CHAPTER 2

PSYCHOTHERAPY TRAINING

IN SOUTH AFRICA

2.1 INTRODUCTION

My seventeen-year journey to become a clinical psychologist has had many rich and varied experiences. During this time I have gotten married, lived, studied and written Unisa exams on three different continents, given birth to my first child in Europe and my second in South Africa, moved residences eighteen times, held thirteen different jobs, changed careers three times, got ordained as a clergyperson and am still pursuing my dream to be a clinical psychologist despite all the distractions.

My journey towards becoming a psychotherapist has been as challenging as getting accepted into the clinical psychology master's program and indeed staying in it and surviving it. Unlike many other disciplines, gaining acceptance to engage as a student in the field of psychology is no mean feat. According to Stylianou & Havran (1998), medical students, for example, are ensured of realizing their dream of becoming a medical doctor, after they have been accepted at medical school. Their status as medical doctors is guaranteed if they pass each exam for the following six years. Potential psychologists go through a

much harder process which is characterized by much less certainty, and much more anxiety.

The first hurdle facing a potential psychologist is the successful completion of an initial bachelor's degree. The second hurdle is obtaining an excellent pass for the Honours degree. A good Honours pass creates the opportunity for applying for admission to the master's program. Eventually, having made it through the extensive application and referee phase, one *may* then be invited to participate in highly competitive and grueling selection processes. One is then invited to participate in a series of formal interviews where one really has to perform well in front of a selection panel of psychology professors. Added to this, one has to compete against hundreds of students for one of the few cherished places at each respective university that offers the master's program. Most universities admit only between five to ten students per year (Stylianou & Havran, 1998). Once admitted to a program, one to two years of full-time study is one of the formal requirements towards attaining a master's degree in clinical psychology.

Another formal requirement of the training program entails the completion of a dissertation. For me this has proven to be a complicating and frustrating aspect of the process. This dissertation represents my third topic with my third supervisor, seeming to be a symbolic struggle of my overall protracted journey. There is no doubt in my mind that this dissertation will always stand as a monument to, and proof of what can be achieved by persevering. My tribute to my own determination.

The written nature of this dissertation is unique. I haven't as yet encountered a clinical psychology master's dissertation that contextualises the journey of a trainee psychologist within the life story of that same person. I hope that the processes that are made explicit herein are as helpful and inspiring to other aspiring psychology students as they have been for me – even though on reflection I find it hard to believe that I survived the journey.

The formal processes of becoming a psychotherapist in South Africa is documented with specific reference to my journey at Unisa. The historical-political context in which mental health care and training needs to be understood is sketched. Thereafter the significant aspects of psychotherapy training in S.A. with reference to contexts of learning, developmental issues and supervision are outlined, as well as the formal requirements for, selection, training, qualifying and registering as a clinical psychologist in S.A. Lastly, an overview of my training and supervision experiences as encountered at Unisa are recounted.

2.2 DEFINING PSYCHOTHERAPY

Psychotherapy is an inclusive term that refers to "the use of absolutely any technique or procedure that has palliative or curative effects upon any mental, emotional or behavioural disorder" (Reber, 1995, p. 621). Psychotherapy is often used in its shortened form – therapy – and is generally associated with clinical psychology. Thus, the term psychotherapist is a broad term and generally refers to a person trained to practice psychotherapy.

In 1950, Raimy (1950, p.14) described psychotherapy as "an unidentified technique applied to unspecified problems with unpredictable outcomes for which vigorous training is recommended". More recently, Watkins (1996, p. 144) has defined psychotherapy as a "uniquely human endeavor made up of various elements like support, catharsis, regression, transference, practice, reframing, reorganization – which all exist in the service of treatment".

From the above definitions and descriptions it is clear that one could therefore describe a clinical psychologist in general terms as someone who is able to facilitate the healing process for a mentally ill person and/ or a person requiring therapy.

2.3 MENTAL HEALTH CARE AND TRAINING IN S.A.

For many years, the availability of mental health centers and resources was almost exclusively reserved for use by the minority of the nation, namely white South Africans. (Stylianou & Havran 1998, p. 6).

Presently a variety of health care professionals from various disciplines within the South African situation provide its people with mental health care facilities. These include social workers, mental health workers, clinical and counseling psychologists, psychiatric nurses, psychiatrists, community health personnel, mental health counselors and student volunteers in mental health (Terre Blanche & Durrheim, 1999).

Any discussion pertaining to health and more specifically, mental health care, in South Africa must take into account its socio-political and economic context of our recent Apartheid past (Seedat, 1984). During the Apartheid era of enforced

racial segregation health care for the majority of the population was more often an experience of suffering rather than healing. The legacy of unequal access to health care was structurally entrenched and its effects are still to be eradicated completely.

Any discussion on the provision of psychotherapy therefore cannot be conducted in isolation from the background of separation, discrimination and consequent racial tension caused by Apartheid (Lambley & Cooper, 1974). Mental health care, and subsequently mental health care training in South Africa is therefore a complex and racially charged topic of discussion. In 1985 Dawes challenged clinical psychology trainers to stop teaching as though mental health care occurs in a socio-political vacuum (Dawes, 1985).

As mentioned earlier, South African psychotherapeutic services have a history of widespread disparity and brutal discrimination. At the height of the political turmoil in South Africa in 1976, only 238 (mainly white) clinical psychologists had been trained in South Africa (Seedat, 1984). At that time the S.A. population consisted of 26,1 million people. As a consequence of discrimination embedded in the Industrial Conciliation Act No.28 of 1956, and the University Amendment Act No.83 of 1983, of the Apartheid regime, there is a resultant longstanding history of a shortage of psychotherapeutic services and trained psychotherapists within the S.A. black population.

