but fear of the unknown I would say made me to opt for teaching instead. I therefore decided to enroll for a Diploma in Higher Education. On completion of my diploma, I worked as a teacher for a period of six years. What intrigues me about my teaching experience was the way in which I would at times move away from my job description as a teacher. For instance, I would find myself acting as what I call a "mini psychologist", a social worker and at times as a counselor to the students, colleagues and parents. Taking a meta-perspective now I came to a realization that I was confused in my role as a teacher. However, during that time I was still "blind" and I enjoyed the confused multiple roles I assigned myself into. It was fulfilling! To make matters worse, I would even go to an extent of consulting with clinical psychologists around my area in which we would talk about psychological issues. One would say I displayed an "obsessive" or "paranoid" behaviour towards the disciple; however, I would call that passion. This passion made me realize that I was never meant to become a teacher. With my father's support and encouragement, I decided to resign as a professional teacher and pursue a career in psychology. This decision made me to approach my journey with optimism and a lot of determination.

Following my resignation, I then applied for an admission for a Bachelor of Science Honours degree in psychology at Medunsa Campus in which I gained acceptance. There were lots of candidates during the selection and only 10 students were accepted into the programme. The selection process was based on panel interviews which lasted for about 20 minutes and questions were mostly based on my personal life experiences and my interests in psychology. It was as if the panelists were assessing my intellectual ability, problem solving skills and my approach to life in general. My Honours year was mostly academically challenging and I am proud that I applied myself into the programme throughout the year and consequently passed with flying colours. It was indeed a life changing milestone achieved.

Towards the end of my Honours year I applied for Masters' entrance in clinical psychology at different universities in South Africa. Due to the highly competitive selection process and the limited number of students trained each year, I was obliged to apply to almost all universities that offer masters programme in clinical psychology throughout South Africa. Fortunately, during my Honours year we were thoroughly prepared and equipped with interviewing skills and some of the aspects that different universities focus on during the selections. At all of the universities I had applied, I was only invited for selection by five and got acceptance in two institutions into which I chose to be trained at Medunsa Campus.

Selections were extremely daunting and the tasks I was expected to engage in were emotionally and academically challenging. Tasks given varied widely from projective tests, individual, panel and group interviews and role plays. The selection process lasted for two to three days depending on the university. At the Medunsa Campus, they lasted for three days and consisted of 35 students into which only 12 students were accepted. Words can never describe how I felt when my name was listed amongst the 12. I was overwhelmed with joy. It was unbelievable, another major highlight of my life!!

The journey into the Masters' program began with great excitement, anticipation and a lot of determination which turned sour. As a very competitive student for the first time in my life I felt inadequate, incompetent, emotionally, psychologically and academically challenged. I found myself in a context that was extremely uncomfortable and anxiety provoking. Firstly, our class consisted of a majority of white students which made me extremely uncomfortable. Considering my background of having studied with black students all my life, the new training context which was predominately white from both the trainees and trainers made me feel uneasy. Having to communicate with them was also very difficult as they spoke in Afrikaans most of the time which I had limited knowledge of. This made me feel inferior and consequently affected my self-confidence dismally.

In addition, the language and specifically clinical language used in the training context seemed difficult to comprehend yet appeared to be easy to my trainers. Each statement my trainers uttered seemed to be difficult to grasp. An hour in the training context felt like the whole year of torture and intimidation. I really grappled with clinical language and to formulate statements and cases clinically. It was for the first time in my life to be exposed to such language as a result I experienced this extremely overwhelming. I often felt like an empty tin, as though my mind was blocked at all times. Furthermore, the new epistemology about human behaviour seemed difficult to understand. It was totally different from what I learnt during my undergraduate and honours years. I was introduced to a totally different world which impacted me drastically. It felt as though one was being exposed to psychology for the first time. What stressed me the most was that I could not even raise my confusion instead I held back. One would say I was crippled by the training context.

There was a concept of "checking in" which was introduced during the beginning of my training. This was to be conducted each day. When checking in, each one of us had to put the rest of the group into context on how he/she is feeling emotionally. This was done to create a common context. It took me the whole year to get used to this process. This was the most draining, anxiety provoking and threatening task for me during my first year at masters' level as it required me to speak congruently and share in the group my genuine emotions every day. At times I would feel exposed as though I was naked. I remember this affected me so much to an extent in which I would even be incongruent during my checking in. This indicates how uncomfortable this process was.

During the early stages of training I was also sensitized to impacts, observations and maneuvers. As a result, I had to deal with registering impacts, observing maneuvers and interpersonal relationships within and outside the training context every day. Thus, my whole being had to change as I was gradually becoming clinically sensitized and driven in

everything I do. This went to an extent of affecting my intimate relationship that nearly went into a breakup. This was extremely overwhelming. I recall at some point I would prefer to be "blind" and live a "normal life" rather than being so overwhelmed with what was going on around me. I felt the more I was being trained was the more I was being scared and confused.

Indeed I have cried many times in my life but that cannot amount the tears I have shed in the training context. I am grateful that despite the upheavals and traumas of training, the thought of quitting never crossed my mind. Certainly I tried to make the best of out of those experiences. I will forever be grateful of the emotional support I received from my family, the group, my trainers and the inner voice that encouraged me to persevere during the darkest hours. Now as I look back I can gladly and boldly say indeed I am more than a conqueror. I am grateful of my training experience for I became a better person. I have regained my confidence and believe without any doubt that I have been thoroughly trained and equipped to deal with any stumbling block that might come my way on this amazing journey.

1.1 MOTIVATION FOR THE STUDY

The above description of my experiences in the clinical psychology training context highlights the journey in which trainees in clinical psychology probably undertake. Consequently, my subjective experiences during my first block of training are what evoked the motivation of this study.

Facing up to the mission that seems impossible is the most challenging task trainee therapists undertake. Training as a psychotherapist is widely known to be an arduous process (Karter, 2002 & Ernst, 2008). According to Orlinsky, Botermans and Ronnestad (2001) trainee therapists around the world, from a variety of theoretical orientations feel overwhelmed in the early stages of their careers. Furthermore, Bosman (2004) stated that training to become a psychotherapist is a journey filled with new experiences and opportunities for personal

growth. The journey is often experienced by trainees as a rollercoaster ride, at times it is filled with excitement and at other times it can be exhausting and very stressful. If training is effective, trainees will most likely undergo personal changes in the process of becoming effective psychotherapists (Fiedelay, Freedheim & Overholser, 1998). These personal changes further affect their interactional style and patterns of behaviour significantly (Bosman, 2004).

According to Bor and Watts (1999) trainees' experiences are unique to each trainee. In contrast, studies suggests that trainees encounter similar challenges and that factors such as being in a new environment, supervision, learning new language, skills and creating a professional identity appear to generate a great deal of anxiety and frustration in trainee therapist (Skovholt, 2001; Orlinsky, Botermans & Ronnestad 2001)). Kottler and Swartz (2004) argued that clinical psychology training programs demand of the trainees a fundamental level of personal engagement with the process, including self questioning, psychotherapy and self disclosure within peer and supervisory settings.

Training to become a clinical psychologist therefore entails more than simply the acquisition of knowledge, skills and experience; it asks for a shift in identity. Trainees undergo a qualitative change in their activity, their attitudes, their perception, and the logic implied in their reasoning. They start to deal with sequences of behaviour more than with isolated units; they analyse symptoms not only in terms of the system of organs involved but also in terms of their effects on others (Bosman, 2004). Trainees also gain self awareness in their interactions. Consequently, Karter (2002) likened the process of training as a therapist to a form of personal deconstruction, followed by a process which involves building a new way of thinking and being.

While research has examined the psychological adaptation and emotional experiences of practicing clinical psychologists, little research has examined the subjective emotional experiences of trainee psychologists specifically during their first block or early stages of training. Formal research into this aspect is necessary in order to base a comprehensive and scientifically founded programme on the results in assisting trainees deal with emotions experienced during their early stages of training.

1.2 AIMS AND OBJECTIVES OF THE STUDY

The current study sought to explore the subjective emotional experiences of the Msc-1 trainee clinical psychologists at the University of Limpopo (Medunsa Campus) during their first block of training with the following objectives:

a) To explore the subjective emotional experiences of trainees during their first block of training within the training context;

b) To explore whether trainees experience these emotions even outside the training context; and

c) To explore how trainees deal with such emotional experiences.

Results from this study should provide useful information and possible intervention if necessary to the trainers and trainees of the above mentioned institution. Furthermore, exploring these subjective emotional experiences is believed as one way of helping trainees to be aware of such emotional experiences and learn how to handle them whilst growing in the process.

1.3 OVERVIEW OF THE RESEARCH METHODOLOGY

In this study trainees' subjective emotional experiences were explored qualitatively through in-depth interviews. The sample size consisted of five volunteered candidates of the 2011 masters' programme in clinical psychology at the University of Limpopo (Medunsa Campus). The researcher used an interview guide which provided a list of questions to be explored during an interview in which the researcher was able to explore, probe and ask questions that will illuminate that particular subject. Data recorded was transcribed verbatim into written text. These transcriptions were presented to two independent clinical psychologists to obtain their clinical observations and comments regarding the subjective emotional experiences of Msc1- trainees in clinical psychology at the University of Limpopo (Medunsa Campus) during their first block of training.

1.4 DEFINITION OF KEY CONCEPTS

The following concepts are considered central and key in this study. These concepts will further be advanced in chapter two. A brief definition of each follows:

Training – a process in order to change human being attitude, knowledge, skills and behavior (Dlamini, 2005). Training can also be defined as a systematic instruction in exercise in some art, profession or occupation with a view of it (Oxford Dictionary, 2008).

Trainee – a person undergoing training for a particular profession (Oxford Dictionary, 2008).

Psychotherapy – an intentional interpersonal relationship used by trained psychotherapist to aid a client or patient in problems of living. It aims to increase the individual's sense of their own well being and to ameliorate the distress in malfunction, cognitive function and behavioural function (Woody & Robertson, 1997).

Psychotherapist – a therapist who deals with mental and emotional disorders. He or she interacts with clients or patients to initiate change in their thoughts, feelings and behavior through adaptation (Corsini & Wedding, 2008). In this study the terms psychotherapist, clinical psychologist and clinician will be used interchangeably.

Context – the whole situation, the background or the environment in which communication occurs (Watzlawick, Beavan & Jackson in Vorster, 2003).

Training context - the environment in which training takes place.

1.5 CHAPTER OVERVIEW

With the above aims and objectives of the study in mind the author proceeds as follow:

- Chapter two sets a context about clinical psychology training and profession by looking into the socio-political context of mental health care in South Africa. The challenges facing clinical psychology training are outlined and the journey a trainee clinical psychologist undertake is documented;
- Chapter three contextualizes training by looking at the theoretical aspects of training during the first block at the University of Limpopo (Medunsa Campus);
- Chapter four presents the appropriate research methodology. The research study is described in terms of the research process, the sample and data analysis;
- Chapter five presents a qualitative analysis of data and the main themes emerging from the results; and
- In chapter six, discussion and integration of the current study is presented. This is followed by the strengths and limitations of the study and making future recommendations.

CHAPTER TWO

THE JOURNEY OF A PSYCHOTHERAPIST

2.1. INTRODUCTION

William Shakespeare once wrote in King John (1564:II.i) 'courage mounteth with occasion' highlighting the well-established phenomenon that human beings when faced with the threat of present danger are often able to reach inside themselves to access hitherto unrecognised and untapped sources of bravery and resilience. A student usually enters psychotherapy training with a strong desire to become a psychotherapist in his or her own right. However, this desire co-exists with a fear of change that might be demanded by certain facets of the training programme. Thus, although the student may be sincere in his or her desire to become a therapist, real change may seem too threatening.

This chapter aims at providing a complete road map of the training process and trainee's journey on becoming a clinical psychologist or a psychotherapist. The socio-political context of mental health care in South Africa and the challenges facing clinical psychology training are outlined. This will be followed by the formal processes of becoming a clinical psychologist in South Africa in which the role of a clinical psychologist as well as formal requirements for selection and admission are highlighted. The significant aspects with reference to the intensity of training and the training context are sketched and lastly, the implications of training on the trainee therapist are documented.

2.2. THE SOCIO-POLITICAL CONTEXT OF MENTAL HEALTH CARE IN SOUTH AFRICA

According to Seedat, MacKenzie and Stevens (2004) any discussion pertaining health care and more specifically mental health care in South Africa must take into account the socio-political and economic context of the Apartheid past. Having said that, it should be expected that the history of psychology in South Africa would be an interesting one considering that H.F. Verwoerd; the former president of South Africa during the apartheid era was himself a psychologist. He was known as the architect of Apartheid. This was due to his influence on the implementation of various apartheid acts and how he strengthened his hold on the black majority of the country by enacting various pass laws limiting education and employment opportunities for non-whites (Ahmed & Pillay, 2004).

Bhana (2007) states that during the apartheid era, blacks were labeled as lazy, unintelligent though physically capable people who lived in crime, poverty and socially deteriorated conditions. According to him, they did so because of their genetically based limited mental capacities, as a result, proper education was denied to blacks. To reinforce this, psychologist M.L. Fick went on to invent an intelligent test of colour castes on how their educational abilities were limited (www.mental-healthabuse.org). Additionally, the Psychological Society of South Africa (PSYSSA) admitted that psychological studies had been deliberately aimed at discrediting blacks as intellectually inferior (Bhana, 2007). Surprisingly; even today, in the post-apartheid era this kind of mentality still exists.

According to Seedat *et al* (2004) and World Health Organisation (WHO) report (1977 & 1981) racism was present in mental health institutions. Based on an investigation that was held by the World Health Organisation (WHO) in 1977 on patient's care in mental health institutions, there were allegations of unexplained patient's deaths in which the most

shocking finding was the high number of needless deaths among black patients in Smith Mitchell facilities. When Apartheid ended in 1994 an inquiry by the health ministry was made into malpractice and racism in mental health institutions. Shockingly, the inquiry found gross patient abuse, falsified death certificates and general mistreatment of black patients (www.mental-healthabuse.org). From the above, it is evident that South African psychotherapeutic services have a history of widespread disparity and brutal discrimination towards a certain group of people, particularly blacks.

Racism was not only experienced in mental health institutions but also in the training of black clinical psychologists. At the height of the political turmoil in South Africa in 1976, only 238, mainly white clinical psychologists had been trained in South Africa (Seedat *et al.,* 2004). At that time the South African population consisted of 26.1 million people. As a consequence of discrimination embedded in the Industrial Conciliation Act No.28 of 1956 and the University Amendment Act No.83 of 1983 of the Apartheid regime; there is a resultant longstanding history of a shortage of psychotherapeutic services and trained psychotherapists within the South African black population (Seedat *et al.,* 2004). Thus, according to Painter & Terre Blanche (2004) psychology made its professional niche in South Africa by investing its intellectual capital in support of an explicitly racist and capitalist political system (Bhana, 2007). This relates to the numerous silences around apartheid policies and practices as well as issues of race, gender and class and how these factors relate to poverty, power, inequality and exploitation (Ahmed & Pillay, 2004).

MacLeod (2004) postulates that during the 1980's psychologists began a debate which has now become the 'relevance debate'. In that debate, psychology in South Africa was said to be in a crisis centre on theoretical relevance and the appropriateness of its practice (Seedat *et al.,* 2004). Various criticisms were leveled against psychology. Psychology was criticized for ignoring the relationship between the individual and the society in which they live, not

criticizing the ideology which they worked under; causing an active or inadvertent support for apartheid, ignoring issues of the working class, maintaining the inequality in service provision and lacking theory to deal with change (MacLeod, 2004). Psychologists dispensed advice to people who sought their help without contextualizing these choices and psychologists ignored the socio-political influences on their clients' lives (Seedat *et al.*, 2004).

The history of psychology in South Africa is therefore aligned with the political history of this country. The following quote illustrates two ways in which psychology aligned itself with apartheid and apartheid policies. According to Bhana (2007:379): "Psychology's response to these problems fell far short of being progressive. In both its active advocacy for apartheid policies based on "results" of mental testing and it's apparent scientific neutrality with regard to matters of discrimination and social inequality".

However, according to Painter & Terre Blanche (2004) not all psychologists in South Africa were guilty of actively or passively supporting apartheid. They argue that in the 1980s, progressive white psychologists and an ever-increasing number of black psychologists began establishing alternate agendas for research and practice. Not only did these psychologists try to address the political crisis looming in South Africa but also attempted to open the political unconscious of the discipline. Instead of helping people to adapt to the adverse conditions that they were living under, psychology needed to help them to change these structures because the political conditions which were at play during apartheid was likely to influence the mental health of the oppressed.

From the rich history of psychology and its alignment with politics in South Africa, it becomes evident that there have been many changes in mental health care and profession since 1994. This is the year in which the new Democratic Republic of South Africa was

established. Black leadership emerged in various governmental structures and in both the Psychological Society of South Africa and in the editorship of the South African Journals of Psychology (SAJP). Before 1994, black authors contributed only 1.4% to 5.1% of articles in major South African journals (Seedat *et al.,* 2004). This jumped to 22% between 1994 and 2003 (Duncan, van Niekerk & Townsend, 2004). Black psychologists were severely under-represented in academia and professional psychology. Until the early 1990s, less than 10% of all registered psychologists in South Africa were Black. Moreover, this number has also increased since 1994, with black psychologists now making up 18% of all registered psychologists (Duncan *et al.,* 2004).

Furthermore, according to The Health Professional Council of South Africa (HPCSA) the first clinical psychologist was registered in 1956 (Pillay & Kramers, 2003). In 2003, there were 1734 registered clinical psychologists in South Africa, this means that there was one psychologist to every 23 000 people. The majority of these psychologists were white who worked and based in the private sector. It is important to note that the private sector provides care to only 23% of the population (Pillay & Kramers, 2003). It is clear that the needs of this minority are different from the vast majority. This gives rise to the need for a psychology that will consider the conditions under which the majority of people live.

Wilson (1999) showed that the ratio of psychologists to the South African population is 1:13996. The supply of professionals is less than the demand and this demand only grows as populations increase. The majority of people in South Africa do not have access to formal psychological services and those who do are likely to receive help from someone who does not speak their language (Ahmed & Pillay, 2004). According to Ahmed and Pillay (2004) these shocking figures contribute to the short duration of therapy in hospitals and clinics, averaging at just two sessions.

More recently, Statistics South Africa (2010) reports that there is a population of over 40 million in South Africa, with black people making up 79.3% of this number. Added to this, 40% of the South African population is living in poverty and 22, 7% of the total population is unemployed (Statistics South Africa, 2010). Poverty is linked to all facets of a person's well being, including their mental health. Poverty has been shown to be linked to many aspects such as violence and HIV/Aids; aspects which require the intervention of a psychologist (Ahmed & Pillay, 2004). Furthermore, only 16.2% of the total population has some form of health insurance or medical aid (Ahmed & Pillay, 2004). It is unfortunate that psychology is biased towards helping the well resourced sector of the South African population. The vast members of the South African population to date who are the most vulnerable, still do not receive mental health care.

The statistics presented above suggest that the number of registered psychologists specifically black psychologists in South African increase at a snail's pace. To date, many psychologists are white, middle class males who focus on individual interventions; these factors make the practice of psychology inappropriate for many South Africans (Fryer, 2008; Naidoo, 2000). There has been a change in the gender bias of psychology, with twice as many women as men have registered as psychologists since the late 1990's (Richter & Griesel, in Fryer, 2008). This shift occurred in other countries earlier than in South Africa. Added to this disconnection, many mental health service providers are situated in urban areas (Naidoo, 2000).

Mental health is therefore a major public health issue in South Africa. According to Seedat *et al* (2004) recent years have seen an increase in the demand for services from clinical psychologists in the corporate world, in private practice and in hospitals and clinics. Like with many other professions, there is a huge shortage of clinical psychologists in South Africa particularly blacks. To reinforce this, the World Health Organization has drawn

attention to the growing prevalence of mental disorders, which accounts for 12% of the global burden of disease. It is expected that by 2020, depression will be the second most disabling health condition in the world (South African Society for Clinical Psychology, 2011). Psychological conditions that are left untreated often result in severe secondary conditions that take a long time to treat. The role of the clinical psychologist in South Africa is thus significant.

Within the discussion, a question may arise as to how come a shortage of clinical psychologists? In attempting to address this question: Louw (2002) stipulates that there is no shortage of students wanting to study psychology in South Africa, with about one in five university students taking a psychology course. A study by Wilson *et al.,* (1998) showed that 8% of the total student enrolments in tertiary studies are psychology first year students. However, the article providing these statistics does not distinguish between those students who take psychology with the hope to pursue a post-graduate career in the field and those who take psychology as a 'filler course' in order to gain enough credits to complete their undergraduate degree. The difficulty might arise in the highly competitive selection and admission process into the masters' course in psychology and the limited number of students accepted at post-graduate due to the intensity of the programme.

Qualitative studies have explored factors that influence black minority ethnic individuals' decisions about pursuing clinical psychology training (Helm, 2002; Baker & Meredith, 2007). The findings suggest that these include uncertain and low paid route into the profession, the community's perception that it has relatively low status in comparison to other professions e.g. medicine, fear of going against the family, and its' 'whiteness'. Factors considered in making the decision to choose clinical psychology include diversity within the course; course philosophy; worthy employment prospects and developing culturally relevant services (Eagle, 2005).

It is worth to reiterate at this point that improvements have been made in addressing mental health issues affecting South African population and profession. Therefore, it is without any doubt that psychology has played a significant role in South Africa's transformation process of post-apartheid (Franchi & Swartz, 2003). The fact that psychology in South Africa has followed the socio-historical context closely has had implications for the contemporary development of the discipline (Stevens, 2002). Since the end of apartheid, there has been a move towards changing the training of psychologists to be more responsive to the mental health needs of the country (Seedat, 2001).

Currently, a variety of health care professionals from various disciplines within the South African context provide its people with mental health care facilities. These includes social workers, mental health workers, clinical and counseling psychologist, psychiatric nurses, psychiatrists, community health personnel, mental health counselors and student volunteers in mental health (Terre Blanche & Durrheim, 1999). Though the number of mental health professionals is not enough to cover the needs of South African population, these measures can be seen as a process. Thus, transforming mental health care process in South Africa will not be an event. It will be a long, challenging and arduous process.

In addition, improvements in addressing the past have been noticed with the abolishment of apartheid a more racially integrated psychological profession was seen to emerge and with the Psychological Society of South Africa being formed in 1994. The formation of the society was accompanied by changes in the curricula of Psychology Departments across South Africa (de la Rey & Ipser, 2004). Kottler and Swartz (2004) highlight the considerable progress that has been made in developing clinical psychology training programmes that are specifically suited to the South African context, noting that "a thorough appreciation of the particular

challenges facing South African practitioners" (Kottler & Swartz, 2004:57) is increasingly a focus of this training. This is supported by De la Rey and Ipser (2004:545) who point out that, currently in South Africa, "almost all professional psychology training programmes in clinical and counseling psychology have a community component" which is seen as a huge development from previous programmes during the apartheid years. Ahmed and Pillay (2004), however, still question the extent to which the recognized competencies, and the training programmes developed around them, prepare trainee psychologists to work in the current South African context. They suggest that there is a lack of focus on short term and systemic therapeutic modalities, as well as a continuing deficiency in preventative, community based psychological interventions.

Impressively, in addressing the past, the National Department of Health is currently attempting to address the shortage of psychological services with particular to the historically black rural areas by introducing compulsory community service for clinical psychologists as from 2003 (www.doh.gov.za). The question is: are clinical psychology graduates willing to work in the context of diversity and disadvantages and are they willing to learn to speak African languages?

From what has been presented above, it is beyond reasonable doubt that the field of clinical psychology in South Africa is still faced with a lot of challenges. The main challenges thus far is for training institutions to train more black psychologists who will cater for South African's needs and to address challenges such as issues of equality, racism and its consequences, development a relevant policy and curriculum appropriate to the South African context (Seedat, 2001). This should therefore be a joined venture in which the government, training institutions and private sectors join hands and play an integral part in improving challenges facing mental health care and profession in South Africa. Furthermore, given that psychology has a relationship with the context it finds itself in, a further challenge is for the

discipline to generate knowledge around the socio-political concerns of South Africa and contribute to the overcoming of inequalities and diffractions of society, along with the psychological issues which accompany these (MacLeod, 2004).

The author acknowledges the progress made in the mental health discipline specifically clinical psychology since the end of Apartheid in 1994; however, it is beyond reasonable doubt that there are still issues of discomfort that pose a challenge to clinical psychology training and profession. Hopefully this study will create a context in which such issues are dealt with. A discussion on some of these issues will be zoomed at below:

2.2.1. The Relevance of the Training Programme

Central themes that have posed challenges in the training of clinical psychology has been that of cultural sensitivity, fairness, appropriateness, embeddedness or the overcoming of cultural bias. Be it in selection procedures, theoretical models, assessment practices, supervisory relationships and/or practicum experiences. Trainers have been compelled to examine and critique existing practices in terms of possible cultural assumptions and biases. While few would question the laudable pursuit of cultural sensitivity in clinical psychology training, attempting to engage with this imperative becomes much more complex in execution. Similar concerns about the difficulties of applying desirable theoretical models in practice are identified in a text on engaging with cultural differences in liberal democracies (Shedder, Minow & Rose, 2002).

According to Perkel (1988) during the 1980's the central critiques of clinical training and practice constellated around notions of "relevance". Such arguments were captured in a range of papers published in Psychology In Society (PINS) including those by Dawes (1985), Anonymous (1986), and Perkel (1988). Dawes (1998) suggests that the "relevance"

arguments pertain to the utilitarian value of clinical psychology in Africa and South Africa, challenging the discipline at this level rather than in terms of overarching theoretical orientation. The relevance debates reflected a concern with the importation of what was generally referred to as Eurocentric or Western theories and models of training that were perceived inappropriate for the South African context.

Sue (2001) argues that the predominantly individuocentric orientation and reliance on the medical model are seen to significantly limit clinical psychology's scope of practice. The individuocentric orientation steers the discipline away from primary prevention and the consideration of social determinants of psychopathology. Therefore, according to Sue (2001) clinical psychology is perceived to be ineffective in the public and political environment, essentially constraining the disciplines involvement public and political policy formulation on a macro level.

As a result, psychological theories continue to be critically evaluated. The use of traditional theories in professional training is geared towards developing mono-cultural clinical competence. According to Sue (2001) trainees not exposed to different worldviews enter the field ill equipped to effectively work in multicultural contexts, giving credence to criticism by multicultural specialities of inadequate, inefficient and even dangerous service delivery by mental health professionals. Indeed clinical psychology has been criticised since its arrival in the past World War II period, described as "the beginning of disaster" (Sarason, in Holdstock, 2009:93) and continues to be attached by the world of its inappropriateness and effectiveness.

In addressing the limitations of clinical psychology training, it has been suggested that the discipline must reflect on the theoretical paradigms that support its individuocentric, patriarchal orientations. Furthermore, clinicians must problematise the reactive nature of their discipline, reflect on the limitations to working creatively and the potential for broader application of the discipline with regard to promoting human welfare (Eagle, 2005; Callaghan, 2006).

The field of counselling psychology is applauded for its contribution in addressing issues challenging training of psychologists and profession. It appears that the field of counselling psychology has ardently engaged with and responded to contemporary training needs, responding to calls for transformation. D'Andrea (2005) argues that counselling psychology has been pivotal in transforming psychology. According to him, counselling psychology has attempted to liberate the profession from what has been described as "intellectual incarceration" (D'Andrea, 2005:524). Counselling psychologists have successfully lobbied for the implementation of more culturally responsive research methods, clinical practices and professional training strategies. They have further contributed to the American Psychological Association's (APA) guidelines for psychologists in 2003 which considered as a landmark in the history of psychology (D'Andrea, 2005). A challenge is for clinical psychologists to be actively involved in area of research, policy development and implementation on issues affecting training of clinical psychologists.

Another pathway that emerged to address the relevance question was the integration of community psychology premises and orientations into clinical training. In the early 1990s Eagle and Malcolm (1991) conducted a survey of South African clinical training programmes focusing on the degree to which they incorporated aspects of community psychology, arguing

that this was a potential solution to some of the debates about relevance and economies of scale of service delivery. Many training courses continue to attempt to straddle aspects of both clinical and community theory and practice, with varying degrees of success (D'Andrea, 2005). Training institutions need to therefore constantly evaluate their programmes and to ensure that it caters for the needs of the context it finds itself in.

2.2.2 Race and Clinical Psychology Training in South Africa

The question of diversity and how to address it in the professional training of clinical psychologists is of concern in South Africa and elsewhere (Swartz, 1998; Suffla, Stevens & Seedat, 2001). According to Nicholas (1993) South African notorious socio-political system of white domination has largely dictated the contexts in which all professional bodies have operated. In keeping with political mores at the time, the professional body of psychology in the apartheid era espoused white racist society's normative standards.

According to Shah (2010) racism is the product of historical, locally prescribed ways of seeing, thinking and talking in which some people lay claim to dominance over others, hence setting themselves up in a position of power over them. Thus 'racial' categories are reified to reflect power relations between groups and racism is used to preserve the socio-historically constructed 'race' hierarchy. Consequently, in considering the brutal history of psychology in South Africa, it is not surprising that Shah (2010) argues that racism is activated in the training context from the selection process to the actual training process. This is because of the power differentials related to being a trainee and also belonging to a minority group.

The issue of race in South African clinical training is reflected in the professional board directives about selection and admission of candidates into programmes. As stipulated by the Health Professional Council of South Africa (HPCSA) from 2004 all programmes are expected to aim to ensure that at least 50% of any class is black. Although often spoke of in terms of contributing to diversity, this target quota is also clearly about redress and puts issues of race squarely on the agenda. However, it raises debates about what constitutes black, whether people of African origin who speak African languages should be given preference, and how to deal with black applicants who may not be South African citizens (Sue, 2010).

According to Seedat (2004) each university seems to engage with these issues differently, although those that emphasize diversity as enriching clinical training programmes may understand "black" more broadly and may invoke notions of cultural difference and breadth to justify selection choices. One would thus argue that selection process and admission in the Masters course in clinical psychology is biased in terms of implementing to what the HPCSA stipulates. This might be due to the lack of clarification in what defines being 'black'.

