

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

**BECOMING A PSYCHOLOGIST: STUDENTS' ACCOUNTS OF  
THEIR EXPERIENCES OF CLINICAL TRAINING**

**SHONEEZ AMIEN**

Submitted in partial fulfillment of the requirements for the degree of Master  
of Arts in Clinical Psychology, in the Department of Psychology,  
University of Cape Town

**2001**

**SUPERVISOR : Ms. Kerry Gibson**

This thesis is dedicated to my brother, Na-aim.

## DECLARATION

The Author hereby declares that this thesis, unless specifically indicated to the contrary, is a product of her own work

---

Shoneez Amien

---

Date

## ACKNOWLEDGEMENTS

To my mother and sister whose unwavering support has literally meant my survival, words cannot capture my gratitude. I also need to thank my mother for teaching me about the capacity of love. To my late father who kept reminding me that I was not alone.

Again I would like to thank my brother who taught me the need for unconditional love. And thanks to you Ken for giving me beginner lessons on how to give it.

To my thesis supervisor for her amazing support and encouragement through the difficult process of this thesis, and my first year of training. A sincere thank you.

I cannot end my training without also thanking. Hans Soltau, for teaching me to trust myself and Sue Blyth for not only listening but for hearing me.

To my friends who give me so much joy and support, M, Serialong, Nolitha Viola and Sam. Thank you.

Thank you so much Pippa and Lindi for editing this thesis. I really appreciate it.

I am very grateful to those who participated in this study. Thank you for sharing your stories and so generously giving your time. I hope that I did justice in capturing your experiences.

The partial financial assistance of the National Research Foundation (NRF) is hereby acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF.

And lastly, I would like to acknowledge the part I played in getting this degree.

## TABLE OF CONTENTS

ABSTRACT.....	vi
CHAPTER ONE : INTRODUCTION.....	1
1.1    AIM OF THE STUDY.....	1
1.2    BACKGROUND TO THE STUDY.....	1
1.2.1    The Training Programme.....	2
1.2.2    Theoretical Orientation.....	3
CHAPTER TWO : LITERATURE REVIEW.....	4
2.1    THE INDIVIDUAL LEVEL.....	7
2.2    THE TRAINING.....	8
2.2.1    The New Situation.....	8
2.2.2    Expectations of the Relationships in Learning.....	9
2.2.3    Professional Identity.....	10
2.2.4    Inexperience of Trainees and Dealing with Clients.....	11
2.2.5    Race and the Training.....	12
2.2.6    Learning Demands of Training.....	13
2.3    THE CONTEXT.....	16
2.3.1    The Organisation.....	16
2.3.2    The Changing Context of Psychology.....	16
2.4    COPING STRATEGIES.....	19
CHAPTER THREE: METHODOLOGY.....	23
3.1    MOTIVATION FOR CHOSEN METHOD.....	23
3.2    PARTICIPANTS.....	23
3.3    DATA COLLECTION.....	24
3.4    ANALYSIS OF THE MATERIAL.....	25
3.5    ETHICAL CONSIDERATIONS.....	25
3.6    REFLEXIVITY.....	26
CHAPTER FOUR: RESULTS AND DISCUSSION.....	28
4.1    NOT BEING 'GOOD ENOUGH'.....	28
4.1.1    Surveillance.....	28
4.1.2    New Situation.....	30
4.1.3    Crisis of Competence.....	31
4.1.4    Race and Inadequacy.....	33
4.2    EXPECTATIONS.....	33
4.2.1    Staff Expectations.....	34
4.2.2    Client and Public Expectations.....	34
4.2.3    Trainees' Expectations.....	36
Of Psychology.....	36
Of the Course.....	37
Of the Classmates.....	38

	Of themselves.....	39
4.3	SUPPORT.....	40
	4.3.1 Staff and Supervisors.....	40
	4.3.2 Classmates.....	45
	4.3.3 Family and Friends.....	49
	4.3.4 Structure.....	50
	4.3.5 Personal Therapy.....	51
	4.3.6 Resources.....	52
4.4	STRUGGLE FOR IDENTITY.....	53
4.5	THE EMOTONAL NATURE OF THE WORK.....	57
4.6	THE CONTEXT.....	59
	4.6.1 The Status of Psychotherapy.....	62
	4.6.2 Interprofessional Marginalisation.....	61
4.7	STRATEGIES FOR COPING.....	63
	4.7.1 Talking.....	63
	4.7.2 Self-care.....	64
	4.7.3 Setting Goals.....	65
	4.7.4 Thinking Positively.....	65
	4.7.5 Emotional Distancing.....	66
	4.7.6 Letting go of Perfectionism.....	67
CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS.....		69
REFERENCE LIST.....		77
Appendix A.....		83

## ABSTRACT

Interviews were conducted with 14 University of Cape Town Masters' students from three consecutive years to explore their emotional experiences of the professional training in clinical psychology. A qualitative analysis was conducted to identify, in particular, what aspects of their training they found difficult and how they coped with these difficulties. It adopts a psychodynamic approach in examining and understanding the interview material.

It was found that trainees struggled mostly with the pervasive feeling of 'not being good enough', feeling unsupported by staff, changes in their interpersonal relationships and challenges facing them in their personal development. Other difficulties identified ranged from trainees' unmet expectations, the heavy workload and the emotional nature of their work. The research highlights the way in which trainees hopes, fears and expectations both conscious and unconscious determines, to a large extent, the way in which the training is experienced and managed.

It was identified that trainees coped with these difficulties in various ways. Mostly, however, they coped by talking to classmates and others in the profession, reassessing their expectations as well as distancing themselves emotionally from the painful and difficult experiences encountered during training..

## **CHAPTER ONE : INTRODUCTION**

The professional training in clinical psychology was one of the most difficult times of my life. I often wondered about why this was so and why this time felt so different to me. It was my third year and I resented having to write a dissertation. I was tired and uninterested in pushing myself any further. I was actually afraid that if I did, I would lose my mind. I needed the time to focus on what I had just been through over the past two years and I needed time to recuperate. Simultaneously, thoughts about the course became intrusive and often all I could do was reflect on the process of *my* training. I then decided to write about the experience of training. I initially approached doing my dissertation with the intention of showing the world how difficult the course was. I wanted to validate and justify why my world seemed to turn upside down, why I felt that the institution did not care about my struggle, and why I felt so alone in it all.

Once I made the decision about my research project, my processing of the experience escalated rapidly. I began to understand why I experienced the course the way I did and exactly how it related to my past. Reading around the subject of training and learning experiences normalised my experience in a very cathartic way. I realised that I needed to process what had happened during the course, to heal and start reintegrating who I had become. The choice of research subject was my unconscious motivation to do so. My feelings towards the training staff and the institution as well as my intention changed because I could make sense of it. I knew that I had to explore others' experiences and perhaps, through my dissertation, offer others an opportunity to make sense of their experiences.

### **1.1 AIM OF THE STUDY**

This study aims to explore students' overall emotional experiences of their professional training and why they may have found it difficult or stressful. It explores how fourteen trainees, at the University of Cape Town (UCT), experienced the two to three years of their training to become clinical psychologists. In particular, it attempts to explore what they perceived as difficult in their training and how they coped with these difficulties.

Semi-structured interviews were conducted with the trainees so that they could share their personal experiences of the training. The analysis of the material aimed to identify patterns within each interview as well as identify common themes between interviews about trainee experiences, difficulties and coping strategies.

## **1.2 BACKGROUND TO THE STUDY**

### **1.2.1 The Training Programme**

The Masters degree in Clinical Psychology at the University of Cape Town (UCT) is awarded through the Department of Psychology, in the Faculty of Humanities. It is a professional qualification which, with the stipulated internship, leads to registration as a clinical psychologist. It consists of two years of full-time study and the submission of a minor dissertation. In the first year, the trainee is based at the Child Guidance Clinic (CGC), a postgraduate training centre registered with the Health Professions Council of South Africa. The training here is geared towards the development of academic knowledge, practical clinical skills and personal development. Academic knowledge includes seminars and discussion groups on theories covering a wide range of topics, but the focus is on problems of childhood and adolescent development, family problems and group work. Trainees' clinical skills are developed through their practical, therapeutic work with children and adults. Students work closely with and are supervised by more experienced clinicians through an experiential method of training (CGC Handout, 2001). As part of this they are expected to provide services to the public.

The second year involves a paid internship with 4 rotating placements in the Cape Hospital system, including Valkenberg and Groote Schuur Hospitals, for training in adult psychopathology and treatment (CGC handout, 2001). Placements include male and female admission and pre-discharge wards, a child and family unit, an adolescent unit, a mental disability unit, forensic units, a neuropsychology unit, as well as outpatient and inpatient units. The therapeutic interventions range from crisis, short-term intervention and case management to supportive and milieu therapy. Students should be involved in research for their minor dissertation in this year. Few students, however, complete the dissertation at the end of their second year and usually extend it to the third year. They have until the end of the third year to complete the dissertation.

The training programme is said to provide the trainee with the knowledge and skills needed for basic competence in the field, but trainees are "expected" (CGC Handout, 2001, p2) to have ongoing training after they qualify, which is considered essential for professional competence. Trainees, once

qualified, should continue to be supervised (CGC handout, 2001). This serves not only as ongoing support for the new professional, it is standard, ethical practice and protects both psychologist and client.

### **1.2.2 Theoretical Orientation**

In general, the theoretical approach in this study will draw largely on psychodynamic theory. In particular, theories are drawn from those who argue that the experience of learning is closely connected to emotional and personal processes (Salzberger Wittenberg, Henry & Osborne, 1983). There is also considerable literature which acknowledges an array of stressors that face those in the caring professions (Obholzer & Zagier Roberts, 1994, for example) and a further body of theory which deals with the particular demands on training psychologists and psychologists (Cushway, 1992; Cushway, Tyler & Nolan, 1996). This literature covers various traditions within psychoanalysis which, for the purposes of this research, will be drawn together to construct a composite understanding of the variety of factors involved in students' experiences of their training. The theoretical framework is one which will allow an exploration of each students' subjective experience of their training and through analysis, offer some ideas about the roots of their particular perception. However, the more sociological aspects such as the actual working and training conditions in the course are also examined.

A review of the available literature is presented in chapter two, firstly establishing the prevalence of stress among those in the helping professions and highlighting the limited research on the experiences of psychologists and psychology trainees. Secondly, it looks at what the individual brings into the training and the possible implications this may have on how the training is perceived. It then looks at the training itself and possible experiences of it. Finally it examines the broader social and professional context in which the training occurs.

In chapter three the methodological approach taken in the study is discussed. As the researcher was also a trainee and member of one of the classes under investigation, particular attention is given to the issue of reflexivity in this section. This is followed by an analysis of the interviews and a discussion of trainees' experiences, with particular attention being paid to difficulties identified and coping strategies employed. It compares the findings to those presented in the literature. The last chapter concludes by giving a brief overview of the findings in this study and makes some recommendations that may have implications for the future training of clinical psychologists.

## CHAPTER TWO: LITERATURE REVIEW

“it is not easy to be a beginner, a neophyte, a tyro. This is true whatever the area of enterprise, but it is especially true for the field of psychotherapy” (Misch, 2000, p172).

There is little research that explores the positive experiences of training in any helping profession. If positive experiences are acknowledged (see Plante, 1996) they are merely flagged or ascribed to the rewards or incentives of a career in the helping professions. Like this study, most studies mainly cover the difficulties of practitioners and students. The helping professions have become synonymous with stress and burnout. There is a plethora of research into the stress involved in work within different helping professions such as Obholzer and Zagier-Roberts (1994); Payne and Firth-Cozens, 1987; and Farber (2000) for example. Studies have mostly been done in relation to nurses (Menzies, 1970), teachers (Friedman, 2000), and lawyers (Berger, 2000). In the area of mental health, studies have focused on mental health nurses (Cushway, et al., 1996) and psychiatrists (L. Swartz, 1987; Margison, 1987) and the levels of stress they experience. Jones (1987) shows that psychiatric nurses may face additional difficulties to their physical health counterparts while Margison (1987) stated that psychiatrists have been noted to have the highest level of suicide among doctors. Millon, Millon and Antoni (1986) did not find higher stress levels for psychologists. They state that due to a lack of empirical literature, the best we can ascertain is that psychologists suffer from the same variety of psychological ailments, in similar proportions, to others of their socio-economic and education levels. However, there is some research into the experiences of psychologists which claims that psychologists, like other helping professionals, suffer significant stress (Kilburg, Nathan & Thoreson, 1986; Varma, 1997; Cooper, 1997). Varma (1997, pi) also says that psychotherapists “experience more stress than other people because they deal with the stressed and stressors”

Investigating stress is very important as it affects the individual at many levels. It causes strong emotional responses, most commonly anger, anxiety, fear and feelings of dejection and sadness; prolonged physical arousal which leads to resistance and exhaustion; behavioural changes and decreased psychological functioning usually resulting in impaired task performance and burnout (Weiten, 1992). Weiten cites studies such as Mandler's (1982), which indicates that high emotional arousal disrupts attention and concentration, leads to poorer judgement and less effective memory retrieval. **Anxiety** also negatively affects performance and results in further concerns about

dejection

performance and an exacerbation of the anxiety. Lotz (1995) cited many studies indicating that stress negatively affects academic performance. Payne & Firth-Cozens (1987) add that it is important to study stress among health professionals not only because stress in work leads to disease, but that in the health professional it also affects "the very focus of their role, the patient" (p. xxi). In considering this contention and the effects of stress, it seems especially important to study students in the helping professions, for whom stress may be especially detrimental. Salzberger-Wittenberg (1983, chap. 4, part II) emphasises that, in order to be receptive to learning, the student cannot feel emotionally overwhelmed. Yet, these students may experience significant stress, facing not only the difficulties associated with the service profession but with the stresses of student life as well, such as examinations, time pressure and financial difficulties (Cushway, 1992).

training

Students in general, at university, are a high-risk population for the development of mental disease (Berndt, 1985). Berndt found that stresses inherent in the university situation were associated with physical disease and depression among students. Gelman (1999) for example found a point prevalence of 29% of minor psychiatric morbidity among students attending the student health services at UCT. She also found the mental health of students to be significantly related to their sense of not feeling adjusted to the social, academic and financial demands that university poses.

Students of the health professions are generally regarded as experiencing greater amounts of stress than students in other courses (Jones, 1987). Most of the existing research abroad investigating students in the helping professions has focused on the medical profession, such as nursing and medical students (Cushway, et al., 1996). However, working within mental health seems to be particularly difficult for these students. Medical students in Firth-Cozens' (1987) study reported that the most stressful period of their training was often their psychiatric placements and dealing with mental illness. Similar findings came from a South African study by Bestenbier (1992) which found that nursing students experienced greater stress during their psychiatric clinical practicals. Also large scale studies of psychiatrists in training have found a considerable degree of mental health problems, high drop-out rates (Cushway, et al.) and "neurotic symptoms and psychosomatic disturbances" (Swartz, 1987, p. 280). Few comparative studies look at psychology trainees and compare stress in these trainees to other professions (such as Cushway, et al.). However, some international research (Kilburg, et al., 1986; Lipovsky 1987; Rodolfo, Kraft & Reilly, 1988; Varma, 1997; Kaslow & Rice, 1985) and South African research (Kottler 1991; Abrahams 1992; Kleintjies 1991; Ahrends, 1995; Gibson, Sandenbergh, & L. Swartz, 2001) suggests that professional training for clinical psychology, like psychiatry, is a stressful experience. These studies suggest that there is widespread stress among

trainee (and professional) psychologists. Cushway (1992) found that 59% of clinical psychology trainees in Britain were distressed, as measured by the General Health Questionnaire. Rodolfa, et al. (1988) compared the stressors of professionals and trainees at counselling centres, finding trainees to experience more stress. Although studies like these tend to identify quantitatively the level of stress and the different stressors associated with the internship year of clinical psychology, they also help us to understand what the overall experiences of trainees in psychology may be. However, it must also be noted that not every student/trainee will experience the anxieties inherent in training as being stressful or unmanageable. French and Bushek (1988) in their study of 62 clinical interns and 56 school interns found that overall, both groups had positive attitudes towards their experience. Notably this study focused less on the affective components of their experience but on whether or not they felt the training met their training-skills needs.

Research on training experiences of psychology students in South Africa is limited. According to Van der Westhuysen and Plug (1999) there has been no comprehensive investigation of the training of psychologists in South Africa since a study by the Psychological Association of South Africa in 1985, and this seemed to have looked mostly at resources. There are a number of South African studies on training but these are mostly evaluations of training programs, which explore whether they adequately and effectively prepare the trainees for work as professionals in the South African context (Parker, 1986 ; Marchetti, 1989; Govender, 1991). As such these studies only involve graduates or qualified psychologists. They also look primarily at course content but they do allude to the emotional experiences of their trainees and the difficulties they faced during their training. Other Cape Town based studies that exist look mostly at *specific* aspects that students may struggle with, such as race (Mokutu, 1998; Kleintjies, 1991), culture (Swartz, 1989), developing a professional identity (Kottler, 1991), personal growth (Kay, 1996), difficulties with formulating psychodynamically (L. Swartz, 1999) or community psychology training (Gibson, et al., 2001).

These local and international studies and other research suggest that there are many factors on a personal, interpersonal, academic, professional, and political level, which are sources of stress for psychology trainees. These factors are listed to reveal *what* is difficult for trainees but more importantly, they are also offered as explanations for *why* the professional training may be difficult. Only a few authors (Salzberger-Wittenberg et al., 1983; Misch, 2000) have looked at the possible underlying and emotional issues that may exist in learning environments, saying that the unconscious dynamics evoked affect the experiences of learning as well as their learners' levels of stress.

## **2.1 THE INDIVIDUAL LEVEL**

Trainees are selected to enter the training in clinical psychology based on skill and personal qualities. Dale (1997) says that to choose to do this work, one will have certain characteristics of temperament, mental functioning and emotional stability (such as love of truth, interest in other people, capacity for empathy, psychological-mindedness and good ego-functioning). He also shows how these help the therapist to deal with stress. Chippindall and Watts (1999) identify two core aspects of good candidates: their relative mastery of early traumas and their capacity for empathic engagement. These authors also state that the mastery of early trauma facilitates empathic ability. This is similar to anthropological accounts of traditional healers who are thought to be 'called' to the practice of healing through unusual illnesses (Torry, 1986; Rippere & Williams, 1985; Thorpe, 1993; Reynolds, 1996). It is believed that the successful resolution of these illnesses and subsequent restoration to a desired state of being enables the potential healer to help others. The latter is thought to possess knowledge of healing and the ability to be empathically attuned to others. Kopp (1974, p7) contends that the psychotherapist is a "contemporary western guru". He says that

"Such a guru starts out on his own tortured pilgrimage as a deeply troubled misfit youth. In mastering his personal afflictions, he gradually comes to the position of being able to help others on their spiritual trips" (Kopp, 1974, p9).

Many authors who write about the motivations of psychologists also say that those who follow this path are motivated by difficulties in their backgrounds that in some way led them to this helping or healing profession (Skynner & Schlapobersky 1989; Dale, 1997; Pines 2000). Dryden and Spurling (1989) share a similar view and say that the need to understand one's own early traumas makes this profession of psychology so appealing as it offers the possibility of healing oneself as well as others. Dare (1997) says that such motivations, however, also make this profession an extremely difficult one.

When an occupation involves such significant underlying issues, Pines (2000) says that people enter it with very high hopes and expectations, high ego-involvement and passion. Failure to meet these expectations, she says, usually results in failure to derive existential significance or a sense of meaning that may lead to burnout. The trainees' phantasy that they will find answers to questions they have or meaning for their lives may be found in the course could be unfulfilled. This could then lead to significant disillusionment and distress. Cherniss (1995) and Misch (2000), add that trainees may have high expectations of themselves. Many trainees, they say, have been high achievers with a

need for order and very high self-imposed standards that may leave them struggling to manage the ambiguity and uncertainty of a training course.

Other personal factors that may affect trainees' experiences is their sense of self. Hellman, Morrison and Abramowitz (1987) looked at the impact that therapist rigidity and flexibility of personal boundaries had on their stress levels in relation to their work and more specifically to their interactions with clients. Their results indicated that more rigid therapists and therapists who struggle to set boundaries reported more stress. Those with difficulty in separating themselves from their clients experienced greater professional self-doubt and difficulty in maintaining relationships in therapy. Interestingly, despite these constructs (rigidity and flexibility) being personality dimensions, effective boundary management seems also to depend on the therapists' groundedness and clarity about who they are and what their boundaries should be. The inexperienced trainee who is trying to deal with the confusion associated with a transitory period often characterised by shifts in identity and self-boundaries (Kottler, 1991) may find this task very difficult. They may enter a cycle in which poor boundary management and stress exacerbate each other.

Trainees' unique histories, personalities, conscious and unconscious beliefs or expectations may not only provide the motivation for pursuing psychology, it may determine, in part, their hopes and expectations of training, how effectively they work with clients as well as their experience of stress.

## **2.2 THE TRAINING**

Entering into the training process presents many challenges for the trainee. They have to deal with the anxiety inherent in entering a new situation as well as working, perhaps for the first time, therapeutically with patients. They have to struggle not only with developing their professional identities but with being evaluated on their ability to be professional. They are also expected to meet the academic demands of attaining their qualification.

### **2.2.1 The New Situation**

Any training is a time of transition and is therefore an exciting and challenging time that may often be experienced as stressful (Cushway, 1997). Transition implies embarking on something *new*. Salzberger-Wittenberg (1983, part I) maintains that every beginning is difficult but the entry into a new learning experience is especially difficult and anxiety-provoking for everybody. She says that it evokes hope and dread about the unknown, about the teachers and the institution, about the peer group and fellow trainees, and about being judged as adequate.