Two bodies are currently addressing these inadequacies, namely the Health Professionals Council of South Africa (HPCSA) and the National Department of Health. The HPCSA has resolved that

" there should be at least 50/ 50 black/ white admission to graduate programs in psychology by 1 January 2004 and that by 2010 there should be a marked increase in black admissions" (official correspondence, dated 30 April 2001, from the HPCSA to all persons registered with this professional board).

The National Department of Health is currently attempting to address the shortage of psychological services with particular reference to the historically black rural areas, by introducing compulsory community service for clinical psychologists as from 2003 (www.doh.gov.za). This is a matter of government policy.

The shocking consequences of racial discrimination in psychiatric hospital care were uncovered by, inter alia, the APA (American Psychiatric Association) when they conducted an investigation (Seedat, 1984). The APA concluded that psychiatric care for blacks was grossly inferior to that for whites. They found "unacceptable medical practices that resulted in needless deaths of black South Africans" (Seedat, 1984, p. 52). Furthermore they found that "apartheid had a destructive impact on families, social institutions and the mental health of black South Africans" (Seedat, 1984, p. 53). Black patients had been laid open to physical and emotional abuse in private South African institutions, and instead of receiving therapy and support, according to Seedat (1984), they had been used as cheap labour.

Stylianou & Havran (1998) examine myths, misperceptions and biases about psychotherapy in South Africa, particularly with its roots in an Apartheid past. The S.A. Truth and Reconciliation Commission process seemed to usher in an era where some of these myths, misperceptions and biases tended to give way to an appreciation for the urgent need of psychotherapeutic services. When South Africans disclosed on national and international TV, the atrocities and gross human rights violations that had taken place in S.A., there appeared to be a greater recognition that many people in our country were and are in dire need of psychotherapy.

Given the history of discrimination in South Africa, mental health care services and training remains a challenging process.

2.4 SIGNIFICANT ASPECTS IN PSYCHOTHERAPY TRAINING

"As much as there is no single way to train effective therapists, there is also no single way to describe psychotherapy training" (Nel, 1996, p. 35).

There are at least four significant aspects in psychotherapy training that need to be taken into account, namely training, contexts of learning, developmental experiences and supervision. Psychotherapy training can be described as a set of systematically planned attempts at introducing trainees to a greater complexity and flexibility of thoughts, feelings and behaviour (Snyders, 1985). Supervision is regarded as an important component of the training of psychotherapists since it is during supervision that "an integration of learning and teaching principles, teaching models, teaching methods, learning problems and problems about

learning, occurs", and training and supervision are therefore integrally linked, in terms of "didactic, experiential, and process dimensions" (Snyders, 1985, p. 6).

2.4.1 Training

Most, if not all, trainees experience training as a journey (Alred in Bor & Watts, 1999, p. 253).

While training is defined generally as "the act or process of teaching or learning a skill or discipline" (Reber, 1995, p. 1479) there seems to be no consensus on the precise definition for psychotherapy training. Bor and Watts (1999) for example, define training as consisting of a mixture of a number of aspects. These include self-exploration in the form of personal therapy, supervised work with clients, skills acquisition, understanding theory and carrying out research. Scholars have thus tended to rather describe characteristics and elements that make up the training of a psychotherapist. In this regard Truax and Carkhuff (1967) have identified three characteristics of an effective psychotherapist. The first characteristic is that of being authentic or genuine and non-defensive during the therapeutic encounter. A second characteristic is having the ability to provide the client with a non-threatening, safe, trusting or secure atmosphere by acceptance, unconditional positive regard and warmth. The third characteristic is the ability to fully attend to the client in an empathetic manner and accurately grasping the meaning of issues raised by the client on a moment-by-moment basis.

Trainer-trainee relationships appear to be crucial in determining the overall development of the trainee therapist. Watkins (1996) recommends that,

specifically with beginning trainee therapists, the trainer provide clear, solid structure, direction, teaching, and guidance in order to facilitate the optimal development of a trainee therapist.

Watson (1996) stresses the importance of taking into account the life cycle stage of the trainee. As a mature female student, I was often older in years or the same age as my trainer. I also brought with me a range of life experiences unusual for black South African women. There were many occasions when I felt disrespected and undermined by various trainers. There were times when I felt that my years of life experience, my additional responsibilities and stressors made no difference in how I was treated and perceived by my equally mature trainers.

2.4.2 Contexts of learning

Peake & Ball (1991) have pointed out that recent considerations of training psychotherapists trace a growing awareness that good psychotherapy training is influenced by "extratherapy" variables such as the *context* in which it occurs and the *developmental issues* of the therapeutic trainee. Training contexts thus seem to have an impact on trainees in creating either a conducive or non-conducive climate for learning to do psychotherapy. This is a particularly important issue to pay attention to when one considers the deeply embedded and internalized prejudices imposed by the Apartheid state.

Psychotherapy trainers may therefore contribute to deferred contextual sensitivity by overemphasizing aspects like clinical skills, personality theory, and

therapy dynamics and underemphasising the influence of the context of learning. Consequently, a false impression may be nurtured that psychotherapy can be implemented in the same way in all milieus (Peake & Ball, 1991).

Various subsystems such as the psychotherapeutic centre, the supervisor, the supervisee and the client interact to create a context within which therapy takes place (Peake & Ball, 1991). Within these subsystems, a number of variables such as attitudes, behaviours and actions make up the environment that could give rise to potential areas of conflict. Dodds (in Peake & Ball, 1996) draws attention to the importance of understanding contextual issues in order to enable the trainer and trainee to function more effectively. He contends that these issues are often overlooked. He highlights the potential unawareness on the part of the trainer to factors that might give rise to conflict and consequently adversely affect learning and therapy. For example, the student may be unaware of the implicit rules of the university counseling centre. In addition, the trainer may fail to make the student aware of these implicit rules. The student may, for example, find himself/herself in a situation of conflict with other staff members and these interactions inevitably impact on therapy outcomes.

