

**A thematic analysis of the obstacles faced by student and intern
psychologists whilst conducting their first therapy sessions**

By Jeethen Ramnanan

Faculty of Humanities and Social Sciences

Department of Psychology

University of Zululand

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Supervised by Prof J. D. Thwala

Co-supervised by Dr C. Hermann

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DECLARATION

I, Jeethen Ramnanan, declare that:

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ABSTRACT

A novice therapist, by virtue of his or her professional status, is exposed, and often susceptible to a plethora of obstacles and challenges which stem from a variety of sources. These include deficits in clinical experience and reasoning, interpersonal conflicts, intrapsychic dynamics, as well as a multitude of other challenges which exist within the field of psychotherapy.

Thus, this research investigation is rooted in fully exploring, understanding and verifying the most significant obstacles and challenges encountered by student and intern psychologists in the greater KwaZulu-Natal region. The uniqueness of the dynamics of the South African society must be highlighted, South Africa being a confluence of cultural, racial, traditional and social norms which add to the body of challenges and obstacles that the psychologist can be expected to encounter and negotiate.

The major findings of this research investigation were that majority of the obstacles and challenges faced by student and intern psychologists are indeed linked to clinical inexperience and the chasm between theoretical academic knowledge and practical, clinical application needs to be bridged. Another facet of this investigation analysed the strategies, techniques and methods employed by the participants to overcome or minimise the impact of these obstacles.

Key words: Obstacles, intern psychologist, psychologist, client, student psychologist, intrapsychic dynamics

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Chapter one

This chapter encompasses an introduction, motivation for, and aims of, the study.

1.1 Introduction

According to Halgin (1999), a therapy session is a planned, emotionally charged, confidential interaction between a trained, socially sanctioned healer and a sufferer. Stevenson (2008) provides an alternate definition of psychotherapy describing it as “an intimate, intense, and transitional space in which the therapist and patient are encouraged to ‘play’ within their counter transference”. Optimally, this means it is a creative and expansive space where therapists and patients allow any thoughts, feelings and fantasies to emerge, allowing formerly foreclosed or subliminal experiences to unfold, be considered and better analysed. Truscott (2010) asserts that psychotherapy is a modality of healing that is intended to reduce human suffering and aid in improving quality of life and wellbeing.

Research findings have revealed that clinicians are faced with many challenges when preparing to meet their clients for the first time and in the ensuing interactions during the hour to conceptualise their experience into a theoretical framework (Skovholt & Ronnestad, 2003). While clinicians focus on acquiring certain techniques such as attending and responding, this tendency to operate from within a particular theoretical perspective has its limitations. This is perhaps why Fontaine and Hammond (1994) argue that clinicians are unable to grasp the broader conceptual foundations and cognitive skills that are needed in the counselling process.

Despite the relative paucity in the literature pertaining specifically to obstacles within the first therapy session, it was deliberately chosen for this research investigation due to its immense clinical significance. It lays the foundation for the clinical interventions and treatment protocols which will ultimately effect change. MacEwan (2009) states that despite it being a critical time in the therapeutic continuum, the first therapy session has not received due empirically and empirical consideration. The first therapy session can be seen as a foundation upon which a therapeutic alliance is built. It is at this juncture where clients and psychologist meet and assess each other in order to establish if they can in fact work together and achieve effective change (Luborsky, 2000)

1.2 Motivation for the study

The Health Professions Council of South Africa (HPCSA) is a statutory body, which presides over the wide array of health care professions within the country. Encompassed in the domain of psychology, HPCSA stipulates clinical and ethical guidelines in the form of policies and protocols which are implemented to ensure adequate training and practice, in terms of skills, knowledge, and exposure for the intern and student psychologists. However despite these guidelines, student and intern psychologists are still faced with the arduous task of transforming their academic and theoretical groundwork into refined practical competencies. It is therefore the researcher's intention to use this investigation to explore the obstacles faced by student and intern psychologists whilst conducting their first therapy session, and how these obstacles effect the therapy session. Finally to examine the strategies that the student and intern psychologists employ to overcome the obstacles that they encounter. So as to enhance service delivery and therefore improve upon the quality of treatment rendered, thus founding a new operational base.

Hogan (1964) suggests that interns and student psychologists are often insecure and dependant on their supervisor for support and motivation. Additionally, the work of Loganbill, Hardy and Delworth (1982) puts forward that novice psychotherapists lack awareness of their short-comings in professional functioning and have a limited worldview. These findings have been consistent with the researcher's experience of being both a student and intern psychologist. It is therefore the researcher's motivation to assist future student and intern psychologists to implement contingency methods so as to ameliorate the obstacles and challenges that they potentially face whilst conducting their first therapy session with a client.

1.3 Aim of this study

Williams, Judge, Hill and Hoffman (1997) have shown that student and intern psychotherapists are often concerned about their therapeutic skills and performance as well as their ability to engage and connect with their patients and clients. Anxiety, self-efficacy and the quality of assessment were also parameters of concern (Williams et al., 1997).

This highlights the potential deficit amongst student and intern psychologists who may lack deeper understanding and clinical skills when dealing with the multi-faceted demands of clinical practice, as well as to manage their own intra-psychic dynamics. The first therapy session is a pivotal point in the psychotherapy continuum, because, placed against the cognitive behavioural therapy perspective, the goals of the initial therapy session includes: updating and re-evaluating the presenting complaint, assessing mood, creating and explaining an agenda which is individualised to the patients' needs and, most importantly, discussing the diagnosis and providing sound psycho-education (Beck, 2011). Therefore, the aim is to explore the obstacles faced by student and intern psychologists whilst conducting their first therapy session, and to examine a comprehensive list of strategies that have been shown to be of practical value in overcoming these obstacles and how these obstacle effect the therapy

session. This may help the student and intern psychologists to better conduct their first therapy session.

Furthermore, this research investigation aims to lay the foundations for other research investigations into this matter, with the hope of creating protocols which can be implemented at a basic level to provide technical and moral support to the student and intern psychologists.

1.4 Objectives

This study seeks to achieve three objectives:

- To explore the obstacles faced by student and intern psychologists whilst conducting their first therapy sessions These pertain to both personal and professional obstacles.
- To explore how these obstacles affect the therapy session.
- To examine the strategies that the student and intern psychologists employ to overcome the obstacles whilst conducting their first therapy session.

1.5 Delimitations of the study

This study pertains to the student and intern psychologists, who are currently enrolled in a Master's of Psychology degree. It does not include intern and student psychologists who are registered in other categories other than Clinical Psychology, and does not include the Community Service Psychologist or the qualified Independent Practice Psychologist. The participants must have had at least one therapeutic session with a client.

1.6 Significance of study

Refining the counselling process and overcoming the obstacles that counsellors experience in the first session will lead to better quality of care for clients. This study aims to identify and explore the obstacles faced by clinicians and suggests how these obstacles may be overcome. It also attempts to bring to the attention of clinicians the obstacles they face. It will hopefully help to alleviate the anxieties of future clinicians during the therapy session. This study proposes strategies that may be of significance in the first clinician-client therapy session.

1.7 Résumé

Chapter one served as an introduction to the study. Basic information regarding the therapy process was discussed, as well as the motivation, aims, and objectives of the study. In the next chapter, the literature that is relevant to this study is examined and discussed.

Chapter two

In this chapter, a review of literature will be conducted. In this review of literature the major obstacles and challenges faced by student and intern psychologists will be discussed. It will also highlight the practical recommendations that have been suggested by the literature in order to overcome them.