According to Salzberger-Wittenberg (ibid) and to a psychodynamic understanding, these hopes and dreads have their roots in infancy and as such they will take on the form of the unique history that every individual carries with them. The nature of the interactions, the perception and management of relationships during the training and the emotions aroused by the very learning situation are all influenced by the unconscious and the primary relationships of infancy. How well someone can deal with a new situation depends on the nature of his/her internalised experiences. Good experiences and introjects of trustworthy parents who are capable of emotional holding, enable the person to not only tolerate being on his/her own but to more confidently explore physically, cognitively and affectively new people and places as well as new situations and in so doing 'learn'. Skinner and Schlapobersky (1989) say that often the infantile experiences of those in psychology are of inadequate parenting and emotional containment. This may complicate trainees' ability to trust teachers and fellow students to modulate their experience and provide sufficient emotional containment to facilitate learning. It may even compromise the trainee's trust in himself/herself to meet the high expectations set to successfully resolve all difficulties independently. S/he may fear that his/her acquired knowledge and skills may fail him/her this time and that s/he will be catapulted into the infantile experience of helplessness, being lost and fearing disintegration (Salzberger-Wittenberg, 1983, part I). The anxiety and mental pain involved in this process may further compromise the trainees' ability to adapt and learn, and to acquire the very knowledge that will assist them in successfully containing potentially overwhelming feelings.

### **2.2.2 Expectations of the Relationships in Learning**

Salzberger-Wittenberg (1983, part I & II) identified some other expectations that a new learner may have of the teachers and of his/her peer group. Amidst the anxieties and fears of feeling lost and helpless in a new situation the student attempts to find someone who cares and to whom s/he matters. The expectation is usually that this someone be the teacher, who is also expected to be a source of knowledge and the provider of guidance and support. The teacher, as such, may either be admired or envied. In Parker (1986), Marchetti (1989) and Kay's (1996) studies, students felt that these expectations were not met. Their primary complaint was about lack of adequate support from staff, especially supervisors. Some students in Govender's (1991) study perceived training staff as poorly trained and autocratic. Salzberger-Wittenberg says that if the students' expectations are not met, the result may be a fear of persecution and distrust. The teacher, an authority figure invested with much power, could then be seen as a judge who will find them to be 'not good enough' and unworthy of the teacher's support. Students' expectations of the peer-group, like siblings, are that they are closer to students' experience than parents and are therefore confided in more easily and

may become a potential source of support. However, as with siblings there may be rivalry and the students may become wary of their peers whom they believe may criticise, humiliate and diminish them in a bid for parental attention and approval.

While Salzberger-Wittenberg (1983) looks at the expectations students have of others, Misch (2000) looks more at trainees' expectations of themselves. He identified six common mistaken assumptions that beginner psychodynamic psychotherapists have about what constitutes good therapy and a good therapist. He said that these assumptions could hinder the development of psychotherapeutic skills and the acquisition of an appropriate identity as a psychotherapist. These assumptions involve telling themselves things like: 'I should completely see and understand everything, immediately without struggle'; 'I should always say and do just the right thing because if I don't I will destroy or irreparably harm my patient'; "if my patient doesn't get better quickly I must not be doing a good job"(p182) or "my patients' failure to improve is a personal failure on my part" (p184). He said that they also feel that 'bad' feelings (anger, envy, sexual attraction) are inappropriate and if either they or the patient have such feelings, it is an indication that therapy is going badly and that there must be something wrong with them. Finally, he says that trainees feel that "Everyone else, including not only my supervisors but my peers, is doing better than I am" (p197). Misch (2000) says that students or beginner therapists developing such unrealistic expectations could be understood psychodynamically as having an unconscious need to be loved, be responsible, be perfect and be omnipotent.

These needs not only place high expectations on the trainees themselves, it places unrealistically high expectations on their therapeutic relationships and their relationships with training staff and peers to fulfil those needs. Their ability to cope with setbacks and ambiguity in the training course may also be compromised, placing them at a high risk of stress.

### **2.2.3 Professional Identity**

The motif of a journey of self-discovery occurs often in the discussion of training psychotherapists or psychologists (Kopp, 1974; Torry, 1986; Thorpe, 1993). For Kottler (1991) the experience of training in clinical psychology is like a rite of passage through to a new *identity*. Erik Erikson speaks of the establishment of a professional identity as part of the normal life cycle towards adult development. He says that this, like with every developmental stage, is accompanied by a crisis which involves a struggle with an aspect of identity (Weiten, 1992, chap.13).

Kottler (1991), Dana (1987), Watts (1987), Levert, Lucas and Ortless (2000) have all looked at the manner in which trainees struggle with establishing a professional identity. Lipovsky (1987) compares the professional training to adolescence where the trainee is developing from a student to an adult professional and the identity crisis that this entails. With the anxiety inherent in these "crises", in the loss of a sense of self and in the assimilation of newly acquired skills (Lipovsky, 1987), it is not surprising that Cushway (1996) revealed the largest stress factor for psychologists and trainees to be 'professional self-doubt'. This process of questioning who and what they are may exacerbate insecurity in themselves as well as foster insecurity about their competence in dealing with clients.

#### **2.2.4 Inexperience of trainees and dealing with clients**

Cushway (1992, 1996, 1997); Hellman, et al. (1987); Rodolfa, et al. (1998) have found that trainees experience more distress than older and more experienced therapists. Cherniss (1995) found that a major stressor for the novice professionals they studied was a "crisis of competence" (p18). Cherniss also said that their expectation that professionals are supposed to be competent, that is to have all the natural powers, physical or mental, to meet the demands of a situation or work, was too high. For these novice professionals achieving an acceptable level of competence became the overriding goal for them to the point where they could think of nothing else. He noted that idealism, altruism and compassion became unaffordable luxuries while avoiding failure and humiliation dominated their thinking. Trainee clinical psychologists at the CGC start seeing clients from their second month of training and though supervised they "take full responsibility for all aspects of case management" (CGC Handout, 2001, p11). Their exposure, probably for the first time, to dealing therapeutically with distressed clients may then be very overwhelming (Cushway, 1997). Corey (1996) says that when beginner therapists face clients, they soon realise that all they have to work with is themselves, which leads to real concerns about their adequacy as a therapist and about what they bring of themselves as a person. Kottler (1991), when talking about UCT trainees, says that they are expected to perform confidently and professionally with clients while being painfully aware of their clinical inexperience and the need to learn. This seeming contradiction may be difficult to reconcile for the trainee. They may face fear of failure and injury to self-esteem because of their inexperience, yet in order to be receptive to learning they will have to withstand the anxiety of being "thrown in at the deep end and begin[ning] from a position of ignorance and naivety" (Mollon, 1989 cited in Kottler, 1991, p51).

The type of therapy being conducted may also add to the difficulties that trainees experience. Dale (1997) explains that if the mode of intervention focuses on the *relationship* between therapist and patient and involves the personality of the therapist, the degree of stress experienced is likely to be higher. He says that psychotherapeutic work becomes more stressful; the more emotionally disturbed a patient is, the greater the frequency and duration of the treatment regime and the less support there is for the therapist and the patient. Trainees in their second year of training often work individually with very disturbed patients, psychotic, neurotic, personality disordered and neuropsychologically impaired patients (CGC Handout, 2001) who have few resources. Dale (1997) also says that if the therapist is not aware of his/her own pathologies or unconscious processes, the primitive communication of the poorly integrated personalities of some patients may become difficult for the therapist to “disentangle” (p21) his/her own unconscious processes from those of the patient. By implication, the trainee psychologist who may be in contact with his/her unconscious processes for the first time either through personal therapy, supervision or contact with patients, may struggle with the therapeutic work and the transference situations. In situations like these, it is not surprising that trainees become resentful of not being adequately contained (Cushway, 1997). This sense of inadequate containment presents another ambiguity that exists for the trainee and lies in the teaching of new skills. The trainees cannot be 'taught' everything they need to know and they have to develop a capacity for self-teaching by utilising their internal resources. This may be true but, ironically, it is a process that gets easier with experience.

### **2.2.5 Race and the training**

The key problem facing psychology in South Africa, since the 1980's, is its relevance in the South African context (Gibson et al., 2001; L. Swartz & Gibson, 2001). Not only is the applicability of a predominantly white, middle-class, individualist practice to the South African context under question, the limited and racially disparate services are of serious concern (Berger & Lazarus, 1987). The applicability of the training in such a context therefore is also under review (Gibson et al.). Parker (1986) and Marchetti (1989) found that trainees felt that their training did not equip them for work with diverse populations groups. Watts (1987) says that when training programmes do not adequately address issues of cultural diversity, the training of both black and white students is limited. This adds to the view that training in South Africa is already inadequate and that universities are “turning out a lot of incompetent psychologists” (Edwards, 1993, p38). The training programme at UCT, over the past decade, has made significant changes with respect to representation in the training and among trainees to redress the Apartheid past and provide adequate services for the country (Gibson, et al.). However, many authors investigating trainees' experiences

of race in Cape Town, mostly the experiences of black students (Mokutu, 1998; Kleintjies, 1991; Abrahams, 1992; Ahrends, 1995) have concluded that black students, especially those in historically white institutions, not only have different experiences to their white counterparts but that they struggle with a lack of space to discuss their difficulties regarding race, culture and language. Kleintjies (1991) found that the overarching feeling among black trainees is their sense of 'not being good enough' and how this permeates their confidence in their abilities and their sense of belonging. The wounds that these students inherited from a racist society where black is still synonymous with inferiority, will be difficult to heal especially when there is a perception that racial issues cannot be addressed. If students, whatever their racial or cultural background, cannot master race issues it may negatively affect client interaction and further entrench therapists' belief in their inadequacy both personally and professionally.

### **2.2.6 Learning Demands of Training**

Gelman (1999) found that 13% of students in her UCT sample felt that they were not coping academically and that this affected their mental health. In clinical training, learning demands on students may be even greater. In addition to internalising their new role, there are huge demands placed on trainees to deal with multiple tasks at an academic and professional level. The most frequently reported stressors for clinical trainees in Cushway's (1992) study fell under academic demands (for example deadlines=22% and amount of academic work=17%). In their first year, from February to December, trainees have to commit to a 5 day working week from 08:30 to 17:30 or 18:00. Students from each class, respectively, attended an average of 26, 17 and 20.5 hours of seminars or academic meetings a week - including the 4 hours spent at community placements (CGC timetable records; Lovric, N., personal communication, Dec. 08, 2001). These seminars require intensive reading and preparation (CGC Handout, 2001). Input is given on childhood development, psychopathology and on a range of psychotherapeutic interventions including play therapy, group therapy, brief intervention, cognitive behavioural therapy, family therapy and adult long-term therapy as well as community consultation and training (CGC handout, 2001). Students are required to have four child cases at a time and a minimum of one adult client who they will treat over their two years of training. These cases involve assessment, clinical formulation, diagnosis, and appropriate intervention. Trainees too are expected to meet academic requirements which consist of clinical record-keeping, report writing, teaching case conferences, psychometric assessment and reports, class preparation, developing workshop material for community placements, liaisons with GP's as well as examinations. There is also the practical work that needs to be done such as child and family case work, long-term clients, and therapy groups.

The second year of training runs from early January to the end of December. Although trainees are only required to meet the minimum of 15-50 hours required by the Health Professions Council of South Africa (HPCSA), they are also expected to meet the service requirements of the hospital wards. Students work a minimum of 8 hours a day with one morning a week dedicated to seminars and further training. Though work demands differ at each ward, the daily schedules are generally full (Kottler, 1991) with case management of numerous patients, hospital ward rounds, administration and staff support. Two interns are assigned an additional community placement, which they attend throughout the year. Trainees are also required to meet the quota of psychometric testing in that year. They also continue working on their research dissertations, which they are expected to start during the holidays of the first year. All these requirements add up to a heavy workload for trainees, which may be academically and personally demanding.

With the heavy workload and the emotional nature of the work, the trainee's personal life is affected. Often trainees have little time to spare or fewer internal resources to invest in friends or family, putting strain on relationships and disrupting social support (Marchetti, 1989; Cushway, 1997; Millon et al, 1986). Some trainees leave their homes, partners or families to attend training courses. This separation both disrupts support and profoundly impacts on trainees already struggling with the developmental anxieties of moving towards a more adult status (Reid, 1970, cited in Berndt, 1985; Cushway, 1992). Difficulties in their relationships outside the course may also affect their ability to work effectively in the course.

In Cushway's (1996) study of mental health nurses and clinical psychologists, both groups experienced 'home-work conflict' as the most consistent predictor of poorer mental health. In her study this category includes too little time for family, friends or recreation, taking work home, inability to separate the personal from the professional role, relationship with partner/spouse affecting work and the work emphasising feelings of emptiness and isolation.

With all these demands, trainees may experience being evaluated on all their activities, academic and therapeutic, as being very stressful. Millon et al. (1986) argue that the ever-present evaluation of psychology trainees' professional development and competence is very anxiety provoking. There are the formal evaluations such as examinations but also informal evaluations. One informal way, according to S. Swartz (1999), is the manner in which trainees are able to formulate their patients psychodynamically. This, she says, becomes a public display of professional competence. However, she notes that formulating may be difficult for trainees who are schooled in varied theoretical

frameworks and have little opportunity for modelling formulations of professionals in an environment which decontextualises the use of a range of psychoanalytic concepts. In fact, Swartz (1999) also says that what trainees learn is that psychodynamic thinking is the preserve of senior clinicians or consultants and that their contributions are of little value or relevance.

Evaluation by staff and supervisors may be experienced as a contradiction to the trainees who may expect that trainers be guides or gurus. Cushway (1997) says that trainees often need, dynamically speaking, for their supervisors to be a source of support to them in their time of need almost like super parents. Yet the supervisor is also the one giving "detailed assessment of students performance" (CGC handout, 2001) and plays the role of "gatekeeper to the profession" (Cushway, 1997, p31). Kottler (1991) says that this situation could feel very threatening and may make it incredibly difficult for trainees to share their difficulties openly for fear of revealing incompetence. It has been suggested by Cushway (1992) that it is probably the role of the supervisor as evaluator and critic of the trainee's therapeutic skill that creates the most stress for trainees, who are often at their most vulnerable when exposing their lack of clinical expertise to supervisors.

In addition, Cushway (1992) found that 'poor supervision' was by far the most frequently reported stressor (37%). Steiner (1994) believes that supervision is the most important learning tool for trainees. If this is compromised, trainees not only suffer the anxiety of poor supervision, they do not gain the necessary skills to achieve competency.

Cushway's (1997) trainees furthermore commented that the stressful nature of the course is largely unacknowledged and often criticise course organisers as unsupportive. This is a common dynamic between students and trainers in any programme and may result from students' idealisation of the trainer or the expectation of the provision of containment, according to Salzberger-Wittenberg and Henry (1983). However, there may be a tendency to attribute much to the students' internal reality and minimise the external one. Refreshingly Salzberger-Wittenberg, et al. (1983, chap.3, prt.2) look at teachers' dynamics and how this influences the learning situation as well as those of students. Gibson, et al. (2001) also identify how trainers may in fact be neglectful of students because of the pressures placed on them.

Another external factor is the financial demands of clinical training, reported as a significant stressor (Cushway, 1992). For example, in Gelman's (1999) study, 42% of the students studied felt that they were not coping financially at university (93% of whom were black). The Masters course can be

very expensive and trainees often have to finance themselves. They may personally pay for university fees, personal therapy and miscellaneous costs. The considerable financial sacrifices that trainees have to make may also involve their families, further complicating relationships. Cushway (1997, p33) says "the paradox is that, while the trainee's own relationships [and lifestyle] may be severely stretched, the trainee is learning to lavish care on his/her clients." In some training programmes, interns receive a small salary that may help them to relieve some financial stress. Plante (1987) however asserts that small salaries, few or no insurance and professional benefits during an internship not only contribute to the stress and strain of the internship training but negatively affects the interns' professional self-confidence and esteem.

Studies, such as Cushway (1992), Gelman (1999) and Millon et al. (1986) have therefore found trainees citing the academic and professional demands of training such as the long working hours, heavy workload, evaluation and financial pressures as difficulties. These difficulties, trainees have also felt, have largely gone unacknowledged by staff and supervisors, perhaps adding to the difficulties of a demanding learning situation.

## **2.3 THE CONTEXT**

### **2.3.1 The Organisation**

Traditionally, organisational research on stress focused on factors such as management style, level of employee support, availability of resources, work ethic, task efficiency, working conditions, and the organisational structure. When there are few resources, lack of clear boundaries, employee sense of autonomy and control, inadequate staff support and poor working conditions, it is said that staff are likely to experience high stress levels (Kets de Vries, 1991). Trainees struggling with few resources, with establishing boundaries because of internal shifts, with a sense of helplessness in a new learning situation, and with perceived lack of support are therefore also likely to experience high stress levels. In the training institutions, structure plays an important role for the containment of student anxieties, fostering an environment of learning and the ability of students to conduct themselves professionally (Obholzer, date unknown). However, Kottler (1991) found that structure could also present difficulties for students. She highlights the disjuncture between students' training needs and patient needs in the hospital system. Students move around in their training and patients are expected to move with them. This, she says, is unsettling for the patients, but also for the students whose internal and external sense of structure is at odds. They may also fear that they are causing damage to their patients, thereby exacerbating notions of incompetence. Although these sociological aspects are very important in understanding the organisation and the experiences of the

workers, Kets de Vries (1991) says that many are feeling uneasy with the simplicity of these "rational action" (p1) models. He says that there is a move towards addressing unconscious factors to explain managerial and organisational behaviour in order to reduce the risk of unhealthy working environments.

In addition to the conscious task of achieving their work goals, psychoanalytic theories suggests that organisations and institutions also have unconscious tasks (Obholzer & Zagier-Roberts, 1994; Menzies, 1970). The premise is that the nature of the work which organisations do affects not only its staff but the organisation as a whole. In considering the training institutions of clinical psychologists, trainees are working with psychologically disturbed children and adults which may affect trainees, thereby permeating all levels of the training institute. The defences against intolerable mental pain of such work (Menzies, 1970) may manifest itself in the organisational dynamics. Hirschhorn (1990) says that feelings of anxiety constitute the roots of distorted, mostly alienated, relationships at work. Not only do they distort the relationships inside the organisation, they also serve to distort the relationship between the organisation and the external environment. Hirschhorn says that often the 'outside' is scapegoated or devalued in some way to preserve the 'inside'. The defences that an organisation utilises may mirror those used by their client/patient group. Children or emotionally disturbed adults may communicate and defend against their distress by splitting off and projecting their 'bad parts' into those working with them such as the trainees. The trainees' unconscious identification with these projected feelings may in turn be acted out within the organisation. (Obholzer & Zagier-Roberts, 1994; Gabriel, 1999; DeBoard, 1995). By implication, trainees working with psychologically disturbed individuals who regard their parents as inadequate, may be left feeling that their training institution is inadequate and that the society out there is bad, ignorant and devaluing.

Kleintjies (1991) examines the organisational dynamics of a psychology training institution at the level of the individual trainee only. She suggests that the deep seated feelings of some trainees of not being 'good enough' may be projected into the staff and the institution, perhaps resulting in the institution holding the persecutory projections of the trainees. Hirschhorn (1990) suggests something similar, saying that once staff or an organisation take on projected feelings, they are seen as 'a threat'.

Cushway (1997) takes a different stance to this bottom-up understanding of organisational dynamics and by so doing highlights a different level of analysis. She coined the phrase 'the Consultant

Syndrome' to explain how qualified psychotherapy trainers may, like medical consultants, have been trained under the same stressful conditions as their present trainees. Thus, she says, they may feel that if they survived then so will the trainee. They may view training as survival of the fittest and think that only those who survive will be able to cope with the stresses of professional practice.

### **2.3.2 The Changing Context of Psychology**

Rouff (2001) maintains that the recent changes in mental health care and the training environment (increased managed care, increase in the use and reliance of medication, the decreased popularity of psychodynamic thinking and the reduced funding for psychotherapy training) have negatively affected the educational experiences of and the development of professional identities in the mental health trainee, especially those with a psychodynamic orientation. She says that trainees, because of such an environment, struggle with problems of demoralisation, professional isolation and less financial opportunities. She says that the tendency to regard psychodynamic therapy as outdated, impractical and ineffectual, causes students not only to be discouraged about their work and completing their studies - but also leave them feeling isolated because they may feel unable to share their ideas publicly. This is especially true in South Africa where there is also a demand for more relevant psychological theory and practice and community-based interventions (Heuchert & Ahmed, 2001; L.Swartz & Gibson, 2001). The structure of professional training is also under review with the introduction of mid-level psychologists (BPsych) and lay counsellors (HPCSA, 2002) to meet the demand for psychological services in South Africa. These factors may serve to heighten the uncertainty of Masters' trainees about their future and their level of experienced stress.

In the changing context of mental health, public opinion of mental illness remains largely unchanged, harbouring notions of 'madness', 'evil', 'danger' and 'unreason' similar to what Foucault (1961) spoke of. Hubert (2000) says that the physical and social exclusion of people classified as mentally ill, is an example of the way in which human beings act in order to separate themselves from those considered 'different'. She cites Gelman (1988) who suggests that this is because people try to rid themselves of the fear of their own mental and physical disintegration by relocating it in someone else, who they can then separate from themselves, and call 'other'. Foucault (1961) provided a similar explanation for the practice of public displays of the mentally ill in the middle ages.

Similarly, those who work with the mentally ill appear to be "marginalised professionals" (Marks, 1999, p269). Nell (1992) says that psychology is generally regarded as subordinate to medicine and

is often met with social indifference. Not only is psychotherapy less valued at times there is little understanding of what psychology is (Farberman, 1997; Bram, 1997, Wollersheim & Walsh, 1993; Berger & Lazarus, 1987). Therapy, for example, is often thought of as 'magical' (Millon et al., 1986) and there are many myths surrounding psychology and what it is that psychologists do (Dare, 1997). Millon, et al (1986) say that psychology's claims of having specialised and esoteric procedures by which they ascertain matters that others have no direct knowledge of, leads to discomfort in many about all-seeing voyeurs. Dare (1997) speaks about two other persistent myths surrounding psychology. The first is that psychotherapy is nothing more than an everyday friendly conversation "commonly available over the garden fence"(p2). The second is that psychotherapy, and psychoanalytic therapy especially, "probably does not work to any beneficial ends but it is potentially dangerous" (p3). Both these myths are disheartening to the therapist and may result in further uncertainty in the therapist and in his work. Moreover these myths, according to Dare, are shared by the public, academics, doctors and psychotherapists themselves.