Snyders (1985), the current head of the psychology department at Unisa, has developed a model for training psychotherapists to become aware of the contexts within which they work. He proposes the linking of various systems with one another. More specifically he suggests the linking of the client system, the therapeutic system, the supervisory system, the observing system and the political system. Snyders' model thus represents a collection of organizing

17

principles designed to assist the supervisor in the process of uniting and separating from his/her trainees. The significance of this model is that it conveys the message that supervision ought to be "a context for various orders of learning by students and their supervisors" (Snyders, 1985, p. 304).

Similarly, Nel (1996) emphasises the importance of creating learning contexts that promote and facilitate the progressive emancipation of the trainee therapist until he/she can successfully separate from the training system.

While Snyders and Nel focus on a systems approach to dealing with context, others, like Webb and Wheeler (1998) draw attention to the power inequalities prevalent within the training context. Jansen (2001) in her analysis of supervisee-supervisor relations points out that supervisors occupy powerful positions relative to trainees. They are imbued with authority and have the potential to shape the professional and personal identity of the trainee.

In addition to an awareness of systems and power relations, Watkins (1996) draws attention to still a different dimension of the context of learning. He contends that the role of the supervisor is to provide a stimulating context for the supervisee that instills a sense of wonder, awe and curiosity about psychotherapy.

It is clear from the above that an awareness of the context of learning has become a critical aspect of the learning process. The above discussion has also highlighted the important role played by the supervisor within the context of

learning. It is clear that supervisors play a major role in creating and maintaining contexts for learning within which supervisees can either thrive and develop or feel stifled and inhibited.

2.4.3 Developmental experiences

Aponte (1994) assigns a dual quality to the training process, by assisting the trainee therapist to develop on a professional as well as on a personal level. Friedman and Kaslow (1986) subdivide the professional development of the therapist into six stages viz. (i) excitement and anticipatory anxiety; (ii) dependency and identification; (iii) activity and continued dependency; (iv) exuberance and taking charge; (v) identity and independence and (vi) calm and collegiality.

The trainee's family of origin, also needs to be taken into account according to Protinsky and Keller (1984), Hardy and Keller (1991) and Getz and Protinsky (1994). These authors feel that a family-of-origin approach enhances trainee development by enabling the identification of interpersonal patterns and thus the aversion of potentially troublesome dynamics (Protinsky & Keller, 1994).

Watson (1993) stresses the importance of the trainee committing to a self-analysis around gender, ethnicity, race and culture to ensure effectiveness in the supervisory process. She also highlights the importance of taking into account the life cycle stages of both the trainee and trainer, and the importance for the supervisor to relinquish his/her expert role and also become vulnerable.

Needless to say, the development of each supervisee is largely dependent on the relationship he/she forges with the supervisor. Thus the interpersonal characteristics of the supervisor, his/her style and demeanour are among the prime determinants of therapeutic effectiveness (Wolgien & Coady, 1997) and indeed the development of the trainee.

2.4.4 Supervision

Psychotherapy supervision has long been a key means by which beginning trainees learn to do psychotherapy (Greben in Watkins, 1996, p. 139).

Supervision has been defined as a "hierarchical arrangem ent of training in which a superior *oversees*, evaluates, suggests gives feedback to, pushes or advises a trainee" (Wendorf, 1984, p. 31). Providing a secure base, a supervisory holding environment, for supervisees is therefore of utmost importance (Watkins, 1996).

Four elements are crucial to the supervisory relationship namely accountability, power and authority, personal awareness, and trust (Kaiser, 1992). According to Henderson, Cawyer and Watkins (1999), and Kaufman and Korner (1997) the trainers' interpersonal characteristics like support, understanding, tolerance, encouragement, warmth, respect, empathy and flexibility are just as vital in order to ensure effective supervision.

Sometimes it is equally helpful to know what to avoid or minimize in supervision. Watkins (1997) found five studies that provided information about poor, bad or ineffective supervisory habits. Some of these habits involved the following: low

empathy, low support, failure to consistently track supervisee concerns, failure to teach, being indirect, intolerant, closed and lacking respect for differences.

The importance of the supervisor's own developmental stages are also considered to be critical in determining the effectiveness of supervision. Rodenhauser (1994) identified four supervisory stages namely emulation, conceptualization, incorporation and consolidation. This is a further development of Hess's (1986) three stage supervisory development process. Hess labels his stages as beginning, exploration and confirmation of supervisor identity.

While Rodenhauser and Hess use different words to describe the first phase of the development of a supervisor, namely 'emulation' and 'beginning' respectively, they in fact describe the same process. For both authors this stage marks a role transition from supervisee to supervisor where the supervisor generally models his/ her previous supervisors.

The middle stage for Rodenhauser is bi-phasic i.e. conceptualisation and incorporation, whereas for Hess it is uni-phasic i.e. made up of one stage which he calls 'exploration'. This is the stage where the supervisor discovers and establishes his/her unique approach/es to supervision.

The final stage which Rodenhauser calls 'consolidation' and Hess calls 'confirmation' of the supervisory identity, is marked by the individuation of the supervisor and the development of his/her consolidated identity through balancing theory and experience.

It is therefore safe to conclude that supervision is enhanced when the supervisor is aware of the developmental phases that impact on the quality of the supervision provided to the supervisee.

A critical aspect in the development of the trainee is the quality of the feedback and constant evaluation conducted by the supervisor. Evaluation is thus vital in enhancing the training of the supervisee since this process enables supervisees to track their development and skills acquisition (Jansen 2001). Henderson, Cawyer and Watkins (1999) affirm that even though students reported evaluation-related anxiety, all were unanimous in declaring the importance of feedback and how essential they considered it to be in ensuring effective supervision.

Bor and Watts (1999) contend that the way in which the supervisor and supervisee negotiate how the supervisee's practice will be evaluated is vital to their relationship. Watkins (1996) recommends that, specifically with beginning supervisees, the supervisor needs to provide clear, solid structure, direction, teaching, and guidance.