2.1 Introduction

Modern day psychologists, like other health care professionals, increasingly face the challenge of adapting a more holistic and multidimensional approach to the health and well-being of a client. The scope of practice of psychologists primarily entails assessing, diagnosing and treating psychological problems and behaviour dysfunctions which are related to physical and mental health (Wahass, 2005). Wahass (2005) regards psychologists as behavioural health care providers, noting that they play a significant role in determining the manner in which biological, behavioural and social factors influence health and illness. However, beyond the scope of practice and conceptual framework, governing the domain of psychotherapy, lies the delicate and complex inner workings of the human condition which influence psychologists themselves. This is an area which is often underestimated and glossed over due to the lack of attention attributed to the intra-personal dynamics of the mental health care worker who, in essence, are also subjected, if not equally susceptible, to the same mental and emotional turmoil as their clients.

Therefore, this research investigation is aimed at providing an exploration and evaluation of the obstacles and challenges encountered by student and intern psychologists whilst conducting their first therapy session. The researcher hopes that by bringing the obstacles and

challenges to prominence, it will set in motion the foundations for further research, which will result in protocols which will essentially improve the academic infrastructure and curriculum in tertiary institutions. This has the potential of enhancing the quality of therapists and service delivery in South Africa.

The South African health care system is burdened with an expansive list of socio-economic and socio-political issues (Maillacheruvu & McDuff, 2014). It is the belief of the researcher that improvements, even at the most elementary and basic level, will contribute to alleviating some of the burden. Thus improvements in the first therapy session will help to create a stronger therapeutic relationship between the student and intern psychologist and the client. This has the potential to negate the increasing rate of defaulted therapy sessions. In doing so, it can also help in the delivery and provision of care, treatment, and rehabilitation of mentally ill individuals.

In accordance to the popularised definition, as prescribed by the World Health Organisation, health is defined as a state of “complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Implied in this definition, is the integral role of psychologists in the health care continuum. This is self-evident despite the spectrum of social stigmas that have, and continue to be, associated with the profession.

Depending on the type of modality chosen within the therapy session, goals need to be established and clarified during the first therapy session. Additionally, these goals need to be achievable, realistic and should be suitable to the emotional state of the client. Castronguay, Constantino, and Grosse-Holtforth (2006) concluded that it is at this point that the therapeutic

alliance is forged, and information pertaining to the therapy session and process is given to the client. Furthermore, any misconceptions are dispelled and misunderstandings clarified. Thus, the first therapy session is a major determinant in the successful outcome of therapy process (Bordin, 1979). Overholster and Fine (1990) proposed five main sectors of clinical activity in psychotherapy which are necessary for competent practice and understanding: technical skills, generic clinical skills and interpersonal attributes, clinical competence and orientation specific technical skills. This suggests that the transformation to clinical competence on the part of the novice and trainee therapist is intense and multifaceted. Thus, obstacles, challenges, pitfalls and short comings can be expected on this arduous transition.

Within the South African context, the term student psychologist refers to a person who is in the first year of completing a Master's degree in psychology. While an intern psychologist is a person who has completed their theoretical training and is completing their practical component of the degree, which is the second year of study. Thus it can be inferred that the intern psychologist has more practical and theoretical knowledge than the student psychologist, as the intern psychologist has passed and completed their theoretical training. An internship takes on the characteristics of real employment and focus on independent application of skills and knowledge within the work setting.

2.2 Developmental pathway of the professional

In order to understand the pathway of professional development which occurs within the student and intern psychologist, Ronnestad and Skovholt (2003) established six phases of therapist and counsellor development. These phases are used to demonstrate the progression and transition of student and intern psychologists as they acquire a greater understanding of professionalism.

The first phase of development is the lay helper phase. Here the inherent desire to help others is examined. This desire is manifested in the lay helpers, in which they provide emotional support and solutions to problems based on common sense which stems from their own experience and frame of reference. Ronnestad and Skovholt (2003) argue that this could lead to over-involvement or a bias on the part of the lay helper. This could be due to the lack of professional education and skills training in the fundamentals of psychotherapy.

In the second phase, “the beginning student phase”, the student acknowledges that the previous ways of lay helping are no long suitable. The transition to this phase is often accompanied by stress and increased self-doubt regarding the student’s possession of appropriate of personal characteristics and ability. These feeling are in reaction to their perceived ability, or inability, to continue with the studies, his or her ability to master the course work and for him or her to translate their theoretical knowledge into useable practical skills with a client in the therapy session.

Following this phase is “the advanced student phase”. Ronnestad and Skovholt (2003) believe that this heralds the beginning of a therapist’s ability to function at a basic professional level.

Then follows the “the novice professional phase”. It is a challenging period, in which the novice therapist actively seeks to confirm his or her theoretical training. Concomitant feelings of disillusionment with his or her professional training prevail, due primarily to the difficulties of translating theoretical training into clinical practice.

The penultimate phase is the experienced professional phase. Here, the therapist has been in practice for a few years and has gained substantial experience in working with a variety of clients, in a multitude of different settings.

Finally, the psychologist enters in the “senior phase” where, as a professional, he displays the necessary competencies.

In accordance with the developmental pathway of the professional as established by Ronnestad and Skovholt (2003), the student and intern psychologist function within the beginning student phase, the advanced student phase and the novice professional phase. Thus this highlights that transitional phases of the student and intern psychologists are documented and therefore this transition from student and finally senior phase is dynamic with no set time frame or limit that is required for the transition from one phase to the next. Thus the student and intern psychologist should be aware of each phase and its parameters.

2.3 The role of the supervisor

The role and value of supervision in clinical practice has been well documented. Clinical supervision by definition is a formalised process of learning whereby clinicians are supported professionally in order to assume accountability and responsibility for their practice through the development of competence and knowledge (National Health Service Management Executive, 1993).

Hyrkas and Paunonen-Ilmonen (2001) delineate the parameters of the clinical supervision relationship by noting that it usually consists of two participants, the supervisor and the supervisee, who consult with each other on a one to one basis.

Hadfield and Booton (2003) describes the uses of clinical supervision, stating that it creates a platform for a clinician to plan, analyse and rehearse skills which build up confidence before the action is actually affected in clinical practice. The work of Heaven, Clegg and Maguire (2006) is consistent with that of Hadfield and Booton (2003), proposing that clinical supervision facilitates the transference of newly acquired communication skills to a clinical setting.

Hines-Martin and Robinson (2006) highlight the key areas of importance in clinical supervision: clinical supervision encourages adherence to ethical standards, provides support to enhance the well-being and work place experience, and to develop and maintain clinical skills and best practice.

This relates to the goals of clinical supervision put forth by Openshaw (2012) who noted that clinical supervision is aimed at building on and advancing the novice therapist skills, knowledge and attitudes with the intent of improving client care and enhancing professional growth and development of the clinician. Clinical supervisors serve multiple functions. They act as teachers and role models, as well as demonstrating practical skills and providing leadership and direction for the novice therapist (Openshaw, 2012).

Thus, it is evident that clinical supervision has an indisputable role to play in all the challenges with which student and intern psychologist are faced. Although supervision may not be able to ameliorate all obstacles in a clinical environment, it can certainly be used as both a crutch and a tool to reduce them. Owing to the relative lack of clinical experience of the novice therapist and especially in the first therapy session with a client, clinical

supervision can contribute to the synthesis of the vast information gleaned from the client thus aiding proper and guided diagnosis, and management protocols.

2.4 Feelings of incompetence

As a novice therapist, feelings of incompetence, inadequacy and a sense of being ill equipped are natural during the early stages of his or her career. Clinical competence is in itself a broad concept. The literature defining clinical competence ranges in complexity. Carr (2004), for example, states that competence is determined by the context in which it is viewed as opposed to other factors. Epstein and Hundert (2002) provide a comprehensive definition of clinical competence, stating that it is a collaboration of theoretical knowledge, technical skills, clinical reasoning, values, and emotional reactions are beneficial to clients and the community.