Such widespread lack of confidence in or ambivalence about what trainees have worked so hard for, may lead to a lack of confidence among trainees in the efficacy of psychological interventions, psychotherapy in particular, and in themselves as therapist.

#### **2.4 COPING STRATEGIES**

There are very few published studies examining coping strategies in trainee psychotherapists (Cushway, 1997). However, most literature cited here, investigating distress in professional or trainee psychologists, has also looked at the methods utilised to cope with personal or professional difficulties (Kilburg, et al., 1986; Plante, 1996; Varma, 1997; Cushway, 1996, 1997; Payne & Firth-Cozens, 1987; Cherniss, 1995). The strategies are usually conceptualised as three-pronged, falling into cognition (cognitive re-appraisal including problem-solving), behaviour (active attempts to deal with the situation) and avoidance (avoidance of the stressful situation). Psychodynamically orientated studies have also examined more internal mechanisms.

The literature suggests that the most important influence on therapists and trainees' coping is their relationships with others. Cushway (1997) found that trainee psychotherapists used 'talking' as their main means of dealing with stress and more specifically, talking with fellow trainees or colleagues was rated the highest. Talking to family and friends, as well as supervisors and therapists were the other means of coping.

Other researchers such as Coster and Schwebel (1997) and Mahoney (1997) have looked at the overall patterns among professional psychologists and identified various factors that may contribute to the ability to function well. In interviews with 6 experienced professionals, Coster and Schwebel's (1997) findings were consistent with other findings that significant weight is placed on relationships and in particular relationships with psychologist peers. They identified 10 factors that were considered to assist in 'well functioning'. These were: peer support, stable personal relationships, supervision, balance between work and relaxation/recreation, affiliation with a graduate department or school, personal psychotherapy, continuing education, and the family of origin being supportive and functional. Mahoney's (1997) study of 155 psychotherapy practitioners reported mostly 'self-care' factors to involve practising meditation or prayer, regular exercise, pleasure reading, vacations, hobbies and artistic activities. In looking at a sample of 339 randomly selected psychologists, other factors were also identified, namely: the consequences of impairment as a deterrent, self-awareness/monitoring and personal values.

The degree to which the trainees cope and moderate their feelings about the course and the anxieties associated with learning also depends on what they have learnt from their unique past experiences and the mechanisms they adopted to contain mental pain (Salzberger-Wittenberg & Henry, 1983; Kottler, 1991). The nature of therapeutic work, their personal growth and the evaluative nature of the training may also force students to explore their usual coping styles in assessing its' usefulness in moving towards becoming psychologists. This may be very difficult for a student whose desire is probably to defend unquestioningly against the peaking of anxieties related to learning and the process of changing themselves into professionals.

The manner in which a trainee may cope with the anxiety and stress of training may include all the psychic defences to avoid anxiety and mental pain that they share with others including their patients. These include denial, splitting, projection and projective identification and avoidance. Salzberger-Wittenberg & Henry (1983) explored such unconscious defences quite extensively. They say that the relationship students have with teachers, like the parent-child relationship, is marked by idealisation and denigration, by love and hate. The students have to go through the same growth process in which they can consolidate and accept the good and the bad in the teacher, and in themselves. They say that such defences can be seen with all student-teacher relationships and as such may apply to the trainees.

Intrapsychic or internal defences, individual and social, may be pathological in terms of the severity of the defence. They may defend the individual to such a degree that they are not open to growth and relinquishing of primitive defences. Avoidance of difficulties may be especially problematic as it may result in higher stress levels and psychosomatic illness (Corey, 1996). Self-awareness of one's attitudes, defences, motivations and an openness to examining and changing these may foster growth.

Another very important factor is trainees' ability to ask for support. Many authors here (Kilburg et al., 1986; Cherniss 1995; Millon, et al., 1986; Dale 1997; Cushway, 1997) say that it is difficult for psychologists and trainees to ask for support because they fear that doing so will reflect personal and professional weakness. Trainees are encouraged to self-reflect and reveal their distress in order to facilitate learning. However, as they are also being assessed academically on their professional adequacy, which also involves personal qualities of them as therapists, trainees often are guarded and not open about their struggles. In addition, their personalities reflect a valuing of autonomy and control and asking for help may be regarded as an indication of personal weakness.

Trainees are required to be in personal therapy (CGC Handout, 2001) which may offer much support. However, therapy could also present problems. Dryden and Thorne (1991) point out that the self-exploration, especially in the initial phases of therapy, involves new discoveries and sudden movement into unknown psychological terrain that may be disturbing and disorienting. They say that students are likely to experience distress and bewilderment and may even, at times, become subject to incapacitating anxiety or depression. Furthermore, students may find it difficult to utilise cheaper state services as this is the context in which they train and work. They may fear bumping into their clients or asking for support from fellow professionals or colleagues for fear of negative evaluation (Nathan, 1986; Kaslow, 1986). Nathan (1986) and Kaslow (1986) both explore the implications of psychologists and students being treated by their colleagues. Generally, Kaslow (1986) said that issues pertaining to professional boundaries, role-modelling, and confidentiality are pertinent in such situations.

Nathan (1986) also says that among fellow professionals, the individual therapist is selected as a role model and mentor as well as a healer. He says that students search for a "guru" (Nathan, 1986, p196) to pattern therapy style, personality and interventions on. He says that if the selected therapist lacks ethical standards, then the 'therapist-patient' (as he called it) is likely to become demoralised, even desperate, as the therapist is seen to be a poor representative of the self-idealised therapist. All

of these aspects may make it very difficult for trainees to ask for support when they need it, thereby compromising their ability to effectively cope with the training.

In summary, it appears that the professional training in clinical psychology can be a stressful experience. Many factors on an individual, interpersonal, professional and social level may contribute to trainees' experience of stress in their training. The literature reviewed suggests that trainees' personality and past experiences may not only provide trainees with the motivation for pursuing psychology, but may also affect the way in which the training situation may be perceived and managed. For example, entering a new learning environment is anxiety provoking and may elicit infantile experiences that lead the trainees to develop hopes and fears about the course, the teachers, their peers and themselves (Salzberger-Wittenberg, 1983, part I & II). Trainees' infantile experiences, it is argued, is of inadequate emotional containment. This may result in a distrust of staff and peers and a lack of trust in themselves to cope with the training (Skynner & Schlapobersky, 1989; Dryden & Spurling, 1989).

In addition, a lack of clinical experience and shifts in identity may make it difficult for trainees to gain a sense of personal and professional competence necessary for therapeutic work with clients (Kottler, 1991). Trainees also have to meet the academic and professional demands to perform while attempting to integrate newly acquired skills. This may perhaps foster fear of failure and insecurities in their competence. Black trainees, in particular, may experience fears of perceived inadequacy. The heavy workload, the emotional nature of the work and financial concerns are other potential difficulties. Furthermore, the recent changes in the profession and in the training may result in professional doubt in trainees and uncertainty about their future. While these changes question the efficacy of psychology, negative public opinions of the mentally ill continue to marginalise those who work with them. All these factors may contribute to trainees experience of their training.

## CHAPTER 3 : METHODOLOGY

### 3.1 MOTIVATION FOR CHOSEN METHOD

Exploring the emotional experiences of different individuals and the meaning they attribute to their experiences already places this study firmly outside the boundary of a study aimed at quantifying data. Words like 'exploration', individual 'experience' and 'meaning' are qualitative research constructs (Neuman, 1997) and this study was only possible through such research methods. Furthermore, the study had to consider that I, the researcher, came from within the constructed group being studied. I was a "member" (Neuman, 1997, p344) who had participated, observed and 'lived' with the group. This could affect my perception and interpretation of the material. Qualitative research actively addresses this issue and especially in recent times, believes that acknowledging and reflecting on the role played by the researcher in a study strengthens the research (Hunt, 1989). Parker (1994, p2) even defines qualitative research as "the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made". Quantitative research, on the other hand, still aims to find objective results that are untainted by the effect of the researcher (Parker, 1994). This study therefore adopts a qualitative approach.

### 3.2 PARTICIPANTS

The participants included: 6 trainees in their third or dissertation year; 4 in their second or internship year (M2); and 4 trainees in their first year (M1) of the Masters course in clinical psychology at the Child Guidance Clinic. They were interviewed in their 7<sup>th</sup> month of the year.

The three groups were selected from three consecutive years. To ensure anonymity, the year (e.g. 1980) of study for the three classes was omitted. Almost all the trainees (only 3 were not eager) volunteered to be interviewed. However, several of those who could not make the scheduled date for interviews were left out of the final sample. This was not problematic as I had in any event envisaged limiting my sample to approximately four in each of the years. The number of those who volunteered and were able to make interviews in my own year was slightly higher (6), perhaps reflecting their personal connection to me and also the relative freedom they had to organise their time. These three classes were selected for the primary reason of interviewing trainees who were still in the process of training rather than interviewing graduates. As the literature suggested that there is a developmental process taking place in training (Lipovsky, 1987; Kottler, 1991), I wanted to capture the emotional experience of trainees as they were experiencing it, at each developmental

stage and not retrospectively. The classes were also easily accessible. A change in directorship at the CGC meant that the students in their first year of training at the time of the interviews may have undergone a different programme than the other two groups. However, despite training programmes undoubtedly undergoing many changes in each year, the basic training requirements remain the same for all trainees. Also, due to the constraints of this minor thesis, the differences in the context of each class were not fully explored.

### **3.3 DATA COLLECTION**

Fourteen one-hour interviews were conducted. Choosing to use interviews as the research tool was based on three reasons. Firstly, as it is a “joint production of a researcher and members” (Neuman, 2000, p370), it made participants' insights, feelings and co-operation vital in the process of revealing subjective meaning. It also allowed flexibility for the researcher to explore and clarify where necessary. Such flexibility, Burman (1994) says, permits exploration of complex issues, enabling contradictions and difficulties to come through. This meant that the aim of exploring fully the emotional experiences and difficulties of trainees could be met. Secondly the literature on psychology students is limited and the intention to possibly help others through this study made the choice for semi-structured interviews pertinent. Burman (1994) says that semi-structured interviews can document perspectives not usually represented, thereby empowering the participants by validating and publicising their views. In addition, doing interviews forces the researcher to consider his/her participation within the research (Burman, 1994) which was very important to this study and for limiting potential bias.

A pilot interview was conducted to assist in designing a semi-structured interview that would elicit each participant's particular experiences. In each case, the interviews began with a general enquiry about the student's experience of the course and in particular the areas that they found most difficult through the training. However, as the literature suggested particular areas to be probed, where these were not spontaneously raised by the interviewees, I elicited them. However, this happened in exceptionally few (3) cases. Areas that required probing included: personal areas of vulnerability and its implications for trainee experiences; the impact of personal therapy; the experience of working therapeutically with clients; the experience of the amount of work; experiences of relationships in the course and of the institution; the support available to students; the experience of being evaluated; and finally, perceptions of change in self-concept. (See Appendix A for some examples of questions asked)

### **3.4 ANALYSIS OF THE MATERIAL**

The recorded interviews were numbered and transcribed verbatim. Each interview text was read individually to get an overall sense of the trainee's experience. The interview was then re-read and the main points and arguments pulled out. These were compared to the overall sense gained. The various aspects of the training, which were identified as both positive and difficult, were also highlighted with quotations taken from the transcriptions to illustrate these. I also looked for coping strategies used by the trainees. When this procedure was complete for all fourteen interviews, patterns were identified across the interviews and sorted into 'categories'. I was then able to see where, and how many, trainees shared experiences and where they differed or disagreed. The most common patterns were then pulled out.

'Data Analysis' according to Neuman (2000, p372) means "the search for patterns...once identified, it is interpreted in terms of a social theory or the setting in which it occurred". The material was therefore analysed and made sense of in relation to the literature and psychodynamic theory. This helped refine the first set of 'categories' into more meaningful units that resulted in fewer, more encompassing themes. This method draws on general practices of interpretive social science (Neuman, 1997).

### **3.5 ETHICAL CONSIDERATIONS**

Firstly the decision made by students and the training institutions to participate in this study had to be an informed one. In this regard I was explicit about the aims of the research and about the dissemination of the information. The confidentiality of the participants was a central concern and great effort was made to ensure that no identifying data was given in the study. However, there was still the possibility of recognition and this was discussed to allow the participant to make an informed decision. Participants were given copies of their interview transcripts to edit before it was seen by anyone, including my supervisor who was involved in the training and knew students. Only the edited transcripts were analysed. This was done to ensure the omission of information that could identify them or information that they did not want to share publicly. Feedback of the findings was offered to all participants, including the institutions, on request. Notably, confidentiality may have been compromised by the trainees themselves, who often informed their classmates and others that they were being interviewed.

### **3.6 REFLEXIVITY**

As a 'member', I was both participant and observer of the subjects in the context of the training programme. It was important, therefore, to reflect on my presence and investment in the study. According to Schefer (1998, cited in George, 1999) self-reflexivity involves locating oneself within the study and exploring ones' ideological and theoretical investments in it.

I had direct interaction with 8 of the participants (some were from my class) over a period of about 20 months and learnt about them in the training setting and beyond. This meets the recommended criteria for doing field research according to many authors (Neuman 1997; Grandal & Salmone 1995; Rosenthal & Rosnow 1991; Bernard, 1994). It facilitated: close learning about them, established rapport and trust, good accessibility and knowledge of the subject matter that allowed for deeper probing. However, as beneficial as it is to be so close to the subjects and subject matter, this interaction with only some of the subjects, and not others, was potentially a weakness. I hardly knew the other 5 subjects and had not participated in or observed them in their own training setting, but instead drew on the knowledge of my experience.

As the researcher, I was cognisant of where I was situated; I too was undergoing the professional training to be a clinical psychologist. As with the sample of respondents - some being my classmates and friends - I had not completed the training, and this research about our experiences as trainees formed the requirement for entry into the very profession which I could be seen as investigating. The research was supervised by a member of staff who was largely responsible for structuring the initial part of the training as well as doing the actual teaching/training. She also supervised many of the respondents.

Evidently, there were many potentially problematic factors inherent in the study, some which enhanced and some which hindered the quality of the research. In particular, my position in the research process had to be explicitly dealt with in the study:

Having gone through 28 months of the professional training, which I found extremely stressful and difficult, I assumed that other trainees had a similar experience to mine. I had to be self-aware and keep my bias from influencing the responses of the participants and from selectively interpreting the interview material in a manner that would confirm only my initial expectation. My concern that I could influence the responses led to some over-cautious passivity and/or hesitance in the interviews, which I believed hindered the amount of information gained.

The trainees' responses, however, appeared honest and not tailored to suit me. Once into the interview they often made comments about my possible bias in researching their difficulties and informed me that they would only give me a balanced account of their experiences including the positive aspects. The level of honesty was very interesting to observe. Some of my classmates, who knew me personally, reported being too open in their responses and they had to omit information from the transcripts. Others found particular areas, especially their personal lives, difficult to discuss and they were apprehensive about how such information would serve to identify them or how it might reflect negatively on them. In responding to questions about the training institution and its' staff they had many concerns about confidentiality. Seven interviewees found it strange to discuss their experiences without reciprocation from me, thus commenting on the "assumptions of control" (Burman, 1994, p58) implicit in the interview situation. To challenge these assumptions, I would answer their questions about my experience of training after their interview. To further ensure that the trainees were not complying with my research demands, the study utilised a technique formulated by Orne (1962 cited in Rosenthal & Rosnow, 1991) to control task-orienting cues. In the pilot study, the participant was asked to monitor the interview process. After the interview, the effects of the research relationship was discussed and evaluated. The research supervisor also acted as a monitor for bias. Open-ended questioning also limited any cueing of participants, allowing them to identify their own areas of positive experience, difficulty and stress.

Only recently have researchers begun to acknowledge the unconscious motivations and the affective complexity behind their choice of study, such as Hunt (1989) who explores some of the psychoanalytic aspects of fieldwork. The exploration of my motivations as the researcher and the dynamics in the research relationship are strengths of this study as well. However, such exploration is limited within the confines of a small research project and perhaps serves to highlight areas for further research needed in the field of social research.

## CHAPTER FOUR: RESULTS AND DISCUSSION

Some of the themes and difficulties in the interviews are outlined in this chapter to gain understanding of students' experiences of training.

All the trainees said they experienced difficulties during their professional training in clinical psychology, but to varying degrees. Regarding their overall experience of the training, nine out of the ten second and third year students found it to be "very difficult". Some experienced significant distress, with reports of lowered immunity, constant headaches, sleeplessness, chronic fatigue and even "depression". The first year students and one third-year reported having more positive experiences of their training than their counterparts. The third-year student said that her whole experience was "amazing" because she actually got the opportunity to do her Masters. However, all fourteen trainees reported the training to be anxiety-provoking and challenging on a personal level, in terms of their personal development as well as it being emotionally demanding. The training was even described as a "two year long ritual process of being stripped emotionally". However, all also said that despite it being a difficult process, they appreciated the reward of personal growth that was facilitated.

### 4.1 NOT BEING 'GOOD ENOUGH'

A theme that emerged across all the interviews with trainees was an anxiety about "not being good enough" to be selected or to do the work of psychology. This theme was common in the literature about clinical psychology trainees (Kleintjies, 1991; Cherniss, 1995; Millon et al., 1986). Every trainee used this phrase during their interviews. Further analysis of the interviews reveal that there are many aspects of the training course and organisational practices that may have contributed to the level of anxiety about not feeling adequate for the course. It was said that "there's something that stirs you up in this course... where you keep on doubting yourself". What follows is an examination of what trainees' thought had contributed to this sense.

#### 4.1.1 Surveillance

The sense of being watched and fear of being found wanting permeated many of the trainees' experiences of training. For eight trainees, this began with the selection process. The professional training in clinical psychology is difficult to get into as only a few students are selected each year to be trained. The University of Cape Town selects 8 students each year. The trainees were taken from

Summary

a pool of 100, 227 and 117 applicants for their respective years (Lovric, N., Personal communication, 29 Oct. 2001; CGC database, 2001). As such there is considerable competition to get into the training programme. The difficulty in getting into the training course may add to the idea that the students chosen are the “la crème de la crème” (Millon, et al., 1986, p120). From what trainees report, there is a sense that this profession is seen by applicants and others as either “elitist” or as a “prestigious course” and those who get in are seen as “special” or “really lucky”. Such images may be carried by the trainees as they enter into the course and they may feel unable to measure up to what they believe to be the expectations of them. Trainees reported that they came into the course feeling anxious about meeting very high expectations of being a special, “hand-picked” member, one of “the ‘chosen’ eight”.

*conclusion*

Trainees perhaps fearing that they may not meet such high standards may feel uncertain about how they were selected. Having little knowledge about the selection process and how and why trainees are selected seemed to exacerbate this problem. Trainees appeared to believe that the selection committee did not always have true and thorough knowledge of who they were and therefore could have made a mistake in selecting them. For example, one trainee said that it would be impossible for them to know who she was from a short interview in a selection process, and she questioned whether they would have accepted her if they did 'know' her. Secondly, there appears to be some guilt about the rejection of others in favour of the trainees. If in fact a mistake was made in selecting them, then others were deprived of an opportunity to study. The idea that they were somehow responsible for the rejection of others, or for possibly depriving someone more capable or committed to the course, may serve to fuel any notions of them being unacceptable or 'bad'. This may thereby reinforce the idea that they do not deserve to be in the training course. In reaction, trainees seemed to feel they had to work very hard to prove to the institution, and themselves, that a mistake was not made in selecting them and that they are worthy. The following quote seems to captures these kinds of difficulties:

getting into the course and the actually making it. You are the chosen 8 and this kind of thing of special children and all the ones that didn't get in... a lot of anxiety about... unconsciously about being found out about really belonging there. The whole class carried that... Of being found out for like having got through incorrectly... So the kind of sense of having to prove yourself and show yourself.

Evaluation also appeared to exacerbate trainees' fears of being “scrutinised”. However, the assessment of themselves as 'not good enough' appears to have resulted in a equally potent anxiety

that they will not only be unmasked as a “fraud” but also “expelled”. They described their first year with phrases like being in “a bit of a goldfish bowl” and “like everybody's watching kind of thing” and that there is “a critical eye all the time”. This was reported by all trainees as stressful and anxiety provoking. For one of the trainees this was to such an extent that she avoided seeing any of the staff. She said that she would come to “the clinic” (as the CGC is commonly referred to) very early so as not to see them and dreaded bumping into them in the passages. She said “I just want to hide all the time because I was thinking what are they thinking of me; 'what a stupid woman this is'.”

The selection process and the evaluation of students' performance appears to facilitate a sense in trainees that they should prove to the staff and themselves that they deserve to be in the programme, or face rejection. For some (4) this sense of not being good enough extended beyond feeling watched. It extended to them not being able to accept positive feedback because they questioned the motives of those giving the feedback. One trainee said that getting positive feedback for her “didn't make any difference’ because she would think “they feel sorry for this poor... woman so they feel like they have to say sweet things”.

It appears that the students interviewed had considerable anxieties about being scrutinised and found wanting. It may be, as Kleintjies (1991) suggests, that this experience harnesses deep seated feelings amongst students of not being ‘good enough’.

#### **4.1.2 New Situation**

Trainees are often entering new situations. They first arrive at the CGC to meet their class and the staff they will work and train with for the rest of the year. They will then move on from this academic environment to the often unfamiliar clinical setting and clinical work. In their second year, they also enter a new placement every four months.