The quality of the relationship between the supervisor and the supervisee is further enhanced by the supervisor's ability to develop a healthy balance between the didactic and the experiential aspect of the work. Rubin (1997) highlights the dual responsibility of the supervisor as that of facilitating both client benefit and therapist development through maintaining this balance.

Supervisors therefore can be likened to midwives who facilitate the birthing process of brand new therapists. The context is a fragile one where the slightest error on the part of the midwife could be life-threatening. No doubt the process for the trainee is painful, uncomfortable, and fraught with the overwhelming sense of helplessness, and dependence. Like all successful births, the midwife is the one who successfully delivers the baby and yet is forgotten. Sometimes, however, the midwife is remembered forever! On the other hand, there are instances where babies are born without the assistance of a professional midwife – for example on the back seat of a car. In short, babies miraculously survive the birthing process regardless of who may or may not assist the birthing process.

2.5 FORMAL PROCESS FOR BECOMING A CLINICAL PSYCHOLOGIST

It takes a total of about seven years of formal full-time study to become a clinical psychologist in South Africa. The processes governing the admission of students into the discipline of psychology vary from university to university as does the duration of the course itself.

Higher education in South Africa is currently undergoing a radic al transformation. Formerly independent and elitist institutions are being merged with historically disadvantaged institutions. In this way it is hoped that more learners will enjoy access to better education and training opportunities.

It is with the transformation context in mind that the discussion below provides a brief descriptive overview of the formal processes and requirements for the training and ultimate registration as a clinical psychologist in South Africa. In so doing I will describe the various categories of psychologists currently registered in South Africa, the formal qualifications required, and the selection processes.

2.5.1 Various categories of psychologists

There are currently five distinguishable categories within the field of psychology. These are clinical, counseling, educational, research and industrial psychology.

According to Stylianou & Havran (1998) the current categories all require the successful completion of an approved Master's degree obtained from a South African university prior to formal registration at the HPCSA. While the discipline of psychology can be more broadly described as facilitating the development of mental health, each category or branch of psychology has its own unique emphasis and specialization. The emphasis in clinical psychology is generally on abnormal psychology, psychotherapy and psychological testing. A clinical psychologist may work in public or private practice, psychiatric or general hospitals, drug and alcohol dependence centers, child and family therapy institutes and mental institutions. The training of a clinical psychologist focuses on healing and treating mental conditions and more severe psychological cases (Stylianou & Havran, 1998). The training is clinically based. Practical training is mainly conducted in hospitals and internships take place either in a psychiatric institution or in a general hospital where working in the psychiatric department is compulsory. Counseling psychologists tend to work at organizations such as

universities and counseling centers providing counseling services. The training of educational psychologists focuses on educational matters such as psycho-educational assessment, aptitude testing and the assessment of learning difficulties. Research psychologists focus on psychological research and this category is 'theoretical' in nature as opposed to practicing psychotherapy that is more 'clinical' in nature. Finally, industrial psychologists primarily focus on people's experiences and behaviour in the work environment as well as organizational behaviour and design (Stylianou & Havran, 1998). Industrial psychologists are generally, though not exclusively, more suited to make valuable contributions to the human resource management departments of organizations.

2.5.2 Formal qualifications and registration

In South Africa, anyone referring to him/herself as a clinical psychologist must be registered with the HPCSA. In order to register with the HPCSA, the candidate needs to have completed a Bachelor's degree (3 years full-time) with a major in Psychology, an Honours degree in Psychology (1 year full-time), a Master's degree in Psychology (1 to 2 years full-time depending on the university), a one year internship at an institution approved by the HPCSA and finally a one year community service program. The community service program as determined by the National Department of Health marks the beginning of professional practice for a clinical psychologist.

2.5.3   Selection processes

In order to be admitted into a master's program, students have to undergo rigorous selection processes. The type and length of the selection process is largely dependent on the university offering the course. For ease of description I have chosen to describe the selection process in two phases.

The first phase is the formal application phase and can be labeled the administrative screening process. Prospective Master's degree program psychology students have to complete detailed application forms in respect of biographical details, achievements as well as structured and unstructured questions. Some universities also require life stories and/or motivational compositions as to why one thinks one ought to be selected. Two referees, appointed by the candidate, have equally detailed questionnaires to complete with regard to the candidate's suitability or non-suitability for the program.

The first phase is governed by strict adherence to deadline dates for submissions from both candidate and referee.

The second phase is more personal and among others involves a face-to-face encounter between the applicant and a panel of psychology professors. Those candidates who were successful during the initial phase of selection are formally invited to the second phase of selection. This second phase of the selection processes can last between three to five days and includes a series of role-plays, individual and panel interviews, writing and analytical skills testing, open discussions and debates.

The competition is stiff and the experience is anxiety producing, especially when one realizes that one is one of at least 300 candidates competing for limited places. At Unisa, only eight to ten students are finally selected from a total of about 350 applicants.

2.5.4 Universities offering clinical psychology courses

There are sixteen universities in South Africa that offer training for clinical psychologists. These universities (listed in alphabetical order) are as follows: University of Cape Town (UCT), University of Durban-Westville (UDW), University of the Free State (UOFS), Medical University of South Africa (MEDUNSA), Natal University, University of the North-West, University of Port Elizabeth (UPE), Potchefstroom University, University of Pretoria (UP), Rand Afrikaans University (RAU), Rhodes University (RU), University of Stellenbosch, University of South Africa (Unisa), University of the Western Cape (UWC), University of the Witwatersrand (WITS), and University of Zululand.

Like all training institutions and disciplines during the Apartheid era, universities were also racially segregated. Since Unisa was a distance-education institution as opposed to a residential campus, it escaped the need to enforce segregated amenities for students. However, Unisa did not escape the Apartheid education philosophy completely since it was forced to succumb to hosting separate graduation ceremonies for black and white students.

Understandably then, the discipline of psychology training, like most other elements of South African society was saturated with a history of ingrained prejudices and stereotypes. The impact of these prejudices on the course offerings and curriculums is still being felt today.