The demands and expectations placed upon student and intern psychologists are gruelling to say the least. Theriault, Gazzola and Richardson (2009) define feelings of incompetence as the mental and emotional reaction on the part of the therapists, which arises when their beliefs in their own abilities and /or effectiveness as therapists are internally reduced or challenged. Feelings of incompetence could arise from the therapists' self-depreciating evaluations of themselves in the therapy session. It is prudent to note that feelings of incompetence are thus an inherent, subjective perception and do not truly reflect the ability or actual levels of competence of an individual. However, if, and when, these feelings do arise, they not only have the potential to disrupt the therapy process, but also have an effect on the overall well-being of the psychologist (Theriault et al., 2009).

To effectively evaluate feelings of incompetence, its relationship to self-awareness and self-doubt needs to be explored. Self-awareness encompasses various aspects, including self-knowledge and insight, and places strong emphasis on knowing the value of and understanding one's own issues, strengths, weaknesses and biases (Edwards & Bess, 1998).

Rochat (2003) proposes that self-awareness is perhaps the most fundamental issue in psychology in terms of developmental and evolutionary perspectives. This means that self-awareness promotes and facilitates a process of growth and change and thus is crucial to the maturity and progress of a psychotherapist. Ehrlich (2001) contributes to this concept by adding that self-awareness on the part of the therapist is pivotal to the success of the therapeutic process.

Safran and Muran (2000) offer an alternate perspective on the concept of self-awareness. They argue that self-awareness, which pertains to immediate consciousness and ongoing internal states, needs to be differentiated from self-knowledge, which refers to a retrospective understanding and insight to inner feelings and processes. However, this appears to be a minor technicality, as both self-knowledge and self-awareness, in essence are intimately related.

It is a well-known fact that within the arena of psychotherapy, the therapist's self-awareness can greatly increase one's proficiency and help the therapeutic process (Theriault et al., 2009). This is mainly because self-awareness enables one to recognise and acknowledge one's limitations and short-comings, as well as one's strengths which can be channelled into the betterment of therapy sessions in terms of quality and efficacy.

Theriault and Gazzola (2006) propose a system of classification for feelings of incompetence, stating that it can stem from four main sources. These are permissible issues, professional issues, process issues and personal issues.

2.4.1 Permissible issues

Theriault and Gozzola (2006) maintain that permissible issues are often minor and inoffensive in nature. These issues arise mainly from the ambiguity of professional practice and human fallibility. This relates to the occasional lapse in functioning that can only be expected owing to human nature.

2.4.2 Professional issues

Encompassed within the category of professional issues are a lack of knowledge, training or experience and the demands of administrative tasks in a clinical setting. These aspects play a role in generating a sense of incompetence in novice therapists.

Theriault and Gozzola (2006) found that a lack of knowledge was the most common cause of feelings of incompetence. Lack of knowledge surfaced in a variety of ways. Examples of knowledge deficits surfaced when clients presented with certain issues or pathologies such as agoraphobia, Borderline Personality Disorder or even eating disorders. In these instances the therapist rated higher feelings of incompetence. This could be due to deficits in understanding clients and their unique presentations, as well as shortfalls in possessing the appropriate repertoire of skills and wisdom to enable effective therapeutic interventions.

2.4.3 Professional tasks

A professional issue, which is perhaps overlooked at times, yet is conducive to generating a sense of incompetence, is the effective management of corollary duties and administrative tasks in private practice (Theriault & Gazzola, 2006). Administrative tasks include filing, managing money, scheduling appointments and taxation practices, which can create or contribute to feelings of inadequacy. Mismanagement and disorganisation can lead to a therapist feeling overwhelmed, inefficient and therefore incompetent. A practical solution to this problem could be to implement practice management modules in the academic curriculum which teaches aspiring therapists the basic managerial and organisational skills need to be efficient and well-rounded when they leave the sheltered training environment.

2.4.4 Process issues

This category pertains to the direct contact between client and therapist which constitutes a therapeutic exchange or environment where formal rules of psychotherapy are applied. These issues have the capacity to generate moderate levels of feelings of incompetence in the novice therapist. Process issues can be sub-divided into different categories.

2.4.4.1 Process-outcome discrepancy

Theriault and Gozzola (2006) state that process-outcome discrepancies are associated with feelings of incompetence on the side of a therapist who is still new in the practice of formal rules governing the therapeutic process. Process-outcome discrepancies could arise when the outcomes of therapy do not match the therapist's expectations, goals and objectives for that

session. An example of this would be when the client is still experiencing emotional turmoil or conflicts despite the therapist's best effort and good intentions to alleviate or resolve them. These discrepancies may be brought to attention in the form of feedback given to the therapist, which has the potential to cause them to re-evaluate and misjudge their therapeutic abilities.

2.4.4.2 Relationship and relational issues

In this category there are two significant factors that contribute to the feelings of incompetency. These are closeness and engagement which pertain to the quality of the therapeutic alliance and communication issues which relate to the effectiveness in communication between client and therapist.

2.4.4.2.1 Closeness and engagement

A good strong therapeutic relationship with clients is viewed as a prerequisite for feelings of competence in a therapist (Theriault & Gozzola, 2006). Therefore, it can be inferred that failure to establish a solid therapeutic relationship with a client is a potential catalyst in generating feelings of incompetence in a therapist. According to Theriault and Gozzola (2006), therapists were often unable to establish an optimal therapeutic relationship when the clients became distant, mistrustful or resistant to the therapeutic process and interventions.

2.4.4.3 Communication issues

Theriault and Gozzola (2006) discovered that when therapists encountered differences in culture, language and religion in their client it actually triggered feelings of incompetence.

2.4.5 Personal Issues

Of particular significance in the personal issue domain is the therapists own current or historical wounds, personal values and vulnerabilities as well as their psychodynamics. Therefore, it is evident that the therapist's internal states have profound effect on the outcomes of the therapy session. These internal states could manifest as feelings of incompetence which could, in turn, result in the therapist becoming "immobilised" (Theriault et al., 2009). This can be considered to be a negative consequence of feelings of incompetence.

Other mundane factors need to be duly noted in the production of feelings of incompetence. These include being tired or hungry during a therapy session and also consulting with a client at the end of a busy day (Theriault & Gazzola, 2006).

Orlinsky, Ronnestad, Ambuhl, Willutzki, Botermans, Cierpka, Davis and Davis (1999) conducted a study on feelings of incompetence, taking into consideration a therapist's clinical experience. They found that approximately 35% of therapists, who had over 10 years of clinical experience, still reported a low sense of mastery. Furthermore, 7.6% of therapists with 23-52 years of clinical experience still continued to judge their own levels of competence. This finding is particularly significant as it infers that experience alone does not exempt a therapist from feelings of incompetence.

2.4.6 Stress-related feelings of incompetence

Psychotherapists, particularly trainees, are susceptible to distress which originates from the nature of their field of work. Varma (1997), states that two main factors are related to the level of stress of a psychotherapist. These stressors are client's distress and self-doubt. Varma (1997) goes on to note that the beginning of therapeutic work usually coincides with the peak of self-doubt due to the stressful nature of dealing with clients. This could be because the trainee is now expected to work with a wide variety of people ranging from physically disabled and mentally impaired, to abused children, and those who perpetrate abuse on others. Related to this concept is the postulation by Theriault et al. (2009) who state that self-doubt is potentially damaging to both the practitioner and the therapeutic process.

In the "real-life" clinical setting, there are no limits to the calibre, magnitude and nature of cases that one has to manage. A feeling of self-doubt is a very real obstacle that a trainee psychotherapist will encounter. This can be attributed to the ever-changing and all-encompassing nature of psychotherapy, compared with the level of preparedness and perspective of the therapist.

Theriault et al. (2009) argue that, although feelings of incompetence have a potentially detrimental effect on the therapy, there are also positive aspects that can be associated with it. These include a heightened sense of direction and purpose of therapy session, strategic and tactical changes when deficits arise and modulating the pace of therapy to suit the needs of the client. It encourages a therapist to become acutely aware of the changing dynamics of the client and the session.