Salzberger-Wittenberg's (1983) argument that any new learning situation is difficult and anxiety provoking appears to be true for 9 trainees who referred to this as a significant source of anxiety. One trainee said

...the newness of it all. A new way of thinking and relating, Uhm I found very challenging on a personal level.

Salzberger-Wittenberg (1983) says that being unsure of what to expect in a new situation evokes phantasies, or unconscious knowledge, that helps provide some frame for what to expect. These

phantasies, usually about themselves and interpersonal relationships, are meant to lessen anxiety. However, they may also be problematic for the trainee. For example, it appeared that for one trainee, 'loss' of relationships was of particular concern to her because her emigration to South Africa had marked the ending of many important relationships in the past. When starting the course, she said that she was mostly worried about meeting her classmates and "forging new relations". Entering the new situation of the course may have evoked this past experience evoking fears of renewed loss.

The rotation of placements in the second year appears to have maintained high levels of anxiety for 5 of the 10 trainees who entered the hospital system. They were continually being placed in a new situation, where all their uncertainties and phantasies would resurface. One trainee said that you are always trying to adjust and when you finally adjust and are able to "establish your own working system... you have to change". Another trainee summed up the effects of this when she said that

No you can't get used to it...as soon as you're getting used to it, you start all over again. It's like, you start all over again with all the anxieties, with all the questions that you have, the doubts that you have about yourself...

The continual re-creation of new situations each time may have re-evoked the uncertainties and insecurities that trainees had of themselves and their work abilities.

#### **4.1.3 Crisis of Competence**

Because trainees were new to the profession, they felt that they were not equipped to do psychological work. One trainee said that what she found difficult was that for the two years "you are always presenting yourself as if you have more experience than you actually have" and that "you are always at the edge of your capabilities". Their inexperience may have exacerbated their anxiety about not being good enough.

Trainees' lack of academic knowledge and clinical experience may in fact increase their uncertainty about coping in this situation. This was true for most trainees with their first client at the clinic and when they first entered into the hospital system and had to work with patients. The hospital system was a very unfamiliar one and students had to be orientated to the practices there. Many, however felt that they had to learn on their own without much assistance. They felt there was not enough time to familiarise themselves with the system before starting to work and they had to learn on the job. One trainee said that on her first day at the hospital, already anxious about being in an unfamiliar space, she was expected to do a clerking and a presentation shortly after her arrival. She did not

know how these things were done. She said that she had to do "all sorts of things that [she] felt [she] didn't have the competence to do or [know] how to do, working in this medical paradigm" She wished that she had been more adequately prepared for her second year. Six others, out of the 10 currently in or who completed their internship, felt the same.

Fear that the knowledge people have will not be adequate for a new training situation, Salzberger-Wittenberg (1983) says, is normal. However, what may have made it even more difficult for trainees to believe that their previous knowledge was adequate, was their perception that staff did not acknowledge them academically or affirm their skills. Two trainees said that the knowledge and work experience they brought with them into the course was not sufficiently recognised. Two more felt that they were being told to put their "intuition on hold" and that what they had to offer was not wanted or valued. Also two other trainees also felt pressure to conform and change their "view of the world" to share in the "formal way of thinking about things". Instead, some of these trainees felt that "old traditions" of the clinic and hospital were being "imposed" on them, the consequence of which seems to be that these trainees felt like they were not given "the space to be" and trusted to work independently. The one trainee felt "trapped" between what was expected of her at the clinic and the sense that "this is my course, I chose to do it, I'm paying for it, ... and I know what I want to do". One trainee said that she did not have the confidence to challenge this practice, but two others tried to regain a sense of control by vehemently protesting against feeling restricted and unable to use their "own personal style". It is important to mention that those who raised this dilemma with their supervisors received good responses and their supervisors were subsequently very supportive. Holdsworth (1994) argues that failure to account for informal knowledge and personal experience of trainees reinforces power and dominance, including the assertion of the superiority of university-based education. This may leave trainees feeling helpless and inadequate.

In their second year, all trainees (except one) enjoyed the opportunity to work more independently and in a professional capacity. When talking to the trainees it sounded like this gave them a sense of competence, and greater self-esteem. This sense of competence was felt by all interns, particularly when they learnt how "the system" worked.

The combination of inexperience and feeling inadequate, particularly in their first year of training, may have left some trainees fearful of being in a position of any power or influence as they feared that they would inevitably hurt others, and themselves in turn. Three trainees indicated that they

were not helpful, even “damaging”, to their clients who had to “sit with [their] absolute beginner feelings”. Another said

Sometimes you even doubt your abilities, like am I going to hurt, because we are in a helping profession ... but you tend to doubt if you are able to do what you want to do. Or are you damaging the people?

Two trainees were afraid that they damaged their patients because they had to move with the trainees as they rotated placements. As Kottler (1991) expected, these two struggled with the dilemma of whether they were placing their training needs above the needs of their patients.

The paradox of feeling that they may damage clients because of inexperience or that they have somehow damaged those who did not get selected, may also in part be the “therapist's narcissism” (Kottler, 1991). The trainees fear that they will ultimately fail and by doing so damage a self-image of being kind and helpful. With their own anxieties about failure, it is likely that the staff's surveillance of them may be perceived as anxiety provoking. The staff's evaluations may heighten self-monitoring (Foucault, 1980; Smart, 1985), and therefore trainees may place even higher, more unattainable expectations on themselves to perform.

#### **4.1.4 Race and inadequacy**

Fear of inadequacy is also evident in studies on black psychologists and trainees. These studies hypothesised that apartheid culminated in black people feeling inadequate or inferior, as people (Mokutu, 1998). While it seems that all the students experienced anxiety about competence and adequacy, being black in the training seems to have carried particular difficulties for trainees. Only four trainees raised the issue of race. One talked about how being black, and having had little exposure to “mixed races schools”, contributed to her strong feelings of inadequacy and her anticipation of racist beliefs, like “blacks are stupid, they are lazy” in classmates, staff and colleagues. She said that this was “the most difficult for [her]” and she “had to work hard to show them that not all blacks are stupid and foolish and lazy”. Another implied that he had similar feelings when he questioned whether or not he had been selected to meet university quotas of black students rather than on merit. Notably, only 5 of the 14 trainees interviewed were black.

## **4.2 EXPECTATIONS**

What came through very strongly in the interviews was the perception that there were many expectations that exist for trainees about how they ought to be as psychologists or as trainees.

Well the M1 year I found was completely different from what I expected it to be...I knew what was expected of me, from people, it's just that the difficulty was how do you actually achieve that type of thing.

The expectations, trainees felt, came mainly from four sources, staff, the public, clients/patients, and expectations they have of themselves. These were not mutually exclusive but I have separated them in my analysis to try and illuminate each area in greater detail.

#### **4.2.1 Staff Expectations**

Trainees felt that staff expectations were too high. In their first year of training students struggled mostly with how they believed staff perceived them and with their sense of high expectations of trainees. One trainee felt that being selected meant "you are judged on how stable you are, how mature you are, how well you know yourself, how you got through your stuff". She said that it is really difficult for trainees to have any grievances because they feel the expectation is for them to know how to manage problems, or that it stems from their internal conflicts. Also having to deal with formal evaluation of their professional progress, trainees may readily accept such expectations because of a fear of being seen as unstable, immature and not good enough, which could affect the academic assessment of them as potential psychologists.

And constantly feeling that you, that I, had to kind of live up to expectations of this kind of parental figures. Uhm that was quite strong.

In the second year, trainees said that as student-clinicians the expectation for them to be "professionals" and "well obviously to be a competent therapist, a competent academic, a competent scholar..., to be ethical, that sort of stuff" was also experienced as being too high. One trainee expressed missing the CGC because she felt that at least there trainees were viewed as "children who are learning to grow" rather than being expected to "just work...and get on with it" as another intern put it.

...I missed the clinic... quite a huge jump from being m1 to m2 in terms of how people view you. ...I found that *really* hard...'I am professional' (laughs) 'and now I shall act professional'.

Fortunately, for this trainee and another, they were able to remind themselves of their student status and assert that staff continue to recognise that they were learning and that they still needed to teach. This appeared to reduce their anxiety about the expectation to perform as seasoned professionals. To lessen her anxiety, another trainee validated her own experiences and "rid" herself of concerns about

high staff expectations which she said made her feel "not good enough". She told me that she tried to think only of her own expectations and whether she was happy with her work.

#### **4.2.2 Client and Public Expectations**

Six trainees felt that client expectations of them were often unrealistically high and unattainable. There are two types of client expectations identified by trainees. One such expectation, two trainees said, was that psychology can "cure" or change people fundamentally. One of them said that this was especially true of the clinic clientele during her first year, who had higher expectations "to sort their lives out" than perhaps some of the hospital patients, who "were just getting through day by day". She elaborated that clinic clientele expected a professional level of service that they as neophytes could not provide despite the support of qualified staff. Like Farberman (1997), one trainee said that "people have a lot of respect for psychologists but they don't know much about what we do". This may lend to the setting up of unrealistic expectations of "a magic cure".

When these first expectations are not met, people may "underestimate the value of therapy and think about it negatively". A trainee said that feedback from people often indicated that psychology was thought to be "a useless kind of profession" that involves charging a lot of money for just sitting and listening to people's problems without yielding results. Other such "myths" (Dare, 1997, p2) that trainees said they faced included "stereotypical things" or comments such as "oh I'm not going to talk to you now because you going to be analysing me" or "are you gonna read my mind". Many students spoke about how they began to anticipate strange reactions from people when they mentioned that they were studying psychology. One trainee said that she dreaded telling people about what she studies because of the kind of reactions she would get. Another laughingly said that "People become scared of you as a psychologist". Millon, et al. (1986) say that such jocular attacks, such as those mentioned by the trainees about psychologists' ability to read minds, often stem from fears that psychologists are intruders on people's private lives and that they can in fact enter areas of thought and emotion best left unexplored. Furthermore, according to these authors, psychologists are "assigned voyeuristic motives and revelatory powers far beyond their due" (Millon, et al., p123) and so inspire both admiration and envy. Yet another trainee alluded to clients' also having expectations of what appropriate behaviour for psychologists are. She told me how all the patients in her wards would ask "what type of psychologist is she?" because she would make ward rounds and sit on patients beds while talking to them.

Dealing with public and client ideas of how they are supposed to behave as well as ambivalent feelings about psychology being both mystical and powerful on the one hand and a useless profession on the other may be very difficult. It may be particularly difficult for beginner psychologists, who are in the process of defining their professional identity and are already struggling with assessing their personal and professional adequacy.

#### 4.2.3 Trainees' Expectations

*Conclusion*  
 As Misch (2000) recognised, the trainees were often the ones placing the high expectations on themselves. In addition to struggling with their sense of what was expected of them by others, trainees admitted to having many of their own stereotyped beliefs. They held beliefs about or expectations of psychology, the training course, their classmates and themselves.

#### **Of Psychology :**

Trainees often had ideas about what "the stereotypical therapist is suppose to be like". Words such as "rigid", "conservative", "goody-goody", "upright", "self-righteous", "scientific", "clinical" all formed part of one trainee's discussion of how she believed psychology could be. She said that though her experience at the clinic was different, there is pressure to conform to that image. She fears that "the magic, the beauty, the grace, the mystique and the intuitive aspects" of psychology can and will be dampened by the pursuit of scientific method and she does not want this to happen. This highlighted her own fear in the beginning of her training that the creative and mystical aspects of herself would therefore be unacceptable in this profession and she would be unacceptable. Two other trainees shared this sentiment. The one felt she had reconciled with herself that she would have to put the creative part of herself on hold until after the training, while the other felt somewhat restricted by such a "respectable" profession. The result seemed to be some resistance to, or simply anxiety about, the developmental transition. One of the three was able to begin to free herself from what she saw as being a prescriptive professional role. She said "I want to live my life without feeling like there's all these rules and things about how I've got to be".

When referring to the practice of the profession, a third year reflected on her initial expectation that being a psychologist meant she would have her "own little private practice,... see 8...clients a day, don't have to do paperwork, no reports you just see clients..." She also said she did not expect that "there'll be so much work and it could be so monotonous potentially".

The perceived role expectations from staff and clients, that trainees felt obligated to conform to, sometimes felt at odds with what suited them, resulting in anxiety and uncertainty about their professional and personal identities.

**Of the Course :** *conclusion*

All trainees had "heard rumours", mostly from previous trainees about how difficult the professional training would be. These rumours set up expectations about an emotionally draining experience with a heavy workload that could negatively affect or end relationships or which at the very least would lead to extreme levels of stress. The first year students and one second-year were relieved to find that it was not as bad as they had expected. They said that although the training was difficult, especially on a personal level, they did not find it so overwhelming and unmanageable. The intern said that he did not "expect to be 'held'" but expected a "less sensitive approach". Many said they entered the training with much trepidation and with a sense of "impending death" (sic). Some trainees, however, felt that this helped them adjust their attitudes and prepare them psychologically for what was to come. But for some, what they found still was not what they expected from the training programme. Cushway (1997) found that "stress and resentment" are a direct result of courses inevitably failing to meet trainees' high expectations of them.

Most trainees expected that the Masters course would train them to be more traditional, psychoanalytic therapists, of the Tavistock kind, in which learning about reconstructive, depth work on a longer-term basis would be facilitated. Sources of this expectation, they said, included experiences of personal therapy and the course material. For three trainees, the realisation that training offered little opportunity for gaining practical experience in ongoing psychotherapy resulted in much disappointment. The training offered a broader range of skills and clinical experience in the hospital system focused on short-term intervention. One disappointed trainee also became very angry that the course in first year continued to offer trainees "pie in the sky" by educating students in conventional western or European theories rather exposing them to "the work of local therapists". Those who still wanted to pursue individual, long-term, psychoanalytic therapy said that it probably meant further studying, and it was disheartening that the completion of this training constituted only "the tip of the iceberg". Not surprising, given the amount of studying already undertaken, many were not prepared to study further. Three even spoke of changing careers.

Despite the changing context in which there is a movement towards shorter-term interventions, most trainees seemed to expect that their professional training would train them in the psychoanalytic

tradition. Some were disappointed that there was little opportunity for practical experience in longer-term interventions while they perceived the theoretical input to be primarily in this tradition. Others felt despondent about further studying in order to pursue more psychoanalytically oriented practice.

**Of their Classmates :**

There was the expectation among some trainees that classmates would be "a bunch of supportive people". This may stem from the idea of psychology as a caring profession, as noted by Wollersheim and Walsh (1993), or perhaps from the personal qualities attributed to someone selected for the course such as their ability to manage and maintain relationships (Chippindall & Watts, 1999). This may be evident in one student's feeling that there was an expectation for the whole class to get along with each other, which she thought in retrospect was an unrealistic expectation.

Five trainees mentioned feeling that fellow trainees had expectations of them, which made them very anxious about either meeting or refuting the expectations. One trainee, who had years of previous experience working in mental health, was afraid that her classmates would expect her to "perform", "do brilliantly" and cope more effectively with the training and find the course easier. She said that the way she coped with that "weight of expectation" was to "become almost overly competent and you know then drive [her]self to complete destruction".

Salzberger-Wittenberg (1983) explained about students' expectations of their classmates, saying this drive to push themselves to improve their performances may be fuelled by sibling competition. Four of the eight trainees from one class mentioned that competition existed and that it was "not terribly overt" and only "a little bit". However, these four were resolute on its potentially negative impact on their class and specifically the potential for anxiety about their own performance. The competition appeared to present the possibility for narcissistic injury that may lead trainees to push themselves even harder to defend against the resultant anxiety.

Related to competition was the way in which classes compared themselves to each other. Each class felt replaced by the new incoming Masters students. Salzberger-Wittenberg (1983) relates this to the desire to be the best beloved child who is thought of and not forgotten. One example of this was the interest and jealousy sparked by the first years, who were the first class with the new director, or the 'new clinic' as it was at times referred to. Other trainees believed them to have a better training,

which was done "with more care", was "more carefully thought about and done with a lot more energy and commitment" and which was "less anxiety provoking". They were also thought of as having more resources and staff support, as well as recognition for how difficult this course could be on trainees. There was also "a lot of jealousy to not be there" on the part of some of the second- and third years. One trainee also spoke about how the CGC building had been "painted, washed out and cleaned" and of how they were "the last group before the massive clean out". It could be hypothesised that there was perhaps a sense for this trainee that they were a 'bad' group who may have soiled the clinic. Notably, three out of the four first years felt somehow different from students in other years. One of them felt that they were regarded as more special and privileged while another was thinking about doing her thesis on some aspect of what it meant to be the class of the 'new clinic'.

#### **Of Themselves :**

Trainees also seemed to place high expectations on themselves to meet the often unrealistic demands of what constitutes a good therapist or therapist in training. An example may be of one trainee who had felt overwhelmed initially when working with suicidal patients. He said that he believed it was the job of a therapist "to contain and not to be overwhelmed". Though this may be true, it appeared that this trainee was criticising himself for not meeting his profile of what a good therapist is (someone able to see and understand immediately and without much struggle) as Misch (2000) said. Trainees actually admitted that their personalities dictate high expectations of themselves, perhaps higher than the outside ones. Margison (1997) says that the therapists' narcissism may again be operating here. The provision of an externalised ideal such as the ideal psychotherapist, he says, causes the therapist to make more frantic attempts to aspire to such ideals, possibly leading to burn-out and a compromising of a sense of self. Cooper (1997) also said that the more insecure, frightened and uncertain we are of our professional work, like the trainees, the more we appear to cling to the defence offered by a pseudo-anonymity that stereotyped role expectations provide.

The high expectations of themselves is perhaps further illustrated in the difficulty some trainees seemed to experience with clients' slow progress, cancelling or not showing for appointments, or with them not returning to therapy. One trainee said that when clients cancelled appointments, he could not help questioning himself and asking "did I do something wrong?" This trainee may show how, when he does not achieve the ideal, he becomes frustrated with his perceived inadequacy. Misch (2000) says that though trainees are aware intellectually that some of the beliefs, conceptions

and expectations of others are untrue or unrealistic, they may struggle emotionally to accept the limitations of psychotherapy and of themselves.

### **4.3 SUPPORT**

Another very strong theme emerging from all the interviews was the issue of support during the training. Every trainee expressed receiving much support, especially from supervisors who were credited for directly helping them to manage and cope in the training. However, trainees also felt that they needed *more* support personally, interpersonally and professionally. What follows is a discussion of the various areas in which trainees felt they got support and areas where they felt they needed more. There is significant overlap between these aspects for the trainees with each affecting the other.

#### **4.3.1 Staff and Supervisors**

“Staff” here refers to the directors, course co-ordinator, but also to clinical supervisors in the clinic and at the hospital. These staff were thought of as separate from other teaching staff and held the greatest importance for trainees. As these staff members had significant contact with trainees, trainees seemed to mostly depend on them for much support.

With the exception of one trainee for whom the training became progressively difficult, the first year of training was reported to be the most difficult and trainees felt they needed considerable staff support during this year. Trainees generally felt that they got support from staff and said that the CGC was a very nurturing environment with lots of supervisory support (formally 2.5 hours a week). One intern said that he had experienced only good, “sensitive supervision”. However, on the other hand, most trainees felt they needed more support and ten trainees often experienced either staff or their supervisors as being unsupportive at some stage. When referring to staff support in her first year, one trainee said that she did not feel “supported or guided enough through a very frightening process”. She said she felt that she needed more “kind of looking after” because that year was such a challenging one.

Of the three classes, the first years felt the most supported by staff and three of the four felt staff (specifically the director and co-ordinator) to be “approachable”, available and “very supportive”. A first year attributed this to the staff who “invested a helluva lot in sort of creating a supportive, very

cushioned sort of environment". Another first year even said: "I feel like I don't want to go out of here. Like the world is out there and I'm safe here."

The CGC appeared to be a significant place for the other trainees, whose dependence on the CGC (the mother-institute overseeing their progress throughout training), for support is also significant. In the second year, despite their appreciation and reliance on their hospital supervisors for support, trainees still wanted support from the CGC and its staff. One student said that she needed "that sense of belonging and that sense of family" that the CGC offered. Three out of the ten second- and third years mentioned that the loss of contact with the clinic after their first year was difficult. They said that they felt the clinic had "kicked them out of the nest" and "dumped" them. They also felt uncertain about whether they still belonged to the clinic and felt uncomfortable whenever they went there. The three trainees suggested that clinic contact be maintained throughout their professional training. One trainee said that this was especially necessary for those in their third year because they have very little contact with classmates, staff or work colleagues. She said that such support "would make the world of difference".

Trainees often described themselves as children, the staff as "parents" and the clinic as a family. One trainee said that the only way he was able to "make sense and meaning" of his "emotional 'goedtes' at the clinic was to see them as a "family". Trainees saw them as "caretakers" and "guides" who were very nurturing and supportive. This image contrasted with the frustration they felt when they experienced staff as: either too busy for them, giving them too much responsibility, having high expectations of them to cope independently, not always listening to them or wanting to hear about their distress, being "absent" and ultimately abandoning them. The trainees often saw themselves as: not "getting enough", "demanding child[ren]", unentitled to 'bad' feelings, ungrateful, burdening, attention seeking, "nagging", "responsible", "angry" and "guilty". It is not surprising that trainees made sense of their experiences and relationships in such a manner because the work that they do involves children and families and the discourse in which they are being constructed is that of the infantile experience. Also, they enter a new situation in which their previous knowledge and experience seem to have no place and they are born anew to place, person and knowledge.

What trainees found most difficult was that staff and supervisors often did not seem to acknowledge, or sufficiently recognise, and respond to their difficulties emotionally. This sentiment was echoed by one trainee who said that in her year, staff were in fact "surprised" "when they were reminded that

[trainees] were having a hard time". She added however, that her class may have been partly responsible for this as they "didn't make much noise" and effectively communicate their distress.