A wide range of subjects is offered at the various universities offering a master's degree in clinical psychology. The required and optional courses vary from university to university. I have chosen to highlight the courses offered at four universities in order to illustrate the variety of courses offered.

At Stellenbosch University the clinical psychology master's training is structured as follows: Clinical Assessment I: Clinical Interviewing, Clinical Assessment II: Psychological Testing, Psychopathology, Person-centred psychotherapy, Cognitive-behavioural therapy, Clinical child and adolescent psychology, Family therapy, Crisis Intervention, Psychopharmacology, Forensic Psychology, Professional Ethics, Clinical Neuropsychology, Group Therapy, Hypnotherapy and Mental health policy (http://www.sun.ac.za).

University of Port Elizabeth's clinical psychology department's training course outline is compiled as follows: In the first year: Psychopathology of adulthood and aging, Assessment of children and adolescents, Individual Psychological Intervention A, Integrative Models of Individual and Group Psychological Intervention, Group Psychological Intervention B, Child Neuropsychology, Professional issues in Psychology, Child and Adolescent Development, Group Psychological Intervention D, Psychopathology of Childhood and Adolescence,

Assessment of Adults, Group Psychological Intervention A, Group Psychological Intervention C, Adult Neuropsychology, Individual Psychological Intervention B, Individual Psychological Intervention C, Individual Psychological Intervention E, Psychological Testing Theory, Research and Presentation and Treatise (http://www.upe.ac.za/psychology).

University of the North-West's clinical psychology master's training encompasses the following: Personality Theories, Psychodiagnostics, Advanced Psychopathology, Individual Psychotherapy, Marriage and Family Therapy, Group Psychotherapy/ Counseling, Child Psychotherapy, Neuropsychology and Thesis (http://www.uniwest.ac.za).

University of the Witwatersrand Master's Clinical Training Coursework entails the following: Alexander Clinic: Psychological Services, Neuropsychological Assessment, Case Presentations, Developmental Theory, Family Therapy, Psychiatry, M1 Psychotherapy Supervision, M2 Psychotherapy Supervision, Trauma Clinic, Psychotherapy Theory and a Research component (http://www.wits.ac.za).

A cursory survey of the institutional location of Psychology Departments within the university setting indicates a variety of locations. For example, some have located it within the Faculty of Arts (Port Elizabeth, Pretoria, RAU, Stellenbosch, Unisa, WITS). Others have located the Psychology Department in the Faculty of Humanities (Free State), and still others in the Faculty of Humanities and Social Science (Natal).

As one would expect, each university places its unique stamp on its training emphasizing its particular orientation. There is no doubt a wide range of emphases to choose from, including a psychoanalytic, phenomenological-existential, behavioural and cognitive, person-centred, a family systems, and an eclectic approach. For example, Rhodes University tends to have a strong phenomenological-existential orientation as well as a strong community psychology focus (Stylianou & Havran 1998). The University of the Witwatersrand emphasises a family therapy course based upon a systemic orientation with integration from a Psychoanalytic perspective (www.wits.ac.za). Unisa focuses on a cybernetics and general systems approach.

2.6 TRAINING AND SUPERVISION AT UNISA

The Master's in Clinical Psychology program offered at Unisa is a two-year residential full-time study course – unlike RAU that is a one-year full-time study course. The program is anchored in the Cybernetics and General Systems Theory (Fouche, 2000). A family therapy approach to psychotherapy is the model of choice at Unisa. A cursory glance of the list of prescribed publications is indicative of their favoured model and includes the work of Auerswald (1985), Haley (1963), Hoffman (1981), Minuchin (1974), Watzlawick, Weakland and Fisch (1974). The didactic aspect of the training is geared to familiarize students with systemic conceptualization and the experiential component exposes students to a wide variety of clinical settings.

With the benefit of hindsight there seems to have been an imbalance in terms of the exposure to other approaches and models. While the emphasis at Unisa is the systems approach, it would have empowered students more if they were more 'broadly' exposed.

It would appear that the responsibility and role of course coordinator for the Master's in Clinical Psychology program at Unisa rotates regularly amongst various members of the department. Professor Stan Lifschitz was the course co-ordinator during the period of my training (2000-2002). Eight lecturers participated in our training over a period of two years. We were required to attend classes at Unisa for approximately three to four days per week during the first year and for four to five days during the second year. Since Unisa is a distance learning institution, it does come as a surprise to most that I was compelled to attend classes almost every day. The Master's in Clinical Psychology is one of the few post-graduate courses at this distance education institution that requires daily residential attendance.

As mentioned above, the training of a clinical psychologist in South Africa can be described in five broad categories namely, Theory, Practicals, Research, Internship and Community Service. At Unisa, the theory, practical and research components are covered during the two year residential course work curriculum. Each of these three components carries equal weight (Unisa, 2003). The fourth component comprises one year of internship at a HPSCA approved institution. The fifth component i.e. one year of full-time compulsory community service

commences once the internship and the dissertation of limited scope, have been successfully completed.

2.6.1 The theoretical component of training

Duhl (1983) says that the key for each training program seems to be found in the trainers' perceptions and conceptualisation of training and teaching as well as the actual implementation thereof. The compulsory theoretical component which was taught during both years of study covered a wide range of topics including, psychodiagnosis, testing and differential diagnosis, therapy according to different theoretical models in individual, family and group situations, community psychology, an introduction to the ecosystemic approach to psychology and a module on ethics (Unisa, 2003).

The content of the first year course of theoretical study was compiled by the co-ordinator and circulated by the student co-ordinator. Five lecturers were involved in our training during the first year of my study. They presented a wide range of courses covering an introduction to assessment, ecosystemic thinking - a conceptual history (readings included those of Bateson, Capra, Whitaker, Auerswald, amongst others), first and second order cybernetics, a focus on the self in therapy, an introduction to family therapy, community psychology – an introduction to models and practice, an introduction to group therapy and a course on the modalities of practice.