Racism within the context of training has been experienced by black trainees on different levels. For instance, Adetimole (2005) reported that black clinical psychology trainees felt a lack of acknowledgement of positive aspects of difference and faced assumptions about the inferiority of black trainees. They reflected on the challenge in talking about these experiences due to the fear of being 'pathologised as draconian, extreme or without foundation', experiencing the micro nature of insidious racism as 'much more disempowering than its overt form' (Adetimole, 2005:11) .

Watson's (2006) review of black trainees uncovered examples of personal and institutionalised racism operating in the training context. Recollecting their training

experience, black trainees reported feeling scapegoated, judged as incompetent, being stereotypically and negatively labeled. They also described feeling excluded, discounted, misunderstood, at times highly visible and at times invisible, and powerless. Rajan and Shaw (2008) reports that there is a lack of consideration given to black trainee clinical psychologists' fears about racism and 'speaking out', by those responsible for providing training. Thus, there are a number of ways in which personal and institutional racism can manifest within training.

Stevens (2001), in his commentary on racism and cultural imperialism in the training of black clinical psychologists in South Africa, argues that black trainee clinical psychologists entering a predominantly white profession, in which Eurocentric and individualistic models of understanding psychological distress dominate, are faced with possible dilemmas and conflict if their personal values are discordant with those underlying the academic teaching on the course. Eurocentrism is reflected in the general tendency of white western groups in Britain to assume that western values, practices and norms are validated over and above those of non-dominant cultures (Patel et al., 2000). According to Shah (2010) as long as the western worldview is privileged, other worldviews will be devalued and may even be thought of as primitive or underdeveloped in comparison. Furthermore, incongruence between the world view of black trainee clinical psychologist and that of the profession can create confusion and ambiguity around personal, social and occupational identities (Stevens, 2001).

Stevens (2001) argues that black trainees are further exposed to the double-bind of either being alienated by the institutions if they reject these models, or being alienated from their own experiences and communities if they accept them. For example, in the UK, Rajan and Shaw (2008) have shown that UK based trainee clinical psychologists expressed concerns about an ethnocentric approach in teaching and the general course philosophy, and

experienced dilemmas about resisting and being critical of dominant ideologies due to a fear of standing out, being labeled and misunderstood. In addition, Burman, Gowrisunkur and Sangha (1996), discuss how as a black practitioner it may be difficult to view mental health models and frameworks through a critical lens, as conformity to a white norm may have been a way of surviving white-oriented training.

On another level, Utsey, Gernat and Hammar (2005) state that the shifting and transforming of the thinking of patterns of white trainee psychologist is an area pertinent to multiculturalism. They argue that the challenge with engaging white psychologists and white trainees in discussions about race has to do with the manifest difficulties experienced by psychologists and trainees when expected to engage with race related topics. Research findings by D'Andrea and Daniels (2005) suggest that generalised apathy as well as anxiety and anger are experienced by white participants when asked to engage with racial topics. There is a general avoidance in talking about race as white trainees reportedly feel guilty about the perceived complicity with oppression.

According to Gray (1999); Sashidharan and Francis (1993) exposure to racism within the context of training can lead to devastating psychological consequences such as feelings of powerlessness, helplessness, rejection, loss, depression and hopelessness. Taylor (1999) also postulates that daily experiences of covert racism which have built up can compromise psychological wellbeing.

Thomas (1992) states that racism can affect relationships between black people and also how they see themselves, in that they may feel mistrustful of and resent other black people who are seen to be seeking to behave or to be 'white', and those who deny that racism exists and

instead promote a benevolent and non-critical view of British society. Moreover, they may come to have lower expectations of and aspirations for themselves, their family members and those from their communities.

The above can be explained by the concept of internalised 'racial' oppression (Lorde, 1984; Lipsky, 1987; Akbar, 1996; Alleyne, 2004). Alleyne (2004:7) defines it as "the process of absorbing the values and beliefs of the oppressor and coming to believe all or some of the stereotypes and misinformation". Thus internalized 'racial' oppression leads to low self-esteem, self-hate, and the disowning of one's ethnic heritage.

In his study on the experience of being a trainee clinical psychologist from a black and minority ethnic group, Shah (2010) listed below some ideas for recommendations:

- Courses need to explicitly state their commitment to supporting trainees from blacks groups with regards to their experiences of 'race', ethnicity and culture;
- Emphasis should be placed on personal and professional development including work on privilege, social disadvantage, racism and the psychological impact of racism. This could incorporate experiential workshops around issues of difference and diversity;
- Programmes should also undertake a commitment to training the course staff in relation to 'race' issues in context of training, e.g. power relations, experience of racism and a minority, issues in groups, and using reflective and reflexive practice on these issues. Placement supervisors should receive training specifically on the importance of raising these issues in supervision;

- As Pewewardy (2004) points out, white therapists need to take the responsibility to do their own thinking when it comes to issues around 'race' and culture. Courses need to support white trainees to work on risk taking and deconstructing 'whiteness';
- While many black trainees found comfort and safety with other black trainees, they were reluctant to only share the cultural aspects of themselves with them. Some expressed a desire to have an open-to-all group for reflecting on diversity issues as a way of finding connections with white trainees, which would help black trainees to feel safe in bringing up issues around race and culture, and their own personal experiences;
- Black trainees' racial /cultural identities should be acknowledged and reflected on in the context of therapeutic work and professional identity and
- Programmes should place importance on systemic training, as these approaches pay attention to issues of power and the social context. This could potentially help enhance perspectives of majority trainees.

The APA document (2003) on 'Guidelines on multicultural education, training, research and practice for psychologists' offers the following guidelines:

- Guideline 1: Psychologists are encouraged to recognised that, as cultural being, they may hold attitudes and beliefs that can detrimentally influence their perceptions of interactions with individuals who are ethnically and racially different from themselves;
- Guideline 2: Psychologists are encouraged to recognise the importance of multicultural sensitivity to, knowledge of, and understanding about ethnically and racially different individuals and;

- Guideline 3: As educators, psychologists are encouraged to employ constructs of multiculturalism and diversity in psychological education;

The discussion above suggests that the field of clinical psychology in particular training of clinical psychologist still has a lot of controversial issues that poses a huge challenge to the profession. Recommendations have been made based on previous studies. The implementation of such suggestions is vital in ensuring training that is effective and appropriate towards to the needs of the South African population. The role of a psychologist is thus fundamental in shaping the society that is non discriminatory. The journey that one undertakes to become a clinical psychologist is discussed next.

2.3. THE CLINICAL PSYCHOLOGIST

The Health Professional Council of South Africa (2007) describes the clinical psychologist as someone who assess, diagnose and intervene in order to alleviate or contain relatively serious forms of psychological distress and psychopathology, or what is commonly referred to as abnormal behaviour. Furthermore, the American Psychological Association (2001) stipulates that the clinical psychologist concentrates on the intellectual, emotional, biological, psychological, social, and behavioural aspects of human performance throughout a person's life, across varying cultures and socio-economic levels.

According to Kubie (2000) the clinical psychologist, often referred to as a psychotherapist or a clinician, performs several functions depending partly on his/her previous training, background, and partly on his/her special interests. The clinical psychologist is flexible in his/her role repertoire in that he/she can act as a psychotherapist for people experiencing psychological distress or for individuals suffering from chronic psychiatric disorders, work with a wide variety of populations, work with specific groups like children, the elderly, or

those with specific mental disorders. He/she may be found in hospitals, community health centers or private practice in which he/she applies different theories and treatment.

Corsini and Wedding (2008) postulate that the clinical psychologist' primary role is to conduct psychotherapy. Their view is supported by Phares (1992) who regards psychotherapy as the activity that most frequently engages the clinician's efforts and to which the most time is devoted. Corsini & Wedding (2008) define psychotherapy as a formal process of interaction between two parties, each party usually consisting of one person but with the possibility that there may be two or more people in each party. This is for the purpose of amelioration of distress in one of the two parties relative to any or all of the following areas of disability or malfunction; cognitive functions, affective functions or behavioural functions.

Additional to the definition of psychotherapy, Reber (1995) points out that psychotherapy is an inclusive term that refers to the use of absolutely any technique or procedure that has palliative or curative effects upon any mental, emotional or behavioural disorder. Psychotherapy is often used in its shorten form 'therapy' and is generally associated with clinical psychology. Thus, the term 'psychotherapist' is a broad term and generally refers to a person trained to practice psychotherapy.

Vorster (2003) defines psychotherapy as a fascinating subject. According to him, it is a subject that posses a unique challenge to human intelligence, knowledge and creativity. This is particularly so because a mind that sets out to gain knowledge about the functioning of a particular species should be in an advantageous position of operating from a higher level of logic than the level on which the particular species that is being studied. This higher logical level of functioning is a prerequisite to gaining full and comprehensive knowledge about the subject being studies. Thus, in his or her attempt to understand human functioning and human behaviour, the social scientist is bound by the limits of his or her frame of reference, in this

case human frame of reference. It immediately becomes clear that the human being, in attempting to study him or herself, should very carefully and deliberately build in certain measures or 'safeguards' in an attempt to compensate for the relatively limited frame of reference from which this endeavour operates.

The Professional Board for Psychology (2007) stipulates the following responsibilities assigned to the role of a clinical psychologist:

2.3.1 Scope of Practice

Clinical psychologists assess, diagnose and implement psychological interventions to assist people with life challenges, particularly those with relatively serious forms of psychological distress and/psychopathology.

2.3.1.1 Psychological Assessment

a) Perform assessments of cognitive, personality, emotional and neuropsychological functions in relatively serious forms of psychological distress or psychopathology;

b) Identify psychopathology in a broad range of psychiatric disorders;

c) Identify and diagnose a broad range of psychiatric disorders;

2.3.1.2 Psychological Intervention

a) Apply psychological interventions to people with psychiatric conditions;

b) Policy Development and Programme Design;

c) Advice on the development of applicable to a variety of sectors and issues, based on various aspects of psychological theory and research;

d) Design, manage and evaluate programmes dealing with psychiatric problems in diverse settings;

2.3.1.3 Training and Supervision Roles

a) Train and supervise other registered psychological practitioners in clinical psychology;

2.3.1.4 Ethics and Legislations

a) Have a thorough knowledge of the code of professional Board;

b) Conduct psychological practice and research in accordance with guidelines for professional practice of the HPCSA and the Professional Board of Psychology;

c) Have the knowledge of relevant legislative frameworks which impact on psychological practice and research;

d) Conduct research and practice in accordance with these legislative parameters;

2.3.1.5 Professional Practice

a) Refer to appropriate professionals for further assessment or intervention;

b) Adherence to scope of practice;

2.3.1.6 Research

a) Design, manage, conduct, research, report and supervise psychological research and implement findings in policy and practice, especially in relation to psychological conditions in diverse contexts;

2.3.1.7 Education and Training Guidelines

a) Complete a programme in clinical psychology at NQF levels 7-9 (Bachelors, Honours and Masters programme) at an accredited education and training institution.

From the above definitions, descriptions and the role of a clinical psychologist, one could therefore describe him/her in general as someone who is flexible in his/her role repertoire and importantly, who facilitates the healing process for someone in need for therapy. Thus, Goldberg (1986), describes a clinical psychologist as a healer who has been called to serve and guide others in their requisite voyages and to understand the nature of suffering. In order to achieve this, one needs to go through the process of training.

2.3.2 Requirements for Training

Admission to a Master degree in clinical psychology requires an Honours degree in psychology. A Master degree in clinical psychology may take several forms, including a Master of Arts, Master of Social Science or Master of Science depending on the institution. The minimum duration of the Master program is two years in which the first year concentrates on clinical training and trainees are required by the Health Professional Council of South Africa to complete a research project usually in a form of a dissertation, the second year focuses on an internship program with a metal health institution under supervision. It takes a total of six to seven years of formal full-time study to become a clinical psychologist in South Africa which includes theory, practicum, clinical training, research and internship. Once the student has met the above mentioned necessary requirements; the most daunting process follows which is the selection.

2.3.3 Admission and Selection

As it has been true over the years that gaining admission to a clinical psychology programme is almost always more competitive than gaining admission to other training programmes for other psychological specialties, for that matter, the admission standards for clinical psychology, some would argue are often more exacting than the admission standards applied in other mental health disciplines (Wood & Robertson, 1997). It is a complex, labour intensive and financially expensive process for students. Trainers and faculty members also find the admission procedure to be demanding and frustrating. For an example, Wood and Robertson (1997:154) mentioned that one clinical director pointed at a pile of applications saying " I have about 700 applications here, with 75 percent appearing perfect in paper, and we are only going to select 12 of them, how can I make recommendations that are based on objective data?". Therefore, it is clear that most of the applications that are not accepted into the program would have been satisfactory if accepted. It is unfortunate that not everyone would be a clinical psychologist as only a limited number of students ranging from 6 to 12 are selected each year due to the intensity of the programme.

Students who fulfill the basic requirements and apply for entry into clinical psychology undergo selection. Selection criteria differ from university to university and procedures range widely from unstructured interviews, group interviews, role plays and projective tests. Additionally, Woody and Robertson (1997) state that key factors evaluated on how students are selected are based on their intellectual capability and personal suitability such as, self awareness, interpersonal effectiveness, ethical sensitivity, respect of cultural and individual difference, trainees are also expected to demonstrate a commitment to social justice and to improving the quality of life of those with whom they come in contact. This process takes two to five days depending on the institution. Thus, selection process into a master's program

in clinical psychology is experienced by students all over the world as daunting (Goldberg, 1986).

On the contrary, Dryden and Spurling (1989) argue that certain types of people are not suitable for the profession of psychotherapy. They argue that there are individuals who are compulsively self reliant, emotionally defended and others who mimic empathic behaviour who do not fit into the profession. There is however little evidence as to whether such people are harmful to their clients, but the general impressions is that they might be. Mearns (1997) states that training courses find that the single most important reason for rejecting someone is that it is too early in the person's development to have confidence that they could make full use of the intensive training. Therefore, 'readiness' for training is essentially a personal development characteristic.

2.4 CLINICAL PSYCHOLOGY TRAINING

Oxford English Dictionary (2008) defines training as a systematic instruction in exercise in some art, profession or occupation with a view of it. For Synders (1985) training mainly involves four components of action: experimenting with new forms of behaviour, practicing specific ways of working, evaluating such experimenting and receiving feedback. Thus, activities such as role plays, stimulation games, interviews, communication training and non-verbal exercises all constitute training activities.

According to Vorster (in Bosman, 2004) clinical psychology or psychotherapy training is the formal entry into the profession. Masters level in clinical psychology training aims to produce clinical psychologists with a basic knowledge of diagnostic and assessment skills, together with a range of possible psychological interventions informed by a variety of theoretical framework. He describes the aim of the psychotherapy training program as a process that facilitates the trainee, within the limited period of one year, to achieve minimum standards of

therapeutic expertise, so that at the end of one year training, as far as psychotherapy is concerned, trainees could proceed with basic psychotherapy during their internship, preferably under ongoing supervision for at least two years. He further states that the aim is not to produce a completely rounded off psychotherapist after one year, which is not possible, but only to set the ball rolling and to achieve a minimal standard.

Nel (1996) postulates that as much as there is no single way to train effective therapists, there is also no single way to describe clinical psychology or psychotherapy training. Training within the context of psychotherapy can thus be described in different ways. Swart & Wiehahn (in Bosman, 2004) describes such training as a learning context in which trainee therapists learn and develop skills, which could be applied to their therapeutic work. Bor & Watts (1999) defines psychotherapy training as consisting of a mixture of a number of aspects. These include self exploration in a form of personal therapy, supervised work with clients, skill acquisition, understanding theory and carrying out research. Synders (1985) describes psychotherapy training as a set of systematically planned attempts at introducing trainees to a greater complexity and flexibility of thoughts, feelings and behaviour. It is a learning context in which trainee therapists learn and develop skills which could be applied to their therapeutic work, where this learning context also offers opportunities to learn about learning and teaching. In line with the latter definition, Dlamini (2005) argues that in the process of becoming a psychotherapist, there is an element of being trained to train, which influences what takes place in training. In other words, training should be designed in such a way that a trainee also engages in training that allows others, for instance, clients, to be trained.

Additionally, psychotherapy training includes experimenting with new forms of behaviour as well as repeatedly practicing a specific way of thinking and working (Plante, 2005). Trainees may be exposed to different training activities to allow them to increase in their role

repertoire. This implies the ability to work flexibly in different cultural contexts. Actually, to work with human difficulties and possibilities almost inevitably calls for interdisciplinary participation and knowledge of the other views in the field (Dlamini, 2005). Therefore, Vorster (2003) emphasizes that training should be a process that entails increasing effectiveness on a particular skill. Consequently, trainees functioning within any training context will be defined as individuals who participate in the receiving of a particular skill, in which they would demonstrate some proficiency according to the requirements of the given training system at some point.

According to Baloyi (in Dlamini, 2005), training as a psychotherapist presupposes the evaluation of, the giving and receiving of feedback on the training experiments and practical sessions. Dlamini (2005) describes that this entails that trainee therapists are challenged to be critical thinkers during training. This involves developing the ability to evaluate existing and new views and methods and their utility concerning the development of psychotherapy. When evaluation of trainees is done and feedback concerning training is given, trainers may contribute to further developments in training trainee therapists. Consequently, trainee therapists have to be both the therapist and the researcher on training by reflecting on their experiences on training. This advocates for trainees to challenge, construct, reflect and give feedback about any training matters and experiences they encounter. This may in turn enable other researchers, trainers and psychologists to broaden their views and development in training and psychotherapy.

Prentice (2001) emphasizes that trainees in psychotherapy are continuously involved in a cycle of negotiating meanings and rules within their many contexts, whilst at the same time being subjected to constant evaluation and commentary on themselves. Therefore, Bateson (1992) postulates that this learning involves a trial and error process. This means that an

individual's behaviour can be revised, marked as wrong and rectified by trying out other forms of behaviour.

According to Dlamini (2005) within the training context, clinical training is the focus and the intense part of psychotherapy. Aponte and Winter (1990) argue that an intensive learning process is undertaken in order to develop the professional skills and competence of a practitioner. Rogers (1951) further emphasized that the most effective learning occurs experientially in the same type of facilitative environment as the patient-therapist relationship. When experiential learning is used in psychotherapy training, there is a shift from the material being presented, to the individual. Experiential training is essential as it affords trainees the opportunity to discover a greater level of awareness of their own biases and assumptions while concurrently developing their therapeutic or clinical skills, especially those of empathy and sensitivity to the experiences and perceptions of their clients.

Punctuating further, Stoltenberg (1981) conceptualized the training process as a sequence of four identifiable developmental stages. He argued that because trainees develop in a fairly predictable manner over the course of their learning, environments which encourage development through each stage need to be created in training:

- Trainee in stage one typically lacks confidence, depends upon the trainer for concrete advice and direction, imitates the trainer and subscribes to techniques. This is the stage of "unilateral dependence". A training context congruent to this level of trainee's development is one that encourages autonomy while providing structure and support. Trying out new behaviours and risk taking is encouraged. It is at times necessary for a trainer to assume the role of a teacher, to clarify connections between training and therapy and to allow observations of live therapy sessions;

- Trainees in stage two can be described as struggling between dependency and autonomy. There is a constant oscillation between being overly confident in newly acquired skills and being overwhelmed by the increasing responsibility of conducting therapy. This often results in fluctuating motivation. Experimentation with different therapy styles takes place, along with increased occurrences of disagreement with the trainer's approach. At this stage, training becomes more non-directive, the trainer becomes more of a reference source and less of a teacher. Instruction and advice are given in a sensitive manner where necessary;

- In stage three, trainees can be described as showing conditional dependency with increased empathy. A decrease in technique boundedness and counterdependence become evident. There is a marked increase in the trainee's ability to work with a wider variety of clients and to be tolerant of different styles and theoretical viewpoints. The training relationship becomes more of a peer interaction where both individuals gain insight and support from reciprocal sharing and exemplification. At this developmental level, trainees are secured enough to respond to direct confrontation without unnecessary resistance. In addition, trainers are in a position to acknowledge their own weaknesses with less fear of losing trainees respect and attention;

- Trainees in stage four, which is the final stage of trainee's development, develop into "master counselors" in which they feel comfortable in conducting therapy and show high levels of independency.

On another level, Plante (2005) argues that clinical psychology training must change and adapt to a changing world just like any other field of study or practice. It would be foolish for clinical psychology to keep its "head in the sand" and try to resist societal changes. Rather,

clinical psychology must grow and develop based on the issues and concerns of the world at large as well as to changes within the field as new research discoveries and clinical practice strategies emerge. Woody and Robertson (1997) suggest that training programmes must demonstrate knowledge of respect of cultural and individual differences. This criterion is specified insofar as "programmes must develop knowledge and skills in their students relevant to human diversity such as people with handicapping conditions, of differing ages, genders, ethnic, local background, religion, lifestyles and from deferent social and individual background" (APA, 1986:4). It must be stated however, that the rate of implementation of the above criterion has been uneven. Understandably, controversy about this criterion has developed because it does not reflect what has been taking place in society at large.

Finally, one would say that clinical psychology training is a challenging, complex journey that is associated with a number of marked transitions: from student to a trainee and a dissertation writer; from a trainee with no case load to a trainee working clinically with clients, from an intern to a clinical psychologist to serve the community and finally to a qualified registered psychologist ready to practice. Indeed, this is a journey that requires passion, determination and patience. The training context will further determine the effectiveness of the trainee therapist.

2.4.1 The Training Context

Plante (2005) postulates that considerations of training psychotherapists trace a growing awareness that good psychotherapy is influenced by the training context. Peake and Ball (1991) point out that effective psychotherapy training is influenced by the context in which it occurs. Training context seems to have an impact on the trainee in creating either a conducive or non-conducive climate for learning to conduct psychotherapy. Nel (1996) emphasizes the importance of creating learning contexts that promote and facilitate the progressive

emancipation of the trainee therapists until they can successfully separate from the training system. Therefore, according to Nel (1996), the training context may be viewed as an evolving relational system. It is a constant process of change and development, a context that continuously restructure its content including new materials in training and that facilitates the self development of trainees.

On a broader level, Woody and Robertson (1997) suggest that the context in which clinical training occurs must be large enough to offer necessary advisement, teaching and supervision of trainees practice and research, yet it must be small enough to provide requisite mentoring and modeling in which are indispensable for developing clinical, scholarly and research competence, as well as fostering a commitment to the program's training model and identification with the profession. They are of the opinion that psychotherapy training should be facilitated by two experienced trainers in order to complement each other, this view is further supported by Patel (2000) who suggests that trainers need to work in pairs ideally one black and one white to minimize the issues of race often experienced by trainees within the context of training.

According to Binder (1993) trainers should be experienced and productive persons who have a major time and career commitment to the programme so that they can provide effective leadership, modeling, supervision and instruction. The expectation is that trainers are responsible for guiding, evaluating trainees practice and competence. Beyond the normal duties of teaching, research and supervision, trainers are expected to be active as licensed practitioners and to be committed to participation in continuing education.

Bor (1989) showed that trainers should create a context in which training activities facilitate the learning and development of three interrelated sets of skills required by a therapist, namely; perceptual, conceptual and executive skills. Perceptual skills refer to the therapist's

ability to make relevant and accurate observations. Conceptual skills comprise the process of attributing useful meanings to observations, while executive skills pertain to the successful application of previous learning experiences to a current therapeutic situation. According to Bor (1989) these skills are needed to facilitate successful engagements, problem identification, change and termination in the therapeutic contexts. Additionally, Synders (1985) points out that trainers should facilitate the unfolding of a learning context in such a way that increased flexibility and differentiation of all the participants are encouraged. This context specifically promotes the progressive emancipation of trainees until they can successfully separate from the training system.

Within the discussion, the accreditation handbook (1986) states that training programmes must:

- Be clearly and publicly identified labeled as a professional psychology programme;
- Have an identifiable psychology faculty chaired by a senior faculty member who has clear authority and primary responsibility for all aspects of the programme;
- Ensure the breadth of exposure to the field of psychology including practicum, internship, field or laboratory research training;
- Be affiliated with an institution that provides reasonable financial support;
- Have adequate facilities in relation to the educational mission of the institution and the program's training model and goals.

The accreditation handbook (1986) further states that description material furnished to applicants and trainees should cover the program model and goals, the program's theoretical orientation, types of professional activities trained for, available training resources and

facilities, the various requirements to be met and how they are evaluated, academic and personal therapy which is one of the most firmly held and cherished beliefs.

Regarding personal therapy, Fromm-Reichman (1950:42) wrote: ‘any attempt at an intensive psychotherapy is fraught and danger, hence unacceptable when not proceeded by personal analyses’. Likewise, Chessick (1974) argues that without personal treatment the psychotherapist is endangering himself and his patients. According to Dryden and Spurling (1989) most therapists follow strongly on this tradition.

The American Psychological Association (APA) stipulates that psychologists must come around to the acceptance of some kind of intensive self-evaluation as an essential part of training the clinical psychologist. What has been suggested by the APA has been a challenging aspect over the years. According to Pilgrim and Treacher (1992) the majority of courses do not require trainees to undertake personal therapy or any sort. Personal therapy it is however a requirement for some training programs. Karter (2002) argues that despite studies showing that therapy can destabilize trainee psychotherapists, he reiterates that personal therapy is beyond questioning. More controversially, he believes it should also be a mandatory in related fields of human interaction such as psychology and psychiatry.

Moreover, Karter (2002) argues that in order to deal with the emotional angst and turmoil of others, trainees must surely have dealt to a greater or lesser degree with their own emotional issues. He further states that if one looks at this whole issue from the point of view of necessary survival of the therapist in the face of difficult or painful patient material, it would be almost impossible to imagine a therapist who found their own issues unbearable or overly destabilizing being able to manage a similar level of angst or disturbance in their clients.

Karter (2002) further argues that it is well established and accepted that clinicians before even thinking of helping others need to embark on their own self explorations to get to know themselves as deeply as possible. It is regarded as a fundamental principle in all therapeutic orientations and establishments of psychotherapeutic orientation that the more you know yourself, the better therapist you will be effective. It is virtually impossible for therapists to understand others and listen accurately and empathically to them if they do not attempt to understand and accept their own vulnerabilities as well as strengths. According to him, personal therapy is not only about knowing oneself better in order to become a more congruent, empathic and effective therapist. Personal therapy can offer trainees the kind of support that is needed through training. That is to say, empathy and a meaningful exploration of issues, which may include, an examination of anxiety, difficult feelings and trauma brought on by training matters as well as personal problems.

Although Kater (2002) believes that personal therapy is the essential medium for self-exploration, according to him, it is by no means the total picture. Therapy can be maintained as an ongoing process or it can be the beginning of a journey of self analysis and self discovery that continues indefinitely with the individuals seeking to understand themselves, to accept their limitations, to work through psychic blocks and difficult issues and to integrate the various aspects of their character. Besides, personal therapy can be done in a variety of ways, which could include, for example, group therapy or co-counseling.

In examining how to maximize the benefits of personal therapy for trainees, Dryden and Thorne (2000:18) offer an interesting angle: “Should trainees allow themselves full rein to discuss whatever they choose in their personal therapy or should the focus be on the experiences and implications of being a trainee? While the former is the norm, it is worth experimenting with the latter. This might be one way to boost the correlation between

personal therapy and therapist effectiveness, for at present there is equivocal evidence that having personal therapy improves one's effectiveness as a counselor or therapist"

On a contrary, Mearns (1997) argues that one of the problems with personal therapy as part of training is that it can too easily become a direction of referral for trainers where they refer difficult issues to the trainee more in hope than in expectation and receive little in the way of feedback. Another problem with personal therapy is that the trainee will, understandably, take those issues which are more salient and will not necessarily present the personal development issues which have been raised by the course. According to Mearns (1997) one solution to these problems is training therapy where the therapy is seen as an integral part of the training rather than an add-on. There is logic in firmly integrating the therapy because the personal development issues which it is addressing have enormous significance to the training course as well as the trainee.

Richards (2003) on another level and as previously discussed stipulates that when training psychotherapist, trainers should bear in mind the issues around the embedded and internalized prejudices imposed by the apartheid era. As mentioned earlier, any discussion pertaining health and more specifically, mental health care in South Africa must take into account its socio-political and economic context of the Apartheid past (Seedat *et al.,* 2004). According to Richards (2003), during the apartheid era of enforced segregation, health care for the majority of the population was more often an experience of suffering rather than healing. The legacy of unequal access to health care was structurally entrenched and its effects are still to be eradicated completely. Therefore, any discussion on the provision of psychotherapy cannot be conducted in isolation from the background of separation, discrimination and consequences caused by the Apartheid.

The present study acknowledges issues of race and culture and, specifically, racism as extremely complex which can arouse intense emotions for trainers and trainees alike in the context of training. According to Patel (2000), black and minority ethnic trainee are invariably within the training context. Thus, as a consequence by the Apartheid era, they find themselves being marginalized, excluded and oppressed on the basis of their ethnicities and this is very present in the arena of training and which also draw attention to the heterogeneity of a trainee group. Similarly, many trainees may have experienced exclusion and oppression on other dimensions of inequality such as, gender, age and disability.

It is important that within the training context, trainees acknowledge at the outset that each one brings differing experiences of exclusion and oppression and this does not necessarily mean or imply that indeed all black and minority ethnic group are oppressed and that all white people are oppressors. Ultimately, trainees will need to work on setting a context for training to be facilitative, non-accusatory, non-oppressive, inclusive of all trainees and conducive to learning. Trainers must also be prepared to respond to situations where this has not been possible (Patel, 2000).

According to Lousanda (1994) focusing on race and racism is often experienced as a duty and a demand, one which rises out of an explicit criticism, perhaps directed at the ideology underlying clinical psychology profession. Such criticism points out to a failure of thinking. Thus, training on issues of race and racism necessitates an acknowledgement and agreement that these failures have impeded clinical psychology professional practice and therefore everyone within this context has an obligation to reflect on and manage their feelings in order to develop this cherished profession. For some, these issues have a specific significance and meaning because of their experiences of having been excluded, marginalized or oppressed because of their colour and ethnicity.