The workload, for example, was very heavy leaving little time for self-care. The fact that their schedule did not allow for much free time, one trainee saw as an indication that staff did not consider the impact of the workload. She felt they were just left to "deal with it". Only the first year students felt that the workload was not unreasonable but manageable. Two other trainees felt that the lack of time allocated to or allowed for thesis preparation made doing the thesis in the second year impossible. One student who started writing her thesis in her second year said that she "suffered from burnout" because it had to be done after-hours. Another trainee, when thinking about this issue, grappled with the seeming contradiction between staff's lack of recognition of students' emotional state while being trained by the very staff to be self-aware and being in touch with clients' emotional needs.

if we're going to practice what we preach it's about saying that what happens emotionally...is important, very very important. And in a sense that's where I think the staff need to be available. And it hasn't been.

On a personal level eight trainees felt that they received little acknowledgement of their personal lives or personal difficulties and the impact these may have on their work. One trainee said that when there are personal difficulties outside the course and you "Sort of having to function at an optimal level at the clinic, to be able to carry on with client work, is trying." An intern pointed to this being a very natural, inevitable process and said "...I cant believe that if you have s\*\*t at home it's not going to impact on the type of therapy or the quality of the service that you're going to deliver." Four others expressed similar ideas.

The eight trainees said that an acknowledgement of their personal difficulties from the staff would have been very valuable for them in terms of their ability to cope. Salzberger-Wittenberg (1983) and Henry (1983) provide further understanding of trainees feeling unacknowledged. They explain that the learner hopes for all-knowing parents who can cater to both their academic and emotional needs. This hope is dashed when they discover that their teachers' knowledge is limited in that it cannot alleviate the frustration and mental pain associated with learning to understand emotional conflict through empathy. They say that at first the learner may become angry at a purposefully withholding parent who is not sharing all. However, later with the realisation that the limitations are real, the disappointment experienced may swing the initial idealisation and dependence to denigration and even rejection. In one case, a trainee who had "10-minute supervision", which was "literally touch

base”, became so disappointed in her supervisor that she sought help elsewhere, from other work colleagues.

Another trainee cautioned against generalisations and said that it often depended on the supervisor, as some supervisors allowed for space to bring “in your hypotheses about maybe your personal life that might be related to aspects of your therapies...”. Notably two trainees felt that their personal struggles were in fact acknowledged. This difference in views could also be understood in terms of trainees' uncertainty in negotiating their personal and professional boundaries (Hellman et al., 1987). Some trainees may be better able to bring personal struggles to supervision and ask for the support they need. Indeed, some trainees explained that they found it difficult to know what was appropriate material for supervision. One trainee who struggled with this said that she would “take the emotional aspects very much to therapy and try to stay with much more of the thinking aspect in supervision...or else things got too enmeshed and confused”. Another trainee, like this one, seemed to err on the side of being over-cautious in discussing personal issues. So like with their patients, trainees, it seems, are trying to establish the boundaries of supervision, which could make asking confidently for support difficult.

Trainees also felt that the level of support they received from staff changed in response to pressures on the organisation. Three trainees suggested that the three classes were going through a period of “transition” with changes taking place in the university and the CGC that resulted in staff being unavailable. One trainee, from the third year, said that “what was happening at the university, in the department itself had a huge impact... a trickle-down effect” on the staff and on her class. She said that the staff became “overstressed and overworked” and did not notice that trainees were struggling. She went on to say that “the shortage of lecturers or money” may have, in part, determined the experience of her class. The other trainee, from the same class, said that their year seemed to be the “transition between a big, comfortable staff complement and the skeleton that it is now”. She also mentioned that “there was secretary upheaval, the future of the clinic, the future of the staff, people leaving under not nice circumstances...the university fired them”. She said that luckily it did not “destabilise” her class but “threw people together” as they needed to cope with the impact of the changes. This made one trainee more tolerant and feel “a lot more compassion for [staff] than anything else” because she could see their daily stressors. However, this created further difficulties. In the interviews, it became apparent that many trainees in her class “didn't feel entitled” to complaints as they, firstly felt “privileged” to be in the course and secondly they could see that staff “were doing the best they could in a s\*\*t situation”.

Another class also experienced changes taking place. One trainee felt that the “changes up in the air” determined their classes’ particular experience. She said that their class was had been named “an anxious class”. She explained that besides the anxiety inherent in the nature of the training, there were two other reasons for this. The first reason was that they were “the last class with [the previous director]” and as such the last class of an era. She felt things were unsettled and like they never “arrived into a settled course that was continuing”. She said that staff’s leaving was the most significant event. Both the director and the course co-ordinator left and there was “definitely a feeling of abandonment” at this point and “actually of having no parents left, looking after us.” Two other trainees said that they never really got over that abandonment and one felt that the matter was not sufficiently discussed. The second reason she said was that “it was fed to us” that we were anxious. She said that they were constantly being told they were anxious, especially by the new staff member who was appointed to replace the co-ordinator. She wondered about the extent to which that notion had been constructed rather than being a true reflection of the class’s emotional experience. Overall this class’s trainees appeared to struggle much with anxiety and feelings of abandonment by staff. This trainee explained how the abandonment made her feel :

You know what, I think it played into my anxieties of not being good enough. And of not being the perfect group, the group that could be abandoned because we were such an anxious group...

With staff having so many other work responsibilities, trainees felt uneasy about asking them for support. They said that they needed the staff’s attention but could not further impose on already busy staff members. The only first year with this complaint said :

If there was something I wanted to talk to [the director] about and I can see she's on the phone and she's got to dash here and dash there, it means first of all ...feeling uncertain to what degree is she available to talk, especially if it's more emotional, ... I feel that I've got to make it brief...I think that it makes it a little more stressful. ...it does always feel kind of like I'm now taking time in a very busy persons day you know.

Besides complaints of busy staff and supervisors, other complaints included supervisors being dismissive or “minimising” of them. Similar to the trainees in Govender’s (1991) study, these trainees felt that not sharing the same theoretical background or position with a supervisor was also a difficulty. Another trainee felt that there were “complex” personal issues on the part of her supervisor that were “being played out” in and intruded on their supervisory relationship. Interestingly one trainee had difficulty trusting her supervisors. She explained that despite

supervision being supportive and her having one very good experience, her insecurities about herself and her abilities made it difficult to be totally "comfortable" and to "trust them" as they were also evaluating her performance. This is in accordance with Cushway (1997) and Millon's et al. (1986) argument that concerns about evaluation may intervene in the amount of support and academic input (on their clinical skills) that trainees can take from supervisors.

An established practice of rotating supervisors in the middle of the first year may have added to trainees difficulties in making use of supervision as a support. Three first year students who reported feeling "lucky" that the old system of rotating supervisors had changed. Their class had initiated this change as their members were "dreading" the change, which was described as "a complete nightmare". Developing sufficient trust to share their mistakes or perceived inadequacies may result in a significant and supportive relationship. To end such a relationship and start a new one could be difficult.

Trainees said that they needed much support through their training. Although they said that they received support from staff and supervisors, they felt that it was not enough. They felt that staff did not acknowledge how difficult the training was for them and were too busy to attend adequately to trainees' need for support. Organisational changes and evaluation may have added to their sense of inadequate containment and support.

#### **4.3.2 Classmates**

All trainees felt that classmates were very important in providing support, informally, for them during their professional training. In fact it was the theme most often discussed and it constituted the most common source of coping among trainees. Only one trainee felt that the support classmates provided was minimal and he had to seek support outside the class. They said that their classmates were able to understand them and what they were going through because they were also going through the same thing. One trainee told me that some of the most memorable times during the course were when she and a few classmates would work at the clinic until the early hours of the morning and on weekends. She said that having coffee breaks, while offering each other companionship and support by talking about their experiences was very important to her and them. When some trainees had an opportunity to share experiences openly through formal group sessions, it was described as "incredible". One trainee even felt nurtured and felt like her needs were being met. She said

It was like the first time that I felt really fed ... I was getting what I wanted and what I needed right then. I needed to know how others were experiencing the course, because I think it can be quite a lonely journey that first year.

Despite trainees reporting that they felt supported by classmates and had at least one positive, formal group experience there were still many complaints from the second- and third year students (9 out of the 10) about feeling "isolated" and "lonely". They said that there was "poor communication" between classmates and a need for "ongoing group dialogue". The way in which the course was structured may have intensified isolation in the second year of training when group interaction and cohesion was determined by trainees needing to be placed at various institutions in their internship. There appeared to be few formal structures in place to facilitate interaction between trainees. According to a trainee from one class, her class formed "little subgroups" to gain some support. Isolation seemed to be especially pertinent for those in their third year of training. Five of the six third years said that writing the thesis was a very isolating and lonely experience as the opportunity for group support from their classmates was not there. Speaking about feeling isolated in the third year, one trainee said:

...gradually the supports you build up is taken away from you, gradually, because now you are just on your own, doing your own thing. I think also it is difficult for me in that way...

Another said: "You're ... just this island on your own with a library. It's just *much* harder for me."

Thirteen of the fourteen trainees were eager to speak with fellow students, one even described it as "a strong need". They said that they needed to hear about how others found the training, how they coped, or to just "keep communication going". Seven trainees wanted to hear about my experience of training in their interviews. They discussed with me the need to have a forum to talk about and compare trainee experiences. They were keen to read my thesis and get such information. In spite of their need for communication however, nine out of fourteen trainees felt that their relationships with, or relationships between, classmates actually served to enhance anxiety. Even the trainee with good memories of companionship said that it took her some time before she could be open about her difficulties in the course with her classmates. There are a number of possible explanations for this seeming contradiction of the class being supportive and yet provoking anxiety. One possible explanation by some trainees appears to be that trainees "didn't feel safe enough" to use the groups or to ask for the support they needed. This firstly may be that there "wasn't really the time or the space to go into things". Very few group sessions were offered to trainees in these three years because of a policy change. In previous years, weekly group therapy throughout the first year of

training was compulsory (Gibson, K., personal communication, 13 Dec., 2001). Examples of sessions given ranged from 3 sessions as part of a lecture on group therapy for one class to 4 group therapy sessions offered in the first year and one session about 'isms', such as racism and sexism, in the second year, for another class. One trainee told me that their group therapy was a "half-hearted" attempt by the CGC and that the time allocated was insufficient :

And those ridiculous group sessions. . . It is not possible to use group therapy or to use a group therapy-type situation once a month for only 4 months and expect people to really engage with the process.

There was also anger regarding the fact that it was not taken into account that one trainee knew the facilitator on a personal level and could not engage therapeutically. This was echoed in a request for a "neutral space" and an "outside person, somebody not connected to the university or to the hospital training" to facilitate the group therapy. What may also be implied in this request is the idea that trainees did not feel safe because they feared evaluation by staff. Their fear of revealing personal inadequacy seemed to have extended to their classmates. This ironically created further anxieties as one trainee said :

And because we didn't have enough chance to communicate, everybody thought that everybody else was doing better than they were.

This assumption that everyone else in the class is doing better than they are, is a common one according to Misch (2000) and it is also possible that trainees' underlying feelings of inadequacy may contribute to this feeling.

Classmates seem to also carry anxieties about being different from one another. Trainees described feeling different to their classmates on the basis of age (5), sex (3), physical appearance (1), race (1), belief systems including cultural beliefs and beliefs about mental illness (4) ways of learning (2) financial security (2) and previous work experience (2). This appeared to make trainees feel that their individual experiences were unique and could not be completely understood by others in their class.

Three trainees raised racial and cultural identity as issues that separated trainees. Two trainees felt that there needed to be more opportunity to discuss issues around race and culture, which they felt contributed to "group anxiety" but was never really addressed. The relative silence around race and culture in one class especially also seemed to make trainees feel unsafe and unable to get support

from each other. In short, one student said that there were issues around race that needed to be addressed and discussed formally.

One female trainee mentioned that there was also tension around gender in her class but that there was no forum to deal with it appropriately. The one male student in her class said that he struggled with being the only male in the class because of his cultural beliefs. He said that he found himself feeling very isolated and unsupported because he could not talk openly with his female classmates. He said that in his culture there are certain topics that are not discussed across the sexes and he had to find his support outside of the clinic with male friends.

There are other possible reasons that each class did not feel entirely safe for trainees. One class, for example, did not take up the offer to have group therapy because they did not want "to create tensions that aren't there". Another trainee suggested that denying that there are any difficulties in the group is an important defence. She said that her class, which it seems felt the least supported by staff, "needed everyone in the class to be okay and not to be freaking out and acting out". The class that felt the most supported by staff, the first years, felt safer to talk about the difficulties between class members.

Two trainees, from different classes, said that they did not want to take on knowing about class members' emotional states because they were already feeling "fragile" and "couldn't take on any more". It appears that the emotional investment required in relationships with classmates may have been too much for some trainees. Two others said that not having to invest emotionally, more than what they already had to in the training, was very helpful. The one said that she could not make that kind of "personal commitment" to people at the clinic because she had to keep up with her demanding commitments at home.

Overall, on the one hand, trainees wanted more formal opportunity to share their experiences with classmates to provide them with support and opportunity to normalise their experiences and to let them know "at least I'm not alone". On the other hand, trainees did not want group support and felt that classmates enhanced anxiety. This may perhaps be due to fears of evaluation and revealing inadequacy, fears of not being understood because they are different, fears of disrupting group cohesion, or having to invest more emotionally than they are able to. The result may be further isolation and less support from a potentially important source of support for trainees.

### **4.3.3 Family and Friends**

Just as the trainees pointed out that their home and personal lives have an impact on their work, so their work has an impact on their home lives. All the interviewees cited that the training and the work had been “emotionally draining” and for some, “all consuming”. It therefore had significant effects on their relationships with friends and family. Consistent with other studies, trainees report that as emotional resources become depleted, they were able to give less of themselves to friends and family (Marchetti, 1989; Millon et al., 1986; Cushway, 1997). Six trainees living with families said that their families suffered because they “had to make sacrifices”. Trainees had limited free time to spend with family and they said that they needed that time to be alone and “reflect”. One trainee’s guilt about this was extreme and she constantly questioned her loyalties to her family. All trainees said that they also withdrew socially, “becoming quite anti-social”. One trainee said that trainees come to lead “a pseudo life” that revolves around the course. Not only was this reportedly to do with workload, it was also because trainees felt they had little energy to listen to friends’ problems. Another student said that she even became “intolerant” of people “using [her] as a therapist”. Four more trainees shared this frustration. They said that they had previously assumed the role of listener with friends, but as it was now their “jobs”, they no longer had the energy to do this. They tried to “set new boundaries” and transform such unequal relationships to “healthier” ones that would provide a listening space for them. They said that they needed more support during this time. Relationships that could not adjust to this change were generally avoided, ending friendships for some.

A third year student suggested another reason for the change in social interaction, which was also highlighted as a difficulty for trainees in Marchetti’s (1989) study. She said that the “extremely powerful” knowledge of intrapsychic and interpersonal dynamics attained in the course “sets us apart” from others because “things are a lot more transparent”. Such knowledge, another trainee said, often left her struggling to negotiate her responsibilities and interactions with friends and family. She also felt that social interactions seem “superficial” because as trainees or psychologists they had become adept at interacting at a deeper level. This distinction, or separation between trainees and “those outside the course” was felt by five other trainees as well. This made twelve of the fourteen feel “different” to other people while others (3) felt criticised by friends or family members for “psychologising” too much. Six trainees felt like it was difficult to adequately explain to others what they were going through in their training and the personal changes they were undergoing. Four felt that others, who have not been through the training, would not be able to understand.

I don't think anyone understands what you going through. I don't know if they can actually grasp the magnitude and the richness of the experience.

On the positive side, eight trainees felt their partners, immediate families and friends gave them the support they felt they needed so much during the course. Four also felt that they could better understand and relate to their partners, children and families because of the knowledge they had attained in the training and/or in personal therapy.

As Nathan (1986) and Kaslow (1986) anticipated, confidentiality was also a key issue for trainees when looking for support. Establishing professional and personal boundaries appeared to be of concern to two trainees especially. Concerns about confidentiality left one trainee unable to get the same support from his partner as before because he could no longer speak as openly as in the past. He also found that confidentiality affected his home life as some clients from the Child Guidance Clinic lived in the same community as he did. Another trainee's dilemma about ethical boundaries affected a friendship of hers. She has two very good friends with whom she is very open, the one is in therapy with the other. This posed some difficulties for her.

I *wont* talk about my friend the therapist in front of her, which is insane. If she asks me what I do on the weekends and I've seen him, I don't talk about it...

Three trainees had relocated to do the course in Cape Town. What was difficult for them was losing their established support networks. It separated them physically from both family and friends. The separation from their families was said to be particularly difficult. These trainees' partners were also far away from them and this put a strain on their relationships. It also left these trainees reliant on their classes for support.

It seems, therefore, that not only did the trainees have to set boundaries with clients and supervision, it was important to set new boundaries for themselves and renegotiate personal relationships with family and friends.

#### **4.3.4 Structure**

Where boundaries were given, such as in the course structure and 'theory', trainees seemed to experience a greater sense of containment and felt more supported. Some trainees reported struggling without the structured timetable of the first year of their training. This was especially true for the third year students. Despite the second year students feeling thrown "into the deep end" in

the hospitals where they had to independently navigate “the system”, the hospital still offered containment through the wards daily schedules. A third year student said:

all sorts of ...very practical things that would make it a lot easier and they're not there... the structure of 1st year and 2nd year where you know you must wake up at 8 o'clock or 6 o'clock and you have to be there from 8 to 9 or 8 to 5...you actually wake up and you keep going.

Third-year trainees all felt that relying on themselves to develop internal structures to provide themselves with the type of containment that the clinic and hospital structure offered was difficult.

and what makes it even harder is the openness of the 3rd year where you have to do your own time management, you have to structure your own day and you have deadlines.

Students reported having theoretical knowledge as being helpful and “containing” for them. Firstly, it was helpful in conceptualising client difficulties and articulating their own internal processes. Secondly, getting theoretical input provided knowledge that prepared them for what awaited them. However, 6 trainees were angry about what they did not know. Trainees generally found that the theoretical input provided in their first year did not adequately prepare them for the work in their second year. Encountering and containing suicidal patients for an intern was very difficult because he said that he was not given enough knowledge about the system. He was “angry...that we hadn't been lectured formally” on things like the procedures to follow in cases of suicidal clients. He felt that he did not even know where the psychiatric emergency unit was. He said that he was still struggling with such dilemmas when we spoke, which was seven months into his second year. Nonetheless, trainees reported that simply learning how to be themselves in a therapeutic relationship helped them more rather than any knowledge of theory.

#### **4.3.5 Personal Therapy**

Personal therapy was a crucial form of support according to 13 of the 14 trainees. The only one who disagreed felt that support from peers and supervision was far more valuable. Therapy, though supportive, had presented trainees with some of the challenges Dryden and Thorne (1991) pointed out, such as the anxiety and vulnerability resulting from the self-exploration and self-discoveries of the initial stages of therapy. One trainee said that it was her first time in therapy and that “for the first time I'm unpacking some of my *own* unresolved issues” and “making peace with what happened in the past”. She said that this was a very difficult personal process and “at the same time having to deal with patients' painful things, some of which [she] could relate to” was “very very difficult”.

The greatest challenge for four trainees was managing the personal changes and growth that therapy had on their relationships with friends and family. For some, the insight obtained about “what pushes my buttons” and the knowledge about themselves and their family dynamics contributed to better family relationships. A trainee said that being in therapy changes you and “you don’t lie to yourself anymore. You don’t lie to those close to you”. She said that therapy makes one “a better person, but then you're more susceptible to hurt.”

As Nathan (1986) has suggested, trainees also found that their own therapy became a model of how to work with their clients and what constituted 'therapy'. This became problematic when trainees felt that their therapy was not in line with what they were learning in the course. For example, trainees who had longer-term therapy felt unable to model that with their clients in the hospital or clinic setting which provided only short or medium-term intervention often with a focus on case management.

One trainee said that she had to continue therapy in her third year because she

couldn't think of life without therapy, because everything had changed in my life... I felt that if I give up therapy it would just be too much loss, too much change.

A few trainees had to give up therapy due to financial reasons and this was difficult for them. The ending of a significant, supportive relationship prematurely in a difficult training process appeared to be difficult.

#### **4.3.6 Resources**

Five trainees noted finances as a big area of concern for them. They, and some of their families, struggled financially and this impacted significantly on their lives and how “stressed” they felt. Fees, student loans, administrative costs (photocopying, printing, stationary, office key deposits, tea and coffee), personal therapy, transport, daily living costs, supporting families, home loans, were some of the trainees’ expenses. I remember being told recently by a classmate, not interviewed for this thesis<sup>1</sup>, that she worried about money all the time. She laughingly told me that she had lost weight during her first year not because she wanted to but because she barely had food for weeks at a time. We spent some time talking about how we both got anxious about going out with classmates or having to give money for Friday morning tea at the CGC. For one, financial difficulties impacted significantly on his/her work and two mentioned that it affected their self-esteem as professionals.

---

<sup>1</sup> permission obtained to include this in study

The internship year was described as being less stressful because trainees were earning a salary. Two third year students mentioned that no longer getting the internship salary renewed financial concerns and added significant stress. "Like the m2 you're kind of earning so you kind of forget about the financial aspects of things for a while and you just focus on your work, what you need to get done." Another third year said that in addition to the work demands of the thesis, the limitations placed on the type of work that unqualified therapists can do, added to "the stress of financial problems". After their internships, intern psychologists are not permitted by the professional board to perform "any act of a psychological nature or professional registration as a psychologist" (HPCSA, 2000, p1). She said "you can't work. You can't do this or you can't do that. That just makes the year so unbearable." One of the five trainees and four others felt guilty that they were financially secure when others were not.

Computer difficulties, technical or literacy problems, was also a "big big thing" for two trainees. Observations during my first year of training was that this formed a significant stressor. Faulty computers and printers were the basis of many meetings during that year and there was anger among trainees that these problems were never resolved.