Once a month, on a Friday, workshops for the first and second year clinical master's students were facilitated by outside speakers covering topics like

alcohol abuse and psychoneuro-immunology. Towards the end of our first year, we also attended workshops facilitated by the then second year students as part of their and our formal training program. The students were encouraged by the trainer to focus and address issues pertaining to their personal and professional development. One student, for example, focused on suicide, while another dealt with fatherhood.

At the end of the first year of study, students were evaluated by means of two projects, two academic papers, one written exam and one oral exam at the end of the first year. We received verbal one-on-one feedback from the course co-ordinator explaining our overall achievements and accomplishments.

The second year of theoretical study included a wide range of topics. These were, research praxis, theories and practice and preparing for internship, hypnotherapy, teddy bear therapy, rituals and ceremonies in the practice of therapy, and workshopping – themes and issues of therapy.

Liddle, Breunlin & Schwartz (1988) recommend that trainers and trainees interact in order to negotiate, define and shape the training. At times, we as students approached certain supervisors in order to communicate our needs and desires – the trainers' responses varied. For example, during our second year, we requested DSM-IV input, in preparation for internship. We were promptly told to organise it amongst ourselves. Subsequent to our enquiry, DSM-IV training has been incorporated into the program of the first year curriculum at Unisa.

At the end of the second year of study students were evaluated by means of four projects, two academic papers, one written exam and one oral exam. We received a verbal one-on-one report from the course co-ordinator as well as a final marks sheet of percentages attained in three areas namely practicals, orals and theory. The evaluation with regard to the practicals included assessment for training received at the psychotherapy clinic, the rehabilitation clinic, research praxis and clinical workshops. The assessment regarding theory covered neuropsychology, research and a final clinical paper.

The course co-ordinator as well as the external examiner who had been present during the final oral examination signed the final marks sheet.

The implementation / roll out of the two year of theoretical component during my training was not without its problems and difficulties. It is perhaps useful to recall the recommendation of Watkins in this regard. Watkins (1996) recommends that, specifically with beginning supervisees, the supervisor should provide clear, solid structure, direction, teaching and guidance. We received our finalized timetable for the first curriculum year of our training on 08 June 2000 – five months after the commencement of the course. At the time of receiving the timetable, we were still unsure whether we would be sitting for written or oral exams in June/July of that year. A course on narrative therapy appeared on our timetable but this wasn't offered. I do not recall an official explanation being offered to us, but apparently the lecturer had retired.

The effect of lack of timeous notice and the obvious lack of planning on the part of the course co-ordinator was negative, especially for me, a student who needed to plan carefully due to family constraints.

In terms of the evaluation of the theoretical component it may be useful to reflect on the comments of Prentice, a psychologist who went through the theoretical component one year before me. Prentice (2000) highlights the inconsistency and confusion around issues pertaining to the evaluation at Unisa. Towards the end of our second year we requested a mutual feedback session where we could give input with regard to our training experiences – this was not encouraged by the course co-ordinator. However, the Monday morning group sessions during our first year of training provided a safe context for trainees to raise concerns related to training. I feel some of our concerns had been heard by a trainer during our first year in the group sessions on Monday mornings.

2.6.2 The practical component of training

The Unisa handbook (Unisa, 2003) describes the practical component of the curriculum as covering three broad areas. These are the application of psychological assessment techniques under supervision, weekly training in psychotherapy with direct supervision and training in report writing.

A particular Unisa feature of the practical component is that it took place during both the first and the second year of the full-time study program. In other words the practical component of my training at Unisa was interwoven into the two-year residential timetable that was dominated by the theoretical coursework.

During our first year of practical training all students spent every Wednesday (from approximately 08H00-18H00) at the practical training site called Agape, located in Mamelodi, an African township situated in the east of Pretoria. This psychotherapy clinic, Agape, was founded in 1989 by a number of academics from the psychology department at Unisa (Jansen, 2001). The clinic is conducted in the open-air. There are no rooms, or houses, in which private consultations can be conducted. During the harsh hot summers and the bitterly cold winters, the sky serves as the roof, and a huge eucalyptus tree in the parking lot provides the only sparse shade available. While Agape is the descriptive name used to identify the psychotherapy clinic, the activities of the clinic itself take place in the parking lot of the Mamelodi YMCA. The only physical structure linked to the clinic is a small lapa (a thatched hut with low walls on one side only) built on top of a piece of cemented ground no more than three square metres. Agape is thus an open-air psychotherapy clinic where the norms of western-styled privacy are supplanted by a context of therapy under a tree in full view of the general public.

Three supervisors provided individual and/or group supervision for approximately twenty students at the Agape site. Five students were from Unisa's first year clinical master's program, three from Unisa's second year clinical master's program, two from the clinical master's program at RAU, 3 from the RAU community master's program, 5 from the RAU Honours bridging course and the remaining were students who had a keen interest in psychology and weren't in any formal university program. The supervision took place in the YMCA parking

lot amidst the bustle of the daily activities at the YMCA in Mamelodi. Additional group supervision, away from Agape, was provided during the middle of the year, as a result of the concerns raised by the Unisa students. The Unisa students felt that they were not getting adequate supervision at Agape. The solution was additional supervision (1-2 hours) provided by the Unisa lecturer on campus and on the day after the Agape sessions, namely Thursday mornings.

It is necessary to point out that the practical training that took place at Agape was probably more beneficial in terms of 'exposure' rather than pure training and supervision per se. It sensitized the mainly white student group to an environment of poverty, lack of resources and a re-negotiation of issues such as privacy and effectiveness of therapy when there are huge language difficulties between client and therapist. The students' need for additional supervision was probably indicative of the need for a better contextualisation of the Agape experience. In this regard Watkins (1996) emphasises the importance of providing a holding environment for supervisees in order to prevent demoralization. Agape psychotherapeutic services were handled in an informal manner, as was the supervision. Experiences of supervision as captured in Jansen's (2001) dissertation coincide with mine. Jansen draws one's attention to the sheer impossibility of three trainers providing adequate supervision for approximately twenty students on any given Wednesday.