2.4.7 Techniques to handle feelings of incompetence

Varma (1997) maintains that the number of published studies which examine coping strategies in trainee psychotherapists is limited. However, there are some simple techniques which can be used to curtail and manage feelings of incompetence. Firstly self-care/self-reflection techniques can be used. These encourage the therapist to seek supervision or consultation, enlist the help of others for personal therapy and take vacations. This will help to provide the therapist with a sense of perspective, essentially allowing them to take a step back to re-evaluate and recuperate. The second technique is Cognitive Relaxation techniques which entail deep breathing, self-coaching and thought-stopping strategies.

2.5 Transference and Counter Transference

According to the research presented by Schröder, Wieman and Orlinsky (2009), working in close proximity with distressed persons brings to recollection to the therapist his or her own distressing experiences. Psychologists by virtue of their profession are trained not only to investigate but also understand the intricacies of the human condition, in order to facilitate an authentic and wholesome healing experience. However, when one identifies too deeply with a client's situation, the quality and even the outcome of the therapy could potentially be compromised (Geslo & Hayes, 2011). This is intimately related to the concept of countertransference, which is a challenge encountered by psychotherapists.

Prasko and Vyskocilova (2010) define transference as “a phenomenon in psychoanalysis characterised by unconscious redirection of feelings from one person to another, in the case of psychotherapy, from patient to therapist.” Conversely, countertransference pertains to the

transference of feelings from the therapist to patient. This definition is substantiated by Gabbard (2004) who refers to counter transference as the therapist's cognitive-affective responses to a client. Prasko and Vyskocilova (2010) also maintain that no therapist is exempt from the phenomenon of countertransference. When countertransference is viewed from a psychoanalytical perspective, it has deeper emotional and psychological implications which represent a psychotherapist's unfulfilled conflictual desires (Schaeffer, 2006).

Schaeffer (2006) proposed that unless a therapist detects and processes counter transference consciously, it has the potential to undermine the positive therapeutic outcomes. However, Heinmann (1950) suggests that the therapist's emotional responses towards a client are not simply a hindrance but in actuality they are an important tool in understanding the client.

Geslo and Hayes (2011) and Horvath (2000) propose that there are three components encompassed within the therapeutic relationship. These are the therapeutic alliance, the transference-counter transference relationship and the real or personal relationship. Gabbard (2004) notes that the transference- countertransference relationship particularly is considered to be central the therapeutic outcomes in psychotherapy.

According to Winnicott (1949) counter transference is encompassed by two primary aspects: subjective and object. The subjective aspect pertains to a therapist response to a client based on the therapist's own personal issues and encounters, whereas the objective aspect relates to the therapist's realistic or natural reaction to a client's personality or extreme behaviour.

The concept of counter transference is a controversial one. There is continued disagreement regarding the concept of counter transference amongst researchers (Norcross, 2001). Hayes (2004) believes that a therapist is required to understand his or her own feelings which may emerge from a client's situation or personality and must not act impulsively on these feelings. Furthermore, both client and therapist contribute to countertransference in a clinical setting.

Counter transference in itself spans a broad spectrum of clinical presentations. This includes feeling overwhelmed or disorganised, helpless or inadequate, over involved, disengaged, over protective or even sexualised towards a client (Betan, Heim, Conklin, & Western, 2005). Leahy (2007) categories some common problems encountered as a result of counter transference in a clinical setting. These include: a sense of inferiority when dealing with narcissistic clients, unnecessarily prolonging the therapy session, passivity in the enforcement of policies and collection of fees, or over emphasising the need for hospitalisation due to poor client management

Leahy (2007) provides some examples of personal and interpersonal schemas which foster feeling of countertransference. This includes "demanding standards" whereby a therapist feels personal responsible to cure the client and meet their highest standards of therapeutic expectations: rejection; sensitivity, whereby a therapist is upset by conflict and avoids raising certain issues with the client, and also the "need for approval". The "need for approval" is characterised by the therapist's desire to like and be liked by a client. Research conducted by Hayes, McCracken, McClanahan, Hill, Harp, and Carrozzoni (1998), investigates the origins and triggers of counter-transference. These included family, parenting, and partner issues, cultural, gender and race issues and changes in the structure of the therapy session such as

cancelling, missing or rescheduling sessions, progression or stagnation in therapy and even termination of therapy.

Due to the subtle, yet direct manifestations of counter transference, it could be difficult for the novice therapist to identify this phenomenon should it arise within the spheres of the therapy session. As such, this represents a gap in the literature, in which novice therapists are not adequately made aware of the forms and manifestations of countertransference and the manner in which it could impact the therapy session. According to Schaeffer (2006), counter transference could range from tenuous feelings, desires or body sensations, to silence, boredom, or irritability in the session.

In its original form, counter transference, as viewed by Freud (1910), was considered negative. However, it is now regarded as having both negative and positive aspects that could either hinder the therapeutic process or aid it. Counter transference usually evokes anxiety, whereby the therapist must make a concerted effort to either repress it or move away thereby dissociating from the anxiety. This has a potential, according to Schaeffer (2006), to rupture the therapeutic alliance. Alternatively, when counter transference is correctly identified, it makes the therapist acutely aware of his or her relationship with his or her clients. It has the potential to alert the therapist to the client's personality traits and his or her interpersonal dynamics. Cohen (1952) asserts, however, that it is only through the therapist's counter transference reaction that a client's personality traits and interpersonal relationship can be ascertained.

2.5.1 Countertransference management

Hayes, Gelso and Hummel (2011) bring to prominence if counter transference reactions have an effect on psychotherapy. They proposed that the outcome of treatment can be viewed on a continuum which ranges from immediate to distal outcomes. Immediate outcomes concern themselves with the effects of a phenomenon in a session. The distal outcomes are the result of treatment and are measured or ascertained by assessing client's function after termination of therapy. These two outcomes, as proposed by Hayes et al. (2011), represent both extremes of the treatment continuum, however, between these two extremes lies the proximate outcome. Hayes et al. (2011) further argue that these proximate outcomes can be viewed as supporting the client to reach the distal outcomes. Cutler (1958) maintains that countertransference has a harmful effect on the therapeutic outcomes, especially when the client's material is significantly related to the therapist unresolved conflicts. This finding was also supported by Rosenberger and Hayes (2002) who have congruent findings.

Geslo and Hayes (2011) proposed that in order to manage countertransference, the therapist must be aware of three important factors that could negate the countertransference effect. These are: the therapist empathetic ability, and awareness of countertransference and its manifestations, and the ability to make sense of these countertransference feelings.

The ability to separate one's self from others, maintain ego boundaries, together with healthy and intact character structures, is known as self integration. Anxiety management is the ability of the therapist to control and curtail anxiety whilst not allowing it to influence their interactions with the client. Empathy, which is a fundamental skill of psychologists, refers to the ability to moderately identify with the client. This allows the therapist to concentrate on the client needs in spite of the difficulties that client may be experiencing. It also refers to

being aware of one's own feelings (Gelso & Hayes, 2011). Lastly, conceptualising ability refers to the ability of the therapist to apply theoretical knowledge when faced with a client in a practical setting.

Fatter and Hayes (2013) explored ways in which these characteristics of a therapist can be developed in order to protect against countertransference feelings. They first examined meditation, which can be viewed as a form of self-regulation that aids the therapist to develop increased attention and awareness. This allows the therapist to gain voluntary control of the mental processes which will generate greater exponential growth on mental wellbeing. In addition, mediation also creates calmness, clarity and concentration (Welsh & Sharpiro, 2006).

Dreifuss (1990) and Birnbaum (2008) suggest that meditation can be an important factor in the therapist's ability to establish himself or herself as separate from his or her clients, thereby aiding the conceptualising ability. Chambers, Lo and Allen (2008) maintain that mediation facilitates increased emotional regulation, while Moore and Malinowski (2009) argue that mediation enhances cognitive flexibility as well as facilitates the process of self-observation.