I was very far behind with technology. I was expected to be able to produce documents and that was the beginning of a stressful life.

Overall the resources, whether financial or technical constituted a significant difficulty for trainees. Cushway (1997) says that these factors are often not given sufficient recognition.

#### **4.4 STRUGGLE FOR IDENTITY**

Trainees seemed to also struggle with establishing a new identity as psychologists. Every trainee experienced changes taking place in themselves, during the training. The "rite of passage" metaphor was used by two trainees to describe their experience of a shift from who they were and what they knew to a new and unknown place. One trainee compared herself to her teenage daughter paralleling this rite of passage to adolescence, a journey from childhood to adulthood, filled with much emotion and confusion. This echoes Lipovsky (1987) who compared the professional training in psychology to a professional adolescence. Another trainee traced the development from the first to third year as developmental stages of child, then adult, and then a time of integration and becoming comfortable with the new identity. The personal growth that accompanied such change was said to be both rewarding and difficult, sometimes "painful".

The process of learning about themselves and human dynamics through personal therapy, the course and the work with clients was found to be rewarding by all the trainees, although only eight enjoyed it. Six trainees saw their personal growth as leading to a changed and new identity, while the other seven believed that their identities were not changing from one person to another but rather that they were "becoming" or concretizing the person they ultimately believed themselves to be. They said it was like "emerging out of [a] cocoon, like a butterfly", "more kind of what is innate coming out". These seven were part of eight who enjoyed the personal growth offered by the training.

What trainees saw as difficult about this process of personal growth, however, was the level of self-awareness that was required and the need to confront oneself. One trainee said that "Maybe you truly within these two years get to face who you truly are... And all your quirks comes out. All your foibles, all your s\*\*t comes out". Dealing with such awareness was especially difficult for two trainees who said they had avoided "feeling things" in the past. Their adjustment was made all the more difficult, according to two trainees, because they felt ill-equipped to cope as "the old defences are now gone". This seems to have provoked further anxiety for them.

Related to, and impacting on, changes in the person, trainees described struggling with three other aspects. Firstly, they struggled separating themselves from their work, for example with issues like learning to negotiate responsibility with clients and not taking on their problems. Secondly, trainees suggested that they had to redefine their role in their personal lives and begin to change the way they related interpersonally. Lastly, they said they began to challenge their expectations of themselves.

Seven trainees stated, and 6 implied that in the profession of psychology, the distinction between work and who you are as a person is not as clear as "if you were working in [a supermarket] somewhere". They said that the job of therapeutic relationships involved the person of the therapist. The personal and professional aspects of the self as being closely connected were addressed in the following example of a trainee who said that she was not being seen "as a whole person". She said that not being seen "holistically" but being viewed only in terms of one aspect of herself, the psychologist, made her feel that she would be judged by those in the field as an inadequate person if she did not succeed professionally. What seems evident is that this trainee felt that there were different parts to her identity and the trainee in clinical psychology forms just one part. However, like other trainees, she appears to doubt her professional abilities as a trainee and therefore her self-worth. Notably, she is also reiterating that this separation between the personal and the professional

is not so distinct in the training and in the field itself. The therapist, Margison (1987) says, is reliant on a sense of identity as a 'therapist', which in turn has been idealised. Ultimately he says that the achievement of an adequate sense of self is not possible when the therapist aspires to an unattainable (ego) ideal of some 'identity' of a psychologist. The trainee aspiring to an ideal professional identity may therefore continue to experience doubts about personal adequacy.

The younger trainees interviewed seemed to struggle more with these identity issues. Two trainees stood out in their struggle with separating their work and their personal lives. It was to the extent that for the one, her clients "came first" and became more important, she said, than herself or those close to her in her private life. The other trainee found that he felt that he was still learning how *not* to be overwhelmed by his patients and taking on as much responsibility for them as he had when he first started. He needed the structures of the hospital to help him feel less overwhelmed and to share the responsibility of patients' containment. Many other trainees found it difficult not to take their work home with them and would often be thinking about their clients in their spare time. These trainees, like as those in Cushway (1992) and Hellman's et al. (1987) study, seem to struggle with setting boundaries between themselves and their patients. One trainee hypothesised that this happens because "what you're doing is finding meaning through your clients, which is probably not a good thing. Got to find [your] own". But Hellman, et al. explain that good boundary management with clients depends on the therapists' clarity about who they are and what their boundaries should be. As trainees are still in the process of establishing who they are and their boundaries in a therapeutic alliance (Kilburg, 1986), it may not be surprising that some trainees noted feeling consumed, overwhelmed and responsible for clients. According to these authors, trainees may experience greater professional self-doubt, lower self-esteem and more stress in working with clients. In contrast, five of the six older trainees seemed to show less of the 'fusion tendencies' with clients described by Hellman et al. than other trainees. These trainees reported to have had relatively less stressful experiences in training than their younger counterparts and did not find a change in their identities. One trainee suggested another explanation. He said that older trainees "come with a particular work ethic... a particular way of doing things" and are more resistant to change.

Kilburg (1986) helps to better understand this phenomenon and identity development. He says that at the time that trainees are facing the changes that the training introduces to them, they are often in the final stages of consolidating their personalities. This is especially true for younger trainees. He goes on to say that the identity that trainees pursue as a member of a profession becomes fused with the concept that they are forming of themselves as adults. He says that for many, as seen with the

trainees as well, profession and self-concept become indistinguishable. "they are as human beings what they have become as professionals" (Kilburg, 1986, p24). This may work well as long as the professional identity is gratifying. The trainees here have expressed much professional self-doubt, which may therefore not only hinder the development of a professional identity, it may also result in a poor self-concept. It is also possible that existing feelings of self-doubt may play into this.

Besides older trainees, there were three exceptions to this difficulty in separating the two identities. These three did not feel that their professional identities were equivalent to the personal identities. This was reflected in a statement one of these trainees made about feeling frustrated by the expectation associated with "the label" of psychologist. She said that it was often frightening to see that some psychologists behave one way with their clients and then another way in their "real" lives. Another said that it was only because she was being trained to be "the listener" as her professional, that she was able to separate it from her personality and begin to redefine her friendships. Interestingly two of the three trainees found that they were less critical of themselves and no longer berated themselves as much as they did before the course. They felt more able to accept themselves and who they were.

Secondly, the strong sense of 'otherness' which twelve trainees had, may have negatively affected their sense of self. Of the twelve trainees, three were very explicit about how different and marginalised they felt. One trainee told me how alien she felt because of her ongoing self-analysis, inherent in such a profession.

And it's like I sometimes feel like where I am in this training and in psychology, that we are, and I am, on the fringe of society. Like on the outskirts. Because people live their lives and they just get on with it. You know I've been in therapy for 12 years for God's sake. I mean it's like a completely different life. It's living so immersed in your inner world. And people who are just people and have their 9 to 5 jobs or whatever *live* their lives. They don't live and immerse themselves and think about their lives 24 hours a day, which in a sense is what I do. And sometimes, as a psychologist, I feel myself on the outskirts in a way and not of this world....

For another trainee, who felt the same said that a person who chooses to study psychology is "somebody who doesn't really mind being on the outskirts of society because in a way you coming from there". She said that having had an "eccentric upbringing" and the profession itself offered her a "socially acceptable way to be different" and gave her a sense of belonging.

#### 4.5 THE EMOTIONAL NATURE OF THE WORK

Every trainee, when questioned about the workload, commented that although the workload was heavy, it was more the emotional nature of the work that they struggled with. One trainee said that the training course would have been very achievable were she just required to do academic work, such as “learning the [Diagnostic and Statistical Manual] like the back of your hand, doing presentations, not necessarily of clients that you're seeing”. Another said that the emotional component of working with patients was difficult, but that it is what psychologists do and therefore trainees have to be prepared for “the real world”. Some of the emotionally difficult types of work cited by trainees included: working in trauma and crisis intervention and dealing with difficult patients. These 'difficult patients' were understood to include abused children, suicidal patients, learning disabled children, psychotic patients and personality disordered, especially borderline patients or highly depressed patients who are either not motivated or who show slow progress. One trainee who spoke about her difficulties in crisis work said that it was very rewarding work, but the nature of the cases and the material itself was difficult to deal with. She gave two examples of difficult cases that she had. The first was dealing with a workplace suicide three hours after it happened. The other case was when she responsible for debriefing in a baby kidnapping. Another trainee grappling with this said that the “evocative nature of the material” affected him personally. He said “... we are dealing with trauma on a daily basis and it's hard not to be affected”.

Hellman's et al. (1986) argument that trainees' difficulty in establishing personal boundaries with clients increases their likelihood of distress was demonstrated in the weight of responsibility that trainees felt towards their clients. One trainee said that unlike academic work, trainees “are dealing with real people and real people's lives and [they] cant do shady jobs...”. Millon et al. (1986, p123) said that when trainees realise that clinical work “is not an academic game but a matter deserving deep human concern” their anxieties and their professional doubt may peak. The trainee who struggled initially with suicidal patients felt very responsible for their lives until the responsibility of decision making was shared (like when his suicidal patient was on a therapeutic ward).

Part of the nature of clinical work is sharing in the emotional pain of clients through the process of transference. Obholzer and Zagier-Roberts (1994) said that clients communicate their distress by projecting it into the therapist, who may then act out these projections. This could be seen in one example of a trainee who facilitated a group of children with learning disabilities. He expressed that it was a “vvvvvveeerrry hectic” group and that he often left the group crying or deeply saddened.

He said that he would carry these feelings of the children from each group for days until supervision, when he could talk about it and so release the feelings. He emphasised the “intense emotions” the children evoked in him. He said that they were extremely sad children who had “needs that were preverbal, which you hoping that someone somewhere is going to see”. He said that he “almost attached to the feeling [of being] alone and lonely and misunderstood”. He says he began acting out these feelings with his partner and CGC staff. Like the children with preverbal needs, he was unable to articulate his distress to either. He told me that on one occasion he could not tell his partner what he was feeling and found himself “shovelling food” into his mouth instead. He said that the group began to feel less overwhelming when he was later able to understand the transference, and could begin to “process in the room” and “give it back to the kids” by verbalising the feelings.

The emotional nature of the work, as illustrated, may be exacerbated when trainees have to face their own issues and pasts “while holding the pain of clients”. They said that in the academic and practicum training, they were “forced to think about” the difficulties in their own past. All trainees agreed that “though you land in the course you come with a whole baggage of things, which precede this particular event”. One trainee said that doing this work: “evoked *every bit* of childhood s\*\*t I ever had in all my life” while another said that it raises “your deepest fears and insecurities”. The essence of this sentiment was captured by a trainee who said

I think that people are dealing with their background. I mean like there's something about everybody's parents in this course [laughs].

Thirteen of the trainees mentioned one difficulty or another in their backgrounds. Most were not specific about their difficulties but some mentioned having: “traumatic childhoods”, childhoods lacking positive affirmation, and childhoods filled with “needs that are not being met”. Others alluded to having to face “things that happened in the past”. It was often these traumatic or emotionally unfulfilling pasts that brought the trainees to the profession of psychology as Dale (1987) Skinner and Schlapobersky (1989), Dryden and Spurling (1989) argued. It also seemed to provide some trainees with meaning in their lives (Pines, 2000). The meaning provided seemed to be either in gaining greater understanding of their own backgrounds or in simply helping others. One possible example, that captures these two elements, was the trainee whose central concern was understanding why she had chosen to do the course.

This trainee said that her only motivation each day was that the work was meaningful to her because she was helping people. On a deeper level, however, she claims that she did not understand the reason behind her leaving her first profession, which she said did not accommodate “feelings”, to follow this career. She constantly asks herself why she “punishes” herself and her family by constantly studying further. In her search to make meaning of this she has also asked herself: “where do I come from? What was I before?” She said that she questions her “existence” as well as how her religious beliefs and convictions fit into psychology and into her pursuit of it. The uncertainty of not fully knowing what meaning lay behind her choice of career, was extremely anxiety provoking and stressful for this trainee. Furthermore, the examining of her background and past also provoked anxiety for her because she said that the past is the past and that she is not a person who dwells on the past.

For four other trainees it appears that their move toward clinical psychology was also partly a quest to understand their pasts. For others, the choice was a more conscious one, with recognition about what childhood experiences had brought them to the profession. Those trainees who entered into personal therapy for the first time, and those who had avoided thinking about their own “stuff” or “issues”, showed greater anxiety and levels of stress than other trainees who had been in therapy before.

Just as Salzberger-Wittenberg (1983) understood it, these students' experiences of training were not about a simple acquisition of academic knowledge, but about a complex interaction between learning and trainees' emotional lives and childhood experiences.

#### **4.6 THE CONTEXT**

The literature suggests that the trainees' experiences may be determined by what happens in the broader context, institutional and social, as well (Hirschhorn, 1990; Rouff, 2001; Hubert, 2000). These issues, however, are often rendered invisible at the personal level (Berger & Lazarus, 1987) and perhaps it is not surprising that trainees did not talk about the socio-political arena of the profession or its relevance to the South African context. They, however, did speak about some broader changes that face psychology in South Africa and how this impacts on their sense of professional identity and self esteem.

#### **4.6.1 The Status of Psychotherapy**

Trainees all generally felt aware on some level that changes were taking place in the profession with a move towards managed health care and more outcomes-based interventions (Rouff, 2000; Heuchert & Ahmed, 2001). Eleven trainees spoke mostly about how they experienced these changes in the training and how they felt about it. What seemed to affect those still in their first year of training, were lecturers' beliefs and attitudes about the relevance of psychodynamic training. The first year students all reported feeling highly discouraged by lecturers "coming into the clinic" continually telling them things like: they should not expect to do long-term psychotherapy as "the chances of [them] actually practising as a therapist and [their] chances of setting up in private practice and using [their] skills are like zero"; or that "there's no clients who will come"; or that psychodynamic work "is...a white elephant". One trainee, though disappointed when considering the current value of the profession, felt that only "in an ideal world" people could have individual therapy "three times a week for the rest of their lives". She stated that that is not realistic given that there is "not much money". She has become "quite uncomfortable with taking up the therapy of that kind" and says that "sometimes it's more helpful just to give people a couple of life skills, and send them on their way". At least three trainees at the end of their second and third year were considering another profession or leaving psychotherapy and using their clinical skills in another field. These feelings of disappointment, despondence and uncertainty about the future were congruent to Rouff's (2000) expectations.

Four trainees also raised some of the key tensions in South Africa about the relevance of traditional psychological theory when they criticised the training course for still being primarily still geared towards teaching trainees (theoretically) about longer-term psychotherapy. They said that it "actually is not equipping [them] to deal with things in the outside world". The first year trainees felt that their lecturers were communicating the same thing to them. They thought that more input on cognitive and brief-term therapy should be offered in the course, as is recommended by many evaluating training in psychology, such as Parker (1986).

Those trainees who wanted to practice long-term adult, individual psychotherapy felt most despondent, but some were determined to pursue this path. One determined trainee said that the changes and the move away from psychotherapy was about fear, avoidance and social control.

it's quite threatening, it's quite frightening kind of work because it is deep and there's challenges. It doesn't just kind of manage problems or control by medicating them. And it's socially quite challenging because it's about the unspeakable...

Even the trainee who had changed her mind about long-term interventions and wanted more cognitive input, felt that sometimes cognitive therapy is about “avoiding” deeper issues even though it holds psychodynamic principles.

Trainees perception that psychodynamic practices and psychotherapy specifically is regarded as inappropriate and is not highly valued in the broader context, seemed to leave some trainees feeling disappointed in their training and discouraged or uncertain about their futures.

#### **4.6.2 Interprofessional Marginalisation**

What may have added to trainees growing lack of confidence in psychology and themselves was the way in which they felt psychology was perceived and responded to in the hospital system. Trainees experienced the interprofessional marginalisation of psychology, which Nell (1992) spoke of. Although 2 first year students mentioned that they sensed that psychology is seen as inferior within the medical framework, the second- and third year students appeared to be most in touch with the changes taking place in the state hospital services. Though most (9 out of 10) trainees felt that their role in the hospital during their placements was valued on the wards, many (7) raised the issue of the poor status of psychology within the medical paradigm. What trainees appeared to take away from their hospital experience was that psychology was regarded as “second rate” to psychiatry, and that there was confusion about their role, and that of psychologists, in the system.

Their biggest complaint was the way they were treated by psychiatrists and psychiatric consultants in particular. Some trainees felt that they were “undermined”, or patronised. One trainee said that she was so frustrated with her work and judgement being questioned, or by psychiatrists diagnoses being taken above hers that she felt that whatever she did was “not right” for them. She felt frustrated that after doing thorough and lengthy assessments, a psychiatrist could see a patient “for two minutes in a ward round and think that it’s definitely like that because ‘my experience says so’ kind of thing”. The result for her was that she stopped putting in the effort she did before and swore that she would no longer “go that extra step” because they would “completely trash it, whatever you’ve done”. Her wish was to perhaps “lobby for equality, at least to recognise and respect our professional competence”. Another trainee who felt similar said that even with the “nice consultants” if you try to say anything, they would “look at you like ‘no no, you stick to Axis II<sup>2</sup> and

---

<sup>2</sup> Axis II is a diagnostic category reporting on personality disorders (or maladaptive personality features and defence mechanisms). It forms part of a 4 point axes in the Diagnostic and Statistical Manual. The implication here is that psychologists are not competent to make diagnoses on axes other than II.

we'll do the rest kind of thing". One first year who has a psychiatrist friend said that her friend confirmed that psychology is not valued in the hospital system and that there is "a hierarchy and a pecking order" there.

The feeling that psychology is regarded as inadequate, even inappropriate may leave trainees with further feelings of inadequacy in their professional roles and in themselves. Holdsworth (1994) suggests that role legitimacy is very important in how trainees may perceive themselves and the success of their interventions. Complicating this even further is the confusion around the boundaries of psychology. One trainee in particular was perturbed by the confusion about who was responsible for psychological and therapeutic interventions in the hospital system, as the role seemed to be shared across disciplines. She said that she felt others shared this feeling:

The whole identity of psychology in South Africa, what I think I pick up on in the system...There's a feeling of threat uhm by psychologists that what they have is being lost, it's been given away to social work or whatever. I just feel it very much in the system, there's this feeling of not knowing what to do.

She told me how confused and somewhat shocked she was when she arrived at the hospital on her first day to find that both she and a sixth-year medical student were assigned the same responsibility, "both given patients to carry and to do therapy with." She said that this makes it very difficult to hold onto your identity as a psychologist especially when the medical orientation places "a lot of pressure to kind of give up what is ours...the psychodynamic view". She, like Millon et al. (1986) and Swartz (1999), said that it requires confidence to be able to "hold onto that" and "find [your] voice" and say "this is what I do. This is my identity and my esteem goes into that, how I feel about myself . . . myself and my job". With the uncertainty about who they are and what they do, in the context of a 'lesser' profession, the trainees who are new to psychology and their professional identities, may not have the confidence to assert themselves against their powerful medically oriented counterparts (Kottler, 1991; Swartz, 1999).

One trainee offered the lack of understanding of what psychologists do on the part of some professionals as an explanation for their negative regard. This explanation would coincide with those of Dare (1997) and Millon et al. (1986) who say that a lack of understanding often results in mistaken beliefs and myths about psychology. The trainee said that doctors do not sit with patients the way psychologists do, and as fewer patients are seen and progress is slow with benefits not always immediately visible, there is a sense of psychology not being effective. Two others agreed

that there is limited understanding among some professionals, but that some do understand and appreciate the work. One said:

I think we are valued yes. And then I also think that we're not valued. . . I think it's very individual to some consultants and people in the system...there are those who recognise what we actually do and I think there's those who have no clue and who . . . sort of undermine it in a way, put it down, through their own ignorance. Or maybe they do know and just put it down, like "you go do your counselling" (imitates patronising tone). And then there are those who are very excited by what we do and would love to be doing it too. [both laugh]

Although trainees reported feeling valued on the hospital wards, they said that they mostly felt that their professional competence was not recognised. They said they felt undermined by psychiatrists, consultants and a system that placed higher value on the medical model of treatment. They also seemed confused by the lack of clarity of their role in the hospital as well as by the diffusion of boundaries in terms of who is responsible for psychological intervention within a multidisciplinary system.

#### **4.7 STRATEGIES FOR COPING**

Many difficulties that trainees experience during their professional training have been noted but only some attention has been paid to how trainees coped with these difficulties. It is important to pay special attention to the coping strategies that trainees employed to help them navigate their way through what has been described as a rewarding, but very difficult and emotional process.

##### **4.7.1 Talking**

In addition to finding that the main areas of support for these trainees were 1) talking to classmates and friends, and family; 2) supportive supervision and 3) personal therapy, trainees also reported feeling the least anxious when they were able to confront staff on issues that were worrying them. Four trainees said that they had felt much relief when they confronted staff individually. For example, one trainee addressed her concerns about being selected for the programme, another spoke to the director about his "absence". Yet another trainee had spoken with a staff member about renegotiating their boundaries in working together in the course since they had known each other socially. When other issues were addressed at a group level, there was also considerable relief felt by the trainees such as when there were class discussions about feeling abandoned by the staff or sharing their experiences of the training or when issues of race were discussed.

#### **4.7.2 Self-Care**

Unlike Mahoney's (1997) study of 'self-care' factors where psychologists mostly used relaxation and recreation as means of coping, only a few trainees used these as their coping strategies. However, many of the trainees spoke about wishing that they could do it. One trainee, for example, spoke about coming home at the end of the day to lie on her bed to relax and process what had happened during the day. She also used exercise to help her de-stress. Only one other mentioned using exercise and recreation to cope. One of her primary challenges was being able to strike a balance in her life and remind herself that she had a life outside of the training programme. She said that she wanted to ensure that she still had contact with friends and still went out. She often went to the movies or to the theatre and went walking with friends every day. She was one of the trainees who appeared to cope well with the course. Some trainees said that financial constraints made it difficult to engage in recreational activities. One trainee said that she was so "traumatised" by the training that she needed to relax after her internship. She said that having financial security enabled her to just "stare at the sky" and reflect on her experience.