When I did manage to secure supervision at Agape, my experiences concur with those of Prentice's (2002) as lacking in clarity, being anxiety provoking and inconsistent. In addition to this I struggled with constant feelings of

powerlessness and confusion. The lack of privacy at Agape, the persistent noise, the pungent smells and lack of protection from harsh climatic conditions impacted on my work. The adverse conditions not only hampered client-therapy sessions, but also supervision sessions.

During the second year the practical training program took place at a variety of clinics. Unlike the open-air Agape environment, these clinics conformed to the normative classic therapeutic context. Three different experiences were encountered namely a conventional hospital setting, a rehabilitation clinic and the university campus clinic.

On Tuesday mornings we performed neuropsychological assessments at Pretoria Academic Hospital's Rehabilitation Clinic. Cases and reports were discussed either in groups or one-on-one, and the Unisa neurospychology professor facilitated these discussions. Reports were formulated and once the professor was satisfied with the quality and content of the reports, they were presented to the patient and/or family and a staff member of the rehabilitation clinic.

In sharp contrast to my experience of supervision at Agape, I felt stimulated and stretched during neuropsychology supervision periods. I felt that this Unisa professor respected my opinion, handled me with empathy and support, and had a high regard for my previous experience as a health care worker.

On Tuesday afternoons from 13H00 to 18H00 we conducted therapy behind a one-way mirror at the Unisa Psychotherapy Clinic on the university campus. The therapist/s and the client/s sat in the therapy room that was equipped with a two-way telephone system enabling supervisees and supervisors from either side of the one-way mirror to communicate with one another. Fellow-classmates and one trainer from a tiny room adjacent to the therapy room provided live supervision. This room was equipped with a TV and video. All sessions were video-recorded with the permission of the client. An interactional analysis of the sessions was handed in after every session with every client.

The live supervision with instant feedback via two-way telephones, and the trainees joining their colleagues behind one-way screens seemed to elicit variable responses. Typical issues pertaining to this type of family therapy supervision included the fear of evaluation, competitiveness with fellow-students, and trainee's spontaneous emotional and physical responses to clients.

On Wednesday mornings we provided therapy for patients with chronic pain at the Pretoria Academic Hospital's Pain Clinic. Reports were written and handed in to a supervisor at Unisa. Sometimes a report was discussed between the trainer and trainee before being signed by the trainer. A copy signed by both the trainee and trainer was then given to the Head of the Pain Clinic.

In addition to the practical clinical work each second year student was required to facilitate a workshop in the presence of all of the first and second year

students as well as the trainers involved in our training. My workshop focused on loss in relation to forced removals.

2.6.3 Research

A formal requirement for graduating with a Master of Arts degree, MA in Clinical Psychology at Unisa, is the completion of a dissertation of limited scope, in collaboration with a supervisor. Internship may proceed irrespective of whether the dissertation is completed or not. However, before commencing community service, the dissertation must have been passed successfully by two internal Unisa examiners and one external examiner. It is not required that the identities of the second internal and the external examiners be revealed to the student.

2.6.4 Internship

The completion of a 12-month internship is compulsory for all Unisa MA Clinical Psychology students. A pre-requisite for commencing internship is that the theoretical and practical components, as stipulated by Unisa, must have been successfully completed. Another selection process occurs each year during August, prior to placement at an institution that has been approved by the HPCSA. Some trainees manage to secure paid internships (i.e. one receives a minimum wage), while others are trained at their own costs. I was one of the fortunate trainees to have secured a paid internship.

My internship took place at two hospitals namely Helen Joseph Hospital and Coronation Hospital. The first four months of my internship I worked at Coronation Hospital. At Helen Joseph Hospital I worked in the psychiatric ward

from May until August of that year, and in the Out Patient Department (OPD) from September until December. Amongst other things, we were required to complete twelve assessments (neuropsychological, school and personality assessments) over the twelve-month period.

The location of the internship (also known as 'placement') is not automatic. One applies at various hospitals and applicants may or may not be invited for selection interviews. Some students apply in different provinces and travel to these provinces at their own cost. If a potential intern is unsuccessful in being offered either a paid or unpaid placement at the various hospitals, the student may negotiate his/ her own internship program. Strict criteria are set out by the HPCSA and have to be fulfilled prior to internship commencement. Some of the criteria include the availability of at least one qualified clinical psychologist, with a minimum of three years' experience, to oversee the internship as well as exposure to a wide variety of experiences e.g. adult and child counseling, psychiatry and psychometric testing. If a student wishes to qualify for a paid internship, he/she needs to go through a selection process, which is conducted by the institutions where the placement/ internship is available.

If a student wishes to be considered for a non-paid internship, the selection process is less vigorous but is still dependent on the institution in question and the availability of places or vacancies for interns. The HPCSA must ultimately approve the candidature at the recommendation of the institution where the candidate wishes to serve as an intern.

In addition to the availability of funds, there are a number of factors that impact on the placement of students. These include the availability of supervisors, the practicalities/ logistics such as travel, the scarcity of institutions at which to serve during an internship and the range of treatment/clinical exposure given the needs of clients presenting at particular institutions.

Attending a formal one-day induction and orientation session is highly recommended by the Head of the Psychology Department (HOPD) at Helen Joseph Hospital (HJH) where I did my internship. All the members of the Psychology Departments at Helen Joseph and Coronation Hospitals, the interns of 2001 and the interns for 2002 were introduced to one another and the Head of Department provided formal orientation information packages on 5 December. I took up my post about a month later on 2 January 2002.