Punctuating further, Carter (1995) postulates that little or no information about race in psychotherapy is provided in the education or training of psychotherapist. This silence about racial influences teaches psychotherapists in training to ignore or deny racial influences in treatment, supervision and psychological development. Furthermore, Franklin, Cater and Grace (1993) point out that most students, from their undergraduate training in psychology are taught traditional theories of personality and human development, which ignore psychological issues associated with a socio-cultural context and that kind of training is devoid such considerations. They suggest that theories of human development and personality must include the subject of race as it is important that students explore the meaning and significance of their own race and to understand how race influences perceptions of the self and the client. They further suggest that, within the context of training, trainers as well as trainees must address issues of race and culture early in their relationship. Moreover, trainers should actively work to promote difference in the agency or program through staff development and the recruitment of racially diverse staff members. In coping with racial differences within the training context, Leong and Wagner (1994) suggest black and white interactions among trainees, for example, when doing role plays, one can be the client and the other be the therapist.

As previously mentioned, clinical psychology provides a service to a population which is diverse ethically and culturally. It is clear that issues of race and culture, specifically, racism, are extremely complex and still exist within the context of training. This aspect has posed many challenges to the profession in the past even currently; therefore, the author is of the view that trainers should discover ways on how to address the issues of race and culture in the context of training. In an attempt to do so, Patel (2000) suggests that it is important for trainers to ensure:

- A safe environment, conducive to learning;

- Explicit ground rules, including rules addressing how a group will attempt to respond to racist comments, which may be made within the context of learning. How will trainees and trainers allow each other to make mistakes and how should they be addressed;
- Support structures, which black and minority ethnic trainees may wish to use confidentiality, either within or outside of the course staff team;
- Trainers work in pairs, wherever possible, ideally as one black and one white trainer;
- Trainees are allowed to 'self select' when they divide into groups for exercises and role plays;
- Trainers continue to explore their own feelings and experiences as black or white people, while continually developing their own skills and styles for managing the range of emotions and reactions which can result from training around issues of race, racism and culture. Working with other trainers who are different in relation to themselves with regard to ethnicity, is always a demanding but a very enriching and useful way to continually develop their skills in training with mixed ethnicity trainee groups;
- Enjoy the experience as this is a process of immense discovery and learning for trainees too.

2.4.2 The Intensity and Broadness of Training

Few people are aware of the long and intensive training process that is involved in becoming a clinical psychologist. Most do not realize that the one year masters training process includes experimental research as well as clinical training in psychological assessment and psychotherapy depending on the institution (Patel, 200). For an example, some programmes

demand highly rigorous research dissertation projects while others allow articles or case studies to be written for dissertation projects, this together with clinical training must be completed in one year. Due to the broadness and the intensity of the program, most institutions in South Africa prefer to equip their trainees with clinical training during the first year followed by a research project the following year. With regard to a research project, according to HPCSA, it must be completed prior to the commencement of the internship (www.hpcsa.co.za)

The intensity of clinical psychology training renders it one of the few post-graduate courses that require daily attendance (Plante, 2005). The first year of the master's program consists of university based training where a combination of both academic and practical training is undertaken. The nature and the content of both the academic and practical components vary widely between training institutions depending on variables such as theoretical orientation, availability and nature of the hospital or psychological clinic through which trainees may gain experience. Academic input and clinical training are more emphasized during the first year (Dlamini, 2005).

According to Luchins (2000), most institutions teaching psychotherapy tend to be devoted to the promulgating of the viewpoints of a particular school of thought. Psychoanalysis has been the dominant theoretical model of training since 1940, followed closely by Cognitive-Behavioural Therapy, Humanistic and lastly Family Systems. According to Knight (2004), it may be surprising to some but after many years of democracy, that the dominant theoretical perspective of psychotherapy remains the psychoanalytic/psychodynamic. Surprising in the sense that, as more members of other racial groups, besides white, become involved in psychotherapy training, psychoanalysis, in the heart of an African society in transition, should still find value. Granted psychoanalysis has changed over the years, and it is the more

contemporary, as well as Object Relations Theories, that are currently taught in psychotherapy classes in most South African universities.

While such training may have the advantage of producing therapists who are highly skilled in the application of a particular approach or school of thought, Luchins (2000) is of the opinion that it possesses certain disadvantages. Klein (1996:216) argues: "psychology has to move with the times and should welcome the opportunity"

Plante (2005) showed that such training maintains a rigid adherence to a particular approach hoping it can be universally applied to each and every situation and person. Strict adherence to a certain theoretical approach can result in limited, rigid views on human behaviour and behavioural change and cult-like zealousness. Whereas each approach had its advantages for understanding human behaviour and offers ideas for intervention, this limited view might lead a trainee to overlook important alternatives to understand, explain and treat patients and thus fail to provide effective assessment and treatment. Trainees about to begin their training in clinical psychology or psychotherapy often must make a decision as to the particular brand they will study before they had sufficient opportunity to acquaint themselves in a systematic manner with principles and practices of prevailing schools or disciplines, and before they have achieved the professional maturity which may be required for a wise choice.

Interestingly, the evolution of clinical psychology has witnessed increasing integration of various theoretical perspectives. While some argue that integrating approaches is a mistake and akin to mixing apples and oranges, more and more institutions are integrating various theoretical approaches and techniques with success in training. Biological, psychological and social factors clearly influence emotional, behavioural and interpersonal functioning. Furthermore, as more research and clinical experience help to uncover the mysteries of human behaviour, approaches need to be adapted and shaped in order to best accommodate

the new discoveries and knowledge (Plante, 2005). Luchins (2000) states that the future will likely further expand the biopsychosocial perspective by better understanding the interplay between biological, psychological and social influences on behaviour and targeting interventions that better suit these influences.

Plante (2005) stipulates that theoretical approaches in which trainees are exposed to during the first year of training provides a comprehensive framework for understanding behaviour and planning interventions. Whether trainees are conducting research or providing clinical services, using a theoretical approach helps to provide competent and theory-driven strategies. Without these perspectives, trainees would "wing" each time they engage in clinical work, deprived of useful guidelines direction in their journey.

In order for the training is sufficiently broad, Luchins (2000) recommends that it should attempt to deal with psychotherapy in general instead of with just one particular type of therapy. The study of various approaches to psychotherapy may help produce a therapist with a broader viewpoint, possibly one who is interested in the refinement of psychotherapy in general. This view is further supported by Woody and Robertson (1997) who suggest that the curriculum must be flexible enough to allow trainees to be exposed to other courses and treatments related to the discipline. Therefore, trainees need to be exposed to a number of therapeutic approaches as training cannot be limited to one model and this will without no doubt challenge their thoughts, perceptions about the world and consequently their behaviour.

2.4.3 Implications of Training on the Trainee

A career in clinical psychology particularly during the first year is experienced by trainees all over the world as a rite of passage, in many respects similar to an initiation process with both tremendous challenges and unanticipated rewards (Kottler & Swartz, 2004). Rites of passage can be seen as processes marking shifts in status and social identity. According to Bosman

(2004) this journey often appears impossible, all encompassing the never-ending round of theory, assignments, seminars, clinical work and supervision. When trainees are simultaneously juggling these with social responsibilities and demands, it is easy for them to feel overwhelmed, alone, unsupported and despondent.

Masters training in clinical psychology is a journey filled with new experiences and opportunities for personal growth. It is widely known to be an arduous process. It demands that trainees become intimately involved in the pain, conflicts, disappointments and hardships of the lives of people whose mental health in some way is in jeopardy. It also demands that trainees examine their own lives, and negotiate their way towards a professional identity that will allow them simultaneously to grapple with the pain of others in a mindful way and protect themselves from this activity's potentially debilitating effect (Kottler & Swartz, 2004). According to Ernst (2008) the journey is often experienced by trainees as a rollercoaster ride, at times it is filled with excitement and at other times it can be exhausting and very stressful.

Kottler and Swartz (2004) point out that many trainees have held the training as idealized life ambition. Once involved in the academic, clinical and personal pressures of training, many begin to question themselves and their work, and to wonder whether they have made a wise choice of career. Some contemplate withdrawing from training and a few do. Some long-standing relationships flounder or end and it is common for trainees to experience period of intense anxiety or depression. Tensions arise from conflicts between a continuous sense of selfhood, a position in a social order in terms of class, gender, sexuality, race and culture, and the demands and prohibitions of a profession that has rigorous rules about how relationships should be conducted. Thus, entry into a professional training impacts upon definitions of self, causing emotional and cognitive turbulence, at least for the period of the training and sometimes longer (Bosman, 2004).

According to Stefano *et al.* (2007) the developmental journey is difficult in the beginning stages of psychotherapy training where trainees are expected to move quickly into the role of a psychologist. This developmental journey is characterized by a number of emotions such as anxiety and frustration specific to the role of a psychologist. Karter (2002) likened the process of training as a therapist to a form of personal deconstruction, followed by a process which involves building a new way of thinking and being.

Karter (2002); Bosman (2004); Dlamini (2005) and Ernst (2008) describe the process of training as a clinical psychologist as extremely overwhelming. Although trainees are not actually taken to a wilderness outside of their own community, there are other ways in which they are detached from a larger body of post-graduate students. They are often expected to attend seminars from 8:30 to 16:30. This is the time during which even family members and friends begin to voice complaints, or express anxiety about the trainee relative absence in their lives; an absence not only in terms of time, but also of a new and more hidden preoccupation. This eventually lead to isolation from their normal surroundings. Consequently, as the journey unfolds, it is easy to feel very alone and to develop a sense of lacking any real support network, with nowhere to offload one's burden or concerns (Bosman, 2004). A feeling of alienation can begin to arise and this can be compounded by a burgeoning sense of distance from partners and family, who not only find it difficult to comprehend this bizarre undertaking in which trainees have become so irretrievably embroiled, but often feel seriously threatened by it as well (Kottler & Swartx, 2004).

Karter (2002) postulates that during the early phases of training, trainees are introduced to a different world to the ones in which they grew up. Ordinarily, everyday social encounters and ways of politely relating, according to a well-acceptable but unspoken conversational rules are challenged. In what feels to some like a nurturing, contained and almost therapeutic space, trainees begin to explore a range of personal issues. These include the reasons for their

choice of clinical psychology career and aspects of their family background and relationships. This challenges aspects of personal identity and once-stable assumptions about self and the world may begin to be questioned. Trainees further experience high levels of anxiety and a sense of fragmentation (Karter, 2002). According to Luchins (2000) these give way to an increasing experience of competence. Therefore, one could view the experienced anxiety as serving a function.

Richards (2003) states that not every trainee will experience the training as traumatic. However, all are likely to experience some turbulence in their sense of social identity and each will engage in his or her own idiosyncratic protective behaviours during training. Some trainees have reported feeling profound alienated, feeling like a 'token black' in a predominately white class, with an all-white staff complement, at a historically white university, or to feeling like the 'token lesbian' in a predominately 'straight' class with a predominately 'straight' staff compliment. In these situations, it is the social identity that becomes the focus of painful experiences of exclusion and voiceless. These experiences reiterate South Africa's history of racism and homophobia; they are carried into everyday encounters, no matter how vigilantly they are guarded.

Kottler and Swartz (2004) argues that clinical psychology training programs demand of the trainees a fundamental level of personal engagement with the process, including self questioning, psychotherapy and self disclosure within peer and supervisory settings. Training, therefore, entails more than simply the acquisition of knowledge, skills and experience; it asks for a shift in identity. Trainees undergo a qualitative change in their activity, their attitudes, their perception, and the logic implied in their reasoning: they start to deal with sequences of behaviour more than with isolated unit; they analyse symptoms not only in terms of the system of organs involved but also in terms of their effects on others (Bosman, 2004). Trainees also gain self awareness in their interactions; they might find that they

suddenly start observing situations and interactions differently, seeing 'pathologies' in their own families and friends which result in them being gradually isolated from the social context (Ernst, 2008).

Moreover, there is constant pressure of an increasing amount of work and trainees might feel trapped in paradoxes, trying to deal with the demands of a student, a clinician, a family member as well as a spouse (Stefano *et al.,* 2007). All of this can lead to a feeling of becoming increasingly frustrated and further contribute to their isolation. More challenging is that trainees literally need to learn new language which the world perceive differently and may wonder how to translate this new language to other contexts. Trainees are confronted with the dilemma of confronting this new awareness through commenting on it or keeping it to themselves (Hall, 2004).

Punctuating further, earlier studies Larson *et al.,* (1999); Skovholt (2001); Skovholt and Ronnestad (2003) showed that mechanical equipment used within the training context such as the use of videotaping, cameras and role-playing while observed by instructors, teaching assistants, supervisors and peers, elicit emotions such as anxiety and frustration. According to Karte (2002) the syndrome of self questioning is thus present during training. This can have a malignant quality which can lead to self-doubt, persecutory and performance anxiety. Moreover, throughout training, trainees are constantly made aware of and receiving feedback on their own interactional styles. There is increasing awareness of appropriate social behaviour as well as what is considered to be outside a social context. Consequently, according to Ernst (2008), people's perceptions and reactions towards trainees change.

Jones (2009) argues that psychotherapists in training may be particularly vulnerable to stress. This is because not only are they experiencing the pressures associated with providing mental health services to others, but they also have to cope with other stressors specific to their

training status such as juggling multiple roles, managing a high academic workload, working in unfamiliar geographical locations and losing one's primary social support network. In addition to all these factors, they are also being continuously evaluated which can cause self-doubt and anxiety. Training in psychology as a career is 'full of intrinsic stressors' presenting trainees with multiple academic demands which often lead to early self-doubt (Karter, 2002).

According to Woody and Robertson (1997), trainees are entitled to have specified advisement on grievances and due process procedures, periodic oral and written feedback on progress, and where indicated a remediation or termination plan. A sensitive issue comes up when a progress review indicates personal unsuitability for continuing professional training. Whether personal unsuitability lends itself to likely resolution by short term therapy, a remediation plan would indicate a recommendation for therapy. Personal unsuitability based on a serious ethical deficiency or legal problem might warrant a termination plan, provided due process procedures are followed. Notwithstanding decisions by the program, the student does, of course, retain his or her legal rights. If a trainee is discharged from a training program, he or she could potentially go through the university appeal route and on to a court of law in search of a judgment counter to what was imposed at the programme level.

Another important aspect that Karter (2002) has observed within the training context is the issue of sibling rivalry among trainees; he offered some constructive thoughts on the nature of competiveness and the fear of failure. In examining the link between culture and neurosis, he is of the opinion that it must be emphasized that competitiveness, and the potential hostility and what accompanies it, pervades all human relationships. The potential hostile tension between individuals results in a constant generation of fear of the potential hostility of one's own. Another important source of fear in the normal individual is the prospect of failure. The fear of failure is a realistic one because in general, the chances of failing are much greater than those of succeeding, and because failures in a competitive society entail a

realistic frustration of needs. They mean not only economic insecurity but also loss of prestige and all kinds of emotional frustrations.

In concluding this discussion, Karter (2002) postulates that when this challenging journey begins, trainees should endeavour not to be too hard on themselves. Feeling inadequate, small, unworthy, lost and alone or a combination of all of the above, is not merely normal but could also be said to indicate an attitude that is desirable and healthy in terms of the capacity for self-questioning and self-reflection, which a good therapist needs. It is also perfectly 'okay' to experience feelings of being deconstructed, undermined and being perceived as different or slightly weird.

2.5. CONCLUSION

This chapter has attempted to explore a road map in which trainee therapists undertake. It can thus be said that the formal processes that govern the training of clinical psychologists indeed seem daunting, destabilizing and impossible for trainee therapists all over the world. However, the aim is not to cause any harm; rather to provide the trainee with a thorough preparatory training as possible. Therefore, such is the preparation required to ensure competency, if not excellence, in trainee's contributions to patient's care, diagnosis, teaching, research and challenges facing the clinical psychology training and profession. Ultimately, the experience brings forth confidence, self esteem, physical and mental health, knowledge, stamina and above all the ability to understand human behaviour in depth. The next chapter will be more specific and attempt to create a context by providing the theoretical foundation for the current study.

CHAPTER THREE

CONTEXTUALIZING TRAINING

3.1 INTRODUCTION

The field of Psychology has many different theoretical paradigms or frameworks. Consequently, there are many forms of therapy. Theoretical paradigms can be understood as worldviews or philosophies about human behaviour that provide a conceptual framework for research, assessment and treatment of psychological problems (Hoffman, 1990). Therefore, training in clinical psychology at different universities in South Africa differs in their approaches, mostly informed by different theoretical paradigms in psychology. Clinical psychology training at the University of Limpopo (Medunsa Campus) is contextualized within the framework of the General Systems Theoretical paradigm.

According to (Swerpersed, 2003) training embodies different levels of human activities. At one level training embodies how people guide and teach one another, at another level, training seems to include how people interact and the impact of such interactions. Yet at another higher level, training seems to depict how people generate from their experiences a set of concepts, rules and principles in improving their own effectiveness. Therefore, this chapter attempts to make sense of the University of Limpopo (Medunsa Campus) training, by specifically zooming into the first block of training at the above mentioned institution. In achieving the aim of this chapter, the background development and principles of the General Systems and Person-Centered Theory will be explored, this will be followed by outlining the clinical psychology training as well as the core aspects of emphasis during the first block of training at Medunsa Campus and how these impact the trainee psychotherapist.

3.2. GENERAL SYSTEMS EPISTEMOLOGY

3.2.1. Epistemology Defined

Keeney (in Clarke, 2002) stated that training from the General Systems Epistemology requires an epistemological shift. The term 'epistemology' has been used and defined in a number of ways. Bateson (1972) defined epistemology as a branch of philosophy. As a science, epistemology is the study of how particular organisms or aggregates of organisms know, think and decide. Bateson (1979) further defined epistemology as the way we know and understand the world around us, which determines how we think, act and organize our existence. Keeney (in Clark, 2002) defined epistemology as how one knows and what one knows. He argued that what one perceives and knows is largely due to the distinctions that one draws and that such distinctions are made one way or another because of the specific assumptions inherited in one's basic epistemology.

Keeney (in Vorster, 2003) elaborated on this concept and emphasized the implications that adopting a particular epistemology had for the individual's approach to therapy. According to him, it is impossible not to have epistemology as all ideas, perceptions and decisions were epistemologically driven. How people came to construct, know and maintain their worlds and experience is basic act of epistemology. Epistemology, thus, can be described as a set of imminent rules used in thought by large group of people to define reality (Auerswald, 1985). It must be reiterated that Bateson's overall epistemology as defined above seemed to explain the human mind and thereby to understand human behaviour. The epistemology proposed in this discussion is a systemic epistemology as training in clinical psychology at Medunsa Campus is embedded within this paradigm.

Few of the General Systems Theory concepts will be briefly discussed next.

3.2.2 General Systems Theory Concepts

3.2.2.1 Definition of a System

The concept ‘system’ has been defined in a number of ways. Barry (1990) defines the system as a collection of working parts that, when combined together, make up a more complex working object or entity. Bor (in Nel, 1992) simply defines a system as objects in relation to one another or as a set of mutually interdependent units. A system has also been defined by Watzlawick, Beavan & Jackson (1967) as a set of objects together with relationships between the objects and between their attributes. In this definition objects refer to components, elements or parts of the system, attributes and their properties and relationships bind them together in a system. Systems are composed of units that stand in some consistent relationships to one another, and thus are organized around those relationships. In a similar way, units or elements, once combined, produce an entity, a whole that is greater than the sum of its parts. This ‘wholeness’ or ‘wholism’ acknowledges the existence of relationships in the form of functional roles, coalitions and relational triangles that contribute to a greater systemic entity than just a headcount of the individual constituents (Corsini & Wedding, 2008).

3.2.2.2 Subsystems

Subsystems are components or elements that make up the structure of a system that carries out a particular process in that system. Bosman (2004) states that the individual is for example a subsystem of the larger family system and that the family itself is part of a supra-system of the community. Subsystems have their own organization, rules, boundaries and interactive patterns.

3.2.2.3 Boundaries and Rules

Boundaries are rules that keep members of the system separate from one another and give the system a certain identity. Therefore, boundaries develop as the result of system's rules (Barry, 1990). For this reason, a system's boundaries and its rules act as a gatekeeper for the flow of information into and out of the system. Rules are the underwritten expectations about what types of roles or behaviour will be acceptable or unacceptable within the system. These rules are related to the transactions which occur in the natural group, transactions which have the quality of communication whether on the verbal or non-verbal level. According to Bosman (2004) the manner in which members of a system communicate, defines the relationships and establishes roles in the subsystem through the setting of rules. System's rules are what distinguish it from other systems, consequently rules may be said to form boundaries of a system.

3.2.2.4 Hierarchies

The concept of hierarchy refers to the fact that living systems have several different levels in which the simpler, more basic subsystems compose the more advanced and higher level subsystems. Subsystems form a hierarchy of related systems and human functioning which is studied in terms of interactional patterns within and between subsystems. Hierarchical organization is one characteristic of living systems that is of great importance to systemic theorists. This means that a system at any level is made up of component subsystem on one hand, and is itself, in turn a component subsystem of a supra-system (Bloch in Bosman, 2004).

3.2.2.5 Context

Bateson emphasized the importance of context regarding the meaning of words or action (Wilder-Mott & Weakland in Vorster 2003). This was not only of paramount importance in respect to human communication and action, but also in respect to any possible kind of communication, all mental process and all 'mind', thus according to Vorster (2003) a clearly defined context provides the meaning. As long as the observation does not include the context in which the phenomenon occurs, it remains inexplicable. By not acknowledging the relationship between an event and the context in which it takes place , between an organism and the environment, the observer is either confronted with something mysterious or may attribute certain properties which the object may not possess (Watzlawick in Bosman, 2004).

3.2.2.6 Communication

Jackson emphasized the fact that relationships and the rules that govern them are established through interpersonal communication. Individuals involved in the early phases of a relationship are thus constantly trying to define the nature of their relationship through their reciprocal communication patterns (Vorster, 2003). According to Watzlawick *et al* (1967) people are constantly defining, or confirming the definition of their relationships by means of their communication. In this respects, one cannot not communicate (Vorster, 2003). Therefore, communication is the interactional nature of living systems that shapes the behaviour of its members. These interactions include both verbal and non-verbal.

3.2.2.7 Nonsummativity

When parts or components are examined separately, the findings cannot be simply added together in order to determine what the whole looks like. The whole must be examined as a whole, as a system rather that as the sum of its parts. A system thus consists of a number of

parts, aspects or elements which are interdependent. Such interdependence implies interaction, organization and integration. It is therefore logical that the alterations of one element would have some influence on the system as a whole. Based on these properties, it follows that the total set of elements that form a system, displays characteristics that none of its elements or subsystems do (Bor in Bosman, 2004).

3.2.2.8 Circularity

According to Becvar and Becvar (1996) in General Systems Theory, the focus is not on linear causality, where B can be described as a direct consequence of A, instead, the emphasis is on circular causality by means of reciprocity, recursion and shared responsibility. This refers to circular influence where A and B exist in a relationship in which each influences the other and both are equally cause and effect of each other's behaviour. Behaviour A is seen as a logical complement to the behaviour B, just as B is a logical compliment to the behaviour A (Bosman, 2004). Thus all behaviour, human or non-human, individual or collective, is recursive circular patterns which takes place within a given context (Vorster, 2003).

3.2.2.9 Feedback

Feedback refers to the process whereby information about past behaviours is fed back into the system in a circular manner (Bosman, 2004). This communication or information flow; is the energy input and output of human systems. This communication can also be described as feedback about whether the product of a system is useful or not. Feedback seeks to maintain near steady state functioning tempering external variation that would otherwise cause fluctuation and serves to increase the probability of the survival of the system (Becvar & Becvar, 2000).

Feedback may either be negative or positive. Positive feedback in systems terms indicates that change has taken place. It is recognition that such change has been accommodated by the system (Watzlawick *et al.,* 1967). Bosman (2004) argues that 'positive' is not to be interpreted here as desirable but merely a descriptive of a feedback loop that increases deviation in a system and causes change. Negative feedback in contrast to positive indicates that the status quo is being maintained and thus provides information that decreases the output deviations and helps to achieve and maintain stability in relationships. In short, negative feedback cancels errors and helps to maintain a steady state in systems; therefore, it plays an important role in achieving and maintaining the stability of relationships (Nichols & Everett in Bosman, 2004). According to Becvar & Becvar (2000) whether feedback is positive or negative, it is relative to the context of the system.

3.2.3.10 Homeostasis

Barry (1990) defines homeostasis as a dynamic, ever-changing state in which a system constantly works to maintain balance. In order words, as one subsystem or a person changes, the others members alter their patterns of communication or behaviour to maintain the balance of the system. Jackson (in Vorster, 2003) considers homeostasis to be a very important force at work in shaping an individual's behaviour patterns. Through a feedback mechanism, a system is able to adapt to changes in the environment, thus maintain homeostasis or equilibrium.

3.2.2.11 Open and Closed Systems

According to Becvar & Becvar (2000) open systems exchange information and other material with the environment and with other systems in the environment. The relatively open system not only processes information freely but also allows its members to come and go with a balance of both protecting and engaging mechanisms (Nichols & Everett in Bosman, 2004).

In addition, open systems allow flexibility in the roles of its members, rich intersystem commerce; that is, their boundaries are permeable. On the other hand, closed systems are perceived to be rigid and allow little change in the roles and patterns in the system. Because the boundaries are rigid, that poses barriers to transition and therefore are especially vulnerable, chaotic and disruptive forces (L'abate, 1998). There is no exchange with the environment and the environment does not influence the systems components. An appropriate balance between the two is desirable for a healthy functioning of the system.

In summary, the key concepts of the General Systems Theory can be described as the concepts that have to do with wholeness, organization and patterning. Events are studied within the context in which they are occurring and attention is focused on connections and relationships rather than on individual characteristics. This study will therefore utilize the General System Theory as a meta-perspective to understand and make sense of the trainees' experiences in the training context during their block.

3.2.3 Development Background and Principles of General Systems Epistemology

Nichols and Everett (in Bosman, 2004) pointed out that the development of General Systems Theory represented one of the major conceptual and practical changes in the scientific and clinical worlds in the 20th century. Theory emerged from long term evolutionary developments. Many people in several different fields were working on similar conception, when Ludwig Von Bertalanffy published his concepts of General Systems Theory in 1945. Consequently, his ideas found widespread acceptance in the scientific world and also became accepted as a major new orientation to clinical work. He used General Systems Theory to describe the principles of wholeness, organization and patterns. According to Becvar and Becvar (2000) it is acknowledged that the General Systems Theory has played an important role in looking at descriptions rather than explanation and towards taking context and its

associated concepts of interrelatedness, wholeness, circularity and patterned events. Hence, the concept of system is important in this paradigm.

The development of a systems theory relating to mental health is generally accredited to Gregory Bateson and his co-workers at the Mental Research Institute in Palo Alto, California. Researchers at the Mental Research Institute were specifically concerned with the study of communication, its different levels and channels and how one message was modified or was significant in understanding another (Bosman, 2004). They further focused on the formulation and testing of a broad systemic view of the nature, etiology and therapy of schizophrenia. Names such as Haley, Watzlawick, Satir, Weakland and Jackson were associated with this work, all of whom shared the view of the family as an interactional social system (Bosman, 2004).

According to Vorster (2003) 'the pattern which connects' seemed to be the central theme that ran through much of Bateson's life and much of his time and effort were spent on studying the first and second order patterns which according to him connected all living creatures. Furthermore, Bateson's theoretical contributions seemed particularly useful regarding an understanding of interactions between human beings, much of which occurred eventually as communication. It could thus be stated that Bateson essentially mane an in-depth study of how human beings utilized rules to view and interpret the world around them and how this in turn influenced behaviour. This defined the introduction of systems theory into the behavioural sciences and the therapeutic arena (Bor in Bosman, 2004).

The term 'cybernetics' also found widespread use in the systemic paradigm. Cybernetics refers to the science of self-correcting systems or self-governing systems. In addition, Keeney (1983) defines cybernetics as a science of communication and control in man and machine. Cybernetics 'identifies the patterns of organization that characterizes the mental and living

processes' (Keeney, 1982:155). It prescribes a way of knowing and identifying patterns that organizes events. In other words, cybernetics is used to describe the general principles of how systems operate. Since the concept of a system is also defined as consisting of a cybernetic network of communication, it is chiefly concerned with control, mechanisms and their associate communication systems, particularly those that involve feedback of information to the mechanisms about its activities. This cybernetic network of communication is viewed to be referring to the context of complexly intertwined and interpersonal relationships (Keeney, 1979). Since cybernetics belongs to the science of pattern and organizations in human systems, it calls for the undoing of materialistic abstractions and the constructing of distinctions that indicate patterns of relationships and recursive processes. From the beginning of the development of the systems perspective and thinking, the term 'cybernetics' played a crucial role in assisting systems theories to conceptualize the phenomenon of recursiveness within systems (Vorster, 2003).

Therefore, the systemic approach instead of looking for linear causality, it highlights the interactional patterns that are formed though the relationships between parts. At the most basic level, a system view posits that objects, events, and experiences of them, are all part of a larger whole. It is thus a holistic approach. Where traditional psychology regarded an individual as the unit of observation and treatment, General Systems Theory was developed with the attention of shifting from the inside of the individual to between individuals. The individual is viewed as being a part of a larger whole, a system (Vorster, 2003).

In line with the above, Keeney (in Vorster, 2003) emphasizes that systemic diagnosis focuses on the interaction in the system and not on individuals in a system interacting. Focusing on the individuals within a system would constitute a linear epistemology. Focusing on the interaction emphasizes the pattern of relationships, process and the here and now, framing the data in terms of information and relationship. Thus, according to Clarke (in Ernst, 2008)

systems training implies a shift from the classical Cartesian-Newtonian worldview, which encompasses linear thought processes, towards a circular, systemic worldview. The classical Cartesian-Newtonian view has its roots in the western scientific tradition, which rests firmly on the foundation of certainty. According to this view, there is only one objective reality which is outside the observer. It is an either/or view where objects are mutually exclusive.