2.5.2 Mindfulness

Mindfulness concerns itself with somatic sensations, feelings and thoughts and has multidimensional qualities. Baer, Smith, Hopkins, Krietmeyer and Toney (2006) propose 5 facets which will help the therapist in managing countertransference. The first is observing and taking notes of sensation. The second facet elaborates on one's internal experiences in

the world. The third facet concerns having and demonstrating awareness and concentration, and having a non-reactive stance towards one's own inner experience. The fourth facet concerns being non critical of experiences. The fifth facet concerns acting with awareness. Neurobiological findings have suggested that mindfulness can enhance counter transference management as it activates the middle frontal lobes. This is the site for emotional balance, empathy and intuition (Siegal, 2007). Lastly, Fatter and Hayes (2013) proposes that an increase of self-differentiation can promote counter transference management. It borrows from the Bowen's theory of family therapy concept of self-differentiation. Self-differentiation refers to the ability to have intimacy, yet at the same time balance this with autonomy in relationships which facilitates emotional and intellectual functioning. Thus, when confronted with an emotionally charged situation, the therapist who is well differentiated is able to think clearly and avoid affective reactions and avoid fusion with his or her clients.

2.6 Silence

Verbal communication is obviously the basis of intervention during psychotherapy session. It is through words that one is able to facilitate emotional healing, processing, and reflection and ultimately effect change. Short and Thomas (2015) describe counselling and psychotherapy as a "talking cure", proposing that this process offers a successful, nonmedicinal alternative in the treatment of various psychological disorders.

Strean (1969) shows that the quality, quantity, tone and content of verbal interaction determines the depth of the recovery process. The counsellor client relationship involves a great amount of talking using words as a way of exploring means (Lovelady, 2005).

Fussell (2014) suggest that one of the major determinants of therapeutic progress is how effectively a client expressed and articulated his or her feelings as well as the manner in which the therapist understands, interprets and responds to these feelings.

There is a broad spectrum of paralinguistic mechanism that are used to facilitate non-verbal communication (Fussell, 2014). These include modulating tone of voice, changing facial expressions, eye movements and unconscious muscular twitches (Shermann, 1965). However, Fussel (2014) asserts that non -verbal communication alone is insufficient for expressing the extensive range of emotions and reactions which people are capable of expressing. This is because non-verbal cues may be generalised to preconceived stereotypical notions (e.g. crying is always equated to sadness) and the fact that people, when communicating their emotions, are not experiencing them with the same intensity as they were experienced at the actual event.

Feltham and Dryden (1993) define silences as “temporary absence of any overt verbal or paraverbal communication between counsellor and client within sessions”. Alternatively, Tindall and Robinson (1947) consider any noticeable pause to be classified as a silence. This suggests that the length of the pause is insignificant in relation to the timing in which the silent moment has occurred. In contrast to Tindal and Robinson (1947), Sharpley (1997) indicates that when pauses in conversation exceed 5 seconds, it is then considered to be a silence.

Due to a lack of theoretical knowledge and practical skills, student and intern psychologists may lack the wisdom as to how or when to break a silent moment which has occurred in a

session with a client. They may also be unaware of the therapeutic value of the silence. As a result, the student and intern psychologist may engage internal conversations with themselves so as to bridge the gap during the silence. Hill and Thompson (2003) noted that therapists were internally active during silent moments, whilst simultaneously observing and focusing on the client, as well as reflecting on the experiences of the therapy session.

Scott and Lester (1998) states that silence may provoke anxiety in both the client and the therapist, and it is not exclusively limited to the domains of the psychotherapy session but can also occur during telephone conversations, group therapy and crisis interventions.

Scott and Lester (1998) go on to question the connotations of silence, posing two pertinent questions: is silence always negative and provocative of anxiety, or can it be a useful therapeutic function? Kurzon (1992) proposes that an inability to speak during certain social interacts can often be perceived as a lack of power on the part of the silent person. This concept translated, into a therapy session, could have a major impact on the quality and outcomes of the therapy, should the therapist continually or frequently remain silent. This silence could be interpreted as the therapist inability to control and direct the therapy session.

Liegner (1974) noted that silence has a dual function. It can represent pleasure, peace or joy, yet can also be encompassing of anger, disinterest or contempt. This is substantiated by the findings of Caruth (1987) who proposes that silence can be interpreted as threatening, yet it could also represent a moment of reflection that could otherwise be interrupted by the spoken word. Jenson (1973) describes five primary functions of silence. Silence can have a linkage function, which is used to bond or separate topics, an effecting function used to heal or

wound, a revelation function, used to hide or explicitly highlight information, a judgemental function which is used to signal agreement or disagreement or an activating function, in which silence can represent mental activity or inactivity. Findings by Lovelady (2005) show that 55% of clients experienced negative feelings towards silent moments during the therapy session. These included feelings of awkwardness, vulnerability, numbness, fear and fury.

Hill (2003) adds that silent moments also have the potential to increase the rate of clients defaulting the therapy session and could also lead to the perception by the client that the therapist is not empathetic. When effectively used in the therapy session, silence can show a great depth of empathy, facilitate reflection, and may allow the client to take responsibility for his or her own actions, words and feelings. Baber (2009) noted that silence can be used as a tool to hold and capture the essence of what was said and unsaid. It could also allow the client to take a momentary break from the session perhaps to gather their emotions and think of the topics or issues that needs to be discussed (Ladany, Hill, Thompson & O'Brien, 2004). Corey (2009) emphasises the value of learning techniques to enhance the therapeutic value of these silent moments is a vital skill. However, excessive reliance on silent moments could lead to mechanical counselling style.

Kurzon (1995) puts forth the idea of intentional and unintentional silences. According to Kurzon (1995), unintentional silences are psychological in nature and occur as result of personal inhibitions, whereas intentional silences could represent the choice to be unco-operative on the part of the client.

While there are undisputed arguments for the effective use of silence in the therapy session, there are a number of strong counter-indications where silence is not effect dependant on the relevant circumstance.

Ladany et al. (2004) postulate that the use of silence as a therapeutic intervention should not be utilised when the client displays extreme anxious, suicidal and psychotic behaviour. They also caution the novice therapist against hiding behind silence so as to manage their anxiety or fear. However, Holmes (1998) discusses protracted silences as a tactical defence which can be employed by a therapist as a means of maintaining appropriate professional distance. In addition to this, circumspection should be exercised with the use of silence with clients who display traits of personality disorder, and who exhibit high levels of suspicion, feelings of persecution or even extreme anger. The stage of the therapy session that silence is utilised needs to be considered as well. Ladany et al. (2004) mention that silence should not be used in the early stages of therapy or even in brief therapy.

Ladany et al. (2004) suggest that when faced with silence in the session, the therapist should use such moments to determine how to respond or react to his or her clients, or to analyse the silence so as to determine if he or she were distracted and the reasons for being distracted. They cautioned that a strong therapeutic relationship is vital to the proper and effective use of silence. In addition, silence works best with well adjusted, “psychologically minded” clients. It is the responsibilities of the therapist to assess whether the client is utilising the silence effectively and to determine when and how to break the silence.

2.7 Vicarious traumatisation

By nature of their profession, mental health care workers are obviously exposed to a wide range of intensely traumatic and emotionally challenging experiences (Helm, 2010). Vicarious traumatisation, also referred to as compassion fatigue, is a phenomenon that occurs in a therapist, pertaining to the inability to maintain the necessary degree of professional distance which facilitates therapeutic objectivity.

Vicarious traumatisation occurs when a therapist becomes over involved and emotionally engaged in the client's traumatic situations. Saakvitne and Pearlman (1996) base the concept of vicarious traumatisation on the constructivist self-development theory (CSDT). This concept forms a basis for the therapist to cope with traumatic experiences. Constructivist self-development is affected through a combination of the therapist's interpersonal, intrapsychic, social, familial, cultural, past and present circumstances. Thus this theory states that a person's history and past has a direct bearing and helps shape their experience of the traumatic event and defines the adaption to the traumatic event. McCann and Pearlman (1990) have proposed the "infection model" upon which vicarious traumatisation is based. This model postulates that clients actually infect the therapist by over loading them with traumatic recollections, fears, despair, nightmares and disgust. Kleinman and Maeder (1999) as cited in Pross (2006) describe therapists who are affected by vicarious traumatisation as being wounded healers. The implication of being a wounded healer is that the therapists themselves are in need of help and psychological care and that until such time that the therapist becomes whole again, the value of the therapy session will be compromised.