The Psychology Department at Coronation Hospital was officially accredited as a training department in 1998. Helen Joseph and Coronation Hospitals were officially pronounced one complex in 1998 – Coronation Hospital serving as a mother and child hospital and Helen Joseph serving the adult population. In 1998, therefore, as a result of Coronation Psychology Department's official accreditation, the two departments commenced the rotation with the interns. (Clinical and Community Counseling Psychology Interns' Orientation Manual – Coronation Hospital, 2002)

Coronation Hospital is situated in a sub-economic area called Westbury, notorious for its high incidence of gang violence, domestic violence, alcoholism

and an unemployment rate of 60%. Westbury used to be a predominantly Malay and coloured area. However, over the past five years or so, families from predominantly African townships such as Soweto and Orange Farm have migrated to this area. There are essentially two main reasons for this. Firstly, Westbury township is closer to the city center, more central, making access to job opportunities far easier. Secondly, Coronation and Helen Joseph Hospitals have a reputation of providing good health care. During the Apartheid era, Coronation Hospital used to provide service for the medical needs of the Malay and coloured population. Helen Joseph Hospital was reserved exclusively for whites. My four months at Coronation Hospital were reminiscent of my childhood at two levels. It visibly reminded me of my growing up, and experientially reminded me of my exposure to the health care system as an asthma patient. There were times when I was painfully confronted with my past. At other times, I enjoyed being able to contribute to a community that desperately needed mental health care services.

Clinical intern psychologists rotated between Coronation and Helen Joseph Hospitals on a four monthly basis. My responsibilities during my rotation at Coronation Hospital were extensive. They included seeing booked patients referred by the paediatric department and other allied departments (e.g. social work and occupational therapy), the developmental clinic and sexual abuse clinic, outside agencies and self-referrals. It also included conducting psychometric assessments of children and adolescents to assist with diagnosis and placement, attending at some of the doctors' clinic meetings, doing a presentation at doctors' clinical meetings, giving feedback at the developmental

clinic meetings and doing a presentation at two or more psychological journal club meetings. In addition I conducted crisis interviews, participated in the Family Therapy Clinic, liaised with doctors, nurses and other staff from allied departments and attended weekly supervision sessions with a registered psychologist at HJH.

My internship at Helen Joseph Hospital was very reminiscent of my having worked as a nurse in various wards including the psychiatric ward at Groote Schuur Hospital in Cape Town. Quite often I'd find myself slipping into the role of nurse e.g. I'd fetch a bedpan or urinal for a patient when he/she needed one, or I'd rearrange the bed linen to make the patient more comfortable, or I'd feed a patient who needed help with feeding. I once stopped myself from suctioning a patient's endotracheal tube.

I gained an incredible amount of experience during my rotation in the psychiatric ward at Helen Joseph Hospital. This included gaining experience of psychopathology and psychopharmacology in a psychiatric population, and becoming familiar with the psychiatric language of the DSM-IV classification system. In addition I gained experience in admitting new patients by assessing their suitability for psychotherapy during the weekly psychiatric clinic. I also assessed the suitability of referred patients for psychotherapy. I saw inpatients for psychotherapy (in a family, group and individual context, and for psycho-education). I conducted psychometric assessments with regard to intelligence, projective, neuropsychological, and personality tests to assist with diagnosis and treatment of inpatients. I attended and participated in daily handover meetings,

44

made clinical presentations to members of the psychiatric ward, lectured medical students on various aspects of psychology, attended to medical consult referrals (i.e. ward patients whom the medical doctor felt required mental health services) at certain prescribed times and attended weekly supervision sessions with a registered psychologist at HJH.

I also worked in the outpatients department. Some of my responsibilities during my Out Patient Department rotation included seeing patients for psychotherapy (in a family, group and individual context, and for psycho-education), assessing suitability of referred patients for psychotherapy, conducting psychometric assessments (intelligence, projective, personality) to assist with diagnosis and treatment of patients. I attended to medical consult referrals at certain prescribed times, facilitated a weekly HIV/AIDS support group, organized and presented a two-day HIV counseling course for selected hospital staff. I also attended weekly supervision sessions with a registered psychologist at HJH. I thus gained experience in short-term and medium-term psychotherapy with both psychiatric and non-psychiatric patients.

2.6.5   Community service

In February 2002, the National Department of Health announced its policy on community service. In short the policy states that as from January 2003 onwards, seven occupational groupings, in addition to medical doctors, would be compelled to do community service for one year at a location decided by the National Department of Health. One of the groupings includes clinical psychologists. As previously indicated, a dissertation must be successfully

completed before community service can commence. The trainee must initiate a formal application to the National Department of Health that then determines where to place clinical psychologists, taking into account as far as possible the selection priorities of the applicants. No clinical psychologist is allowed to practice independently until this community service requirement has been fulfilled. The community service psychologist functions as a 'qualified' psychologist but will only get registration papers after community service. This seems to be the government's way of ensuring that psychologists don't leave the country before completing community service.

2.7 CONCLUSION

The practice of mental health care in South Africa has an appalling history and legacy to overcome. The rectification of the imbalances both at the level of trained black clinical psychologists as well as making quality mental health care available to the majority of South Africans remains the challenge.

The formal processes that govern the training and certification of a clinical psychologist in South Africa, as outlined above, are daunting. Unisa's specific application of the formal requirements is designed to provide the learner with as thorough a preparatory training as possible. The two years of course work interspersed with the mandatory practicals provide a well-balanced training program albeit a year longer than most other institutions. While the program is intense, it is not without its difficulties and shortcomings.

The training process and journey of a trainee psychologist as outlined in this chapter should ordinarily take no more than seven years of full-time study. My journey has lasted seventeen years.

I had not thought of documenting my seventeen-year journey until my previous supervisor, Patricia, suggested that I do so in terms of an autoethnographic approach. As previously indicated, the documenting and data gathering and collation process took place during January and March 2003. It is this process of data collection and the underlying epistemological assumptions to which we now turn our attention in the following chapter.