In contrast, the circular or systemic view encompasses an either/and view. Multiple realities are thus acknowledged. There is no absolute reality. This notion links up with the saying that the truth lies in the eyes of the beholder (Ernst, 2008). Reality is seen as co-created. Thus according to systems thinking, reality is a result of the observer's own constructed perceptions. The observer cannot be separated with that which is being observed. The aforementioned may have serious repercussions for trainees as it leads to a questioning of their foundation of what they know and has known their whole life. It ultimately leads to massive confusion, uncertainty and more inherently serious; self doubt. Consequently, the trainee's core assumptions about the world; the rules used to define reality are challenged during systems training (Clark in Ernst, 2008). The trainee's foundation is shaken, which ultimately leads to inner turmoil, conflict and uncertainty on cognitive, spiritual and emotional levels.

In addition, Harder (in Ernst, 2008) states that training within a General Systems Theory framework focuses on:

- the development of the human aspect of the therapist;
- fostering therapeutic spontaneity by using different aspects of the self of the therapist;
- training therapists to trust and make use of their inner symbols; and
- engendering problem solving skills.

Therefore, General Systems Theory is an interactional approach to psychotherapy. The functioning of systems in terms of wholes, patterns, structure, organization and relationships is emphasized during training at the University of Limpopo (Medunsa Campus). The focus of training in clinical psychology is on assisting the trainee in becoming an effective therapist by using himself/herself as a tool in the therapeutic relationship.

According to Vorster (2003) General Systems Theory as a meta-perspective allows for the integration of various theories and one such theory is Person-Centered Theory which is central during the first block of training.

3.3 PERSON-CENTERED THEORY

3.3.1 Background and Development

Parrot (1997) states that Carl Rogers is seen as the father of the Person-Centered Theory. Rogers believed that people are capable of growing and developing into what he called 'the fully functional person' and viewed this development as the goal of counseling, psychotherapy and group work (Rowan, 1998). He saw the person as a constructive force reaching towards health and self fulfillment. According to him, every person has the ability to take responsibility for their own growth and find constructive ways for growth. Each person has a tendency towards positive growth, which Rogers called the 'actualizing tendency' (Avis, Pauw & Van der Spuy, 2004).

Person-centered approach is a non-directive psychotherapeutic approach that is based on the assumption that clients have the potential to sort out their own problems and to develop positively. The requirement, however, is that the psychotherapist has to generate a warm atmosphere, where clients can discuss their problems uninterruptedly and through this find a better understanding of themselves. The psychotherapist plays a non-directive role through

not advising, interpret or intruding in any way, except when motivating and every now and then when reformulating, with the goal to emphasize and enlighten (Plug, Gouws & Meyer, 1997).

To understand the nature of Person-Centered Theory, it is necessary to understand the context in which it was developed. Carl Rogers (1902-1987) theory is one of very few theorists which actually originated within the therapeutic context. Rogers developed a non-directive counseling approach in reaction to the behaviouristic and psychoanalytic trends of the time. This development stemmed from his work with children and schizophrenic patients which led him to believe in the innate goodness of each individual (Meyer, Moore & Viljoen, 2003).

Parrot (1997) states that Carl Rogers work can be categorized into three main stages:

- **Stage one (1940-1950)**

This stage was known as the non-directive approach. During this phase Rogers focused on accepting the client. This entailed creating a positive non-judgmental climate. The method used was clarification of the client's world and great emphasis was placed on the skills of the therapist.

- **Stage two (1950-1960)**

This stage was regarded as the client-centered approach. During this phase Rogers changed his non-directive approach and called it client-centered therapy. He did this by publishing the book 'Client Centered Therapy' in 1951. Client-centered therapy focused on the reflection of the client's emotions. There was a shift from the clarification of feelings to a deeper understanding of how the client's frame of reference developed (Corey, 2005). The therapist's task was to reflect but also clarify the client's emotions. This enabled the therapist to identify incongruence between the ideal self and the real self. During this time frame, there

was a significant shift from the skills of a therapist to the therapist as a person (Anastasi, 1979).

- **Stage three (1961)**

The third stage was known as the person-centered approach. Rogers felt that his therapeutic principles could be used in many contexts other than the therapy. Emphasis was placed on relational issues and even more intense focus towards the here and now became evident. According to Parrott (1997), Person-Centered Therapy focuses on the present rather than the past whilst having an optimistically view concerning human behaviour. A broader perspective to include societal issues, cultural differences and the use of power differentiated this stage from others. Additionally, this is experiencing oneself as a person in relation to others. This stage is especially illustrative of the existential-humanistic orientation which focuses on individual's choice.

3.3.2 The Basic Principles of Person-Centered Theory

3.3.2.1 The Person

The foundation of this approach is the concept of the sovereign human person. The fundamental criterion that differentiates the person-centered approach from others is the image of the human being as a person. 'The bedrock of Rogers' philosophy was the notion that the person is a living experiencing organism whose basic tendencies are trustworthy' (Brazier, 1993:7). It further recognizes that deep down every human being is 'smart' (Barlow & Durand, 2005).

Based on the work of Kurt Goldstein (1934/1959) and Rogers own observations of clients, Rogers postulated that all living organisms are dynamic processes motivated by an inherent tendency to maintain and enhance themselves. In human beings, this actualizing tendency is

expressed by ongoing attempts to realize the individual's uniqueness. Rogers (1980) described the actualizing tendency as part of a more general formative tendency, observable in the movement towards greater order, complexity and interrelatedness that occurs in stars, crystals and micro-organisms as well as in human beings. From the person-centered perspective, persons are constantly evolving toward complexity and more effective self creation. By contrast, the medical model of therapy views a person as a 'patient' with problematic 'parts' in which conflicts, self defeating behaviours and irrational cognitions are fore grounded in treatment directed by an expect. These two radically different epistemological paradigms lead to crucial differences in the interpersonal, social and moral space that is; the therapy relationship. Therefore, the purpose of Person-Centered Therapy is to give clients the opportunity to get to know their own potential in a therapeutic climate where the therapist unconditionally accepts the client. Rogers saw the person as a constructive force reaching towards health and self-fulfillment. Thus, every person has the ability to take responsibility for their own growth and to find constructive ways for growth (Rowan, 1998).

3.3.2.2 Person-Centered Therapist

Person-centered theory is a central approach within humanistic psychology (Rowan, 1998). Humanist therapists have great faith in the ability of human relations to foster growth. Humanistic therapists propose that relationships, including therapeutic relationship, have the greatest influence in the facilitation of human growth. There is a basic respect for client's frame of reference and trust in the capacity of the client to make positive and constructive conscious choices (Brazier, 1993).

Thus, the person-centered therapist trusts the person's inner resources for growth and self realization, in spite of impairments or environmental limitations. The therapist aims to follow

the client's lead and to avoid taking authority over the client. The therapist's believe in the client's inherent growth tendency and right to self-determination grounds the approach to therapy and is expressed, in practice, through commitment to the non-directive attitude. If the aims of psychotherapy are to free the person for growth and development, one cannot employ disempowering means in the service of emancipatory ends (Rogers, 1951).

To be a person-centered therapist is to risk relinquishing the props provided by degrees, graduate training and technique and instead to meet the client as a person, to be of service in an authentic relationship that has yet to take shape. It is the difference between using the self to achieve certain ends and being oneself in relation to another person (Brazier, 1993). According to Corsini and Wedding (2008), to undertake to develop as a person-centered therapist, one must be willing to take on what is both the art and the ethical discipline of learning how to be an open, authentic, empathic person.

Parrott (1997) postulates that according to Rogers, the role of the therapist is that of a listener. Listening could provide a foundation for interpretations, feedback and even confrontation. The therapist focuses on 'being' rather than 'doing'. The challenge for the therapist lies in creating a safe and trusting atmosphere within the therapeutic relationship in order for the client to become self-actualized and self-valued. The therapist accomplishes this through accurate empathic understanding, congruence and unconditional positive regard. The therapist will rarely take on the role advisor, teacher or try to interpret the behaviour of the client. Boy and Pine (1990), suggest that therapists should rather enable the client to participate in a journey of self-discovery.

Vorster (2003) states that it is of utmost importance that the therapist focuses on observable behaviour, since that is the primary role of the person-centered therapist, to be a participant observer and not to make inferences. Since making inferences or intra-psychic speculations

may corrupt the authentic and scientific facts, if a therapist were to make inferences, the danger arises for including the therapist's frame of reference and thus corrupting the 'true' picture of the client's problem and functioning. This is in support of the non-directive attitude the therapist should maintain.

3.3.2.3 The Therapeutic Relationship

According to Corey (2005), the value of the therapeutic relationship becomes the crux of a successful therapy. The therapist then finds the link between the presenting problem and the client's behaviour with standardized and scientifically based methods. Corsini and Wedding (2008) postulates that psychotherapy outcome research supports Rogers original premise that the therapeutic relationship accounts for a significant percentage of the variance in positive outcome in all theoretical orientations of psychotherapy. The person- centered therapist intention is to realize the core therapeutic attitudes of congruence, unconditional positive regard and empathic understanding of the client's internal frame of reference which is simultaneously informed by the intention to honour the self-determination of the client. In practice, the therapist's way of being, characterized by these experienced attitudes and intentions, creates a climate of freedom and safety. Within this climate, the client is a source of active creation of meanings; the client propels the process of self-definition and differentiation.

Because both the therapist and the client are unique persons, the relationship that develops between them cannot be prescribed by a treatment manual. It is a unique, unpredictable encounter premised on the response of the therapist to the request for help from the client. Person-centered therapists tend to be spontaneously responsive and accommodating to the requests of clients whenever possible. This willingness to accommodate requests by changing

a time or making a phone call on behalf of a client, results from the desire to establish a harmonious, human relation (Corey, 2005).

On a practical level, person-centered therapists trust that individuals and groups are fully capable of articulating and pursuing their own goals. The person-centered approach endorses the person's right to choose or reject therapy or treatment, to choose a therapist whom he or she thinks may be helpful, to choose the frequency of sessions and the length of therapeutic relationship, to speak or to be silent, to decide what needs to be explored and to be architect of the therapy process itself (Corey, 2005). The exercise of freedom is thus significant in this approach.

Boy and Pine (1990) states that an effective therapeutic relationship consists of two phases. The first phase requires that the therapist builds a substantive, collaborate and therapeutic relationship with the client. Once this is accomplished, it will serve as a basis for further interactions with the client. During this phase, the reflection of the client's feelings is vital to make the client feel understood, accepted and open to reveal their true emotions. When these emotions are accurate, the therapist assumes the client's internal frame of reference. During this phase the therapist is expected to be an empathic and a sensitive listener which will enable the client to grow as a person. The rationale behind this mirroring of the client's emotions is that the client becomes aware of it, releases it and understands it better. This phase should enable the client to engage with their problem and then move beyond it.

The second phase of therapy will only be effective once there is trust in the therapist and the process of therapy. The client will then be mobilized to collaboratively focus on the needs of him/herself. Phase two is characterized by facilitating the client to make choices according to his/her needs and perceiving the client holistically. The client plays a more active role in regard to his/her problems which results in him/her becoming more independent (Boy &

Pine, 1990). Furthermore, according to Vorster (2003) the therapeutic relationship should be a complementary relationship with the therapist in the one-up position and the client in the on-down position. Thus, the therapist gives the client permission to control the therapy situation and in this manner the therapist retains control.

3.3.3 The Core Conditions in Person-Centered Theory

Rogers (1961) stated that *congruence, unconditional positive regard* and *empathic understanding* of the client's internal frame of reference were the three therapist-provided conditions in the Person-Centered Therapy. These will aid clients to be more straightforward, honest and will allow enhancement of their innate tendencies towards growth (Barlow & Durand, 2005). These variables will be explored below:

3.3.3.1 Congruence

Rogers was always opposed to the idea of the therapist as a 'white screen'. He designed a 'face to face' type of therapy in which the therapist is highly involved with client's experiential world and in which the therapist consequently shows little to him/herself. Yet, the therapist does show his/her involvement in an open and direct way, without hiding his/her real feelings behind a professional façade. By adopting such a natural, spontaneous attitude, the person-centered therapist certainly does not favour the process of regression and transference. More than the psychoanalyst, Rogers believed in the therapeutic value of a real relationship between the client and the therapist and saw other more important advantages in it as well. In such a working relationship, the therapist serves as a model; his/her congruence encourages the client to take risks in order to become him/herself. Along with this, Rogers gradually came to consider the therapist congruence as a crucial factor in establishing trust and came to emphasize the idea of acceptance and empathy only being effective when they are perceived as genuine (Brazier, 1993).

Congruence can be seen as genuineness, realness and authenticity of the therapist (Rowan, 1998). According to Hackney and Cormier (1994), it is a condition which reflects honesty, transparency and openness to the client. The therapist is without the front façade. It is a human quality and not a skill which can be used at will. It requires that the therapist is aware of his/her feelings and process as well as that of the client. Thus, Corey (2005) is of the opinion that congruence is when a therapist's inner experience and outer expression of that experience match. On a more practical level, congruence can be seen as when verbal and non-verbal behaviour match.

Casemore (2006), postulates that congruence is an internal sate, which can be defined as the level of harmony between how an individual is feeling and how they are presenting their feelings, first of all to themselves and then to others. Someone who shows their feelings and behaves in the way corresponds with how they are feeling can be said to be congruent or authentic.

In addition, Casemore (2006) indicates that Rogers later in his life used terms 'authenticity' or 'genuineness' referring to congruence. By congruence Rogers (1957) meant that the therapist is genuine or whole in his relationship with the client, there being no discrepancy between what he overtly expresses and what he internally experiences. Moreover, Corsini and Wedding (2008) state that congruence refers to the correspondence between thoughts and the behaviour of the therapist, thus, genuineness describes this characteristic. Genuineness is marked by congruence between what the therapist feels and say, and by therapist willingness to create on a person to person basis rather than through a professionally distant role. The therapist has to be genuine about his/her feelings and not hide behind his/her profession as someone who does not experience feelings.

Therefore, congruence in therapy means that the therapist is his/her actual self during his/her encounter with the client. Without façade, he/she openly has the feelings and attitudes that are flowing in him/her at the moment. This involves self-awareness, that is, the therapist feelings are available to him/her and the therapist is able to live with them and to experience them in a therapeutic relationship to even communicate them if they persist. The therapist encounters the client directly, meeting the client person to person (Brazier, 1993).

According to Rogers (1996) since this concept is liable to misunderstanding, it does not mean that the therapist burdens the client with over expression of all his/her feelings. It does mean, however, that the therapist denies to him/herself none of the feelings experienced and that he/she is willing to experience transparently any persistent feelings that exist in the relationship and to let these known to the client. It means avoiding the temptation to present a façade or hide behind the mask of professionalism or to assume a confessional-professional attitude.

The fully functioning person is completely open to experience, is able to understand and accept himself with all feelings and be aware of himself as coherent. He can thus be equally open to the feelings of others, can sense empathically how others are open to feelings, can value their experiences and by definition never become incongruent or never identifies with what the other person is experiencing. The fully functioning person in the person-centered stance is invariably congruent. There is no incongruence between the total past experience, the present and the self-experience represented in the self concept. The fully functioning person can objectively be aware of his/her bodily felt state and subjectively feel how he/she is, identify as his/her own and accept or integrate them into the self concept (Thorne & Lambers, 1998). Without openness, there can be no empathy either. In this sense, congruence is the ‘upper limit’ of the capacity for empathy. To put it differently, according to Rogers (1961) the therapist can never bring the client further than where he/she is as a person.

3.3.3.2 Empathy

Within the context of psychotherapy, Rogers considered empathy to be crucial as one of the three conditions which the therapist's relationship offer must meet, so that the client can use this relationship for constructive personality change (Rogers, 1957). According to Rowan (1998), empathy can be defined as showing a deep understanding and respect for another person and endeavoring to understand their life world. Empathy involves the understanding and acceptance of the client and his/her thoughts and feelings. Rogers considered empathy as a key part in the main task of the therapist to provide a growth climate in which actualization of the individual can take place. This is provided through empathic understanding. Therefore, the actual experience of being given empathy is what inherently therapeutic and corrective to the client.

Rogers preferred the term empathic understanding which involves the ability to enter into the experience the of client's phenomenological world active, immediate, and an ongoing process in which the therapist becomes aware of the client's feelings, experiences those feelings and creates a mirror through which the client can discover meaning associated with their feelings (Nystul, 1999). Rogers' definition of empathy reflects depth of understanding that goes deeper than just reflection of emotions and here the complicated nature of defining empathy is evident.

According to Vorster (2003), empathy is not only understanding someone but to accurately understand someone from their frame of reference and also to be able to communicate that frame of reference. Empathy is attained by the accurate reflection of the client's feelings. Brunner and Shostrum (1997) identifies that when the therapist is accurate in the reflection of the client's emotions; clients feel deeply understood and in some cases even clarify their thoughts by enabling them to be more objective. They will then be able to examine their overt

motives. Through reflecting emotions, clients are also able to see that their emotions are causes of their behaviour. Rogers (1951) considered empathy, as a key part in the main task of the therapist to provide a growth promoting climate in which actualization of the individual can take place. This is provided through emphatic understanding. Therefore, the actual experience of being empathized is what is inherently therapeutic to the client, thus both cause and effect.

Clark (2007) considered the following variables as the most basic ingredients in the empathic process:

- **Attending**

The intent of the therapeutic relationship is to gain insight into the experienced world of the client; ‘ to be inside this skin, behind these eyes, to live in the context of the memories of this history has provided and the beliefs these experiences have generated’ (Clark, 2007:91). The therapist therefore, has to attempt to enter the internal frame of reference of the client. Rogers (1957) maintained that if the emphasis remains on the client’s frame of reference, the therapist’s personal biases and conflicts are less likely to hinder the therapeutic process. Therefore, a perquisite for effective empathy is a developed self awareness on the part of the therapist of the possible impact on the client of an external frame of reference.

Attending as a purposeful listening to what is said and observing behaviour in the here and now. The intent is to gain insight into the client’s experienced world (Brazier, 1993). Rogers (1980) maintained that a prerequisite for effective empathy is a self awareness on the part of the therapist of the possible impact on the client of an external frame of reference. An awareness of the therapist own emotions and own experiences facilitate a greater perception of emotions and by default a more accurate empathic understanding since it is only through

self-awareness that it is possible to see behaviour of the client as the expression of his and her emotional state.

- **Understanding**

Empathy is the active cognitive process of becoming aware of another's inner state as well as their beliefs, desires and feelings and communicating these, it is the experience of being touched by another's suffering (Power, 2008). Rogers (1951) emphasized this 'being touched' or experiencing the client's frame of reference as a sustained attitude. Vorster (2009) however states that this experiential aspect of the frame of reference does not imply that the therapist need to feel exactly or has experienced exactly what the client is feeling, but it rather implies an understanding of what the client is feeling. In addition, in empathic therapy, the therapist is displaying the response to the latent and the manifest content of the client's communication. The therapist understands sensitively and accurately the nature of the client's experience as well as the meaning that the client attaches to this experience. It further entails the understanding of the client's world cognitively and empathetically from the client's point of view (Kadushin, 1992). In other words, being able to punctuate from the client's frame of reference is vital for empathic therapy.

- **Conveying Empathic Understanding**

Empathic understanding includes conveying understanding and making certain that the client is aware of this understanding (Vorster, 2009). Empathic understanding improves the helping relationship only when the client clearly recognizes what it is the therapist understands. Communicating empathy therefore enables the client to a sense of caring and understanding and can engender therapeutic change and thus, empathy should be communicated to the individual (Brazier, 1993). Vorster (2009) concurs that a client needs to feel that he/she is being understood wholeheartedly and completely, as well as feel as if the therapist is

respecting him/her and not judging the client to the highest possible level, with the therapist also providing unconditional positive regard and congruency.

Understanding needs to be conveyed in a congruent manner. Effective empathy is evoked and influenced by similarity, familiarity and affection which are conveyed by the therapist to the client. Although empathy is rather a posture or position rather than a repertoire of particular strategies, since certain manners of engaging with and within the therapeutic relationship have come to be seen as effective empathy in practice. This means that the therapist's position is one of empathy and that empathy is not a collective of strategies that are executed upon the client in order to encourage a change in behaviour. One of the most relevant are the therapist's spontaneous, nonverbal responses such as facial expression, these are read by the client as empathic understanding (Vorster, 2009).

At the cost of laboring to the point, the difference between sympathy and empathy will be reiterated. As previously mentioned the empathic therapist feels with the client and not for the client. Feeling for the client is referred to as sympathy and serves as a mechanism to bind people together, it is used as a survival technique and is unwanted, unwelcome and insulting (Kadushin, 1992). The reason for this is that sympathy creates a 'poor me' image of the client, thus immobilizes and places the client in the role of a victim, whereas empathy has an empowering and actualizing force (Vorster, 2009).

According to Kadushin (1992) sympathy is a purely emotional response and is the experience of another/s suffering and therefore not the same or on the same level of empathy as an observational, experiential and communicative entering of one's inner world. These aspects define empathy as an intellectual response. Even though effective empathy is evoked and influenced by similarity, familiarity and affection which is conveyed by the therapist to the client, it also allows the therapist to distinguish him/herself from the client. Sympathy,

however, results in difficulty maintaining a sense of whose feeling belong to whom and confuses the logical levels of communication in the therapeutic context. In such a context, a corrective therapeutic relationship is not possible hence (Clark, 2007) considers empathy as a counterproductive reaction.

3.3.3.3 Unconditional Positive Regard

Unconditional positive regard (UPR) is a central concept in the theories of Carl Rogers, both for psychotherapy and for interpersonal relations. He stressed that the therapist listens intently to clients, sees and feels things from their framework, fully understands their thoughts, feelings and behaviours. According to Rogers (1959) UPR in therapy is a quality of the therapist experience towards the client. He shed a light on various aspect of this construct:

- *Unconditional* – one experiencing UPR holds no condition of acceptance, it is at the opposite pole from a selective evaluating attitude;
- *Positive* – one offers warm acceptance, a prizing of a person, it means a caring of the clarity, showing interest in what the client shares and;
- *Regard* – one regards each aspect of the client's experience as being part of the client, it means a caring of the client but not in a possessive way or in such a way as simply to satisfy the therapist's own needs. It means caring for the client as a separate person, with permission to have his /her own feelings and his/her own experiences

There are a number of key components that make up unconditional positive regard stated by literature review (Corsini & Wedding 2008, Kirschenbaum & Henderson 1990, Ellis 2005 & Tudor & Worral 2006). These are respect, non-judgemental, acceptance, valuing, prizing, caring, nurturing, compassion, warmth and love.

According Rowan (1998) unconditional positive regard can also be called non-possessive warmth. It allows clients to express whatever feelings or thoughts going on inside them. UPR can therefore be defined as caring and valuing somebody unconditionally, without expecting certain behaviours before accepting them. This entails respecting the client regardless of differences in values and worldviews. It is an attitude of valuing the client and expressing appreciation of the client as a unique and worthwhile person. Furthermore, Vorster (2009) states that UPR is when there is no value judgment or judgment of morals and when the client feels accepted and has an experience of congruency and genuine acceptance from the clinician. He states that once the clinician truly understands the client, then there will be no judgment of the client. Therefore, UPR communicates to the client that the therapist does not judge him/her and does not regard him/her as different from other clients.

The understanding of unconditional positive regard lies in the ability of the therapist to have acceptant attitude towards whatever the client is at that moment (Rogers, 1980). According to Rogers, the therapist needs to communicate a deep and genuine caring for the client as a person. The clients need to feel that they are being accepted with whatever immediate feeling is going on. It may be confusion, resentment, fear, anger, courage, love or pride. It mobilizes clients to feel safe when they know they do not have to defend or explain themselves to the therapist in terms of why do they feel the way they do. The process is done by the therapist ability to communicate a genuine caring for the client that is unconditional. This mobilizes the client to be and also enable clients to become more accepting of who they are (Rowan, 1998).

According to Corsini and Wedding (2008) this process does not just happen. It is facilitated by the special conditions of the therapeutic conditions of the therapeutic relationship, the complete freedom to explore every portion of the perceptual field, and the complete, freedom from threat to the self which the person-centered therapist in particular provides. The

literature reviewed above confirms that whenever the therapist is congruent, understanding and caring towards his/her client, the actualizing potential of the client will be released and the client will begin to change and grow. Indeed, UPR sounds like an amazing and positive experience to offer, and to receive, and in many ways it is. According to Sanford (1984) UPR is also a potent agent of change, and as such it precipitates processes that question the status quo and demand new responses to life. Thus, UPR has a significant role in assisting clients in therapy to feel that they are being accepted with no judgment from the therapist and enable them to challenge their own feelings and thoughts. Even within the training context, the three core variables need to be exhibited by both the trainers and trainees.

From the discussion above, it is evident that the two theories centered in this section are mostly emphasized and applied throughout training at Medunsa Campus. Thobejane (2011) therefore summarizes training within this epistemology as learner-centered approach implying "what you put is what you get" (Thobejane, 2011). This suggests that the effectiveness of training would depend on how much the trainee applies him/herself into training. Consequently determination, the use of one as a tool for change, optimism and resilience despite the upheavals that goes with training will contribute in one's success on becoming an effective psychotherapist.

3.4. MASTERS IN CLINICAL PSYCHOLOGY TRAINING AT MEDUNSA CAMPUS

Training in any field involves a systemic series of activities trainees are subordinated to in order to gain new knowledge, skills or behaviour change (Plug, Louw, Gouws & Meyer, 1997). Vorster (in Bosman, 2004) states that training within the context of the University of Limpopo (Medunsa Campus) is experiential, implying that the focus is on participant-learning as opposed to content or rational and intellectual activity alone. It is also based on the premise that psychotherapy is not done, but that one strives to become a psychotherapist.

It is a way of living, a way of existing in the world and within the social environment. If training is effective, significant changes in the interactional style of the trainee, as well as significant changes in the trainee's frame of reference, the way they perceive the environment and others in that environment are to be exposed.

The General Systems Theory is used as a meta-theory into which other major theoretical approaches seemed logically and constructively to fit. The different models and their respective methods are presented separately while still adhering to the overall systemic epistemology. Focus thus remains on integrating these perspectives into punctuating appropriately at different levels of system's functioning.

Below is a summary of modules offered during the masters training at the University of Limpopo (medunsa campus) as outlined by Ernst (2008); Bosman (2004) and Msc1 (2009) study guide :

3.4.1 Modules offered in Clinical Psychology Programme at Medunsa Campus

- **Person-Centered Therapy**

The course begins with Person-Centered Therapy. In this module, close observation of behaviour, impact on others and the reflection of emotions accurately is emphasized and developed. Trainees are also sensitized to the importance of continually being aware of the context in which observed behavior occurs. Furthermore, trainees are introduced to ideal therapist characteristics as propagated by Carl Rogers, which are; empathy, unconditional positive regard and congruence. The expression and communication of empathy is highlighted, as trainees are encouraged to place themselves in the other person's position as well as to hone their ability to accurately reflect emotions.

- **Relationship Therapy**

The main focus of this module is to facilitate the trainee to formulate interactional patterns of behaviour that exist between people. Therefore, the trainee acquires the ability to identify repetitive patterns of behaviour and their components. This allows the trainee therapist to gain an understanding of the client's symptoms and to select appropriate therapeutic interventions. In keeping within the systemic overview, it is emphasized that interventions from various theoretical approaches can be applied. The trainee is thus provided with an in-depth knowledge of selected mainstream approaches in subsequent modules.

- **Couples Therapy**

Trainees are introduced to nuances of conducting therapy with two people involved in a relationship. The main focus is on analysis and facilitation of participant's communication skills. Students are being trained to assist clients in developing an awareness of the clarity of their communication as well as their respective contribution to the interaction. Therapeutic techniques targeting the development of negotiation and accommodation skills are engendered.

- **Psychodynamic**

Aspects covered by the psychodynamic component of the course cover various theories and techniques. An overall perspective of the psychodynamic approach is created through the use of particular theories and techniques. Psychodynamic theory is presented on various levels, from both a structural and topographical perspective with a view of psychopathology and the use of defense mechanisms. These include the process of psychodynamic theory and an understanding of its uses and limitations within psychotherapy. Trainee is also exposed to

psychodynamic techniques such as analysis and use of dreams, imagery, collages and free association.

- **Behavioral Therapy**

Behaviour therapy is approached as an integral basic part of psychotherapy within the context of using the systemic perspective as meta-theory. The basic premise underlying behavioural therapy is explored within specific reference to the fact that, from this premise all maladaptive behaviour is learned and that the focus is on the behaviour and not on the underlying cause. Classical and operant conditioning are dealt with in detail to understand the fundamental role this played in developing behavioural therapy as well as utilizing its principles in effective psychotherapy. Functional Analysis is explored as a diagnostic tool in order to establish the function of the behaviour and ultimately to modify the behaviour of the individual within a therapeutic interaction. Specific behavioural therapy techniques are also covered such as rational emotive therapy, systematic desensitization and assertiveness training.

- **Child Therapy**

Child therapy is a growing development in psychology. It is different from adult therapy as the age and developmental stage of the child influences therapy. It is therefore ensured that trainees have a comprehensive understanding of the child's developmental milestones. The importance of building rapport with the child is stressed. During the course of child therapy, various aspects of child therapy are covered such as normal and exceptional child development, developmental disabilities including causes and classifications of psychiatric conditions as defined according to the DSM IV-TR. The trainee is also exposed to Teddy Bear Therapy developed by Professor Charl Vorster. His therapy has proven to show remarkable effectiveness in addressing specific issues experienced by children.

- **Family Therapy**

The family system perspective holds that individuals are best understood within the context of relationships and through assessing the interactions within the entire family. Symptoms are often viewed as having been passed on across several generations. This perspective is grounded on the assumption that a client's problematic or symptomatic behaviour can serve as a function or purpose for the family and may be a symptom of the family's inability to operate productively, especially during developmental transitions. Trainees are exposed to different symptoms family members present with. They are also equipped on how to become strategic therapists in addressing problematic behaviour. In addition, different models of family therapy are dealt with.