Morrisette (2004) notes that symptoms of vicarious traumatisation encompass behavioural, physical, cognitive and obviously emotional states. Symptoms of vicarious traumatisation may manifest as a therapist being unable to experience pleasure, emotional detachment, exhaustion, despair, or resentment. It can also surface in the form of the therapist experiencing moments of intense rage, nightmares, intolerance, self-loathing and crying. These symptoms would prevent the therapist from engaging fully and attending to the client's emotional and psychological needs.

Meichenbaum (2012) notes that vicarious traumatisation can also have a negative impact on job satisfaction which can lead to increased absenteeism and low morale on the part of the therapist. Wilson and Lindy (1994) considers vicarious traumatisation to be a lapse in the patient therapist relationship. This is not only counter-productive to the therapeutic alliance and therapy goals and outcomes but also to the overall emotional and psychological well-being of the therapist. Meichenbaum (2012) explores client's characteristics which renders a therapist more susceptible to the phenomenon of vicarious traumatisation. This includes working with suicidal patients, rape or torture victims, Holocaust survivors, graphic details and re-enactments of sexual abuse as well as dealing with victims who are also perpetrators of some form of abuse.

In order to manage vicarious traumatisation tendencies a therapist needs to implement certain strategies for personal and professional preservation. These strategies or coping mechanisms are a combination of internal and external factors.

Pross (2006), states that proper professional distance and limits must constantly be maintained in order to prevent clients from emotionally exploiting the therapist. Pross (2006) goes on to list factors for the management and potential prevention of vicarious traumatisation. Self-care in the form of limiting caseloads and engaging in leisure activities and hobbies with friends and family can be useful in disengaging from the professional demands of the therapy sessions. There are also a variety of assessments that can be used to identify the risk of vicarious traumatisation in student and intern psychologists. These include Pearlman's (1996) Traumatic Stress Inventory Life Event Questionnaire, Maslach's (1996) Burnout Inventory and The Impact of Event Scale (IES) proposed by (Horowitz, Wilner & Alvarez 1974). These could be implemented for periodic re-evaluation of vicarious traumatisation to reduce or prevent it from occurring in student or intern psychologists. Therefore if a student or intern psychologist scores high for vicarious traumatization scales, then that student or intern psychologist may benefit from techniques to manage vicarious traumatization which will be discussed in the next section.

2.7.1 Management of Vicarious Traumatisation

Reivich and Shatte (2002) have developed a practical solution with regards to dealing with vicarious traumatisation. This comes in the form of recommendations stipulated in General Resilience Training. It postulates that therapists should avoid thinking traps. This means that the therapist should not get caught up or become obsessive regarding one particular case or aspect of a client's story. Furthermore a therapist should identify deep seated or hidden beliefs and explore the impact of these in the therapy session. Rigid beliefs should be challenged and a therapist should put a case into perspective to avoid undermining or catastrophising it.

An important mechanism is also regular self-examination by collegial and external supervision. This means that therapist need to engage in regular discussions and therapeutic techniques with their colleagues and supervisor, who will serve as emotional sounding boards and filters to reduce the magnitude of emotional and traumatic experiences which a therapist is expected to contend with.

Meichenbaum (2012) recommends that student and intern psychologists should engage in debriefing after a traumatising therapy session. This can be informally or formally undertaken with a supervisor. A major social aspect relating to vicarious traumatisation is the low levels of social recognition attributed to psychotherapists. As a means of combating a sense of low social recognition, therapists could be afforded higher titles, positions or promotions and increases in salary structures. Furthermore, vicarious traumatisation is linked to job dissatisfaction, absenteeism and low morale in the clinical setting.

Bloom (2003), notes that the actual cause of vicarious traumatisation has not been conclusively established, but that a lack of experience as a therapist is certainly a major risk factor. This is obviously a challenge to student and intern psychologists who may lack not only clinical experience but also may lack support and intrapsychic mechanisms such as firm therapeutic boundaries to effectively cope with and overcome this particular challenge. Bloom (2003) goes on to provide protective factors which have been proposed to be of benefit to countering the tendency toward vicarious traumatisation. These include a sound social and moral support structure, firm ethical principles and personal boundaries and on-going training.

Another possible means to countering vicarious traumatisation is engaging in continued education about the latest developments in trauma management. On-going training is a noteworthy concept when dealing with student and intern psychologists. On-going training implies that one is required to constantly update themselves by exposing themselves to the latest and most topical clinical information so as to be on par professionally. A possible option for the student intern psychologist to engage in on-going training is by means of Continued Professional Development (CPD). Hakim (2008) notes that profession ability; quality of care and service delivery has improved exponentially through the process of continued professional development.

Although CPD is not a professional requirement at the student and intern psychologist level, it is strongly recommended that student and intern psychologists should capitalise on this. Attending regular CPD meeting could help the novice therapist gain necessary competencies to negate and overcome the obstacles that they encounter in the first therapy session as well as to handle any symptoms of vicarious traumatization as noted by Morrisett (2004).

2.8 Anxiety

Performance anxiety is yet another obstacle encountered by student and intern psychologists whilst conducting their first therapy session. Although a certain degree of anxiety can be expected on the part of the intern and student psychologist, there needs to be a heightened sense of awareness regarding the manner in which this anxiety is managed. In the words of Mullenbach (in Skovholt and Ronnestad, 2003), the requirements of the novice therapist are exhausting. They are expected to effortlessly access, integrate, synthesise and adapt the information which they are bombarded with from their clients.

Skovholt and Ronnestad (2003), report that a major catalyst for stress in the novice therapist is the ambiguous nature of professional work. This means that there are often vague or unclear areas in terms of presentation, diagnosis and management of clients. Orlinsky and Ronnestad (2003) adds that a novice therapist is prone to feeling overwhelmed in the early stages of their careers, due to the deficits in professional confidence that acts as a buffer to anxiety which may arise in challenging situations.

A study conducted by Jacobsson, Lindgren and Hau (2012) investigated the self-reported struggles of psychotherapy students. They found that students were uncertain about managing feelings and emotional encounters which emerged during the therapy session. Students were unable to distinguish whether the emotional experiences that surfaced were their own and therefore private, or whether they actually belonged to the client and therefore could be incorporated into the therapy process. Furthermore it was found that students felt that their own feelings were being magnified during the psychotherapy session. This could lead to increased levels of anxiety that is experienced by the students especially within the first therapy session because as previously stated that the first therapy session provides the impetus for clinical interventions and treatment protocols.

It is a well-known fact that novice psychotherapists have some level of co-dependence on their supervisors for direction in the treatment process and management of a client. Fisher (1989) found that at the beginning of supervision, students prefer an authoritative relationship with their supervisors. This is perhaps due to a lack of clinical experience and elevated levels of anxiety. The student may find it easier to simply imbibe the teaching ideals and approaches specified by the supervisor.

In the domain of psychology, there are limitless theories, approaches, methods and conceptual frameworks that can be applied to any given situations. This can lead to uncertainty and confusion Skovholt and Ronnestad, (2003) as different supervisors may have conflicting views on the approach of the same subject. In addition, Jacobsson et al. (2012) propose that it is a false assumption that all psychotherapists reach the same outcome and effects by their techniques of treatment and therapy. In actual fact, personal styles significantly impact the outcome of psychotherapy. Furthermore, therapist can also become anxious when there is a discrepancy between the supervisors' view on a treatment plan and their own. Thus effecting the outcomes of the first therapy session and subsequent therapy sessions as well. This could lead to misdiagnosis and at a greater consequence mismanagement of the client. Thus novice therapist may begin to doubt their own abilities and clinical judgement and become anxious or distressed regarding the quality of their work. Jacobsson et al. (2012) fittingly state that anxiety "must be analysed and understood in its context".