Another way in which trainees reported coping was getting breaks and holidays which provided them with time to rest, even if not completely. One trainee said that she was so tired near the end of her second year that she would motivate herself by checking the calendar all the time to look for any breaks or public holidays. For some, however, breaks and vacations had a flip side. One trainee said that after a break she would find that her energy and motivation would be less than before. She explained that she "was actually at 100% functioning before [breaks] and then went to zero and couldn't get back to 100".

#### **4.7.3 Setting Goals**

One trainee said that she had set really big "long-term goals" for herself because she felt pressured by the enormous expectations placed on trainees. She said that these began to feel overwhelming and she "felt like she was sinking into some deeper hole". Her work "started dragging" and she "felt bad" about not meeting those goals. Once she stopped thinking about those expectations she "came up with a system of setting daily goals". Setting smaller and more realistic goals made her feel a "sense of achievement" at the end of the day. She said that having step-by-step goals not only allowed her to achieve the larger goals, it made her less anxious and more able to feel good about herself as a person.

For another trainee, having an “end goal”, which she saw as her “coming out with a degree, nothing more and nothing less”, was important and helped her cope. She said that she had made a conscious decision to deal with the training as it was a goal that she was striving towards and that she would achieve that.

This was attempted with less success by another third year student who said that each time she hoped that things would feel better or more manageable once she had reached her goal, this would not happen. She would postpone the rewards she was meant to feel to the next goal she set. She said that she had looked forward to the second year because it was supposed to be easier. When she got to the internship it was not easier so instead she hoped that perhaps it would be better in the next year and pushed herself further. She then found writing a thesis to be equally difficult and felt that perhaps finishing the thesis would bring the desired rewards. This trainee appeared to use this mechanism to keep her motivated to work and to persevere.

#### **4.7.4 Thinking Positively**

Four trainees utilised this method very effectively during their training. They said that they always tried to see the positive aspects in situations and that they had always used this method in their lives. When experiencing difficulties, they were able to evaluate the situation and see that there were many advantages to the situation. For example, when trainees were having difficulties with the sacrifices their families had to make, they said that they “concentrated on the positive things” that would make the sacrifices worthwhile. These included things like providing a role model for their children, or increasing the earning potential for their families when they qualify, or that they were gaining knowledge about themselves, children and family dynamics which helped them to understand and relate better to their families. It may, however, be difficult for trainees to hold onto the positive experiences as this trainee's comments suggests:

...Well it's been great because I've been able to do more at home. Uhm I'm the kind of person that's more anxious before a thing is happening and after wondering how I got through, than when I'm in it. Then I just do it. So this year I wonder *'how* did I get through the last two years!' you know in terms of the things that have to be done at home, you know all the just keeping the house running, in order. And we did scramble, and no wonder that my youngest daughter is angry with me, things *were* messy (laugh). I've lost my train of thought. Uhm but I've enjoyed this year. I've just handed in my first draft. I've kind of strung it out, done other things, gotten the house a little more in order.

In this comment, it seems that when the trainee begins to talk about feeling overwhelmed, she switches to talking about feeling on top of things. Taking a positive approach may, however, not always feel appropriate, especially for those engaged in process and work of uncovering anxiety and distress.

I have to watch that I don't pretend that I'm coping when I'm not. I'll cope with plenty of stuff that maybe I shouldn't cope with. That's *my* failing,

Another first year student said that before she came into the course “think positive” was her catch phrase and she was a very active, energetic person. Since starting the course she said she realised that she had avoided ‘feeling’ and now she is less talkative and does not avoid ‘feelings’ by thinking positively.

Underneath the desire to ‘think positive’, there seemed to be a genuine sense of the reward of psychological work for many trainees. Many enjoyed the challenges that faced them in learning about mental illness and mental dynamics. They enjoyed learning about themselves through this process as well, even though it was difficult. Some trainees enjoyed working with certain patients such as one trainee who said that she “really really enjoyed [her] psychotic and schizophrenic patients”. Also the sense that some trainees had about being able to help others and feel that they have a meaningful job which brings about positive change helped motivate them and helped them cope through their professional training. One second year trainee just lit up when she spoke about the patients thanking her. Improvements in clients or patients also inspired them to continue the difficult journey. Trainees' narcissistic needs may also be met when patients do well and show appreciation to or attribute their progress to the trainee.

#### **4.7.5 Emotional Distancing**

Though Dale (1997) said that avoidance or denial is not a legitimate option for psychotherapists, for these trainees it seemed to be the most frequently utilised coping strategy in the training. Some trainees seemed to consciously seek ways of distancing themselves from the emotions evoked during the training. Two trainees expressed that they were very protective of themselves and their emotions in the course because of their past experiences. The one trainee said that she had been “stabbed in the back” before and was now wary. This trainee also stood out in her attempts to distance herself emotionally. She had also relocated to do the course and when she went home for vacations she did not talk about the course or her experiences of it at all. She said that she “left everything behind here in Cape Town” and went home to relax and be pampered. She also prefers talking about her experiences when they happen, so if there is no-one to discuss her day with when

she gets home, then it is not “rehashed” later. She also felt unable to be vulnerable with classmates. When we began the interview, it was initially overwhelming for her as she did not want to think about the experience of the professional training until it was all over and she was more settled. She said that the interview was getting her to reflect on her experience and she was unsure whether she wanted to “continue to dig in”. When I asked her later about this and processing her experience she said:

I do exactly what I always do. I just shove it. Shove whatever is there. I just completely like de-role. I don't know how it happens, it's very automatic for me. I just completely push it under the carpet or whatever so I didn't even think about it anymore after that.

Part of the attempt to cope may also have involved other ways of distancing themselves from the encounter with difficult feelings. One trainee related an incident that reflected this for her. Her class had been observing a family with a psychotic member in it and she said:

the hysteria, the giggling about somebody whose a little bit crazy. I find myself getting quite angry with that because I think that we're all crazy, we all have the potential to go psychotic or to go off the rails and that. I think that it's that kind of us-them, that sort of 'I'm better'. And I don't think that sort of arrogance is real...I think that it's actually anxiety. It's a laughter based on anxiety but there's something judging in it as well. As if there was this great separation between a therapist and a client and there really isn't.

The above quote seemed to reflect the kind of 'othering' of mental illness which Foucault (1961) and Hubert (2000) speak of. Psychologists, we have been told by Kilburg, et al. (1986), suffer from the same psychological disorders, in similar proportions to the rest of people from similar backgrounds. As the trainee explains, there may therefore be denial of the potential for mental illness that may exist within them, the potential to become 'insane' (Hubert, 2000). Trainees may also fear the stigmatization and marginalisation their patients suffer. Trainees in these pages have already expressed feeling misunderstood, isolated from and marginalised by their non-psychology peers and colleagues as well as society in general on some level. These realizations, and the “unspoken expectation that healers should need no healing” (Millon et al., 1986, p131) may be very anxiety-provoking for professionals, and perhaps even more so for trainees.

#### **4.7.6 Letting Go of Perfectionism**

Trainees tell themselves that they have to be perfect or they will be seen as incompetent, or that they will damage their clients. When their clients cancel appointments and show slow progress, they

blame themselves. Placing such ideals of perfection on themselves may be very pressurising. Some trainees recognised their tendency to place heavy demands on themselves and how this may have contributed to their stress levels. Also, such need for perfection may compromise trainees' ability to deal with the uncertainty and confusion involved in any shifts in identity. Instead, they say that they have to begin to challenge those very traits in themselves in order for them to manage the ambiguity of a clinical training. As one trainee said, dealing with uncertainty was one of her biggest challenges.

It certainly has changed me...I think some of the biggest changes had to do with (sigh) sort of moving towards a place of living with ambivalence and not knowing and confusion, that for me who liked everything nice and neatly worked out! ... So that was quite a big thing.

Another way in which three trainees tried to place less pressure on themselves was by maintaining "perspective" on things in the course and placing difficult events in the broader context of their lives. The purpose of this method for the three trainees, it seems, was to lessen the gravity of a difficult situation by looking at the overall meaning or purpose of it. One trainee said that she tried seeing that "this is not my whole life", "it's only 10 months anyway" or that things change all the time and "you know that you're gonna feel something different a week or a month or a year from now ... and then you wonder what all the fuss was about."

In summary, the strategies which trainees utilised in order to cope with the training were many. Primarily, trainees used talking, and talking specifically to those in the profession as their coping strategy (as in Coster & Schwebel, 1997; and Cushway, 1997 findings). A few used relaxation and recreation to cope, but many felt financially unable to engage in recreational activities. Some also used setting achievable goals as a means of increasing a sense of competence. Beyond these behavioural strategies, some trainees tried to see the positive aspects of situations to help them cope better while others began to challenge the high expectations to perform perfectly which they placed on themselves. Another common coping strategy among the trainees was to distance themselves from the emotions evoked during the training. They did this by either not talking about their emotional experiences or by denying their own potential vulnerability to experiencing severe emotional distress or mental illness.

## CHAPTER FIVE : CONCLUSION and RECOMMENDATIONS

As students and health care workers, trainees experienced difficulties on the individual, interpersonal, academic and professional levels. The interaction of the internal and individual factors with the external training demands resulted in complex emotional experiences for the trainees. Firstly, they reported feeling that they were 'not good enough' for the training or for therapeutic work. Secondly, they felt that too much was expected of them and that there was insufficient support for them in an academically and emotionally demanding training. In addition, the developmental 'crises' resulting from their move towards establishing their professional identities contributed to their difficulties in the course. Furthermore, trainees seemed to find that the changes taking place within the profession and the poor status of psychology negatively affected their sense of value and their career opportunities. Lastly, the many ambiguities and paradoxes that trainees seemed to face in the training and in their own experience of it added to the complexity and difficulty of their experience.

The factors reported to contribute to their feeling of not being good enough appeared to lie, in part, in the organizational practices of selection and evaluation. Trainees reported feeling anxious about living up to expectations that they believe existed for them as the "crème de la crème" (Millon et al., 1986, p120). The constant evaluation of their performance, trainees reported, left them feeling scrutinized and afraid that they would be found wanting and consequently rejected. Their perception that they were expected to display competence while being inexperienced novices exacerbated fears that they would fail and be seen as being inadequate by staff and peers. The notion that what they had to offer was perhaps not good enough seemed to be exacerbated by their feeling that they had to set aside their previous work experience and knowledge to heed the worldview of the training institution. This fear of revealing personal or professional inadequacy was pervasive, filtering into many other spheres of the training and contributing significantly to trainees' difficulties. For example, it impacted on their ability to trust themselves to intervene successfully or to cope, often resulting in them placing higher expectations on themselves to achieve. Other explanations have been offered for this feeling of not being good enough. One argument is that when people enter a new situation, a learning situation in particular, they fear that the knowledge they have will not be enough and they will fail to negotiate and manage the situation (Salzberger-Wittenberg, 1983). Trainees also bring their unique backgrounds and psychological issues to the training, which may determine their experiences of it (Gibson et al., 2001; Kopp, 1973; Kottler, 1991, Dryden & Spurling, 1989). One suggestion made is that trainees have deep-seated feelings of personal

*include in  
Lit rev.*

inadequacy, which are harnessed during the training (Kleintjies, 1991). The suggestion here is that underlying feelings of personal inadequacy results in trainees perceiving organisational practices, such as evaluation and selection, as threatening. They may also ultimately feel unable to accept positive feedback, believe that they deserve the privilege of training to the exclusion of others, or that they could intervene successfully with clients. With South Africa's Apartheid history of inculcating beliefs in the inferiority of black people, these feelings of inadequacy may be especially true for black trainees as Kleintjies (1991) and Mokutu (1998) suggest.

In addition, trainees struggled with feelings of being inadequately supported. They reported feeling unsupported on many levels; financially, technically, socially as well as in terms of the heavy workload, academic demands, staff and peer support. Particularly distressing for trainees was the disruption of social support. They said that their social support was disrupted as a result of work overload and the emotional demands of training. These demands seemed to leave them with fewer emotional resources to invest in family and friends (Millon et al., 1986; Marchetti, 1989, Cushway, 1997). The psychological knowledge attained about interpersonal dynamics and their developmental transformation resulted in trainees perceiving themselves and others differently, which they often said made them feel different to and misunderstood by those not in the profession. The resulting shifts in interpersonal relationships may have been difficult for trainees already struggling with experiences of internal flux. With all the work demands and the diminishing support from those outside the training course, trainees depended heavily on support from those within the course. Trainees said that they needed more support from staff than what they received. Again, however, many trainees were faced with changes and flux within the CGC and the psychology department. They said that staff were too busy to attend to their needs and that the changes taking place meant that staff were overworked and could not be burdened further by their needs. The most noticeable aspect, however, was trainees' experiences of training staff and supervisors not acknowledging their personal lives or recognising how difficult the training course was for them on a personal level. This echoes trainees' complaints in Cushway's (1997) study about the stressful nature of training being largely unacknowledged. With their classmates, trainees felt that they needed more formal opportunities to share and normalise their experiences of training, to feel understood and to eradicate feelings of isolation. Although the training institution should address the provision of more resources and support, the issue appears to be more complex than this. The underlying fears of exposing inadequacy may also have prevented trainees from asking for or even accepting support from staff, supervisors and peers. For example, despite supervision being identified as an important source of support, trainees still feared negative evaluation from supervisors. Furthermore, it is

hypothesised that trainees, motivated to pursue psychology by past experiences of inadequate emotional containment (Skynner and Schlapobersky, 1989; Dale, 1997; Pines, 2000), are distrustful of others to provide sufficient emotional holding and support. These childhood experiences of inadequate parenting may lie behind trainees' perception of not feeling "supported or guided enough". It may have resulted in trainees valuing self-reliance and autonomy because they do not trust that they could be 'held'. Salzberger-Wittenberg (1983) suggests that when staff, like parents and teachers, fail to meet trainees' high expectations of them, trainees' idealisation turns to denigration. When staff therefore do not provide the expected knowledge and emotional support, trainees may feel frustrated and angered by withholding parents. The irony of trainees' anger about not being taught enough to equip them to do clinical work is that they cannot be *taught* everything there is to know about empathy, dealing with psychic pain and establishing a therapeutic relationship. Trainees ultimately have to rely on themselves and their clinical experience to help them navigate therapeutic relationships (Corey, 1996). This may be anxiety provoking for trainees who have little experience and a strong sense of personal inadequacy. Another possible explanation given for trainees' feelings of inadequacy and experiences of staff as unsupportive is offered by the analysis of the dynamics of organisations working with mental distress and illness. It is suggested that the trainees carry the projections of their clients/patients (Obholzer & Zagier-Roberts, 1994; Gabriel, 1999). The clients' primitive forms of communication and defences affect the trainee who in turn may adopt similar defences with the staff and the training institution. The trainees may use splitting in their perception of staff as either the ideal all-knowing parent who will teach them everything they need to know or as the withholding, frustrating and inadequate parent. They may also project all their insecurities about being 'bad' or 'not good enough', into staff or peers, and consequently identify with that split off part of themselves ((Obholzer & Zagier Roberts, 1994; DeBoard, 1995). However, as Holdworth (1994) suggests, trainers may also be responsible for the dynamic set up in a training institution by repeating their own experiences of a difficult training with students.

As with staff, classmates, too, may represent unconscious expectations. Classmates may become not only the supportive siblings who will understand their experiences but also rivals for the attentions and positive regard of the 'parents' (Salzberger-Wittenberg, 1983). They may also constitute a source of narcissistic injury (Kottler, 1991; Margison, 1997). As they competed to get into the course, they may again become competitors who will reflect for individual trainees that they are not doing as well as they should be, further injuring a sense of being good and worthy.

Another difficulty for the trainee lay in the ambiguities they faced in the development of their professional identities. As with the wounded healer, the journey toward becoming a clinical psychologist can be emotionally demanding, with the greatest and most difficult lessons being about themselves and their past experiences (Kopp, 1974; Kay, 1996). In the short term, exploring one's own psychic dynamics, which lends to a better sense of self, may be a difficult and emotionally exhausting process. While learning about themselves, they are also engaged in the process of integrating a new identity, which can be a confusing and frightening process for the trainee, who may be left feeling very uncertain about who he/she is.

Even when trainees felt like they were coming into themselves and their identities as psychologists, it may have been difficult for them to appreciate this process entirely when feeling separate and different, even criticised, by family, friends, other professionals and society. Their expectations that they would gain respect and status within the broader professional and social context may be challenged by ignorance about what psychology is or does (Wollershien & Walsch, 1993); by popular ambivalence about psychology and psychotherapy (Dare, 1997); and by the professional questioning of the relevance and efficacy of psychology and psychotherapy in particular (Berger & Lazarus, 1987). In addition to the increasing use and reliance on medication, the advent of managed care seemed to further marginalise psychology and therefore trainees within the professional hierarchy (Holdsworth, 1994; Plante, 1996; Rouff, 2000). Role confusion and role diffusion with other professions may have complicated the trainees' sense of what their responsibilities were or the value of what they were doing within the system (Holdsworth, 1994). It also created uncertainty among some about their futures and what they could do with their clinical training. Those trainees wanting to practice long-term, individual, adult psychotherapy, were despondent about their future because what they felt was being communicated to them was that these practices constitute a tradition that is being replaced by shorter-term interventions with measurable outcomes. Those seeking training in brief-term therapeutic interventions also felt disappointed by the theoretical emphasis on the traditional systems of psychoanalysis or psychodynamic interventions. For trainees trying to establish and anchor themselves in a professional identity, the changes and flux within the profession may add to the anxieties they face with learning and in the training generally.

This lack of external affirmation may be especially anxiety provoking for the trainee who regards his/her professional status as a marker for a personal sense of self, according to Kilburg (1986). The idea that his/her professional self is not valued may translate into a sense that s/he is not of value.

This may either hinder the development of a professional identity, or exacerbate fears of personal inadequacy, or both.

The manner in which trainees dealt with the difficulties and ambiguities experienced in the training varied. They utilised both cognitive and behavioural coping methods (Cushway, 1992; 1997) as well as more internal processes (Salzberger-Wittenberg, 1983; Obholzer & Zagier-Roberts, 1983). Talking, and talking with others in psychology specifically, was their main means of coping during the training. Although trainees said that personal therapy was difficult especially during the initial stages, they cited it as offering invaluable support. Self-care techniques such as recreation and exercise were not often engaged as coping strategies, perhaps due to a lack of time and money. Vacations and time off from work were also vitally important for trainees' ability to cope. Some techniques of realistic evaluation of expectations and setting of achievable goals were very effective in helping some trainees cope. The rewards of being in a helping profession also gave some trainees a sense of meaning and personal satisfaction.

On a more internal level, the most significant psychological method of coping was the process of distancing themselves from the difficult emotions evoked by the training and by the often painful experiences of working with mental illness and trauma. One such method was trainees' attempts to 'think positive'. Although this is not always problematic, some trainees were wary of the extent to which it allowed them to deny aspects of a situation which they should not. Furthermore, by locating psychological distress in their clients, trainees may deny their own vulnerability and need for healing, thereby deflecting any perception of personal and professional inadequacy.

Having identified the many difficulties facing the trainee during their professional training as well as the various strategies used to cope with these difficulties, some recommendations to assist trainees in their training are necessary.

Firstly, the institutional practices cited as anxiety producing and creating feelings of inadequacy, such as the selection evaluation procedures, should be reviewed. Perhaps the criteria for selection should be made more transparent and selected trainees could be given feedback on why they were successful (just as feedback is given to unsuccessful applicants). If this is not possible, trainees should perhaps be reassured that they have been carefully selected and that they do have the potential to be good clinicians. Giving trainees the reassurance they seem to seek at this anxious time of entering a new situation could be helpful. The reason behind this need for reassurance may

be addressed at a later stage. Due to the sometimes 'soft' qualitative nature of evaluation, it may not be possible to give exact stipulations on how trainees are evaluated but there should perhaps be some clarity about the areas being looked at.

Another critical aspect has to do with trainees' expectations of the training. Realistic assessment of expectations should take place early on in the training. The expectations of students need to be examined and the aims, objectives and structure of the course could perhaps be reviewed, to make them clear and explicit. Some of these factors, such as the curriculum structure, are mentioned in the student handbook (CGC handout, 2001) that is distributed to students when applying for the course. However, it may be important to revisit these factors at the start of, or during, the course itself when trainees are more settled. It would be useful if discussion involved further exploration (other than simply outlining the course structure in the handbook) about some of the difficulties encountered with the structure. Trainees also recommended certain changes that they felt would better prepare them for what to expect. One said that they should attend hospital ward rounds at all the units before they are signed onto the course. Two trainees suggested that students attend a ward round to prepare them for the hospital system. The other said that students should attend ward rounds at the hospital during their first year to orientate them to the system and what they would be expected to do as interns. Although this recommendation may reflect trainees' need for containment, staff cannot fully prepare trainees academically for therapeutic work. Perhaps the reasons why they cannot be fully prepared could also need to be discussed openly and not taken for granted.

Trainees' recommendations generally focused on support. Some suggestions were about maintaining contact with the clinic after the first year of training in order to provide an easier transition into the second and third years. Contact with the clinic for third year students who feel the most isolated was specifically emphasised. Other suggestions centred on the provision of group support for the classes. Most of the trainees who mentioned this aspect said that the current practices need reviewing. As the demands to perform and achieve in an academic course are heavy, trainees feel unable to ask for support. Such support could be partially structured into the course. Peer support, for example, should be offered through formal group sessions. If formal support groups are provided, then the groups have to be run more regularly and consistently with an outside facilitator not connected to the university or the hospital. As peer or collegial support is so important to trainees, perhaps because "mental health professionals speak the same language - affectively and intellectually" (Millon, et al., 1986, p132), regular group therapy for trainees should be re-introduced at the CGC,

with the above changes. However, these changes only reduce the fear of evaluation from staff and not from peers.