- **Group Therapy**

Training in group therapy is essentially an experiential module and though trainees are continually sensitized to interactions and circular processes during the course of training, trainees attend a compulsory weeklong workshop in Group Therapy, where they are exposed to the group experience. This affords the chance to gain first–hand experience of the processes and corrective emotional experience, upon which second-order theoretical explanations are provided. Special attention is paid to the role of the therapist in group therapy, the structure and formation of a group, group dynamics, membership problems, sub-grouping and conflict within the therapy group.

- **Psychopathology**

According to systems perspective, psychopathology is approached in terms of ineffective interpersonal relationships. Punctuating systemically, special attention is paid to interpersonal maneuvers which could be effective or ineffective. Schizophrenia would for an example be

described as a style of interaction, where the client maneuvers for extreme distance, and therapy would focus on facilitating a more flexible style of interaction. Diagnosis according to systems approach rests on a thorough analysis of the person's interactional pattern, because it can be hypothesized that an individual with a rigid style will be interacting in a similar pattern with the therapist. Psychopathology can also be attributed to ineffective communication through double bind messages and unclear communication. Furthermore, theoretical training in psychopathology consists of an in-depth study of the DSM IV-TR.

All the psychiatric disorders and classifications with the diagnostic criteria are addressed. Additionally, psychopathology is also defined in terms of different theoretical perspectives, primarily from the psychodynamic and behavioural perspective.

- **Neuropsychology**

This is a specialized module in which the anatomical arrangement and function of different neurological structures are covered in depth. The connection between neurological deficits and psychological problems are covered in depth. Trainees are instructed in evaluation techniques specifically geared to assess neurological functioning. A variety on interventions and techniques that can be employed with both the client and his/her family are explored. In this module, the role of the psychologist within a multidisciplinary team of para-medical professionals is emphasized.

- **Medical Psychology**

Within the context of training at the University of Limpopo (medunsa campus), trainees are prepared to function in the hospital environment and face the various demands in the different medical scenarios. Trainees are further required to function as part of a multi disciplinary

team in the various hospital wards; therefore the role of the clinical psychologist is explored in various setting such as the spinal unit, the renal unit and the neurological unit.

- **Psychopharmacology**

Psychopharmacology prepares the trainees to their role within the multi-disciplinary team in clarifying the use of mechanisms of major psychotropic treatments. Different groups of drugs are studied such as antipsychotics, antidepressants, stimulants, hallucinogens, anti-convulsants, narcotics and sedactives.

- **Psychometric Assessment**

One of the roles of the clinical psychologist is to administer psychometric assessment. In this module trainees are provided with adequate skills in the assessment of personality and intelligence. The background and application of instruments are covered as well as the administration of the tests in a professional and ethical manner. The scoring and interpretation of test results are addressed, with special attention to the communication of assessment findings and the writing of professional reports. The tests that are covered include projective tests, intelligence tests, personality tests as well as neuropsychological tests.

- **Community Psychology**

This segment, more than any other, relies on the application of skills. Trainees are expected to formulate and institute projects that would benefit the surrounding community. In addition, various socio-economic and cultural issues prevalent in South African society as well as the psychological well being of individuals, groups and the community at large. The impact of these issues on trainee therapists and how it influences their perception and understanding of behaviour also receives significant attention.

- **Ethics**

The focus of this module is on equipping trainees with regulations, guidelines and the code of conduct within the practice of psychology as stipulated in the Health Professional Council of South Africa (HPCSA) and the Professional Board for Psychology.

- **Research Methodology**

As required by the Health Professional Council, trainees are expected to complete their dissertation during their first year of training or prior the commencement of their internship, in order to accomplish this requirement, they are provided with personal input and instruction by their dissertation supervisors. Therefore, due to the emphasis on research methodology at undergraduate and postgraduate levels of study, no formal module is provided in the curriculum. Personal input from supervisors include aspects such as writing a research proposal, research planning and design, formulation of research questions, review of literature, data collection methods, presenting research findings and the general input on the style, format and writing of the dissertation.

The above modules are presented in a block format, where specific modules are carefully grouped together in order to stimulate trainees and to elicit certain responses that will hopefully facilitate learning and their growth as clinicians. Because the focus of the current study is on the experiences of masters in clinical psychology trainees during their first block of training, the next section will focus on aspects that entail the first block at Medunsa campus. While other blocks importance is acknowledged, they shall not form part in the next section.

3.4.2 The First Block of Training in Clinical Psychology at Medunsa Campus

In an interview with Professor Charl Vorster (2011), the trainer and the course coordinator for masters students at the University of Limpopo (Medunsa Campus), he postulated that the first block of training aims at starting to develop a frame of reference in the trainees which is suitable to form a basis as a therapist. The main focus is on equipping trainees with a person-centered stance or person-centered approach and the necessary skills that go with it such as high of levels of empathy, unconditional positive regard and congruence. Furthermore, the training programme aims to maintain philosophical consistency at all levels of the programme while still acknowledging the influence of the traditional linear approach and integrating various approaches in psychology in a logical an appropriate manner.

According to Vorster (2011) the biggest challenge during the first block is to deal with what trainees have been taught in undergraduate and honours years especially to change the intra-psychic perception towards inter-psychic orientation. This is supported by Sluzki (1974) who states that trainees are usually already well schooled in concepts derived from either a traditional medical model or an intra-personal psychological model, both of which tend to channel their reasoning along dichotomous lines. Therefore, clinical psychology training at Medunsa campus attempts to change the acquired epistemological framework of the trainees with the aim of acquiring the new frame of reference and epistemology.

Several authors raise the question of resistance towards systems thinking on the part of the trainees (Bertalanffy, 1962; Sluzki, 1974; Liddle, 1991). It would seem that this resistance is derived from the trainees' embeddedness in the traditional, linear cause-effect paradigm. According to Bor (1984) this might manifest in overt or covert attempts to contest or reject systemic ideas. It appears that the dominance of the medical paradigm and the linear, dualistic approach in universities result in such behaviours. Important to consider that

trainees from undergraduate and postgraduate studies have been channeled to operate from an intra-psychic point of view which is highly recognized and applauded by universities throughout the world, it therefore becomes a challenge for trainees to adapt and acquire the inter psychic or systemic epistemology after many years of studying and operating in a certain way (Thobejane, 2011).

Vorster (2011) in addition stated that during the first block of training at Medunsa Campus, trainees almost instinctively tend to interpret what they observe instead of sticking with what they are observing; the challenge is to get them to realize what they are observing without interpreting it. According to him, trainees have to move to a frame of reference where there is no interpretation, they have to learn to observe and most of the observation are socially informed and that includes the use of interpretation and judgments. Therefore, to move into a frame of reference where they have to observe purely is overwhelming for them.

The first block further introduces trainees to the non-directive approach which is person-centered therapy. The other bigger challenge during this early stage of training for trainees according to Vorster (2011) is to deal with their own prejudices, to discover that they present with judgmental behaviour and to be confronted with that and be able to start to accept other individuals unconditionally. More challenging is when they have to conduct peer interviews in which they are expected to apply the person-centered interviewing skills under observation. In addressing this, trainees within this context are constantly given feedback by their trainers; by making them aware of their behaviour and the consequences thereof.

Vorster (2011) further argued that language is of paramount importance if one wants to become a psychotherapist. Trainees are often confronted with the challenge of language. According to him, psychotherapy is conducted through communication. Person-centered interviewing as an initial assessment approach is communicated through language and if

trainees do not have a command of at least one language which can be expressed effectively and accurately, they cannot facilitate optimal assessment and psychotherapy as the medium is language. He argues that psychotherapists work with words, without language a therapist cannot be a therapist.

In line with the above, Thobejane (2011) a trainer at the above mentioned institution argued that there is a difference between English language and process or clinical language and the way the two are applied in training. According to her, within the context of training, English as a medium of instruction may seem to favour trainees who are fluent in it and/or those who use English language as their 1st language (mother tongue). These trainees due to their fluent vocabulary seem not to struggle with clinical or process language learned in training as process language is communicated through English. On the other hand, trainees who present with limited or poor vocabulary or who learned English as a second language may seem to struggle with process language used in the training context. Thobejane (2011) further added that for these trainees in their initial phase of training, are faced with a challenge of learning English as a medium of instruction and also clinical language which is communicated in English at the same time. According to her, this might be overwhelming for such trainees.

In dealing with the issue of language, trainers constantly point out the importance of language hence trainees are encouraged to improve their English language by making use of the language laboratory on campus, reading and making use of dictionaries to teach themselves new words as this will assist them to expand their vocabulary. Consequently, fluency in English language will automatically improve their process language.

The above discussion suggests that the first block of training in clinical psychology at Medunsa campus is the most challenging, daunting and overwhelming block as it affects trainees' views about the world significantly. Being exposed to this block implies not only

the acquisition of knowledge, skills and experience but also a shift in identity which involves building an entirely new way of thinking and being within the field of psychology. Additionally, trainees undergo a qualitative change in their activity, attitudes, perception and the logic implied in their reasoning (Bosman, 2004). This implies that the trainee is in a state of flux, in other words there is a high degree of confusion and discomfort. Hence at the beginning of psychotherapy training trainees at Medunsa campus are explicitly warned of the implications of training on them and their significant others. According to (Vorster, 2004) this warning is basically due to personal growth which goes hand in hand with the impact of training.

3.5 CONCLUSION

In keeping the principles of General Systems Theory in mind, this chapter has attempted to make sense of the theoretical aspects associated with clinical psychology training at the University of Limpopo (Medunsa Campus). The researcher specifically zoomed into the first block of training in which this investigation is based on. It can thus be stated that training at the above mentioned institution is experiential and that experiential learning is the vehicle from doing therapy towards being a therapist. This kind of learning requires patience and determination from the trainee psychotherapist.

Trainees thus enter in the world in which they have to form significant relationships with their clients that aims to serve as an emotional corrective experience. Their alliance should certainly be characterized by genuineness, respect and a deeper empathic understanding. During training, trainees strive to exhibit an understanding of the client's frame of reference and to display the core conditions in which the Person-Centered Therapy was developed. However, it must be stated that being able to facilitate the process of displaying congruence, empathy and unconditional positive regard can be challenging. These core conditions that any

effective therapist must obtain cannot be done but can only be a part of a person and a way being. That is, an individual cannot do empathy rather be empathic, one cannot do unconditional positional regard rather be non-judgmental. If these core conditions are done then they will be perceive as incongruent. Thus, trainees in the early stages of their careers struggle in being therapists; however, that is part of experiential learning and becoming effective therapists.

The research process of the current study will be presented in the following chapter.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

Scholars seeking to answer questions about human behaviour and meaning have found experimental and quantitative methods to be insufficient on their own in explaining the phenomenon they wish to study. As a result, qualitative research has gained momentum as a mode of inquiry (Conger, 1998). In addition, there is an increased recognition of the strengths of qualitative inquiry generally since this new science or naturalist paradigm is best fitted to studying social phenomena (Babbie, 2010). Therefore, in the light of the exploratory nature of this research, a qualitative research is deemed appropriate where the researcher immerses him/herself in the world of the participants under study (Neuman, 1997).

Qualitative research can serve many purposes. The most common and useful purposes of qualitative research are exploration, description and explanation. Exploration is the attempt to develop an initial, rough understanding of some phenomenon; description is the precise measurement and reporting of the characteristics of some phenomenon under study and explanation is the discovery and reporting of relationships among different aspects of the phenomenon under study. Although a given study can have more than one of these purposes, and most do, examining them separately is useful as each has different implications for other aspects of research design (Babbie, 2010). In this chapter, the research design and the method of the study will be set out. This will be preceded by a motivation and theoretical grounding for utilising the qualitative approach to research.

4.2 QUALITATIVE RESEARCH APPROACH

Naturalism or qualitative approach is an old tradition in qualitative research. The earliest qualitative researchers operated on the positive assumption that social reality was 'out there' ready to be naturally observed and reported by the researcher as it 'really is' (Babbie, 2010). Trochim (in Ernst, 2008) believes that many qualitative researchers take a specific philosophical stance. On an epistemological level, qualitative researchers believe that the best way to understand any phenomenon is to view it in its context. The qualitative researchers, on an ontological level, do not assume that there is single unitary apart from our perception. Thus, each person experiences reality in his/her own point of view and therefore experiences a different reality. Conducting research without taking this into account violates the fundamental view of the individual.

Shank (2002:5) defines qualitative research as "a form of systematic empirical inquiry into meaning". By *systematic* he means "planned, ordered and public", following rules agreed upon by members of the qualitative research community. By *empirical*, he means that this type of inquiry is grounded in the world of experience. *Inquiry into meaning* pronounces that researchers try to understand how others make sense of their experience. According to Babbie (2010) qualitative research as a method of inquiry is employed in many different academic disciplines, traditionally in the social sciences, but also in market research and further contexts.

Literature proposes that qualitative research as an enquiry process is based on distinct methodological traditions of inquiry that explores a social or human problem in their natural context (Neuman, 1997; Shank, 2002 & Babbie, 2010). This happens in an attempt to make sense of or interpret phenomena in terms of the meanings that people generate among themselves (Gergen & Davis, 1985). Denzin and Lincoln (2000) assert that qualitative

research involves an *interpretive and naturalistic* approach: "This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln 2000:3).

The distinction between quantitative and qualitative research marks a series of differences in approaches to research. At the most surface level, according to Bryne (2001) quantitative and qualitative researchers' base their conclusions on different kinds of information and employ different techniques of data analyses. Quantitative researchers collect data in a form of numbers and use statistical types of data analyses. Qualitative researchers on the other hand collect data in the form of written or spoken language or in the form of observations that are recorded in language and analyze data by identifying and categorizing themes. Qualitative methods allow the researcher to study selected issues in depth, openness and detail as they identify and attempt to understand the categories of information that emerge from the data. Quantitative methods, in contrast, begin with a series of predetermined categories usually embodied in standardized quantitative measures, and use this data to make broad and generalized comparisons. Thus, qualitative approach was considered appropriate for the current study.

4.2.1 Aims of Qualitative Research

Qualitative research is usually equated with a new way of thinking about the world. Qualitative researchers aim to gather an in-depth understanding of human behavior and the reasons that govern such behavior. The qualitative method investigates the *why* and *how* of decision making, not just *what, where, when*. Hence, smaller but focused samples are more often needed, rather than large samples (Kvale, 1996).

In addition, qualitative research aims to understand social life and the meaning that people attach to everyday life and to understand the subjective world of the participants. In its broadest sense, it refers to research that elicits participant's accounts of meaning, experience or perceptions (Patton, 2002). It also produces descriptive data in the participant's beliefs and values that underlie the phenomena. The qualitative researcher, therefore, is concerned with the understanding of a phenomena being studied. The data in qualitative research is in the form of words, including quotes or descriptions of particular events (de Vos in Ernst, 2008).

4.2.2 Characteristics of Qualitative Research

Some general qualitative research characteristics have been identified by Moon, Dillon and Sprenkle (1990). According to Moon *et al* (1990) qualitative researchers explore naturally occurring events in context. This concurs with Bateson's view that: "the emphasis in social research is on studying naturally occurring behaviour without disrupting the historical and international integrity of the whole setting" (Keeney & Morris, 1985:49). This indicates that there is no interference by the researcher in the context of the research. To reinforce on this aspect, Bateson (1979) states that words and actions gain their meaning from the context. Therefore, the context becomes an important medium through which people's words and behaviour can be understood. Participants are allowed to be and every input needs to be from the perspective of the participant. In this way, it is maintained that qualitative research is sensitive to human situation, as it involves a dialogue with the subject being studied and it may contribute to the emancipation and empowerment of the participants. According to Dlamini (2005), punctuating from the psychological point of view this maybe therapeutic.

(Neuman, 1997) stipulates the following characteristics of qualitative research:

- Concepts are in the form of themes, motifs and generalization;

- Methods are created in an ad hoc manner and are often specific to the researcher or individual setting;
- Data is in the form of words, formal documents, observations and transcripts;
- Theory can be causal or non-causal and is often inductive;
- Research procedures are particular and replication is very rare;
- Analysis proceeds by extracting themes or generalizations from evidence and organizing data to present a coherent, consistent picture.

4.2.3. Strengths and Limitations of Qualitative Research

According to Bless and Higson-Smith (1995) qualitative research is considered to be very helpful in exploratory research. Qualitative research permits the researcher to study selected issues in depth and detail (Patton, 1990). Approaching fieldwork without being constrained by predetermined categories of analysis, contributes to the depth, openness and detail of qualitative enquiry (Mouton, 2001). This enquiry further allows for the investigation of phenomenon that is not easily controlled (Neuman, 1997). In line with this approach, themes and patterns are identified by logical reasoning and then described in a narrative manner. The idea of describing the identified patterns is to generate or confirm hypotheses and to explore new frontiers (Mouton, 2001). These techniques will thus help to clarify concepts and problems and would also allow for the establishment of a list of possible answers or solutions which might facilitate the construction of multiple choice questions, etc. In addition, qualitative enquiry allows for the discovery of new aspects of the problem by investigating in detail some explanations given by respondents (Bless & Higson-Smith, 1995).

In contrast, Babbie (2010) argues that the major criticism against qualitative research is the notion that introspection is very subjective and there is no way to establish how reliable a person's description of his/her own experience is. The subjectivity of the researcher or researcher's bias is also an area of concern. Researcher's bias contaminates objective facts and should be eliminated (Bosman, 2004). Moon *et al.,* (1990) argues that in qualitative research, the human mind tends to select data in a way that confirms a tentative hypothesis. Therefore, the end product of that which the researcher wants to illuminate, might expose one context of training to have been worse than the other, in that way channelling the study and showing bias in the study itself. According to Dlamini (2005) there is also a tendency for first impressions to endure even in the presence of considerable contrary data.

Science as an enterprise is dedicated to 'finding out' (Babbie, 2010). No matter what the researcher wants to find out, though, there will likely be a great many ways of doing it. Ultimately, scientific inquiry comes down to making observations and interpreting what one has observed. Before the researcher can observe and analyze, a plan is needed. That is what a research design is all about.

4.3. RESEARCH DESIGN

According to Babbie (2010) any research design requires researchers to specify as clearly as possible what they want to find out and then determine the best way to do it. Therefore, qualitative research design involves the entire process of research, from conceptualizing a problem to writing the narrative. In developing a research design, the researcher must make a series of decisions along four dimensions as highlighted by Terre Blanche and Durrheim (1999):

- The purpose of the research;

- The theoretical paradigm informing the research;
- The context or situation within which the research is carried out; and
- The research techniques employed to collect and analyse data.

Multiple considerations that derive the above four dimensions must be woven together in a coherent research design in a way that will maximize the validity of the findings (Terre Blanche & Durrheim, 1999). This process that encompasses the four dimensions alluded above is discussed next.

4.3.1. The Aim of the Study

The aim of this study is to explore the subjective emotional experiences of the Msc1-Clinical Psychology trainees at the University of Limpopo (Medunsa Campus) during their first block of training.

4.3.2. Research Question

What are the subjective emotional experiences of the Msc1-Clinical Psychology trainees at the University of Limpopo (Medunsa Campus) during their first block of training?

4.3.3 Objectives of the Study

The objectives of the study are:

a) To explore the subjective emotional experiences of trainees during their first block of training within the training context;

b) To explore whether trainees experience these emotions even outside the training context; and

c) To explore how trainees deal with such emotional experiences.

4.3.4 Procedure

The research needs to be accepted and the necessary research permission granted by the Medunsa Research Ethics Committee (MCREC). Permission will be obtained from the participants and the course coordinator while the researcher will ensure that each participant signs a consent form before commencing with interviews followed by a biographical questionnaire (Appendix A & B). Participants will consist of trainees in the 2011 training course and will be interviewed in the training context during their first block of training.

Interviews will be scheduled according to the availability of the trainees and will be conducted in the training context. The interview will start off with the setting of the context and giving a short summary of the aims and objectives of the study. Interview guide (Appendix C) will be used to collect data in which specific questions will be asked and probing will be used to clarify answers. The researcher will maintain the person-centered stance in which communication will be expressed with congruency, empathy and unconditional positive regard. The time frame of the interview will be approximately an hour.

4.3.5 Sampling

Babbie (2010) defines sampling as a process of selecting observations. Moon *et al.,* (1990) define it as a process used to select cases for inclusion in a research study. According to Terre Blanche and Durrheim (1999) all empirical research is conducted on a sample of cases, which may be individuals, groups, organizations or archival documents. Sampling is a very important aspect of research as the type of conclusions that can be drawn from the research depend directly upon whom the research was conducted. Therefore, the researcher must ensure that the sample is collected in a systematic manner, so that the impact of the sample members on the results can be estimated and evaluated (Terre Blanche and Durrheim, 1999).

Kumar (1996) argues that the process of selecting a sample from the total population has advantages and disadvantages. The advantages are that it saves time as well as financial and human resources. However, the disadvantage is that the researcher does not find out the facts about the population's characteristics of interests but only estimate or predict them. Hence, the possibility of an error in the researcher's estimation exists. Tolerance of this possibility of error is an important consideration in selecting a sample.

Due to the nature of the clinical psychology training programme, only a limited number of trainees are selected each year. For this study, a sample of convenience will be drawn from the present 2011 first year trainees in the Masters course in clinical psychology at the University of Limpopo (Medunsa Campus). The sample size will consist of 5 volunteered candidates. De Vos (in Ernst, 2008) postulates that if the population itself is relatively small, the sample should comprise a reasonably large percentage of the population. Therefore, the proposed sample is considered to be adequately representative.

4.3.6 Data Collection

Data is the basic material with which researchers work (Terre Blanche & Durrheim, 1999). McMillan and Schumacher (2001) state that qualitative researchers collect data in a face-to-face situation by interacting with selected persons in their settings. Through data collection, a detailed narrative description, analysis and interpretation of a phenomenon is provided. It provides verbal descriptions to portray the richness and complexity of events that occur in their natural settings from the participant's perspectives.

According to Kumar (1996) interview is a common method of collecting information from people. It is the predominant mode of data gathering in qualitative research. Any person-to-person interaction between two or more individuals with a specific purpose in mind is called an interview. Interviewing can be very flexible when the interviewer has the freedom to

formulate questions as they come to mind around the issue being investigated, and on the other hand it can be inflexible when the investigator is to keep strictly to the questions decided beforehand. Therefore, interviews are classified according to the degree of flexibility as structured and semi-structured.

Kumar (1996) highlights the following as the advantages of qualitative interview:

- *The interview is more appropriate for complex situations:* it is the most appropriate approach for studying complex and sensitive areas as the interviewer has the opportunity to prepare a respondent before asking sensitive questions and to explain complex ones to respondents in person;
- *It is useful for collecting in-depth information:* in an interview situation, it is possible for an investigator to obtain in-depth information by probing. Hence, in situations where in-depth information is required, interviewing is the preferred method of collecting data;
- *Information can be supplemented:* an interviewer is able to supplement information obtained from responses with those gained from observation of non- verbal reactions;
- *Questions can be explained:* it is less likely that a question will be misunderstood as the interviewer can either repeat a question or put it in a form that is understood by the respondent; and
- *Interviewing has a wider application:* an interview can be used with almost any type of population.

On the contrary, Neuman (1997) states the following as major concerns regarding qualitative interviewing:

- Errors by the respondents such as forgetting, misunderstanding and lying;

- Unintentional errors or interviewer's negligence such as omitting questions, misreading a question or misunderstanding the respondent;
- Intentional subversion by the interviewer such as purposeful alterations of answers, omission or rewording of questions;
- Influence due to the interviewer's expectations about a respondent's answers;
- Failure of an interviewer to probe or to probe properly; and
- Influence on the answers due to the interviewer's appearance, tone, attitude, reactions or comments made outside of the interview schedule.

In the present study, data will be collected through semi-structured interviews conducted by the researcher. In a semi-structured interview, the interviewer develops a framework called an interview guide within which to conduct the interview. An interview guide provides a list of questions to be explored during an interview where the interviewer is able to explore, probe and ask questions that will illuminate that particular subject (Patton, 2002). According to Bosman (2004) probes are used to deepen the response to a question, to increase the richness of the data being obtained and to give cues to the interviewee about the level of response that is desired. In addition, Babbie (2010) argues that probes are more frequently required in eliciting responses to questions. An interview guide will further help to reduce the potential sources of bias. Kumar (1996) postulates that this approach of data collection is extremely useful in situations where either in-depth information is needed or little is known about the area. Interviews will therefore be conducted in a qualitative manner utilizing an interview guide (Appendix C).

These interviews will be audio taped and later transcribed. Patton (2002) states that audio recording is indispensable during interviewing because the interactive nature of in-depth interviewing can be seriously affected by the attempt to verbatim notes during the interview.

Furthermore, interviews will be conducted in a person-centered manner. According to Bosman (2004) person-centeredness creates a climate in which the participant could feel understood, accepted and respected. It allows the participant to reveal his/her opinions without being restricted in any significant manner and with little interference from the researcher. Patton (in Bosman, 2004) in addition postulates that a good interview lays open thoughts, feelings, knowledge and experience. Thus, a person-centered stance facilitates this process.

4.3.7 Data Analysis

Data analysis is an assessment of observations made through participant observation (Babbie, 2010). It is the process of bringing order, structure and meaning to the mass of collected data (Bosman, 2004). Therefore, the qualitative researcher interprets data by giving it meaning, translating it or making it understandable.

According to Terre Blanche and Durrheim (1999) data analysis techniques should be carefully considered when designing a study, since the aim of data analysis is to transform information or data into an answer to the original research question. A careful consideration of data analysis strategies will ensure that the design is coherent, as the researcher matches the analysis to a particular type of data to the purposes of the research and to the research paradigm. Qualitative data techniques begin by identifying themes in the data and relationships between these themes. The qualitative researcher thus ensures that the type of data analysis which is employed matches the research paradigm, data and can answer the research question.

In this study, data recorded will be transcribed verbatim into written text. According to Patton (2002), full transcriptions of interviews are the most desirable data to obtain because transcripts are useful in data analysis and also in replications or independent analysis of the

data. In order to safeguard this study against bias these transcripts will be presented to two independent clinical psychologists, to obtain their clinical observations and comments regarding the subjective emotional experiences of Msc1- trainees in clinical psychology at the University of Limpopo (Medunsa Campus) during their first block of training.

The method of data analysis that will be used in the present study is discussed next:

4.3.7.1 Thematic Analysis

There are many ways to analyze information about participants' experiences, and thematic analysis is one such way (Aronson, Boyatzis & Bryne in Sethuntsa, 2009). According to Braun and Clarke (in Sethuntsa, 2009), thematic analysis is widely used but it is rarely acknowledged and there is no clear agreement about what it is and how to go about doing it. However, it is widely used to explore and report experiences, meanings and realities of participants.

Thematic analysis is a method that works to both reflect reality and to reveal the underlying meanings. Data usually originates from interview transcripts or observation notes and must represent major themes or categories that describe the phenomenon being studied (Fereday & Muir-Cochrane, 2006).

Different authors and researchers use varying steps to conduct thematic analysis. The following step-by step process of analysis is a method of demonstrating transparency of how data in the next chapter will be analyzed by the two independent clinical psychologists:

- *The first step*: is for the analyst to familiarize herself with the data by reading and re-reading the transcripts (Bryne, 2001);
- *The second step:* is to engage with the data by reflecting on what each participant communicated their thoughts, comments, the interview process and the emotions

presented. Notes will be made on the transcripts regarding anything that appears significant and of interest (Denzin & Lincoln, 2000);

- *The third step:* is to summarize the brief biographical information of each participant and then to identify natural meaning units in the interview data. Kruger (1979); Frith and Gleeson (2004), define meaning units as statements made by the subject which are self-definable and self- delimiting in the expression of a single, recognized aspect of the subject's experience. The data will be analyzed and presented in relation to the questions that form the framework for the interviews (Gleeson 2004; Fereday & Muir-Cochrane, 2006). The natural meaning units will be supported by quotes from the text to ensure that data interpretations remain directly linked to the words of participants. According to Fereday and Muir- Cochrane (2006), participants' reflections, conveyed in their own words, strengthen the face validity and credibility of the research;

- *The fourth step:* is to, based on the previous steps present a description of each participant's experiences related to the various questions posed during the interview. The analysts will identify possible underlying meanings in the text (Silverman, 1993);

- *The fifth step:* is to identify themes from the data of all participants in relation to each question. A theme will be an experience that has been very strongly emphasized by one participant as well as those experiences that are mentioned by more than one participant (Bryne, 2001 & Silverman, 1993); and

- *The sixth step:* is to present an overall description of the identified themes that emerged across the participants (Kruger, 1979).

The researcher on the other hand, will focus on the themes identified by the analysts which will be later displayed in a conceptually ordered cross-case display utilizing a visual displayed bar graph. According to Bosman (2004) a visual display is used because it provides a concise summary of the research findings and enables the reader to assess the importance of themes and identify patterns at a glance. Kumar (1996) states that bar chats offer a useful means of presenting large amounts of detailed information in a small space. They are useful for displaying categorical data. Through the visual graphic display integrated with the identified themes by the analysts, the researcher will hopefully establish the subjective emotional experiences of the Msc1-Clinical Psychology trainees at the University of Limpopo (Medunsa Campus) during their first block of training.

4.3.8. Quality and Trustworthiness

Lincoln and Guba (1985) posit that trustworthiness of a research study is important to evaluating its worth. In any qualitative research project, four issues of trustworthiness demand attention. These are credibility, transferability, dependability and confirmability. To ensure quality and trustworthiness, these concepts will be briefly discussed and how they will be applied in the current study:

- **Credibility:** credibility is an evaluation of whether or not the research findings represent a credible conceptual interpretation of the data drawn from the participants' oral data (Lincoln & Guba, 1985). To ensure credibility in the current study, participants will take part voluntarily. Participants will also have the right to refusal should they feel uncomfortable to engage in the study. Interviews will be conducted by the researcher, who has been trained in interviewing skills and has acquired knowledge and experience as she worked as an intern clinical psychologist at Dr George Mukhari Hospital, where she conducted psychotherapy within the hospital

context. In addition, constant discussions and guidance from the supervisor of the current study will assist the researcher to validate the interpretations and findings of the present study. To further ensure credibility data will be analysed by two independent clinical psychologists who are experienced in qualitative research.