The supervisor also has an important role to play in containing the student and intern's anxiety and not misinterpreting it as a sign of weakness in the individual. Student and intern psychologists erroneously believe that supervision is the primary gateway to gaining greater clinical insights. However, as Skovholt and McCarthy (1988) aptly note, clients in fact serve as the main teachers in a clinical setting. Owing to the uniqueness of each and every client, their situation, background and clinical presentation, a therapist has greater opportunities to gain first-hand clinical experience. This effectively contributes to reducing the gap between theoretical knowledge and practical experience. It is also wise to note that in internship programmes a supervisor may act as a sounding board and a buffer in the clinical setting, novice therapists are denied this luxury post-internship.

It is therefore evident that a therapist anxiety is multi-factorial. Novice therapists have not yet mastered the art of sifting through the complexities and material that needs to be grasped and attended to in order to effect optimal performance.

Skovholt and Ronnestad (2003) maintains that's there are major deficits in educational literature regarding the sources and nature of academic difficulties encountered by students in the health care profession. However, a commonly recognised problem in students is the tumultuous transition from theoretical knowledge and clinical practice. Skovholt and Ronnestad (2003) notes that students gain entry to graduate programmes and professional training as a result of successfully completing a programme of study which is richly embedded in a theoretical framework. Therein lies the challenge of applying and adapting theoretical knowledge into effective practice. This challenge is particularly prominent in the first therapy session conducted by a novice therapist as it is at this crucial juncture where a therapeutic relationship and rapport is formed and treatment protocols are formed. Lack of confidence is a significant source of anxiety. Hill, Sullivan and Schlosser (2007) further explore sources of anxiety in the novice therapist. They note that biases towards and against clients, critical self- evaluations regarding performance in sessions, concerns about adopting the role and responsibility of a psychotherapist and challenges pertaining to meeting the clients expectations are all factors which affect the student and intern psychologist. This is substantiated by the findings of Williams, Judge, Hill and Hoffman (in Stovholt & Ronnestad, 2003) who stipulate that therapeutic skills, problematic reactions to clients and ability to fully engage with clients are parameters of concern on the part of the therapist.

Student and intern psychologist have not yet established their professional identity. As a result, it promotes anxiety which possibly stems from self-criticism and the conflicting nature of personal development. Orlinsky and Ronnestad (2003), state that there are few studies pertaining to the complex development of psychotherapeutic identity during training. This is substantiated by the beliefs of Jacobsson et al. (2012) who state that the complex and time consuming process of learning the nuances of therapy should be duly acknowledged and that a greater emphasis needs to be placed on the development of practical skills and personal traits in psychotherapeutic training programmes.

2.9 Dual/Multiple Relationships.

A dual-relationship is defined as any situation which compromises or contaminates the therapeutic alliance as a result of fostering a second relationship beyond the scope of the clinical setting. (Meyer, n.d.). Meyer (n.d.) enhances this definition by stating that dual relationships can arise when there is an incompatible combining of professional roles which is detrimental to the client who is owed fiduciary duty by the psychologist. Fiduciary duty can be categorised as duty of loyalty and duty of care (Frankel, 2011). This means that the therapist is obliged to act in the client's best interest at all times. Frankel, (2011) describes the characteristics of a fiduciary partnership. These are "sincerity without reserve" and "loving care". It is therefore evident that the fiduciary relationship needs to be duly noted throughout the therapeutic process, however, this, needs to be contained in professional limits.

Dual or multiple relationships established between client and therapist is considered to be harmful owing to the risk it poses to the quality of therapy and therapeutic outcomes. Borys and Pope (1989) highlight some examples of dual relationships which include: rendering

psychotherapeutic treatment to employees, supervisees, relatives, close friends and students. Some ways in which a psychotherapist can overstep the boundaries of the therapeutic alliance consist of disclosing details of current personal stresses to a client, inviting a client to a social event or party, going out for a meal with a client after a therapy session and engaging in sexual activity with a client after termination of therapy. Another category of dual relationship that has emerged of late is the concept of digital dual relationships, which can be fostered through emailing, texting and social networking between the client and the therapist.

Borys and Pope (1989) state that dual relationships serves as a basis for financial losses through malpractice suits, ethical misconduct complaints against psychologists as well as licensing disciplinary actions.

Meyer (n.d.) points out the risks involved in engaging in multiple relationships to both client and therapist. The major negative outcome of these types of relationships is loss of professional objectivity. It can also result in confusion, misinterpretation of personal communications or feelings of rejection by both parties. This is substantiated by the findings of Sarkar (2004) who adds to the list of harmful consequences of boundary violation within the therapeutic relationship. These include emotional turmoil, cognitive distortion, shame, fear or rage, depression and even self-harm or suicide which could manifest in the client.

Sarkar (2004) explores some of the mechanisms which are involved in the process of boundary violation. This includes exception fantasies whereby a therapist considers himself

exempt from consequence due to his special status or high regard, mismanaged transference and counter transference frustration, rescue fantasies and rebellion against institutional rules.

Zur (2004) discusses the types of dual relationships which can exist viz. concurrent or sequential. As the name implies, concurrent dual relationships occur at the same time as the psychotherapy sessions. Sequential dual relationships occur once psychotherapy sessions have been terminated. Doverspike (2008) adds yet another layer to the classifications of dual roles noting that they can differ in predictability being either foreseeable (contemplated) or unforeseeable. The APA Ethical Standards (2002) offers a word of caution regarding foreseeable dual relationships stating that a psychologist should refrain from engaging in these relationships as one can expect it to impair objectivity, competence and effectiveness of therapy. Should unforeseeable dual relationships ever arise, the psychologist is expected to take necessary steps to resolve it whilst fully complying with their ethical code and working in the best interest of the client.

Zur (2004) proposes some key points to maintaining clinical integrity and effectiveness regarding dual relationships.

Firstly Zur (2004) recommends that psychotherapists regularly re-evaluate their attitude, approach and treatment plan paying particular attention to the effectiveness of treatment. This can be achieved through introspection and evaluating their counter-transference reactions.

Secondly, keep excellent records and documentation of all clinical interventions and any challenges or changes which may arise in the therapeutic relationship. This is to allow careful

assessment of the therapist's own progress and management (as a professional) as well as the management of obstacles. These records should also include the responsiveness and progress on the part of the client. Records are invaluable from a medico-legal perspective. These points are of particular relevance to the student and intern psychologist when they are conducting their first therapy session as it could help them avoid entering in a dual or multiple relationships with their clients and emphasises the need for proper administration such as note taking and signing of therapeutic contracts within the first session.

Although not exclusive to the first therapy session, dual relationships are not an obvious challenge to the novice therapist owing to the intimate nature of the profession. However, dual relationships have a direct bearing on the first therapy session because of the overwhelming amount of inter and intrapsychic variables that need to be processed and attended to. The novice therapist may be distracted from ethical codes of conduct which caution against dual relationships. For example a novice therapist can be overwhelmed by a client's presentation. One that they strongly identify with and thus disclose personal opinions or information to the client, thus blurring of the client-therapist relationship.

Ethical transgression, such as engaging in a dual or multiple relationships, has the potential to change the dynamics of the therapeutic process. If boundaries are over stepped, dual or multiple relationships are fostered by default. A boundary is a term used to express the threshold of appropriate behaviour on behalf of a practitioner in a therapy session. It signifies the expected and accepted psychological and social distance between the patient and practitioner. Transgression of boundaries, in effect, results in a breach of the clinical role. (Aravind, Krishnaram & Thasneem, 2012).