Personal and professional development go hand in hand during this time and with the changes and shift in identity taking place, it is important perhaps that staff and especially supervisors take the initiative in helping and guiding students to establish the boundaries of supervision. Trainees depended on supervision to help them cope and provide clinical skills. Dale (1997, p57) states, "supervision is the equivalent of having a guide who has been there before, who can indicate the signs that tell you when you are going in the right direction or have lost your bearings". Supervisors should therefore take cognisance of students' personal and emotional experience of the training as well as transference issues with clients. They should also perhaps take an active role in assessing students' coping mechanisms. They could, for example, see if trainees are withdrawing from classmates, gaining or losing weight, which Margison (1997) says are simple indicators of distress commonly ignored by therapists working with other therapists. However, it is ultimately the responsibility of the trainees themselves to be clinically alert to signals of stress in themselves and to take the necessary precautions.

Two trainees suggested that technological and computer support be offered to trainees who have minimal computer literacy or who do not have computers readily available. Another suggested that the male-female ratio be reviewed in terms of trainees selected for each year and to avoid having only one male. Another was the recommendation that students get at least one morning off a week from formal seminars. Although these suggestions do not reflect the complexities inherent in the training, they are vitally important and added to the stressors that trainees experienced on a daily basis.

The results of Cushway's (1997) national survey of trainees, relied on heavily in this study as well, was used to inform a model of support instituted in the Birmingham University. It is a model that could prove useful to UCT and the CGC. It looked at support on 5 levels: philosophy, structure, formal teaching, support systems and awareness raising. In essence it says that the philosophy of training institutions and staff should be that trainers model a system of coping rather than one of mastery, in which trainees' experiences of stress are normalised and acknowledged. This would be good for these trainees for whom one of the biggest complaints was that staff did not acknowledge their distress and that they felt like they were the only ones not coping.

Birmingham University also reduced formal teaching and increased private study days. They also developed a stress handbook and introduced a professional self-care course as part of the formal curriculum. Furthermore, they have assigned independent tutors, an independent person who serves as guide and mentor for the trainee. Secondly, they provide a personal awareness group aimed at personal support, for which trainees could volunteer. The group is run weekly in term-time, throughout the course. Group facilitators are independent of the system and the process is confidential with no feedback being given to course staff. It also covers many topics that have been raised by the trainees in this study, such as assertiveness, barriers to obtaining support, issues in the therapeutic relationship, working in teams, personal issues in working with clients or the work in general for example. Complex and sensitive issues such as racism, sexism and ageism could also be addressed in such a forum. Individual counselling is strongly recommended. The university compiles a list of counsellors willing to give free, individual support ranging in approaches and length of interventions. They also campaign for the raising of awareness among trainees, teachers, supervisors and qualified professionals about stress in training and how to approach it.

In conclusion, trainees have identified many difficulties on different but interwoven levels, personally, interpersonally and professionally. They confirm that beginnings can bring many rewards, but can be painfully difficult and can evoke all the hopes and expectations moulded from past and present experience. Their professional training marks not only the beginning of their professional lives and dealing with the challenges of a changing profession - but also the beginning of who they will be as adults, in themselves and with their family and friends. The training is a significant beginning and what trainees learn in this time will carry them forward. It is essential therefore that they are taught how to care for themselves and shown that in doing so they display strength rather than weakness. They need to learn how to practice what they preach. As Nathan (1986), Dale (1997) and Kopp (1973) also said, it is important that those they depend on for guidance on their pilgrimage, who themselves have been pilgrims, help them navigate the as yet uncharted paths.

## REFERENCES

- Abrahams, A. (1992). An Explorative Study of the Professional Training Experience of Black Psychologists in the Western Cape. Unpublished Masters Thesis, University of Cape Town, Cape Town.
- Ahrends, I. (1995). Different Stories: Multicultural Issues in Training. Unpublished Masters Thesis in Clinical Psychology, University of Cape Town, Cape Town.
- Berger, B. (2000). Prisoners of Liberation : A Psychoanalytic Perspective on Disenchantment and Burnout among Career Women Lawyers. Journal of Clinical Psychology/ In Session : Psychotherapy in Practice, 56 (5), 665-673
- Berger, S. & Lazarus, S. (1987). The views of community organisers on the relevance of psychological practice in South Africa. Psychology in Society, 7, 6-23
- Bernard, H.R. (1994). Research Methods in Anthropology: Qualitative and Quantitative Approaches (2nd Ed.), California: Sage Publications.
- Berndt, L.L. (1985). Stress, Cognition and Physical Disease Among Students. Unpublished Masters thesis, Rand Afrikaanse Universiteit, Johannesburg.
- Bestenbier, M.C. (1992). Experience Of Stress by Nursing Students during their Psychiatric Clinical Practical. Unpublished Masters Thesis, Rand Afrikaanse Universiteit, Johannesburg.
- Bram, A.D. (1997). Perceptions of Psychotherapy and Psychotherapists : Implications from a study of Undergraduates. Professional Psychology : Research and Practice, 28(2), 170-178
- Burman, E. (1994). Interviewing. In Bannister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. Qualitative Methods in Psychology: A Research Guide. Bristol: Open University Press.
- Cherniss, C. (1995). Beyond Burnout: Helping Teachers, Nurses, Therapists and Lawyers Recover from Stress and Disillusionment. London: Routledge Publishers.
- Child Guidance Clinic. (2001). Professional Training in Clinical Psychology. Handout. University of Cape Town, Cape Town
- Chippindall, R.J., & Watts. J. (1999). An Investigation of the pre-eminent assumptions of selectors underlying the admission of candidates to the MA (Clinical Psychology) programme at the University of the Witwatersrand. South African Journal of Psychology, 29 (3), 109-116
- Cooper, C. (1997). Stress in Psychotherapists Who Work with Adults. In Varma, V.P. Stress in Psychotherapists. London: Routledge,
- Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy (5<sup>th</sup> Ed). USA: Brooks/Cole Publishing Company.
- Coster, J.S., & Schwebel, M. (1997). Well Functioning in Professional Psychologists. In Professional Psychology: Research and Practice, 28(1), 5-13
- Cushway, D. (1992). Stress in Clinical Psychology Trainees. British Journal Of Clinical Psychology, 31, 169-179

Cushway, D. (1997). Stress in Trainee Psychotherapists. In Varma, V.P. Stress in Psychotherapists. London: Routledge.

Cushway, D., Tyler, P.A. & Nolan, P. (1996). Development of a stress scale for mental health professionals. British Journal of Clinical Psychology, 35, 279-295

Dale, F. (1997). Stresses in Child Psychotherapists. In Varma, V.P. Stress in Psychotherapists. London: Routledge,

Dana, R.H. (1987). Training for Professional Psychology: Science, Practice and Identity, Professional Psychology : Research and Practice, 18(1), 9-16

Dare, C. (1997). The Experience of Being a Psychotherapist, in Varma, V.P. Stress in Psychotherapists, London: Routledge.

De Board, R. (1995). The Psychoanalysis of Organizations. London: Routledge,

Dryden, W., & Spurling, L. (1989). On Becoming a Psychotherapist, London: Tavistock Routledge,

Dryden, W., & Thorne, B. (1991). Key Issues in the Training of Counsellors. In Dryden, W. & Thorne, B. (eds.). Training and Supervision for Counselling in Action, London: Sage Publishers.

Edwards, D. (1993). Training Issues. Forum on the role and function of psychology in a new South Africa. Johannesburg, 2-4 September, 1993.

Farber, B.A. (2000). Introduction: Understanding and Treating Burnout in a Changing Culture. Journal of Clinical Psychology/In Session, 56 (May), 589-594

Farberman, R.H. (1997). Public Attitudes about Psychologists and Mental Health Care: Research to Guide the APA Public Education Campaign. Professional Psychology : Research and Practice, 28(1), 128-136

Firth-Cozens, (1987). The Stresses of Medical Training. In Payne, R. & Firth-Cozens, (1987). Stress in Health Care Professionals. Great Britain: John Wiley and Sons Ltd.

Foucault, M. (1961). Madness and Civilization : History of Insanity in the Age of Reason. London: Tavistock Publications.

Foucault, M. (1980). Power and Knowledge : Selected Interviews and Other Writings, 1972-1977. New York: Pantheon Press.

French, J.L. & Bushek, M.C. (1988). Interns' Perceptions of their Internships. Professional Psychology : Research and Practice, 19(1), 3-5

Friedman, I.A. (2000). Burnout in Teachers: Shattered Dreams of Impeccable Performance. Journal of Clinical Psychology / In Session 56, 595-505

Gabriel, Y. (1999). Organizations in Depth. London: Sage Publications Ltd.

Gelman, T. (1999). The Prevalence and Detection of Possible Minor Psychiatric Morbidity in Students Attending the Student Health Services at the University of Cape Town – A pilot study. Unpublished MA. Clinical Psych. Thesis, University of Cape Town, Cape Town.

- George, M.E. (1999). An Exploration of Women's Experiences of being in an Abusive Relationship. Unpublished Masters Thesis, University of the Western Cape, Cape Town.
- Gibson, K., Sandenbergh, R. & Swartz, L. (2001). Becoming a Community Psychologist: Integration of Community and Clinical Practices. Psychologists Training, South African Psychology, 31 (1), 29-35
- Govender, S. R. (1991). Graduate Perceptions of Clinical Training in Psychology. Unpublished Masters Clinical Psychology Thesis, University of Durban Westville, Durban.
- Grandal, B. & Salamone, F. (1995). Bridges to Humanity. Illinois: Waveland Press Inc.
- Health Professions Council of South Africa (HPCSA). (2002). Professional Board of Psychology: Education and Training. Retrieved January 15, 2002, from [http://www.hpcsa.co.za/Professional\\_Boards/Psychology/education&training.htm](http://www.hpcsa.co.za/Professional_Boards/Psychology/education&training.htm)
- Hellman, I.D., Morrison, T.L. & Abramowitz, S.I. (1987). Therapist Flexibility/Rigidity and Work Stress. Professional Psychology : Research and Practice, 18(12), 21-27
- Henry, G. (1983). Part III: Understanding the Individual Child in the Classroom. In Salzberger-Wittenberg, I., Henry, G. & Osborne, E. (1983). The Emotional Experience of Learning and Teaching. London: Routledge and Kegan Paul Ltd.
- Heuchert, J.W.P. & Amed, R. (2001). Community Psychology: Past, Present and Future. In Seedat, M., Duncan, N. & Lazarus, S. Community Psychology: Theory, Methods and Practice: South African and Other Perspectives. Oxford: Oxford University Press.
- Hirschhorn, L. (1990). The Workplace Within. London: The MIT Press.
- Holdsworth, M. (1994). Consultation and Training Challenges at the Mamre Community Health Project. Unpublished Masters Thesis, University of Cape Town, Cape Town.
- Hubert, J. (2000). Introduction: the complexity of boundedness and exclusion. In Hubert, J. (ed.), Madness, Disability and Social Exclusion : The Archaeology and Anthropology of 'Difference'. London: Routledge Publishers.
- Hunt, J.C. (1989). Psychoanalytic Aspects of Fieldwork: Qualitative Research Methods Series 18. California: Sage Publications.
- Jones, J.G. (1987). Stress in Psychiatric Nursing. In Payne, R. & Firth-Cozens. Stress in Health Care Professionals. Great Britain: John Wiley and Sons Ltd.
- Kaslow, F.W. (1986) Therapy with Distressed Psychotherapists: Special Problems and Challenges. In Kilburg, R.R., Nathan, P.E. & Thoreson, R.W. Professionals in Distress: Issues, Syndromes and Solutions in Psychology, USA: American Psychological Association, Inc.
- Kaslow, F.W. & Rice (1985). Developmental Stresses of Psychology Internship Training. Professional Psychology: Research and Practice, 16, 253
- Kay, J. (1996). Growth Experiences of Clinical Psychology Students in Training : A Phenomenological Study. Unpublished Masters thesis, Stellenbosch University, Cape Town.
- Kets de Vries, M.F. (1991). Organisations on the Couch: Clinical perspectives on organisational behaviour and change, Oxford: Jossey-Bass Publishers,

Kilburg, R.R. (1986). The distressed Professional: The Nature of the Problem. In Kilburg, R.R., Nathan, P.E. & Thoreson, R.W. Professionals in Distress: Issues, Syndromes and Solutions in Psychology, USA: American Psychological Association, Inc.

Kilburg, R.R., Nathan, P.E. & Thoreson, R.W. (1986). Professionals in Distress: Issues, Syndromes and Solutions in Psychology. USA: American Psychological Association, Inc.

Kleintjies, S.R. (1991). Black Clinical Psychology Interns at a 'White' University: The Experience of Colour During Training Unpublished Masters Thesis, University of Cape Town

Kopp, S. (1974). If You Meet the Buddha on the Road, Kill Him, London: Sheldon Press.

Kottler, A. (1991). Learning Therapy - Some Reflections on the Constraints and Dilemmas Involved : A Case Study. Unpublished Masters Thesis, University of Cape Town.

Lipovsky, J.A. (1987). Internship Year in Clinical Psychology Training as a Professional Adolescence. Professional Psychology: Research and Practice, 19(6), 606-608

Lever, T., Lucas, M., & Ortles, K. (2000). Burnout in Psychiatric Nurses. South African Journal of Psychology, 30 (2), 36

Lotz, J.W. (1995). Die Invloed van Stres op die Akademiese Prestasie van die Volwassene-Leerder: 'n Orto-Andragogiese Studie. Unpublished Doctor Educationis. Pretoria: University of South Africa

Mahoney, M.J. (1997). Psychotherapists' Personal Problems and Self-Care Patterns. Professional Psychology: Research and Practice, 28(1), 14-17

Marchetti, M.C. (1989). Professional Training in Clinical Psychology: Graduates Perceptions and Evaluation, Unpublished Masters Thesis, Rand Afrikaanse Universiteit, Johannesburg.

Margison, F. (1987). Stress in Psychiatrists. In Payne, R. & Firth-Cozens. Stress in Health Care Professionals. Great Britain: John Wiley and Sons Ltd.

Margison, F. (1997). Stress and Psychotherapy: An Overview. In Varma, V.P. (1997). Stress in Psychotherapists. London: Routledge,

Marks, S., (1999), 'Every facility that modern science and enlightened humanity have devised' : race and progress in a colonial hospital, Valkenberg Mental Asylum, Cape Colony. In Melling, J., & Forsythe, B. Insanity, Institutions and Society, 1800-1914, London: Routledge,

Menzies, I.E. (1970). The Functioning of Social Systems as a Defence Against Anxiety. London: The Tavistock Institute of Human Relations.

Millon, T., Millon, C. & Antoni, M. (1986). Sources of Emotional and Mental Disorder Among Psychologists: A Career Development Perspective. In Kilburg, R.R., Nathan, P.E. & Thoreson, R.W. Professionals in Distress: Issues, Syndromes and Solutions in Psychology. USA: American Psychological Association, Inc.

Misch, D.A. (2000). Great Expectations: Mistaken Beliefs of Beginning Psychodynamic Psychotherapists. American Journal of Psychotherapy, 54 (2, Spring).

Mokutu, M. (1998). Black Clinical Psychologists in the Western Cape: Their Perspectives on their Work. Unpublished Masters Thesis, University of Cape Town, Cape Town.

Nathan, P.E. (1986). Unanswered Questions about Distressed Professionals, in Kilburg,R.R., Nathan, P.E. & Thoreson,R.W. Professionals in Distress: Issues, Syndromes and Solutions in Psychology. USA: American Psychological Association, Inc.

Nell, V. (1992). The case for an independent licensing board of psychology. South African Journal of Psychology, 20(3), 129-140

Neuman, W.L. (1997). Social Research Methods: Qualitative and Quantitative Approaches (3rd Ed.), U.S.A.: Allyn and Bacon.

Neuman, W.L. (2000). Social Research Methods: Qualitative and Quantitative Approaches (4th Ed.). U.S.A.: Allyn and Bacon.

Obholzer, A. (n.d). The Individual, the Institution and the Climate for Learning, Symposium

Obholzer, A. & Zagier Roberts, V. (eds.). (1994). The Unconscious at Work: Individual and Organisational Stress in the Human Services. London: Routledge,

Parker, A.D. (1986). An Evaluation of the Present Status of Clinical Psychology, Unpublished Masters Thesis, University of Cape Town, Cape Town.

Payne,R. & Firth-Cozens. (1987). Stress in Health Care Professionals. Great Britain: John Wiley and Sons Ltd.

Pines, A.M. (2000). Treating Career Burnout: A Psychodynamic Existential Perspective. Journal of Clinical Psychology. In Session: Psychotherapy in Practice, 54(5)

Plante, T.G. (1987). The Clinical Internship: A Call for National Standards (The Forum). Professional Psychology: Research and Practice, 8, 3

Plante, T.G. (1996). Ten Principles of Success for Psychology Trainees Embarking on Their Careers. Professional psychology: Research and Practice, 27(3), 304-7

Reynolds, P. (1996). Traditional Healers and Childhood in Zimbabwe. U.S.A : Ohio Univeristy Press.

Rippere, V. & Williams, R. (1985). Wounded Healers: Mental Health Workers' Experiences of Depression. Great Britain: John Wiley & Sons Ltd.

Rodolfa, E.R., Kraft, W.A. & Reilley, R.R. (1988). Stressors of Professionals and Trainees at APA-Approved Counselling and VA Medical Centre Internship Sites. Professional Psychology: Research and Practice , 9(1), 43-49

Rosenthal, R. & Rosnow R. (1991). Essentials of Behavioural Research: Methods and Data Analysis (2nd Ed.). U.S.A.: McGraw-Hill Inc.

Rouff, L.C. (2000). Clouds and Silver Linings. American Journal of Psychotherapy, 54, (4, Fall), 549

Salzberger-Wittenberg, I., Henry, G., & Osborne, E. (1983). The Emotional Experince of Learning and Teaching. London: Routeldge and Kegan Paul Ltd.

Salzberger-Wittenberg, I., (1983) Beginning (Part 1). In Salzberger-Wittenberg, I., Henry, G., & Osborne, E. (1983). The Emotional Experience of Learning and Teaching. London: Routledge and Kegan Paul Ltd.

Salzberger-Wittenberg, I. (1983). Learning to Understand the Nature of Relationships (Part II). In Salzberger-Wittenberg, I., Henry, G., & Osborne, E. (1983). The Emotional Experience of Learning and Teaching. London: Routledge and Kegan Paul Ltd.

Skygger, R. & Schlapobersky, J.R. (1989). Institutes and How to Survive Them: Mental Health Training and Consultation. London: Tavistock/Routledge.

Smart, B. (1985). Michel Foucault. London: Routledge Press.

Steiner, J. (1994). Teaching the Theory of Psychotherapy: the relationship of theory to clinical practice. American Journal of Psychology, 46 (Winter)

Swartz, L. (1989). Aspects of Culture in South African Psychiatry. PHD Thesis, University of Cape Town, Cape Town.

Swartz, L. & Gibson, K. (2001). The 'old' versus the 'new' in South African community psychology: the quest for appropriate change. In Seedat, M., Duncan, N. & Lazarus, S. (2001). Community Psychology: Theory, Methods and Practice: South African and Other Perspectives. Oxford: Oxford University Press.

Swartz, S. (1999). Using psychodynamic formulations in South African clinical settings. South African Journal of Psychology, 29(1), 42-48

Thorpe, S.A. (1993). Shamans, medicine men and traditional healers. Pretoria: University of South Africa.

Torry, E.F. (1986). Witchdoctors and Psychiatrists: The Common Roots of Psychotherapy and it's Future. London: Hudson Ltd.

Van der Westhuysen T.W.B. & Plug, C. (1999). The Training of South African Psychologists: Summary of Findings of the PASA Council Committee for Training. South African Journal of Psychology, 17 (4), 165-169

Varma, V.P. (1997). Stress in Psychotherapists. London: Routledge.

Viljoen, D.J., Beukes, R.B.I. & Louw, D.A. (1999). An Evaluation of the training of psychologists at the University of the Free State. South African Journal of Psychology, 29 (4), 201-208

Watts, R.J. (1987). Development of Professional Identity in Black Clinical Psychology Students. Professional Psychology : Research and Practice, 18,(1), 28-35

Weiten, W. (1992). Stress, Coping and Health (Chap. 13). In Psychology: Themes and Variations (2<sup>nd</sup> ed.). California: Brooks Cole Publishing Co.

Wollersheim, D. M. & Walsh, J.A. (1993). Clinical Psychologists: Professionals Without a Role. Professional Psychology : Research and Practice, 24(2), 171-175

## Appendix A

➤ **Personal areas of vulnerability and their implications for the experience of the course**

Why do you think you had those particular struggles during the course?  
How have you made sense of your particular difficulties?

➤ **The impact of personal therapy**

Have you ever had the experience of being a client? What was that like?  
How do you feel about the recommendation that trainees be in personal therapy?  
Do you think that therapy has helped you?

➤ **The emotional experience of working with painful material brought by clients**

Did you prefer working with certain types of patients? Why?  
How did your clients/patients leave you feeling?

➤ **The demands of workload**

Was there a lot of work that you had to get through?

➤ **The work-home conflicts**

Did you find that you took work home?  
How did work affect your home life?  
Did you have enough time for family and friends or to relax.

➤ **The degree of support available for students at home or work**

Where did you get your support from?

➤ **The experience of being evaluated**

What were your feelings about being assessed?

➤ **The demands of being a professional or acquiring a professional identity**

As a student, did you find it easy to do therapeutic work with clients/patients?  
What do you think your role is? Is it different from what you think it 'should' be?  
Did you ever doubt your ability to do the therapeutic work with patients/ clients?  
Do you feel that you've changed since starting this course?

➤ **The experience of the student group**

What was it like being in the class of (19...)  
What were some of the difficulties that you experienced as a group?

➤ **The experience of the institution**

What do you think about the way the institution responded to your difficulties?