- **Transferability:** transferability is the degree to which the findings of this enquiry can apply or transfer beyond the bounds of the project. Findings from the study should be able to be transferred to similar situations or participants (Lincoln & Guba, 1985). To ensure transferability of this study, the number of sampled participants of the current study was mentioned, the method of data collection and analysis were discussed in depth and the context in which the interviews will be conducted was provided.

- **Dependability:** dependability is an assessment of the quality of the integrated processes of data collection, data collection and theory generation. The findings of a study are to be dependable, consistent and accurate (Lincoln & Guba, 1985). To ensure dependability in the current study, the researcher discussed at length the research methodology, the research design, the method of data collection and data analysis appropriate to the present study.

- **Confirmability:** confirmability is a measure of how well the inquiry's findings are supported by the data collected (Lincoln & Guba, 1985). In achieving confirmability in this study, a detailed step by step process of data analysis was provided. Furthermore, the next chapter will present findings of the study systematically according to the steps outlined by analysts (see page 109).

The next section presents the method followed during the research process.

4.4 RESEARCH METHOD

4.4.1 Research Context

According to Bosman (2004) in qualitative enquiry the researcher is the instrument, a qualitative report must therefore include information about the researcher. It is thus deemed appropriate to consider the experience, training and perspective of the researcher in this study.

In line with the above, Patton (in Bosman, 2004) states that every researcher brings preconception and interpretations to the problem being studied, regardless of methods used and it is important to consider the researcher's personal connections to the people, programme or topic under study. The principle is to report any personal and professional information that may have affected data collection, analysis and interpretation; either negatively or positively in the minds of users of the findings.

The researcher in the current study was trained in clinical psychology at the University of Limpopo (Medunsa Campus) and thus trained in the principles of General Systems Theory and its applications as a meta-theory. The researcher fully identifies with the emotional experiences of trainees during their first block of training as she herself has experienced such. In the current study, the researcher has taken advantage of her personal insight and training and this enabled participants to feel comfortable and engage openly in the study.

According to Neuman (in Bosman, 2004) rather than hiding behind "objective" techniques, the qualitative researcher is forthright and tells readers how she gathered data and how she sees the evidence. The two Clinical Psychologists involved in the data analysis were selected on similar grounds. They were both trained at the University of Limpopo (Medunsa Campus) and therefore operate from the same epistemological paradigm as the researcher. This

provided appropriate information and analysis of the study, which was incorporated with researcher's own investigation, experience and observations. The analysts are however, not involved in the training programme at the university. According to Bosman (2004) this might have influenced the analysis and concerns regarding confidentiality.

4.4.2 Research Procedure

The research procedure as set out under the research design was followed.

4.4.3 Research Sample

Sampling was done as outlined in the research design.

4.4.4 Data Gathering

Data was gathered as set out on the research design. In addition, due to the in-depth nature of qualitative interviewing, interviews were experienced similar to a therapeutic situation. Therefore, it was important as highlighted in the research design for the researcher to remain person-centered.

4.4.5 Data Analysis

Interview transcripts were presented to two clinical psychologists who did a thematic analysis as originally planned. These transcripts were based on the following question: "what are your observations and comments regarding the experiences of trainees in clinical psychology at the University of Limpopo (Medunsa Campus) during their first block of training?" The clinical psychologists then reached a consensus through a process of discussing the main themes in the transcripts provided by the researcher.

4.4.6 Quality and Trustworthiness

Quality and Trustworthiness of the current study was ensured as stipulated in the research design.

The following chapter presents a qualitative analysis of data and the main themes emerging from the results are outlined.

CHAPTER FIVE

PRESENTATION OF RESULTS

5.1 INTRODUCTION

The aim of this chapter is to present the results of the current study; this will be followed by a visual displayed bar graph of summarized identified themes from the analysts. Important to note that in presenting the results of this study, the steps outlined by the analysts in the previous chapter will be followed for each participant.

5.2 AIM OF THE STUDY

The aim of this study is to explore the subjective emotional experiences of the Msc1-Clinical Psychology trainees at the University of Limpopo (Medunsa Campus) during their first block of training.

5.3 RESEARCH RESULTS

As outlined in the research design, two analysts conducted a thematic analysis by identifying themes and reaching a consensus based on the following question: "what are your observations and comments regarding the experiences of trainees in clinical psychology at the University of Limpopo (Medunsa Campus) during their first block of training?" The research results are presented in the next section.

Full transcripts of the interviews will be available on request from the researcher.

5.4. PARTICIPANTS EXPERIENCES

5.4.1 First Participant

5.4.1.1 Summary of the biographical information and identification of natural meaning units in the interview data.

- **Biographical description**

First participant was a 22 years old single black female. She did her undergraduate studies at the University of Pretoria and her Honours in Psychology at the University of Limpopo (Medunsa Campus). She had no working experience in psychology.

- **Identification of natural meaning units from the interview data**

She gained insight and described the first block as tormenting.

> *"....I am almost seeing the light compared to when I first started, the first block was harrowing…"*

She had to make a shift from being employed to being a student and depend on others.

> "*….I got here straight from working and you know I wasn't really used to being a student…… being a child again depending on someone else…"*

She experienced the first block as emotionally draining and felt vulnerable.

> "*…It was an emotionally draining experience……. You feel emotionally vulnerable……. It was overwhelming…"*

She expected to be trained in psychodynamics as she was familiar with this school of thought and was introduced to a different paradigm that left her feeling like she had wasted a lot of time during her undergraduate years.

"....I got here expecting you know, we going are to be trained in… whatever you know, psychodynamic you know and you know so much from undergraduate and then you get here and they tell you, no, that's not how we going to train you and this is what we are doing, and it seems like whatever I have done, you know from undergrad up to honours, I've just wasted my time, what about all those studies that I've actually done you know because it seems like they were nullified…."

She experienced her previous knowledge acquired in psychology as invalid, she had to become an empty vessel and subsequently she felt incompetent and inadequate.

"…all you've learned all your life is psychology as we know it and then suddenly (giggles) when you get here is like disregarded, you now forget what you've learned, you become an empty vessel and you like left there so.., It was just one of the worst feelings ever because you just felt like you were alone, no one understood what you were going through, you felt bad, you felt stupid, you felt inadequate…"

She expected to do assessments and receive knowledge based on the psychiatric frame of reference, however, she found out she was going to punctuate from a systemic perspective and learn person-centred therapy; as a result she felt her dreams were shuttered.

"…I thought I'm going to do assessments, I'm going to learn tests and knowledge based on the psychiatric frame of reference and when I got here we were told no, we are doing systems, we doing person- centered and you like.. Ja.. okay fine but you still expecting to do assessments, they emphasis the use of person- centered therapy you know and you thought wow all my dreams are crushed…"

She experienced ambivalence as her expectations were not met; however she got insight into the importance and effectiveness of thinking about the best interest of her clients and being in the client's frame of reference.

> *"...I wanted so badly to excel in psychometric testing and research and all of that but at the same time it was enlightening because if I think about how we always do or see therapy, it's always about what the therapist's know, always about the therapist knows best you know but when I actually thought about it, you being in the clients frame of reference, you actually there with the client you know and it was actually something that I've never experienced before, it was quite deep, it was quite deep…"*

She experienced training as anxiety provoking as she was worried if the world was ready to accept the paradigm as other universities punctuated from different paradigms.

> *"...It felt like literally me against the world because it's new stuff and is the world ready to accept what we are learning here because if I'm not mistaken we are the only university which is training in this kind of way. So I was actually very scared, I was very afraid…."*

She found it challenging to learn process language and to learn how to accurately reflect emotions and the intensity.

> *"...When it comes to process language it's something else, you know nothing, you don't even know how it's like when you know something…..... It's like you know the feeling but you can't pinpoint it you know, until your lecturer actually says it's disappointment... because at most you knew the emotion but then depending on the intensity as well, that was another thing because it would be sad and you are told no..*

there is an element of sadness, it's not quite sad and you sit there and scratch your head…"

Despite the challenges, with practice she gradually felt competent and confident.

"…but as time went on it was a lot simpler with practice you know and then you start feeling adequate, you start feeling a bit confident again…"

The inability to reflect feelings inaccurately left her feeling despondent and it also affected her self confidence. She described herself as very competitive in nature; as a result, she put pressure on herself and when her standards were not met she felt depressed.

"…I actually got to a point where I was despondent because you think you know the emotion and you come to class and listen to it and it's like that reflection was not accurate…. your self confidence it's like took a knock you know….. for me as a very competitive student you know I felt inadequate, I felt that if I don't get this, I felt pressured as well…. if I don't perform you know.., then it led me to actually become a bit depressed…"

She described the first two weeks as horrible as she was adjusting to the context of being a student again and at the same time she was experiencing family conflicts, consequently she became isolated.

"…at the most I think the first two weeks were just horrible…. I was used to being working and I was independent… I just felt so alone, I'm struggling with school and on the other hand there is rift within my family you know, I just felt bad. I would come to class and smile, be incongruent….. I just isolated myself…"

During the first two weeks she had a fight with her friend and she was able to take a meta-perspective and acknowledge the long standing pattern and decided to distance herself from that relationship.

> *"...I had emm... a fight with a friend of mine a very dear friend of mine..... you know interpersonal communication and what happens between people. I suddenly just saw things that were there that I never saw, and it was just hard to actually acknowledge that and it was hard to actually accept that it has been happening all along..... I distanced myself from her"*

She lost friends; became a-social and she was prepared by her trainers that this would happen.

> *"...I actually lost a friend and a couple more but they are not so close but they are also part of my network. I remember our trainers told us when we started that you should expect to lose friendships, don't make any life changing decisions within the first two years of your training just wait, whatever he was talking about has happened to me"*

She felt ambivalent regarding how the training has impacted on her interpersonal relationships as she feared inevitable isolation.

> *"In a way I'm happy because it has opened my eyes to see what has been happening in my relationships.... it's sort of a blessing and it's sort of a curse because sometimes I just think maybe if I didn't know what was going on it could have been better you know but at the same time I think that as a person I need to grow, I need to move on and if it means that my eyes are opened and life moves on in this way, I just have to realize what the consequences are but then it leaves me kind of emm... I'm a bit anxious about it, apprehensive, I'm scared because I know what the possibilities*

are and I'm… I don't know what the future holds but it leaves me a bit scared because does this mean how many more of my relationships will experience you know this sort of distance and to what extent will I be isolated as a clinician eventually"

She seemed to be settling into the training context but still concerned about the academic, mental and emotional challenge; she described the process as a long journey.

"I'm settling in quite nicely…. after we received feedback on Monday about our assessments…… I was motivated… in terms of the turmoil emotionally emm… from the first block, I think now I can handle things a bit better……. you know there is still a bit of concern…. there is the academic challenge, there is mental challenge and there is emotional challenge. So I think the emotional challenge scares me the most…. exploring emotions all the time and speaking about things that are uncomfortable for me you know that's gonna be a challenge….it seems like it's going to be a long journey, a very long journey"

She described the training process as experiential learning and she was forced to use her mind unlike in other contexts that she described as mainstream in which answers were readily available.

" …it forces you to…. apply your mind in a different way, you don't go within typical mainstream that you will find the answers readily available for you, so you know this one I feel it's more open, it's experiential learning"

She experienced the training context as supportive.

"I find it very supportive because it's not one on one with our lecturers, everybody is involved so you don't feel at all like you are alone…. you always have support from your group members"

She experienced the training context as uncomfortable as she felt guarded.

> *"…how can I put it not comfortable, uncomfortable in the sense that it takes you out of your comfort zone…. here you sort of guard yourself…."*

She lacked clarity on how the lectures rated the assessments.

> *"…we don't know how we were assessed, we were just assessed and we got a mark that's it…. I just feel that like at times you don't get a clear answer"*

She experienced favouritism during the mark giving process that was associated with racism which worried her.

> *"….but I feel at the moment that there was sort…emm… of…favouritism that happens…I just thought perhaps the marks were also influenced by that…. that just makes me worry because if you are not liked what's gonna happen to your marks and if you are penalized because you are black that's not fair you know…"*

She also felt conflicted that the favouritism may not be racial as she was black and favoured by the lectures.

> *"I just feel that certain individuals are favored more so than others because if it were racial I would have been excluded from that group, but I'm one of the people that are always picked on to speak….I can't really say it's the issue of colour but it must be something else but I'm not sure what it is but there is something there"*

> "*…so yes there is a black person victimized because she doesn't speak English properly so why is the Afrikaans speaking persons not victimized because their English is also not good, what is the difference? Skin color? so it's sort of racial in that respect"*

She spoke about the favouritism in an appalled manner and felt that the lectures were not practicing what they preached to them.

> *"….there is definitely favoritism where certain members of our group are always teased or you know laughed at than others….I don't know or whether they are trying to test us in a way. I'm not sure but there is something definitely going on there, so I hope it's addressed…..there shouldn't be favouritism in the first place because this is not a context for such, it's a learning context and no one should be discriminated for having something or for not having something. I believe if you are preaching unconditional positive regard for people then you should have unconditional positive regard for everyone in class, otherwise then, you are being incongruent and that confuses me, you teaching us one thing then you are doing something else but then because you are a lecturer does that makes it okay you know…. it just doesn't sit well with me…"*

She experienced intense concern regarding racism and this impacted on her emotionally.

> *"I am very concerned because it really hurts because as a black person how much are we really gonna struggle still to be heard to be equal to everybody else, why should we be secluded, why do we have to fight for everything you know.. it's tiring…. so it really hurts me that what I can do at the most is keep quite during class when other people are been victimized… and then afterwards give my support…..it makes me really angry"*

She interacted with her group mates to avoid racial divide.

> *"....I speak to the rest of my group mates because I feel it's important not to segregate myself and I feel that it's important not to have a divide because I have already seen that there is already a racial divide"*

She received empathy from her group mates as she did not receive empathy in her social context.

> *"I normally talk to my group mates because that's the best I can do, they understand our context, no one outside this context understands".*

She had a need for support system and feared to be isolated.

> *"....You can live alone and get time to reflect but you still need some support system you know..."*

5.4.1.2 Description of the participant's experiences relating to questions posed.

The first participant gained insight during the first block of training and described the first block as tormenting. She had to make a shift from being employed to being a student and dependent on others.

She expected to be trained in psychodynamics as she was familiar with this school of thought and was introduced to a different paradigm that left her feeling like she had wasted a lot of time. She experienced her previous knowledge acquired in psychology as invalid, she had to become an empty vessel and subsequently she felt incompetent and inadequate.

She expected to do assessments and receive knowledge based on the psychiatric frame of reference but she found out she was going to punctuate from a systemic perspective and learn person-centred therapy, as a result, she felt that her goals were shuttered. She experienced

ambivalence as her expectations were not met; however she got insight into the importance and effectiveness of thinking about the best interest of her clients and being in the client's frame of reference. The newly found experience was anxiety provoking, she was worried if the world was ready to accept the paradigm as other universities punctuated from a different paradigm.

She found it challenging to learn process language and to learn how to accurately reflect feelings and the intensity. Despite the challenges; with practice, she gradually felt competent and confident. The inability to reflect feelings inaccurately left her feeling despondent and it also affected her self confidence. She describes herself as very competitive in nature; as a result she put pressure on herself and when her standards were not met she felt depressed. She further experienced the training context as emotionally draining and this made her feel vulnerable.

She described the first two weeks as horrible as she was adjusting to the context of being a student again and at the same time was experiencing family conflicts, consequently she became isolated. In addition, during the first two weeks she fought with her friend and she was able to take a meta-perspective and acknowledge the long standing pattern and decided to distance herself from that relationship. She further lost friends, became a-social and she was prepared by her trainers that this would happen. She has ambivalent feelings regarding how the training has impacted on her interpersonal relationships as she fears inevitable isolation.

She seemed to be settling well into the training context but still concerned about the academic, mental and emotional challenge, however, she described the process as a long journey.

She described the training context as experiential; she is obliged to use her mind unlike in other contexts that she described as mainstream and answers are readily available. She experienced the training context as supportive. On the other hand, she experienced it as uncomfortable as she felt guarded. She lacked clarity on how the lectures rated the assessments as she experienced that as lack of transparency.

She further observed favouritism during the mark giving process that was also associated with racism which worried her. On the contrary, she also felt that favouritism may not be racial as she was black and favoured by the lectures. She spoke about favouritism and racism in an appalled manner and felt that the lectures are not practicing what they preach to them. She experienced intense concern regarding racism and favoritism which impacted on her emotionally.

She tried to communicate with her group mates to avoid the racial divide. She received empathy from her group mates which she did not receive in her social context. She further stated a need for a support system and fears isolation.

5.4.2 Second Participant

5.4.2.1 Summary of the biographical information and identification of natural meaning units in the interview data.

- **Biographical description**

The second participant was a 22 years old single black female. She did her undergraduate studies at the University of Pretoria and her Honours at the University of Limpopo (Medunsa Campus). She had no working experience in the field of psychology.

- **Identification of natural meaning units from the interview data**

She approached training with enthusiasm; however, she expressed feeling shocked when she was introduced to different concepts which she struggled with.

> *"…when I first got here it was yeh superb, this is masters, I'm so excited about this and then as time went on we were introduced to so many things and I was really shocked….They introduced concepts that has PCT, the empathy and the congruence and what's the other one ..UPR. The empathy I get that but the judgment one I really still grabbling with that one because I have so many opinions about everything I was taken aback by also the fact that we need to be empty vessels and I'm really struggling with that… "*

She felt the concepts of PCT sometimes seemed mechanical.

> *"…it's like a person is talking to me and I'm thinking UPR, UPR, no judging, no judging like, Ja so oh it's a bit mechanical like I don't know. I hope I get to the point where you know it, becomes natural you know that I can just come off. I don't have to consciously think about it, that it's a part of me"*

She experienced feelings of frustration when she learnt that the previously acquired knowledge in psychology was useless.

> *"….they told us that the things that we have learned for the past four years undergraduate and honors were almost completely useless. I was really flawed…and I was like what is the point of doing undergrad and honors"*

She felt frustrated that they were not introduced to an inter-psychic way of thinking during her previous studies and all along she thought that psychology was about psychoanalysis and this made her feel stupid.

"…I was really frustrated by the fact that we didn't know these things you know during our prior training, the four year degree that we did. I feel completely stupid because I would have been so far by now…we've been trained in the more psychiatric frame of reference and now we are trying to go to more inter- psychic, it's a really fresh concept that makes sense to me now, at first I was like what is the point. I thought psychology was about psychoanalysis, there's nothing more to it…"

She experienced checking in to be irritating and uncomfortable and wished it could be optional.

"…I really found checking in irritating, initially I was like why do we have to do this, I don't get this, like why can't we just come to class? Can't this be optional? I don't want this people in class; lecturers and my colleague knowing what's going on in my life. I don't feel comfortable maybe if it's one or two persons I can confide in them but the rest of them it's like no…"

She fears being judged which resulted in her feeling vulnerable and exposed.

"…I don't want them to know because I feel like some of the things you know are confidential. I may experience judgment from them although most of the time they are not judging me, I still have that preconception that if I say stuff like this people are just gonna be shocked and then judge me and question the type of person I am so Ja... I feel like this context it's just removing all the layers now because I'm a person who is constantly guarded you know. I do not like people to get under my skin to know me, to know what's going on with my life, it's maybe one or two persons who are my close friends but for other people, I feel like they are just shredding away those or peeling them off rather so it's quite an experience…"

She has acquired awareness on the importance of checking in.

> *"…but then emm I've come to understand that you know in checking in, we are trying to establish a common context…"*

During the first block she struggled with making observations which made her to withdraw from participating in training activities.

> *"…I remember during the first block we had to make observations, it's like emm… people would interview each other, two participants and emm… after the interview our trainers would be like what did you guys observe? I was scared, clueless. I felt really out of place, completely stupid. I even came to a point where I didn't want say anything in class like when one of our trainers ask a question, I would keep quite even though I think I wanna say something but I just hold back like okay I don't wanna sound stupid."*

She experienced high levels of anxiety in the training context especially when she had to participate in certain tasks.

> *"….I felt very anxious…like every day coming to class was like oh no not this again especially the checking in and then there's this thing they like doing, we will discuss a certain topic and then they would be like what do you make of that and now I will be like what do you want me to say, that's not very clear like what is your clinical view of this….?"*

She questioned her competency as she compared herself to others who seemed knowledgeable and experienced, as a result, she ended up doubting herself and perceived herself unfit for the program.

"…I even started questioning my competency. Why did they even select me in the first place you know… I just felt completely out of place, thrown out by these things. I have this bad habit of comparing myself to other people, so when I looked at others, they seemed so knowledgeable, so experienced. I felt rather hopeless, very inadequate in comparison to other people…"

As awareness and clarity developed, she gradually grew more confident.

"….So, now you know and lately, I've just improved on that and they have acknowledge it you know, so I really feel glad like if they say well that was very interesting outlook. I feel rather tough and more confident"

She experienced the effectiveness of person-centered interview and it helped her to be more open in sharing her problems on a deeper emotional level in the training context.

"….the other day now surprisingly, me and my group we had PCI practice, we had to talk about our own problems, so now I really had to dig, it took me a while to actually say well I'm gonna talk about this. I was talking about ehh…my stepfather, how I used to resent him… I was like really… I'm gonna sound a bit superficial but the way which the interview was conducted like the reflections of feelings and the way the interview showed, the empathy, the understanding and you know sort of anyway pushing me towards acknowledging those feelings and experiences you know completely. I completely broke down and found myself saying a lot more than what I normally would really express my emotions, which was quite traumatic. I would never break down in class, I see all these other people breaking down in class, what's wrong with them? and then now I found myself in the same situation, all emotional crying my eyes out…"

She felt understood within the training context as they spoke the same language and felt misunderstood outside the training context.

> *"…for now I have people who understand me in my class, out there they don't understand me, so what?..... My class mates and I talk the same language you know and we know what's going on, we know that when this person says this, this is what's happening and this is what you are supposed to do, we are congruent in our communication…*"

She experienced the training context as a cult, fun and exciting environment in which she felt safe.

> *".....we call this a cult, like we coming here, it's like a little religion, it's completely different. I love it, I love it, it's fresh, it's innovative it's just wow! we've been told you can express yourself, you can be emotional, you learn and you can talk, your communication you know on a higher logical level, you don't discuss menial things you know, so Ja, I love this, I love this, it makes me feel all smart…it's funny you know, we laugh about it in class of course, so Ja it's really really enjoyable and glamorous"*

With the awareness and development of clinical knowledge and skills, she distanced herself in other contexts which resulted into isolation.

> *".....coming out of class and then going back into the world it's like… now what I find myself actually being like…I'm starting to feel actually like isolated more, I'm not gonna sit and discuss the latest hair style and talk about oh you did this, you went to a party so what, what does that mean, you know, so I don't have lot of friends, my*

friends are really people in class and all the other people are sort of.. I'm sort of distanciating myself from people slowly…"

She expressed sensitivity and awareness to impacts and observation on maneuvers.

"….I don't have a chance to talk to my family face to face, so I don't know what's that gonna be like when I'm with them. I'm gonna suddenly recognize all these maneuvers and you know really it's gonna be a challenge because I know them you know, they have very judgmental behaviour, they take a very judgmental stance…"

She felt her trainers presented differently each day and they at times display concern.

"…like on Tuesday, we all felt like they came in with an objective that day and because they were just reaping apart everybody's emm… during checking in, they were like you did this, you jumped logical levels emm.. you are blaaa blaaa… too much detail or too much content because some people tend to raise some facts in the article and talk about that, so we felt like they came with an objective and this felt a bit hostile… it was really scary"

She felt the manner in which trainers give feedback tended to be hostile but they took it as a constructive criticism.

"…I was like okay…constructive criticism but Ja, but then we thought about it and was like, that was not hostility, that was pushing us towards more effective, something that we were supposed to be doing…"

She perceived her trainers differently, one is empathic and the other one super intelligent and racist. This made her to experience fluctuating emotions within the training context, at times the training context seemed exciting and at time daunting.

"....because our trainers are not the same, the other one is still empathic you know, I feel like Ja I can actually express myself more freely, say whatever even if it's wrong at least I will be corrected in sort of gentle way but with the other one, I don't say as much you know because I'm thinking well he is super super intelligent, super super whatever, his gonna be like mmh mmh... gonna like humiliate me like the whole humiliation thing like that I carry from primary school even now in this context is still present, so Ja I don't know how to get over that like really.....I'm too scared of him. I also think he's a racist, the way he would treat black students from whites its completely different you know. I still do my work though as I'm suppose to because now with the intimidation and racism thing you are supposed to work hard, then it's sort of pushes me anyway, so it sort of pushes me to work hard"

5.4.2.2 Description of the participant's experiences relating to questions posed.

She approached the training context with enthusiasm; however, she felt frustrated to learn that her previously acquired knowledge regarding psychology was almost completely useless. During her undergraduate and honours studies, she was trained in psychiatric frame of reference and at present she was being introduced into a more inter-psychic frame of reference which was a new concept that made sense. She was annoyed by the fact that she was not introduced to the inter-psychic frame of reference earlier in her studies as a result she felt completely stupid and frustrated that she had wasted time as all her previous knowledge was being disregarded.

During her first block she was introduced to new concepts that shocked her; these included person-centered therapy that has concepts of empathy, congruency and unconditional positive regard. She struggled to remain non-judgmental and to be an empty vessel. She was concerned as this was the core principle in her training and she may not be an effective

therapist as a result. She was pushing herself to display unconditional regard, empathy and congruency. She had been taught that therapy was a way of life and she had to apply these core principles in every context.

In the beginning, she experienced the checking in to be an uncomfortable, irritating process as they were expected to share information and punctuate from a clinical frame of reference and to share information that has had an impact in their lives. She wished it could be optional. She was extremely uncomfortable doing this in a group setting in the presence of her colleagues and lecturers. She was skeptical of being judged and felt that some information was confidential. She was and still guarded during the check-in and discloses information on a superficial level and did not disclose anything significant. She worried that other people will know everything about her life and anticipated that her lectures will give her feedback on her superficial interaction. She is not used to sharing information with other people and this stems from her upbringing as she worries about what people will think.

The first block training required them to do interviews and make observations. She was scared, clueless, felt out of place and completely stupid. It came to a point where she withdrew from participating in class. They used to discuss certain topics and they were introduced to terms such as clinical view, clinical judgment which left her feeling confused and questioning her competency. She further experienced the training context to be anxiety provoking. She felt incompetent and inadequate as she compared herself to others who seemed to be knowledgeable and experienced. She started doubting herself and questioning how she was selected into the programme. The knowledge that seems to be required led her to the perception that they selected older people with some clinical experience. She therefore felt unfit for the programme.

In addition, she felt some people did not understand how come she was not grasping the information at the same pace as them and that made her feel stupid as others seemed to have the answers. However, with each passing day she was gradually grasping the information and became more confident to speak in class.

She felt she had improved; during the checking in she was able to punctuate from a clinical frame of reference and had acquired awareness on the importance of checking in. She further experienced the effectiveness of person-entered interview as it got her speaking about her problems on a deeper emotional level during practice and got to understand better how come some people in class were emotional.

She experienced the training context to be different from other contexts as she described it as a cult; like a little religion; it is innovative. She was constantly impressed as she learnt something new every day. It was a safe environment that allowed her to express herself, she learnt to communicate on a higher logical level and that made her feel smart.

On the contrary, coming out of the class context and engaging with the world leaves her feeling isolated. She was not able to engage with other people on the same level as she did with her classmates as a result she distanced herself from the social contexts. She believed that some people had misconceptions about psychologists and got irritated when they voiced out their opinions as they had limited and inadequate knowledge and lacked empathy for people in the field. She also felt that because her interaction style is changing, she will not engage on the same judgmental level as her friends and this will further distance herself from her environment. She felt content with the distance as she has never been a social person. She further anticipated changes in her interaction with her family. Her family often took a judgmental stance and she was not willing to engage with them on that level. She was aware

that she will recognize the maneuvers in her family system, which will be challenging for her and she will have to prepare herself when meeting with them.

She expressed uncertainty on how she dealt with her experiences and elaborated that she felt understood in the class context but not outside the class context. She received empathy and support from her colleagues in which they were developing a close relationship and there was sense of cohesion.

In the context of training, they applied the concepts of congruency in communication which sometimes felt mechanical as she is constantly thinking about unconditional positive regard and being non-judgmental. She would like to reach a stage where it comes natural and she will not have to consciously and constantly think about it. However, she felt she was in the process of becoming a therapist.

She enjoyed being different from other people based on the experience she received in class and described it as glamorous and fun. For the first few weeks it was uncomfortable as the trainers were communicating non-verbally and they appeared to be having fun at their expense. They however presented differently everyday as they at times displayed concern.

She felt the manner in which feedback was given tended to be hostile but they took it as a constructive criticism. She perceived her trainers differently; one is empathic and the other one as super intelligent and racist as he treated black and white students differently. She intended not to humiliate herself in his presence and that gave her more courage to push herself to work harder.

5.4.3 Third Participant

5.4.3.1 Summary of the biographical information and identification of natural meaning units in the interview data.

- **Biographical description**

The third participant was a 30 years old single white female. She did her undergraduate and honours studies at UNISA. She has worked as a counsellor.

- **Identification of natural meaning units from the interview data**

She described her experience in the training context as a rollercoaster ride.

> *"….it's quiet a rollercoaster ride since the beginning and up until where I am now, very difficult to explain umm… exactly what it is that I'm going through, all that I know is I go through so many feelings in one week…."*

She had to make an adjustment from a working context to a study context.

> *"….I came from a working context, coming to a study context again, to the university, that was quite umm... adaption from my side…"*

She experienced training as impactful and experiential.

> *"… so it's a lot of pressure as well and the training so far has been incredibly impactful...we learn quite a bit umm… but we do everything experiential and I think because of that it really got an enormous impact…"*

The experiential learning impacted on her social context and brought change in her relationships.

"....the learning experience impacts you know on my social context, for instance the book that we read on impact you know umm... about the interactions helps me, I actually gone to my social context and where I had quite a experience after reading the book and umm... when I went to my friends it was quite a disturbing experience at first you know, becoming aware of what is going on also you know keeping in mind what I brought into the conversation you know..."

She felt excited and privileged to have been accepted into the programme and approached training with a lot of determination.

"....really this is something I worked for very hard and I'm very determined to make this work, so on the one side, I'm feeling incredibly determined and I think also because I feel so determined and because it's so important to me"

She was concerned and worried that her need to perform best might have a paradoxical effect.

"....this is incredibly important to me. There was actually a time that you know that I felt that I actually put myself in a paradox a bit you know, because it's so important and you know and so Ja incredibly umm... excited about it and I'm so determined to, to you know make a success out of this you know..."

She experienced performance anxiety which affected her confidence and this worried her.

"....this context makes me quite anxious because you know when I'm becoming anxious you know I become a bit worried you know, umm... am I gonna meet the standards, am I gonna you know succeed umm... there it's quite a couple of things... so on the one hand I want really to perform and on the other hand it actually made me anxious to perform"

She presented with mixed emotions

"…I go…. actually through quite a couple of confusing emotions as well"

Checking in made her feel exposed and it was perceived as an anxiety provoking task.

"..being put on the spot, I mean that obviously every morning we need to check in and there is, there's lot of things that you know that they explore, at first it was, it was quite new to me to do that, and at first it was quite you know it was absolutely out of my comfort zone. I didn't, I wasn't used to doing a check in and you know having not to speak about you know my feelings and where I am now and what is happening in the news and everything. So that is something that was new to me that I had to learn, so in the beginning it made me quite anxious you know…I felt exposed you know"

Learning a new language and new concepts was challenging for her.

"…It's a challenge you know...umm...well, we learning a complete new language that is very foreign to me and it becomes a bit more you know… learning how to do person-centered therapy you know and interviewing, learning how to do IPA's you know. Umm… understanding and broadening our frame of reference to such an extent that it actually changes everything, so that is quite challenging"

She spoke optimistically about her trainers and had faith in them and the process

"….I'm very pleased emm… with them, I'm very pleased with the training that I get, I'm incredibly excited about it, I'm incredibly happy to be here you know and I'm just privileged you know. I feel content and I have a lot of trust in the process, really I have lots of trust in them"

She appreciated the experience of being trained at Medunsa campus by experienced and knowledgeable trainers.

> *"....I feel incredibly lucky you know to be trained through our trainers because they really seem very equipped and expects in this field you know and I realize that not all psychologists have this client-centered background, not everybody is trained in that way, so I feel incredibly privileged you know to go through this training, to learn in this level that we currently on"*

She experienced the training context as world on its own and completely different from other contexts in that members understood each other.

> *"....It's completely different, this is a context on its own, it's a world on its own with the people in class, I think we have quite an understanding of each other"*

She felt misunderstood in other contexts and experienced difficulty to relate to others in her social environment.

> *"....when I get home it's very difficult for people to understand what I am doing in class because it's such a complete different context, it's a completely different world, then it feels good to sometimes speak to my fellow students and we understand one another of what is happening and what is going on, but people on the outside find it very difficult to understand me."*

She had noticed changes in her interactional style even though some of her old habits still manifested.

> *"...My whole frame of reference is starting to change, you know emm… how I look at things how I respond to things. I know sometimes old ways still slips through you know and I know that, I'm aware of that. I know sometimes for instance being*

judgmental… it sometimes still slips through because that is so part of life in general and now becoming so aware of it, responding differently to it or trying to respond differently to it for instance emm… makes a difference, it makes a huge difference in my relationships and you know.. I'm trying to work on that emm…not being judgmental, understanding things differently, understanding the broader picture…."

She highlighted the importance of a support system within the group.

"…I think support system is incredibly important, there was a time that I felt very little understood because I went through quite a confused stage or phase, In this context, we speak the same language, they understand my crazy feelings at times, they understand my insecurities and, and also the change that is, that is taking place they understand, we're all going through similar experiences and similar feelings, so we really support each other throughout this process."

She felt more comfortable in her subgroup in which a sense of trust has been developed among members.

"…we were divided into sub-groups so in our sub-groups we emm… we get to know each other quite well because we do lots of interviews with each other, so there's already a strong sense of trust between us"

5.4.3.2 Description of the participant's experiences relating to questions posed.

She described her experience as a rollercoaster. She had to make an adjustment from a working context to a study context. She described the training context as incredibly impactful. Every day she experienced different impacts on an emotional level and experiences different feelings each week. They went through experiential learning which had an enormous impact on her. The experiential learning impacted on her social context which is

disturbing as it brought change in her relationships. There was observable and significant change.

She was excited and determined to be in the programme and on the other hand she felt anxious and worried if she will meet the standards of training and perform. She constantly experienced the need to perform and do well which had a paradoxical effect on her. That in itself has been challenging. She experienced mixed feelings each day; she felt confident one day and less confident the next day. She experienced confusing emotions, different emotions every day in class and this was unpredictable. She felt she had to be grounded in the training context and perform to the best of her ability and this made her feel anxious.

She felt she was put on the spot at all times, especially the checking in which was something out of her comfort zone, she was not used to expressing and talking about her feelings and this experience was daunting for her. It was a new context as she did know her classmates and her lecturers; she was uncomfortable but with time she got to know them, she then gradually became comfortable and they started opening up to each other and that made a difference.

She further experienced challenges adapting to the context; learning a completely new language that she described as foreign, learning how to do person-centered therapy and interviewing, learning the Interactional Pattern Analysis (IPA), understanding and broadening ones frame of reference to such an extent that it changed everything. The experiential learning had an impact on her and not only on an academic level even emotionally.

She had been learning more about the application of person-centered theory and discovered that there was more to it and it was a humbling experience. From her previous working experience, she thought the way she applied person-centered theory was appropriate but now she had come to the realization that it was not. She acknowledged that not all psychologists

are trained in this manner and she felt privileged and lucky to receive this particular training. She had faith in her trainers and the process. Her goal was to be trained at Medunsa campus; she appreciated the experience and felt overwhelmed with joy.

She experienced the training context as completely different from other contexts and described it as a world on its own. They had an understanding for each other, whilst other contexts had no understanding of the impact of experiential learning on them. She got a sense of cohesion with her classmates; she felt comfortable talking to them as they understood her context.

She is experiencing some personal changes as this was an emotional experience but people in her life did not have an understanding of this. When she felt vulnerable they did not understand why she was getting emotional. She further experienced changes with her frame of reference in terms of how she perceived things and responded to them. Some of her old habits slipped through for instance being judgmental of which she became aware of. Responding in a non-judgmental manner made a huge difference in her personal relationships, understanding the broader picture and brought about change in her.

For the last few weeks she felt overwhelmed by the experience, the impact and everything that the course brought. She felt the need for a support system as she was going through a confusing phase, which she is still experiencing at times and she felt isolated. Her partner was overseas and they were experiencing communication difficulties and her friends made her feel isolated or misunderstood. In the class context, they spoke the same language, they understood even her crazy feelings and her insecurities. She felt there is a sense of cohesion and they supported each other throughout the process especially in their sub-groups.

5.4.4 Fourth Participant

5.4.4.1 Summary of the biographical information and identification of natural meaning units in the interview data.

- **Biographical description**

The fourth participant was a 30 years old single white male. He did his undergraduate at the University of Pretoria and his Honours at University of KZN. He has worked as a counsellor and a tutor for first year psychology students.

- **Identification of natural meaning units from the interview data**

His expectations were met since he was familiar and comfortable with the kind of training Medunsa provides.

> *"I think for me it was what I kind of expected. I was in UKZN for my honours which was far more smaller group with this kind of setting, with one lecture generally, one lecture and a group of twelve to fifteen so we got interactive in that regard…"*

He experienced mixed emotions that of excitement and anxiety.

> *"…I had kind of mixed of excitement and a bit of apprehension as well because it's masters course and I don't know anyone, am I going to cut it…"*

The lack of structure made him feel anxious and confused.

> *"…I expected a bit more structure okay. I know there is structure but I'm talking about superficial structure that this are the books, these are the exam dates here, that wasn't there, so for me in that regard it made me more anxious, it made me a bit of mmh well… I'm a bit confused…"*

In the beginning he had limited interaction with the group members as he was guarded.

> *"…You know in the beginning I was a little guarded, I knew only one lady. She and I were together about six years ago, so we knew each other but we're not incredibly close you know…"*

He was challenged with how person-centered interview was conducted.

> *"I think also what really struck me was the approach to it of person- centered interview, how it is done, limited conversations, and limited input from the therapist but there is still certain amount of questioning and certain amount of reading…"*

He initially struggled with the reflection of emotions.

> *"…I remember the first exercise we got was interviewing, we were told to give an interview and then reflecting emotions which I found very difficult to not put a tail to it and to keep like this… that was quite difficult…"*

He struggled with being non-judgmental which frustrated him.

> *"…I also struggle with being non-judgmental, it's a lot amount of frustration because it's something I generally aim at and I have aimed to be as non judgmental as possible, that's something that I have aimed for years, actually as this course came along. I'm working on areas where there is judgment and trying to reduce and remove, but still like a said it's a process…"*

He found the first find block of training emotionally training and frustrating especially to apply what they were learning in class.

> *"…I found it more emotionally draining but not as… impactful emotionally as perhaps some of my class mates do during the week…the first week I did find to be*

very frustrating emm… and that was not to the frustration towards the course but was more with my ability to apply what we were doing…"

He observed cohesion within their group.

"…I mean there are lots of similarities between lot of us which I think is the aim emm… and I think just the amount of closeness that occurred…"

He experienced it challenging to express his emotions which had its roots from his upbringing.

"…You know I think being in touch with my emotions is not a problem; the problem to me has always been expression of emotions, I guess it's a process, I take a look at how I was brought up, how I was brought up very much this is way to behave you are a male this is you know…"

He experienced the training context as stimulating and satisfying.

"…I think there's a lot more of a people, it's comfortable to challenge each other which I like, I like to be challenged…"

He felt supported by group members which was meaningful to him.

"…I have found that I have form strong bounds with everyone in this class. I feel more comfortable with all of them and we understand each other"

He felt more comfortable in his subgroup as he could not depend on ineffective relationships.

"…I think in the subgroup, I feel…. far more comfortable emm… I feel more comfortable in the subgroup or in the relationships. I rely so much on them for emotional support I actually don't have too many friends…I can't rely or expand upon friendship that is no longer working."

5.4.4.2 Description of the participant's experiences relating to questions posed.

The participant's expectations were met in that he comes from University of KZN which was the same set up with a group of approximately fifteen students, with one lecturer and it was interactive as the context of training at Medunsa Campus.

He described his initial experience of the first block as exciting mixed with apprehension because he had been working for approximately three years and that was a huge adjustment. He did not expect the shift in the approach, he expected a more superficial structure such as books and exam dates and realizing that the structure was different from what he anticipated made him feel confused and anxious.

What really struck him was the approach to person- centered interview; how it is done, limited conversations, and limited input from the therapist but there was still certain amount of questioning and certain amount of reading. He was expecting a bit more structured interview style. He found the first block of training specifically person-centered interviewing style to be emotionally draining.

He experienced the first week as very frustrating and the frustration was not towards the course but was more about his ability to apply what they were doing. He noticed that training requires lot of self reflections from them.

Initially, he was guarded as the training context was uncomfortable but gradually everyone got to know each other. He felt comfortable to share his problems with his group members as he relied on them for emotional support especially his sub-group. He shared that his good friend passed away and everyone responded with empathy. He was emotional and found it difficult to express his emotions. He described that day as strange as he was not guarded. Being in touch with his emotions is not a problem; the problem for him has always been the

expression of emotions and he perceived this as a process. Thus he felt the training context exposed him.

He experienced the training context as especially different in that it was comfortable to challenge each other whilst in the past, challenging others got him misunderstood and judged. He has aimed to be as non judgmental as possible for years, as a result of this course he was working on areas where there was judgment and trying to reduce and remove it, but for him it remained a process.

He lived alone and he did not have anyone to talk to; he thus acknowledged the strong bounds he has formed with his classmates. He felt comfortable with them as he expressed his emotions to them. They however have formed subgroups where he felt more comfortable. In his subgroup, they were open and honest with each other and he relied on them for emotional support as he could no longer depend on ineffective relationships.

5.4.5 Fifth Participant

5.4.5.1 Summary of the biographical information and identification of natural meaning units in the interview data.

- **Biographical description**

The fifth participant was a 24 years old single white female. She did her undergraduate and honours studies at the University of Potchefstroom. She has worked as a psychometrics.

- **Identification of natural meaning units from the interview data**

She felt disappointed and shocked with the university's administration in that they were not thoroughly prepared for registration.

"…At the initial stage, I felt disappointed at the universities' admin and that they didn't previously let us know that we would need ID documents or you know err…your results or whatever from previous universities on the day that you come for the first time university. So it was quite a shock for me"

She described the training context as experiential and interesting.

"….Well I must honestly say that I experience it as err…very much experiential err… I found it quite interesting, because whatever we're learning you experience it and you're part of it…"

They started with person-centered interview in which she was impressed by her trainer's knowledge and experienced in reflecting emotions.

"…I can't specifically remember what I said when I was the client and then my trainer reflected on emotions, so spot on and it blew me out…"

She felt emotional and exposed whenever she shared about her personal life.

"…Ja emotional… I cried and I felt it really had an effect on me, the emotions that was reflected emm… it surrounding my family and the fact that emm I felt very exposed within the group…"

She was concerned that she was losing some of her family members as a result of training.

"…I'm losing some of my family members but that also came along the way already…. the emotion which was reflected was a sense of loss…"

She experienced training as challenging and confusing as they work on different logical levels; firstly they were trained academically to be psychologists, secondly, on their personal issues and lastly they were exposed to group therapy.

> *"…what I'm noticing at this stage is how we work on so many different logical levels, you work being trained in academicals way as a psychologist emm… working with yourself as a person and your own issues and then working also you know in a group isn't as if almost group therapy…, it's quite so confusing…"*

She expressed her gratification with what she described as a rollercoaster.

> *"…I really enjoy, it's a roller coaster ride, sometimes you get quite hit hard with certain stuff that's dealt in class even if it's not on your own, it may be someone else that also trigger something in you, emm… and other days it's also so very exciting, if you get something right and actually you see it and understand it…."*

She had to establish boundaries with her parents regarding the intensity of training and what she expected from them.

> *"…I told them that I need to set boundaries that it's gonna be a busy year for me and that…I can't just let them come and visit or at any stage interrupt me also force…"*

She had observed how judgmental her parents were for that she felt her morals and values were challenged

> *"…I started to notice things about them and how judgmental they actually are and then I started wondering…. I'm learning to get rid of this moral judgments and part of that might mean that you would not want judgment from me to agree with you, but I'm not going to… I coming from a family where I was raised with certain morals and values and now my morals and values are being challenged…"*

She valued her relationships as they form part of her support group and she presented with fear of losing them

> *"…I have few valuable relationships which I cherish very much, the relationship with my mom and dad is very important to me, they have been quite mentors throughout my life and very enormous part of my support system, so the thought… of… losing that support system… (cries) makes me really uncomfortable and makes me… really emotional you know"*

Being exposed to person-centered interview made her realize differences between ways of interacting thus her whole being was changed.

> *"…so Ja with that made me actually to be aware of myself and made me very aware, all three variables made me aware of how I communicate emm… made me very aware of everything I do, how empathetic am I, how congruent am I emm… and then with the judgment again, becoming aware of your own judgments…"*

She struggled with clinical language and the meaning which she described as challenging.

> *"…it's like you are in land where you understand the language but you don't understand the meaning if I can put it in like that, your whole being is sort of challenged because it's a new way of being, it's a different way…"*

She described being intellectually challenged.

> *"…I felt very challenged but also on an intellectual way…. Ja just being as a person, being challenged by your views, being challenged of how you speak…how you speak I mean how you usually would go by in a social manner, and I mean throughout life…"*

She experienced English language as a barrier.

> *"….part of client- centered therapy is to reflect emotions. I experienced that difficult, very difficult emm…well there was a challenge that English was not my first language so there was a challenge to learn the emotional words and then put the words together what it looks like, what, what does it looks like if the client is expressing this without interpreting and but then as well getting the right word out of your head to fit that emotion, it's very difficult. Emm… and as well the challenge of English not being your first language"*

She felt validated within the training context.

> *"….What I also like about this context is that it makes me feel valid as a person, valid experience that I'm going through and it's not just you know not recognized you know I actually feel that I'm validated as a person…"*

She valued the support she received from her subgroup.

> *"…I found a strong support system within my subgroup and emm… what is quite interesting it is quite remarkable, quite noticeable. Initially I told you that my main support system were my parents, my family and few close friends and what happened now there is a shift in that, they are still my support system but within my subgroup, I feel more support emm… in which they understand and experiences are the same…"*

5.4.5.2 Description of the participant's experiences relating to questions posed.

She expressed her disappointment and shock with the universities' administration as they were not informed to bring their identity documents and results from previous universities; this experience made her feel like a first year student again. After two days they were told to

register at the HPCSA which was overwhelming for her since she was not familiar with the process; she has never registered with them and did not know where their offices were.

When she reflected back on the process, she acknowledged that some of her class mates who are former students of Medunsa Campus assisted them to go to the right places. She recognized that during that time the group had formed a unit. She felt proud that she completed the process and as a group they were comfortable with each other. During the first two weeks there was also a university strike that affected their studies and some of the students. After six days of strike based on her subjective experience she felt that the group was fragmented.

The first block began with person-centered interview where she was in a role of a client and she was impressed by how spot on her trainer was when reflecting emotions. She was very emotional and she felt exposed within the group as it reflected on what was happening in her family context.

Part of person- centered therapy was to reflect emotions and she found that challenging as English was not her first language; therefore, there was a challenge to learn the emotional words. During the first block she was working on her language skills and increasing her vocabulary. She felt language was very important in mastering communication and she was also learning a third language which was a requirement during the selection process.

In improving on her vocabulary, she mentioned that she received assistance with her English from her colleagues as well especially those who's English is their first language. She felt language is crucial; the words, broadening the vocabulary and the pronunciation. She populated that two students failed their first oral test and one of them had so much potential but the language was a barrier because her vocabulary was too limited. She felt sad for them

and has observed that one them had become a hindrance in the group that whenever she spoke the group became restless.

After exposure to person-centered interviewing she came to awareness that there is a difference between the social way of interacting and getting a clinical frame work and the way she had been interacting all her life had to change, thus her whole being was challenged. For this reason she further experienced training as intellectually challenging.

She has observed that they work on many different logical levels; first of being trained academically to be a psychologist, secondly working on their personal issues and lastly working in a group as if its group therapy. This she described challenging, confusing and experiential.

She expressed her gratification within the training context with what she described as a roller coaster ride; sometimes she was being hit hard with certain stuff that was dealt with in class even if it was not her own, it may be someone else that also triggered something in her.

Within the training context she liked the fact that she felt validated as a person, by context as well as by her colleagues. Even when trying to reflect an emotion she knew that she was listened to and that made her feel valuable.

She has noticed that the training is affecting her relationships. She shared that initially they were prepared by their trainers that their relationships may be affected and she was witnessing that. She lived with her parents and when she moved in she had to set boundaries as this was going to be a busy year for her and interruptions were not welcome. When she did this, she started with person-centered interview, composed of the three variables of empathy, unconditional acceptance and congruence. She noticed how judgmental her parents were. Therefore, she felt her morals and values were challenged.

She came to awareness that she did not have a lot of friends but she had a few valuable relationships which she cherished very much. The relationship with her parents was very important to her as they have been her mentors throughout her life and they were an enormous part of her support system. The thought of losing that support system made her feel uncomfortable and emotional. She has thus negotiated clear communication and transparency with them. As trainers prepared them that the course might have an impact on their relationships with their families as well as their partners, she realized that as suggested by her trainers, it was important that she took her parents along on her journey. This was frustrating for her especially because her partner was in Namibia and communication was limited.

She has formed a strong support system within her subgroup and this has become interesting. Remarkable and noticeable for her is that initially her main support system were her parents, her family and a few close friends and now there has been a shift in that, they were still her support system but within her subgroup she felt more supported because they understood her and they shared the same experiences. She also felt supported by the entire group not only the subgroup where she received empathy when her partner was arrested in Namibia. As colleagues they also check with each other and assisting when someone else is going through a difficult time either personally or in class.

Verbalizing her experiences within her subgroup was one of her coping mechanisms within the training context. Her other way of coping was to realize that she was a hard worker, she tried hard to get ahead that she was actually preventing herself from getting there. As a result she often found herself drained and she constantly felt the need to read. Overall, she expressed being excited about the experience in class.

5.4.6. Identified Themes for all Participants

- **Biographical Descriptions**

Marital status

All the participants were single.

Ethnicity

P1 & P2 were black and P3, P4 & P5 were white.

Gender

P1, P2, P3 & P5 were female and P4 was male.

Undergraduate studies

All the participants had completed their undergraduate studies.

Postgraduate studies

All participants' highest level of education was honours in psychology.

Work experience

P1 & P2 did not have work experience in psychology. P3, P4 & P5 had working experience in psychology; that of a counsellor, psychology tutor and psychometrist.

- **Identified Themes**

Shifting from working to student

P1, P3 & P4 had to make a shift from being employed to being a student again.

Psychodynamics/psychoanalysis

P1 & P2 thought that psychology was about psychodynamics / psychoanalysis and felt they have wasted a lot of time during their undergraduate years.

Previous knowledge

P1 & P2 found that their previously acquired knowledge was perceived to be useless and a waste of time, that knowledge that was nullified and disregarded.

Empty Vessel

P1 & P2 came to the awareness that they had to be empty vessels by disregarding what was previously learnt and they were struggling with this concept

Experiential learning

P1, P3, & P5 experienced the training context as experiential.

Rollercoaster ride

P3 & P5 described the training context as going through a roller coaster ride.

Person-centred approach/ interviews / therapy

All Participants were introduced to person centred approach/ interviews/ therapy and its importance was emphasized, they found it interesting, insightful and were fascinated by how it was applied.

Judgemental

P2, P3, P4 & P5 struggled with the concept of being non-judgemental.

Reflections

P1, P3 & P5 had difficulty with reflection of emotions accurately.

Process language

P1, P3 & P5 did not know what process language was and how to phrase words clinically. This was very challenging and difficult to grasp.

Language barrier

P3 & P5 experienced English language as a barrier as it was not the first language for them.

Incompetence and stupid

P1 & P2 felt incompetent and stupid within the training context.

Anxiety

P1, P2, P3 & P5 reported feeling anxious on different levels. For P1 & P5 anxiety was based on the fear of losing important relationships in their lives. P2 & P3 felt anxious every time they had to check in.

Checking in

P2 & P3 experienced checking in to be anxiety provoking and intimidating.

Comfort Zone

All participants felt that the training context took them out of their comfort zone.

Academic, mental and emotional challenges

P1, P3 & P5 experienced the training as academically, mentally and emotionally challenging which was overwhelming for them.

Sensitivity to impacts and observations

P1, P2, P4 & P5 became aware of interaction in social context; of what was happening in their relationships, the way they interact, how they impact on others and their impact on them.

Empathy

All participants received empathy within the training context.

Cohesion

All participants felt a sense of cohesion and belonging in the training context as they spoke the same language and they shared the same experiences.

Sub-groups

P3, P4 & P5 felt more comfortable in their sub-groups and it was important for them to have a support group.

Racism

P1 & P2 felt that there was racism and racial divide in the class context which was manifested through favouritism and teasing.

Attitudes of trainers

Two participants perceived their trainers differently. P1 experienced the trainers as hypocrites who preach unconditional positive regard but they do the opposite. P2 perceived one trainer as brutally honest, intimidating and hostile and the other one as empathic.

Lack of empathy

P1, P3 & P4 did not receive empathy in their social contexts.

Isolation

P1, P2 & P4 felt isolated in their environment as they felt misunderstood by their family and friends.

5.4.7 Description of the identified themes that emerged across participants.

All the participants were single. Two participants were black and three were white. Four participants were female and the one was male. All participants had completed their undergraduate studies and their highest level of education was an honours degree in psychology. Two participants did not have work experience in psychology whilst three had working experience in psychology. Participants who had working experience had to make a shift from being employed to being a student again. Adjusting and being dependent on others was difficult for them.

As they started with the first block, participants were shocked and disappointed to realize that their perceptions about psychology were wrong as they always thought that psychology was about psychodynamics / psychoanalysis. This meant that their previously acquired knowledge was perceived to be useless and a waste of time, thus they felt that their previous knowledge in psychology was nullified and disregarded. Subsequently, they came to the awareness that they had to be empty vessels by disregarding what was previously learnt and experienced difficulty in dealing with this concept.

Participants were introduced to person- centred approach/ interviews/ therapy and its importance was emphasized which they found interesting, insightful and were fascinated by how it was applied. They were also introduced to interviewing skills and exercises which were based on the person-centred approach. They found it difficult and challenging to reflect emotions accurately and also identifying the intensity of the emotion and to remain non-

judgmental. Furthermore, participants learnt that they had to broaden their frame of reference and to be in the client's frame of reference. Therefore, the entire training process was experienced by participants as experiential learning and a roller coaster ride in which participants attached a lot of value to this type of training.

In order for them to be able to conduct person-centred interview effectively, they realised that language fluency was very essential. Since reflecting emotions required a broad vocabulary of emotional words, they found that English was a barrier as it was not the first language for most participants. Therefore, they were challenged to expand on their vocabulary.

Part of the process was to learn clinical or process language which they described as "foreign". Since they were not familiar with what process language was and how to phrase words clinically, they experienced this to be very difficult and confusing to grasp. They also had to understand and make use of concepts such as clinical view or/and clinical judgement which left them feeling more confused. Consequently, failure to reflect emotions accurately; understanding concepts such as clinical view or / and clinical judgement and to use process language lead to them feeling incompetent, inadequate and stupid. They experienced this to be anxiety provoking as they felt under pressure to perform which might have had a paradoxical effect on them. Within the context of training, participants perceived training to be academically, mentally and emotionally challenging which left them feeling overwhelmed.

Participants were further introduced to checking in which they initially found to be irritating, uncomfortable, exposing, anxiety provoking, and often felt as though they were being put on the spot. Participants felt they were taken out of their comfort zone, as they did not like sharing intimate details about their lives. They did not feel comfortable and some remained guarded and spoke on a superficial level as they worry what people will think of them.

However, they later understood the importance of checking in and regarded their experiences as a process.

In addition, since the group had formed cohesion, participants experienced the training context to be a safe environment where they can be understood, express themselves and be emotional without being judged. They felt validated as people and they received empathy within the training context. They also formed sub-groups from the larger group in which they do their practicum. These sub-groups formed a huge part of their support structure and felt more comfortable in their sub-groups. Therefore, participants felt it was crucial for them to have a support system since they experienced lack of empathy in their social context and tended to be isolated and misunderstood in their social contexts.

The participants were concerned that there was favouritism in the training context, thus; certain individuals were favoured more than others and some members were always teased based on the things they have no control over. The favouritism was associated with racism as the participants felt concerned that black people struggle to be equal to everyone and strongly felt that they should not be secluded and victimized.

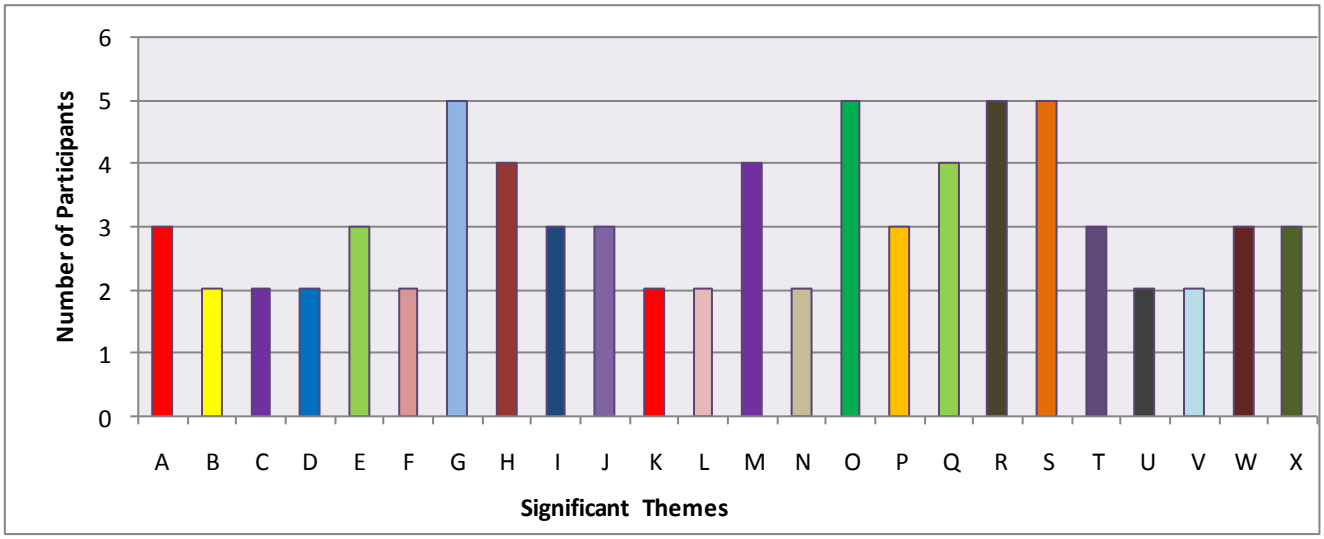
Participants perceived their trainers to have fluctuating attitudes. One of the trainers was perceived as racist, brutally honest and hostile whereas other one was experienced as empathic. Trainers were further perceived as intimidating, incongruent and hypocrites.

Outside the training context, since the participants were sensitised to observations, they observed changes in their interpersonal relationships; however their trainers had prepared them that they may lose significant relationships and suggested that they should not make life changing decisions within the first two years of their training. The observable changes in their interpersonal relationships were also perpetuated by the lack of empathy in their social

context and in their environments. Subsequently, this left the participants feeling isolated in their social environments as they felt misunderstood by their family members and friends.

Visual presentation of results will be displayed next.

5.4.8. Visual Presentation of Results



A. Participants had to make an adjustment from a working context to a study context. B. Participants thought that psychology was about psychodynamics/psychoanalysis. C. Previously acquired knowledge was perceived as nullified and disregarded. D. Participants became to an awareness that they had to become empty vessels. E. Training was experienced as experiential. F. Training was experienced as going through a roller coaster ride G. Person-centered interview/ therapy was experienced as interesting and insightful. H. Participants struggled with being non-judgmental. I. Participants experienced difficulty with reflection of emotions accurately and its intensity. J. Participants experienced difficulty with process language. K. English language was experienced as a barrier. L. Participants felt incompetent and stupid in the training context.	M. Anxiety was experienced on different levels; fear of losing significant relationships and during checking in. N. Checking-in was found to be irritating, anxiety provoking and intimidating. O. Training took participants out of their comfort zone. P. The course was experienced as academically, mentally and emotionally challenging. Q. Participants became sensitive to impacts and observations. R. Participants received empathy in the training context. S. Participants felt a sense of cohesion and belonging in the training context. T. Participants felt more comfortable in their sub-groups. U. Participants experienced racism and racial division in the training context V. Trainers were perceived to have fluctuating attitudes. W. Participants did not receive empathy in their social contexts/environments with resulted in isolation.

The next chapter attempts to discuss and integrate the results of the current study into which the strengths and limitations of the current study and future recommendations will be sketched.

CHAPTER 6

DISCUSSION OF RESULTS

The aim of the current study was to explore the subjective emotional experiences of the Msc1 trainee clinical psychologists at the University of Limpopo (Medunsa Campus) during their first block of training. The objectives of the study were; (a) to explore the subjective emotional experiences of trainees during their first block of training within the training context; (b) to explore whether trainees experience these emotions even outside the training context; and (c) to explore how trainees deal with such experiences.

The experiences of trainees varied from trainee to trainee, although certain identifiable themes emerged across all the interviews. As suggested by Bryne (2001) and Silverman (1993), a theme was considered as an experience that has been very strongly emphasized by one participant as well as those experiences that are mentioned by more than one participant. These themes were considered significant as presented visually in a form of a bar graph in the previous chapter (see page: 164). Most of these themes were found to be supported by the literature conducted in chapter two and three (see pages: 11, 22, 39, 47, 50, 85 & 92); however, there were few themes that emerged from this study which caught the researcher's attention as there are few studies conducted on them, are often overlooked and may create a platform for future research and possible intervention. These themes were thus found exceptional and will form part of this section.

According to Vorster (2003) and Waltzlawick, Beavin and Jackson (1967) communication never takes place in a vacuum. Communication always takes place within a particular setting or a particular surrounding. Additionally, what is being communicated in itself also create a frame for further or subsequent communication. The setting in which communication occurs or the context is crucial as context defines the meaning of all communication. The same word

or phrase in different contexts can have very different meanings and this often leads to massive confusion, misunderstandings and frustration if not clearly defined within its specific context. Clear, effective and unambiguous communication is dependent of an adequate context for the communication. If no context is created or if contexts are "mixed" the effects on the receiving end of the communication could be quite confusing. This could result in avoiding someone who communicates in a vague or confusing manner and subsequent isolation for the speaker.

The issue of the importance of communication brings to the discussion the central role that language plays in shaping human activity. As a core theme that emerged across participants in the current study, language, specifically English language was identified as a barrier in the context of training. P5 expressed the following:

> *"…part of client- centered therapy is to reflect emotions. I experienced that difficult, very difficult emm…. a challenge that English was not my first language it's very difficult …"*

The emphasis on language has a number of important implications for thinking about psychotherapy training. Following the work of Maturana, Le Roux (1987) concluded that human beings are always embedded in language. Put differently, human beings can be described as always existing in language and communicative action (Adernson & Goolishian, 1988). Hence the training system, like any other human system is a communicative or a linguistic system (Nel, 1992). Thus, the training context evolves through communication discourse and according to Nel training reality is created in and through dialogue. Checking in, conducting person-centered therapy, tasks or activities that take place in the training context are all facilitated through language. Language is therefore a crucial aspect during training and as suggested by Vorster (2011) measures should be taken by trainees to improve

and expand their vocabulary. The importance of language was elaborated in personal communication with Vorster (2011) and Thobejane (2011) in chapter three of the current study (see pages: 92 & 94).

It appeared from this study that not only trainees experienced English language as a barrier; they further experienced clinical or process language used in the training context as difficult to comprehend. This was illustrated by P1 who reported the following:

> *"….When it comes to process language it's something else, you know nothing, you don't even know how it's like when you know something…."*

Thobejane (2011) outlined the difference between English language and process or clinical language and the way the two are applied in the context of training (see page: 94). It became evident in this study that trainees with limited vocabulary struggled not only with English language as a medium of instruction in the training context but also with process language which is foreign to them. According to Thobejane this might be overwhelming for such trainees as they are confronted with a challenge of learning both languages at the same time.

During the first block of training, trainees were exposed to person-centered interviewing which they experienced as experiential and impactful. P4 reported the following: *"….we do everything experiential and I think because of that it really got an enormous impact…"*

Experiential psychotherapy has arisen naturally from the work growing out of Carl Rogers' (1957) initial formulations. According to Vorster (2011) the greatest strength in introducing trainees to person-centered therapy and its application during their first block of training is its emphasis on personal development work. He postulated that person-centered approach is an experiential, open-ended approach to life in which the personal experiences of the individual is considered in the highest authority. When experiential learning is used in psychotherapy training, there is a shift from the material being presented to the individual. Thus, experiential

training is essential as it affords trainees the opportunity to discover a greater level of awareness of their own biases and assumptions while concurrently developing their clinical skills, especially those of empathy and sensitivity to the experiences and perceptions of their clients (Vorster, 2011).

Rogers (1957) emphasized that the most effective learning occurs experientially in the same type of facilitative environment as the patient-therapist relationship. When experiential learning is used in psychotherapy training, there is a shift from the material being presented, to the individual. Experiential training is essential as it affords trainees the opportunity to discover a greater level of awareness of their own biases and assumptions while concurrently developing their therapeutic or clinical skills, especially those of empathy and sensitivity to the experiences and perceptions of their clients (Vorster, 2011). From this study, it appeared that the experiential learning thus seems to have an enormous impact on the trainees. P4 experienced experiential learning as *"…incredibly impactful…"*

According to Karter (2002) this kind of learning allows trainees to constantly work on their personal issues which might be viewed as personal therapy or therapeutic. Moreover, Gibson, Sandenbergh and Swartz (2001) concur that experiential training in psychotherapy can be very impactful and demanding for students; thus according to Gibson *et al.,* it is important for trainees to reflect and learn from their own emotional reactions. Therefore, experiential training allows trainees to receive immediate feedback from trainers and increases congruence through personal growth (Gendlin in Corsini, 1973).

In their study on trainees' experiences of impasses in counseling, Stefano *et al.,* (2007) concluded that the developmental journey for trainees is difficult in the beginning stages of psychotherapy training where trainees are expected to move quickly into the role of a psychologist. This developmental journey is characterized by a number of emotions such as

anxiety and frustration specific to the role of a psychologist. Punctuating further, earlier studies (Larson *et al.,* 1999; Skovholt, 2001; Skovholt & Ronnestad, 2003;) found that mechanical equipment used within the training context such as the use of videotaping, cameras and role-playing while observed by trainees elicit emotions such as anxiety and frustration. Thus, according to Karter (2002) the syndrome of self questioning is very much present during training. This can have a malignant quality which can lead to self-doubt, persecutory and performance anxiety. The feeling of anxiety and self-doubt in this study were illustrated by P1 & P2:

> *"…I felt very anxious…like every day coming to class was like oh no…. not this again especially the checking in…"*
>
> *"….I even started questioning my competency…"*

A longitudinal study of the psychological adaptation of trainee clinical psychologists conducted by Kuyken, Peters, Power, Lavender and Rabe-Hesketh (2000) reported significant increases in work adjustment problems, anxiety and depression. However, this study was conducted over the three year period of clinical psychology training. Cushway (1992) in his study on stress in clinical psychology trainees showed that high rates of distress and anxiety were higher in the second and third year of training than in the first year of training. Based on the above research findings, a tentative hypothesis can be made that the anxiety experienced by trainees during their first block of training might increase during the course of their training. According to Gibson *et al.,* (2001) the experience of learning is necessarily anxiety provoking more when students have to get to grips with what is often a new body of knowledge for them.

Previous studies showed that there is a considerable evidence of stress-related problems among practicing psychologists and trainee psychologists (Cushway, 1992; Schoup, 1995; Cushway & Tyler, 1996; Murtagh & Wollersheim, 1997; & Zemirah, 2000). Based on these studies, it seems as if stress peaks during clinical training and according to Lazarus (1999); Kuyken, Peters, Power and Lavender (1998) and Derogatis and Coons (1993) the emotional manifestation of stress experiences by trainee clinical psychologists is largely characterized by anxiety that can lead to feelings of self doubt and trainees questioning their competency.

Stoltenberg (1981) conceptualized the training process as a sequence of four identifiable developmental stages which were discussed in chapter two (see page: 37). It became evident from the information yielded from the interviews that trainees during the first block of training go through the first developmental stage. Trainees in the first stage lacked confidence, depended upon the trainer for concrete structure of how to do things, advice and direction, imitated the trainer and subscribed to techniques. According to Stoltenberg, this is a stage of "unilateral dependence" (Stoltenberg, 1981:61). Thus, the definition of trainer-trainee relationship at this stage can be defined as complimentary in which the facilitators or the trainers take a leading role whist the trainees assume a followers' position. Moreover, according to Thobejane (2011) at this stage, trainees are introduced to a totally new world different from theirs, in which they try out new behaviours as well as risk taking behaviours, they are further challenged in the way they think and are sensitized to impacts of behaviour and to sharply observe human interaction. Therefore, it is beyond reasonable doubt that these experiences by trainees will be overwhelming and inevitably evoke a great deal of anxiety which is expressed on different levels through activities such as checking in and conducting person-centered interview.

According to Stoltenberg (1981) a training context congruent to the level of trainees' development and vulnerability is the one that encourages independence while providing structure and support. Thus, Carl Rogers' variables of congruence, empathy and unconditional positive regard are considered important during this vulnerable stage of trainees' development. An ability to provide these variables by the trainers according to Stoltenberg constitutes an effective trainer-trainee relationship and conducive environment that would facilitate trainees' growth and actualization. Vorster (2011) postulated that absence of empathy, genuineness or unconditional positive regard in a relationship can be detrimental to the mental health of the participants in any relationship. Furthermore, Rogers (1951) stipulated that the importance of the three variables become clear when any of them is lacking. This may be triggered by personal issues, vulnerabilities and blind spots that trainers should constantly work on (Brazier, 1993).

It goes without saying that a high degree of empathic understanding and the ability to display empathy will be central to the person-centered trainers. Not surprising that all trainees within the context of training received empathy. P4 reported the following:

> *"….What I also like about this context is that it makes me feel valid as a person, valid experience that I'm going through and it's not just you know not recognized you know, I actually feel that I'm validated as a person"*

On the other hand, trainees experienced trainers to speak of unconditional positive regard yet not practicing it, this act has been perceived by participants in the current study to be incongruent as expressed by P1:

> *"….I believe if you are preaching unconditional positive regard for people then you should have unconditional positive regard for everyone in class, otherwise then, you are being incongruent and that confuses me, you teaching us one thing then you are*

doing something else but then because you are a lecturer does that makes it okay you know…. it just doesn't sit well with me"

It may seem contradictory that within the training context participants received empathy from their trainers yet trainers did not display unconditional positive regard. One may argue that any of these variables cannot be exhibited without the other as according to Rogers (1980) the three are the core conditions in any relationship. Mearns (1997) offers a different view on this point, according to him, UPR does not mean giving the trainee ubiquitous approval. It does not necessarily even imply "liking" or "favouritism". What it means is that the trainer retains a fundamental unshakeable valuing of the trainee as a person of worth. Within the context of training which according to Mearns is entirely different from a therapeutic context, this will mean that the trainer offers judgments and challenges in relation to the trainees' work. Therefore, Mearns (1997) argues that offering judgments and challenges is no way contradicts to the notion of unconditional positive regard. It is perfectly possible to retain an unshakeable valuing of the trainee as a person of worth, while still offering feedback about his/her work. Furthermore, according to him such judgments and challenges should be conveyed in a manner that is empathic. However, if such judgments and concerns are only being manifest to a certain kind of people and only experienced by certain individuals than the other then it raise a concern. P1 illustrated the following: *"…there is a black person victimized because she doesn't speak English properly so why is the Afrikaans speaking persons not victimized because their English is also not good, what is the difference? Skin color?"*

As expected and supported by literature in chapter two and three, training was perceived as emotionally, mentally and academically challenging by trainees. Furthermore, in describing the challenging nature of training, most participants equated it to a "roller coaster ride". P1 & P4 illustrated the following:

"....there is the academic challenge, there is mental challenge and there is emotional challenge…"

"…it's quiet a rollercoaster ride since the beginning and up until where I am now, very difficult to explain umm… exactly what it is that I'm going through, all that I know is I go through so many feelings in one week…"

According to Kottler and Swartz (2004) masters training in clinical psychology is a journey filled with new experiences and opportunities for personal growth and is widely known to be an arduous process. Millon, Millon and Antoni (1986: 242) suggested that training in clinical psychology as a career is "full of intrinsic stressors" presenting "student practitioners with multiple academic and clinical demands which often lead to early self-doubt". It demands that trainees become intimately involved in the pain, conflicts, disappointments and hardships of the lives of people whose mental health in some way is in jeopardy. It also demands that trainees examine their own lives, and negotiate their way towards a professional identity that will allow them simultaneously to grapple with the pain of others in a mindful way and protect themselves from this activity's potentially debilitating effect (Kottler & Swartz, 2004). Ernst (2008) stated that the journey is often experienced by trainees as a rollercoaster ride, at times it is filled with excitement and at other times it can be exhausting and very stressful.

Plante (2005) postulated that the intensity of clinical psychology training renders it one of the few post-graduate courses that require daily attendance. The first year of the Masters' programme consists of university based training where a combination of both academic and practical training is undertaken. The workload is often high and the training requires the student to develop a complex set of skills which fall outside of the purely academic range of tasks. Additionally, Swart and Wiehahnn (1979) argued that clinical psychology training

programmes combine personal growth, experience, an awareness and improvement of personal deficiencies with training skills. Training demands of the trainees is a fundamental level of personal engagement with the process, including self-questioning and self-disclosure within peer and supervisory settings. Psychotherapy training therefore entails more than simply the acquisition of knowledge, skills and experience; it asks for a "shift of identity" (Kottler & Swartz, 2004:69). It can thus be stated that combined with the demands of the coursework, training in clinical psychology would have an emotional effect on the trainee which is overwhelming. This is supported by Gibson, Sandenbergh, and Swartz (2001) and Karter (2002) who stated that training in clinical psychology can be extremely stressful, demanding and overwhelming for trainees. P1 training reported the following: *"...It was an emotionally draining experiences...You feel emotionally vulnerable...It was overwhelming".*

In studies exploring the levels of distress among clinical psychology trainees; Kuyken, Peters, Power and Lavender (1998) have found that although trainees reported high levels of stress, they were able to adapt to stress fairly well resulting in their psychological functioning at home and work being within the normal range. However, 25% of trainees were still experiencing difficulties, most notably in terms of self-esteem, work adjustment, depression and anxiety. A follow up study by the same authors showed that these problems tended to endure over time (Kuyken, Peters, Power & Lavender, 2000). Similar prevalence rates were reported by Brooks, Holtum and Lavender (2002). In the current study, trainees seemed to be coping and mobilized with the overwhelming experiences in the training context as illustrated by P1 *"....I was motivated… in terms of the turmoil emotionally emm… from the first block, I think now I can handle things a bit better…."*

In a personal communication with Vorster (2011), a trainer at Medunsa campus, he postulated that the biggest challenge during the first block is to deal with what trainees have been taught in undergraduate and honours years especially to change the intra-psychic perception towards inter-psychic orientation. Therefore, clinical psychology training at Medunsa Campus attempts to change the acquired epistemological framework of the trainees with the aim of acquiring the new frame of reference and epistemology which is unfamiliar to the trainees. This seems to bring a great deal of frustration, disappointment and uncertainty to trainees as experienced by P1 & P2:

> *"….I thought I'm going to do assessments, I'm going to learn tests and knowledge based on the psychiatric frame of reference and when I got here we were told no, we are doing systems, we doing person- centered and you like….you thought wow all my dreams are crushed…"*

> *"….I was really frustrated by the fact that we didn't know these things you know during our prior training, the four year degree that we did. I feel completely stupid because I would have been so far by now…we've been trained in the more psychiatric frame of reference and now we are trying to go to more inter- psychic…I thought psychology was about psychoanalysis, there's nothing more to it…."*

It is evident from the above and as supported by Sluzki (1974) that trainees who enter psychotherapy training are usually already well schooled in concepts derived from either a traditional medical model or an intra-personal psychological model, both of which tend to channel their reasoning along dichotomous lines. Several authors raise the question of resistance towards systems thinking on the part of the trainees (Bertalanffy, 1962; Sluzki, 1974 & Liddle, 1991). It would seem that this resistance is derived from the trainees' embeddedness in the traditional, linear cause-effect paradigm (Sluzki, 1974). According to

Bor (1984) this might manifest in overt or covert attempts to contest or reject systemic ideas. Furthermore, the dominance of the medical paradigm and the linear, dualistic approach in universities result in such behaviours (Liddle, 1991). P1 illustrated the following:

> *"...It felt like literally me against the world because it's new stuff and is the world ready to accept what we are learning here because if I'm not mistaken we are the only university which is training in this kind of way. So I was actually very scared, I was very afraid..."*

Thobejane (2011) argued that it is important to consider that trainees from undergraduate and postgraduate studies have been channeled to operate from an intra-psychic point of view which is highly recognized and applauded by universities throughout the world, it therefore becomes a challenge for trainees to adapt and acquire the inter psychic or systemic epistemology after many years of studying and operating in a certain way.

On the other hand, Klein (1996:216) stated: "psychology has to move with the times and should welcome the opportunity". According to Klein, strict adherence to a certain theoretical approach can result in limited, rigid views on human behaviour and behavioural change and cult-like zealousness. Whereas each approach had its advantages for understanding human behaviour and offers ideas for intervention, this limited view might lead a trainee to overlook important alternatives to understand, explain and treat patients and thus fail to provide effective assessment and treatment. Klein argued that trainees about to begin their training in clinical psychology or psychotherapy often must make a decision as to the particular brand they will study before they had sufficient opportunity to acquaint themselves in a systematic manner with principles and practices of prevailing schools or disciplines, and before they have achieved the professional maturity which may be required for a wise choice.

Therefore, Luchins (2000) recommended that psychotherapy training should attempt to deal with psychotherapy in general instead of with just one particular type of therapy. The study of various approaches to psychotherapy may help produce a therapist with a broader viewpoint, possibly one who is interested in the refinement of psychotherapy in general. This view is further supported by Woody and Robertson (1997) who suggested that psychotherapy curriculum must be flexible enough to allow trainees to be exposed to other courses and treatments related to the discipline. Consequently, trainees need to be exposed to a number of therapeutic approaches as training cannot be limited to one model and this will without no doubt challenge their thoughts, perceptions about the world and their behaviour (Luchins, 2000).

General Systems Theory as a holistic approach to psychotherapy is therefore used at Medunsa Campus as a meta-theory into which other major theoretical approaches seemed logically and constructively to fit. The different models and their respective methods are presented separately while still adhering to the overall systemic epistemology (Vorster, 2003). Consequently, being trained within this framework allows the trainees to be flexible in their treatment plan for clients as they are able punctuate effectively from different models of psychotherapy.

The issue of race and specifically racism is extremely complex and can arouse intense emotions for trainers and trainees alike as argued by Patel (2000). It is worth reiterating at this stage that a theme on racism emerged from this study. Black trainees specifically raised issues around racism in the training context as captured by P1 & P2:

> "*...so yes there is a black person victimized because she doesn't speak English properly, so why is the Afrikaans speaking persons not victimized because their English is also not good, what is the difference? Skin color?...*"

"....I'm too scared of him. I also think he's a racist, the way he would treat black students from whites its completely different you know. I still do my work though as I'm suppose to because now with the intimidation and racism thing you are supposed to work hard..."

Previous studies on racism within the context of psychotherapy training indicated that black trainees experienced racism on differenced levels (Adetimole, 2005; Watson, 2006; Rajan and Shaw 2008; & Shah, 2010). For instance, in his study on the impact of racism on the experience of training on a clinical psychology course: reflections from three Black trainees, Adetimole (2005) reported that black clinical psychology trainees felt a lack of acknowledgement of positive aspects of difference and faced assumptions about the inferiority of black trainees. They reflected on the challenge in talking about these experiences due to the fear of being "pathologised as draconian, extreme or without foundation", experiencing the micro nature of insidious racism as "much more disempowering than its overt form" (Adetimole, 2005:11) .

Punctuating further, Watson's (2006) review of black trainees' uncovered examples of personal and institutionalised racism operating in the training context. Recollecting their training experience, black trainees reported feeling scapegoated, judged as incompetent, being stereotypically and negatively labeled. They also described feeling excluded, discounted, misunderstood, at times highly visible and at times invisible, and powerless. In her study on the experience of being a trainee clinical psychologist from a black and minority ethnic group, Shah (2010) argued that racism is activated in the training context from the selection process to the actual training process. Rajan and Shaw (2008) reported that there is a lack of consideration given to black trainee clinical psychologists' fears about racism and 'speaking out', by those responsible for providing training. Thus, there are a number of ways in which personal and institutional racism can manifest within training.

According to Gray (1999); Sashidharan and Francis (1993) exposure to racism within the context of training can lead to devastating psychological consequences such as feelings of powerlessness, helplessness, rejection, loss, depression and hopelessness. P1 expressed the following: *"I am very concerned because it really hurts because as a black person…why should we be secluded, why do we have to fight for everything you know.. it's tiring…. so it really hurts me that what I can do at the most is keep quite during class when other people are been victimized… and then afterwards give my support…..it makes me really angry"*

Given the brutal history of racism in South Africa, psychotherapy training remains a challenging process. Thus, according to Richards (2003) and Seedat et al (2004) any discussion on the training of psychotherapists and the provision of psychotherapy cannot be conducted in isolation from the background of separation, discrimination and consequences caused by Apartheid. According to Patel (2000), black and minority ethnic trainee are invariably within the training context. Therefore, as a consequence by the Apartheid era, they find themselves being marginalized, excluded and oppressed on the basis of their ethnicities and this is very present in the arena of training and which also draw attention to the heterogeneity of a trainee group. From this study it became apparent that issues of race and culture, specifically racism, are extremely complex and still exist within the context of training psychotherapists. Suggestions on how to address such issues were discussed in chapter two (see page: 22).

Karter (2002) stated that trainees during the course of their training are likely to be detached from a larger body of post-graduate students, family and friends due to the demand of the course, this eventually lead to isolation from their normal surroundings. Consequently, as the journey unfolds, it is easy for trainees to feel very alone and to develop a sense of lacking any real support network, with nowhere to offload one's burden or concerns. According to Bosman (2004) this journey often appears impossible, all encompassing the never-ending

round of theory, assignments, seminars, clinical work and supervision. When trainees are simultaneously juggling these with social responsibilities and demands, it is easy for them to feel overwhelmed, alone, unsupported and despondent. This is supported by P4 who reported the following:

> *"....when I get home it's very difficult for people to understand what I am doing in class because it's such a complete different context, it's a completely different world…people on the outside find it very difficult to understand me."*

From what P4 reported, it becomes evident that the feeling of alienation begin to arise and this is compounded by a burgeoning sense of distance from partners and family, who find it difficult to comprehend this bizarre undertaking in which trainees have become so irretrievably embroiled. Therefore, from this study it became evident that trainees experienced the training context different from their social contexts in that they felt misunderstood and isolated outside of the training context: P1 illustrated the following: *".....coming out of class and then going back into the world it's like…I'm starting to feel actually like isolated more, I'm sort of distanciating myself from people slowly…*"

In dealing with the above discussed experiences, it became evident that the already formed subgroups are a crucial source for emotional support for trainees in the current study. P4 expressed the following:

"...I think support system is incredibly important…in this context, we speak the same language, they understand my crazy feelings at times, they understand my insecurities and, and also the change that is, that is taking place they understand, we're all going through similar experiences and similar feelings, so we really support each other throughout this process..."

These subgroups can be viewed as a platform in which trainees shared the same experiences and felt supported and understood. In a preliminary investigation on the effect a one year clinical psychology programme on the family systems of trainees conducted by Bosman (2004), based on the research results; it was concluded that trainees in clinical psychology underwent significant changes in their interactional style and patterns of behaviour. This affirmed the personal changes trainees are expected to undergo during the training process. As trainees further experience isolation in their family context, they rely on their subgroups for emotional support. According to Vanier (1998) belonging is a rock on which individuals stand. It fosters emotional security and cohesion as it exposes an individual to learn a lot about him/herself, learning about own fears, blockages, capacity to give to others, to share, to grow, to live and to work together.

Since therapy focuses on solving problems, it is therefore important for trainees to develop some degree of problem solving skills. According to Vorster (2011) coping with environmental demands on a day to day basis obviously necessitates a degree of skill in solving a great variety of problems. Thus trainees, as much as they are faced with different challenges within and outside of the training context; they should be able to solve such. Consequently, training is facilitated in such a way that trainees are sensitised to acquire the ability of talking different approaches in solving problems as well as to apply some element of flexibility in problem solving. The ability to exhibit flexibility will further prepare them in dealing with multiple roles they will assume within and outside their profession.

In conclusion, Plante (2005) stated that considerations of training psychotherapists trace a growing awareness that good psychotherapy is influenced by the training context. Peake and Ball (1991) further pointed out that effective psychotherapy training is influenced by the context in which it occurs. Training context seems to have an impact on the trainee in creating either a conducive or non-conducive climate for learning to conduct psychotherapy.

Nel (1996) emphasized the importance of creating learning contexts that promote and facilitate the progressive emancipation of the trainee therapists until they can successfully separate from the training system. Therefore, according to Nel, the training context may be viewed as an evolving relational system. It is a constant process of change and development, a context that continuously restructure its content including new materials in training and most importantly that facilitates the self development of trainees for them to come forth as effective psychotherapists who are self actualized.

The overall picture that emerged from this research project suggests that trainees in clinical psychology during their first block of training undergo different challenges which are not only emotional but mental as well as academic in nature. Moreover, it became evident that trainees further experience challenges in their social contexts such as families and relationships outside the training context. It can further be stated that training of clinical psychologists in South Africa is faced with tremendous challenges for both the trainers and trainees. Early involvement of the trainers in addressing the themes emerged from this study specifically those that pose a challenge to the discipline could be the key towards effective training and intervention where possible. Hopefully the results from this study will pave the way for future research and developments in the field of training future clinical psychologists.

6.1. STRENGTHS OF THE STUDY

- This study has never been conducted within the context of the University of Limpopo (Medunsa Campus). It has thus brought new knowledge and awareness that might be valuable for trainers and trainees of the above mentioned institution;
- The methodology used in this study enabled the participants to open up to what is seemingly a sensitive matter;

- This study was conducted a week after trainees first block in the training context which lasts for about four weeks. This allowed the trainees to reflect back on the process, take a meta-perspective and make sense of the training whilst the experience is still recent;
- The researcher took advantage on her personal insight and training but with full awareness of her own values and assumptions. This allowed participants to engage fully and openly in the study.

6.2. LIMITATIONS OF THE STUDY

- As exploratory in nature, this study consisted of a relatively few participants from the University of Limpopo (Medunsa Campus). Therefore, the generalisation of the findings to the bigger population of trainees in Clinical Psychology should not be done;
- This study was conducted shortly after the first block of training and did not explore the experiences of trainees in other blocks. Thus, results from this study are exclusive to the first block of training at the University of Limpopo (Medunsa Campus);
- The researcher might have brought her own values and judgements into the study. This is motivated by the researcher having been trained on similar grounds as the participants on this study. It became difficult for the researcher to distance herself from the process. Therefore this study might carry biases, prejudice and blind spots of the researcher.

6.3. RECOMMENDATIONS

According to Higson-Smith (1995) research is only relevant if it has implications for the improvement of human condition. Based on the research findings, the following recommendations can be made:

- A comparative study be conducted at the end of the last block by an outside researcher to establish how trainees handled these experiences;
- A similar study be conducted across different institutions preferably with a larger sample to establish whether trainees go through the same experiences;
- Further research is recommended that will focus on the issues of race and specifically racism within the context of training psychotherapists.

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APPENDICES

Appendix A

INFORMED CONSENT

UNIVERSITY OF LIMPOPO (Medunsa Campus) CONSENT FORM

Statement concerning participation in a Clinical Research Study.

Name of Study: An exploration into the subjective emotional experiences of the Msc1 Clinical Psychology trainees at the University of Limpopo (Medunsa Campus) during their first block of training.

I have heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this Clinical study is completely voluntary and that I may withdraw from it at any time and without supplying reasons.

I know that this study has been approved by the Research, Ethics and Publications Committee of the Faculty of Medicine, University of Limpopo (Medunsa Campus) / Dr George Mukhari Hospital. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study.

……

Name of Recipient

…….. …… ……..

Place *Date* *Witness*

Statement by the Researcher

I provided verbal information regarding this study.

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to the approved protocol.

Mhambi Realeboha **……** **…….** **…….....**

Name of Researcher *Signature* *Date* *Place*

Appendix B

BIOGRAPHICAL QUESTIONNAIRE

Please complete the questionnaire below:

1. Age ……
2. Gender…...
3. Ethnicity…….
4. Home language……..
5. Marital status…….
6. Where are you currently residing? ……..
7. Whom are you staying with currently? ……
8. Do you have children? If yes how many? …….....
9. Where did you do your undergraduate training?**.....**
10. Where did you do your honours degree? ……
11. Any work/training experience related to psychology? If yes, please elaborate

    ……..

Appendix C

INTERVIEW GUIDE

1. What are your experiences currently within the training context?

2. Does the training context differ from other contexts? If yes how?

3. How do you deal with such experiences?