Aravind et al. (2012) state that appropriate maintenance of boundaries in a clinical setting helps to preserve the integrity of the therapeutic alliance as well as expand and enhance the public's faith in a profession. Boundaries are also important because it creates safety for patients, practitioners and society. It also clarifies the practitioner's role and defines the scope of practice of a particular profession.

Boundaries may be crisp, flexible or blurred in nature depending on the type of relationships established and cultural climate. Gutheil and Gabbard (1993) identify the major types of boundary issues. These are boundary crossing and boundary violations.

Boundary crossing can be defined as a harmless deviation in therapeutic activity which is non-exploitative in nature. It may in some instances be of benefit to the therapeutic process. On the contrary, boundary violations are potentially harmful circumstances which are characteristically exploitative and pose risks to the patient and therapy process.

The onus is upon the practitioner to preserve boundaries and ensure that violations do not occur as these may start off as small but can eventually escalate into larger, more significant problems. This is known as the Slippery Slope Concept (Welsh, Ordenez & Christian 2015).

Zur (2004) proposes that boundary crossing does not necessary constitute dual relationships, and can be very helpful in certain circumstances. Examples of helpful boundary crossing include hugging a grieving client, making a home visit to sickly client, attending a client's wedding and even helping the client gain mastery of their pathological fears through systemic desensitisation. However, this is by no means an exhaustive list of circumstances that

constitute beneficial boundary crossing. More complex or subtle circumstances may arise during one's clinical training whereby the distinction between helpful and harmful boundary crossing is not clear. In this regard, clinical guidelines need to be brought to the attention of the intern and student psychologist so that they are equipped with the abilities to deal with these circumstances as and when they arise.

The therapy session can be compromised when ethical issues are not given due consideration. Three major ethical considerations within the scope of psychology are informed consent, confidentiality and privileged communication (Herlihy & Corey, 1996). These three concepts are intimately related and all contribute to building and solidifying the foundations of a therapeutic alliance.

2.10 Informed consent

Corey (2009) defines informed consent as the client's rights to be fully informed about all aspects of their therapy process and to make autonomous decision pertaining to it and states that informed consent is both an ethical and a legal requirement. Informed consent is the process by which clients learn about confidentiality and its limits (Lasky & Riva, 2006). Sharkin (1995) maintains that confidentiality is an ethical obligation, whereby the therapist is mandated not to reveal information about their client without the client's consent.

Informed consent goes beyond just simply informing clients of their rights. It has bigger implications in the therapy process. It helps empower the client and helps build a relationship of trust between client and clinician. Jacob and Power (2009) concur that confidentiality in combination of an explanation of its limits are a cornerstone to building a trusting

relationship between the therapist and the client. Conversely, ethical dilemmas which compromise the right to confidentiality of a client may in fact have grave consequences, including allowing a client to suffer or even harm themselves or others (Blunt, 2006). This reiterates the critical importance of maintaining confidentiality. Woods and McMamara (1980) found that clients would often be more self-disclosing when they were guaranteed absolute confidentiality. Blunt (2006) describes a transition regarding the ethical principles of confidentiality, noting that there is a movement towards autonomy. This means that the client has a more significant role to play in the process of recovery and interaction with their practitioners. Clients are becoming more conscious of their rights in the therapeutic alliance as well as the responsibilities of those that treat them. Related to this concept is the ethical consideration of confidentiality from a legal perspective, Corey (2009) states that, save in exceptional circumstances, the therapist is legally prohibited from disclosing any information about the client. Privileged communication is the corner stone of the therapeutic alliance. Corey (2009) provides a succinct definition of privileged communication as “a legal concept that generally bars the disclosure of confidential communication in a legal proceeding”. From a psychological perspective, Duncan, Williams and Knowles (2012), claim that confidentiality is an important component in the establishment of a strong, effective therapeutic relationship between the therapist and the client. The Health Professional Council of South Africa stipulates that the psychologist:

“...shall safeguard the confidential information obtained in the course of his or her practice, teaching, research or other professional duties, subject only to such exceptions to the requirement of confidentiality as may be determined by law or a court of law. A psychologist may disclose confidential information to other persons only with the written, informed consent of the client concerned.”(Health Professions Act No. 56 of 1974, 1974).

Although there is an international consensus regarding levels of confidentiality in the Mental Health care profession, this could still be an obstacle for the intern and student psychologist as they may not know when or how to divulge sensitive and confidential information. Blunt (2006) asserts that the effectiveness in obtaining valid informed consent is dependent on a therapist's level of training, experience and sound judgement in conveying the scope of the therapy session, as well the limitations which result from the disclosed information. Duncan et al. (2012) argue that despite the fact that there are numerous recommendations and suggestions regarding the handling and the disclosure of sensitive and confidential material about clients, the implementation of such is still complex and difficult. Confounding the concept of confidentiality, are a plethora of factors. These include legal safeguarding, institutional and professional policies and guidelines (McMahon & Knowles, 1995) and ambiguity of the law and professional codes. However, the Health Professions Council of South Africa provides guidelines for the effective management of confidentiality. They state that the psychologist must discuss with the clients about the limitations of confidentiality and not disclose any confidential information without the client's permission. The code of ethics goes on to state that a psychologist may disclose information when it is a requirement of the law, to other professionals but only for professional purposes, and to protect the client or others from harm. Allan (2008) asserts that confidentiality is not final and that confidentiality may be broken to protect the rights of others. Lazovsky (2008) maintains that when a psychologist is faced with the extraordinary circumstance where breaching confidentiality is required, the psychologist needs to pose critical, ethically orientated questions to himself or herself such as, "What is necessary information?", or "What constitutes the best interest of the client?".

As part of the student and intern psychologist training and professional development, they have to interact with members of a multidisciplinary team. In order to provide the client with the most effective and proficient treatment, the intern and student psychologist has to provide feedback and engage in discussions with the multidisciplinary team about the client progress and recovery. This poses an ethical dilemma to the student and intern psychologists as to what information gleaned from the therapy session with the client can be shared with the multidisciplinary team. Strein and Hershenson (1991) state that when a counsellor is operating within a multidisciplinary team, he or she can adopt an approach in which all communication between the client and counsellor is regarded as absolutely confidential. This entails not sharing with the other team members the clinical impression of the client or comments made by the client. This increases the therapeutic relationship and level of trust between the client and counsellor. However, this approach of absolute confidentiality has its drawbacks. Strein and Hershenson(1991) assert that this approach has the ability to isolate the practitioner and to decrease the overall effectiveness of the multidisciplinary team and thus it may in turn be harmful to the client. In contrast, Strein and Hershenson (1991) state that the counsellor could adopt what they refer to as a corporate practitioner approach. This assumption entails that all members of the multidisciplinary team are bound by their ethical code and that confidentiality is guaranteed. Another crucial factor pertains to the client giving consent to have their information discussed with the multidisciplinary team.

Strein and Hershenson (1991) stipulate that when intern and student psychologists are in supervision session, confidentiality can still be maintained. They maintain that the supervision session is related to the supervisee skills' development. In such cases, a client's personal details, such as identifying information, can be deleted thus ensuring the client's anonymity

2.11 Culture

Culture as a concept is both vast and varied. It can be contextualised to represent different things depending on the setting and situation in which it is used (Spering, 2001). Thomas (1994) offers perhaps a more comprehensive understanding of culture, stipulating that it is the subjective view of a shared belief, social norms and values of a particular group of people. These beliefs, social norms, values and practices have been entrenched into the prescribed social standards and institutions and have been historically cultivated, transmitted and accepted as a functional and viable means across time. Culture is an inextricable part of the human condition. Humans do not only produce and sanction culture, but they are also influenced by it (Segall, Dasen, Berry & Poortinga, 1999).

Translated to the domain of psychology, culture predictably has a profound role to play not only in the act of seeking psychological help, but also in participating and being receptive to the therapeutic process. Spering (2001) boldly suggests that culture, as a source of influence on human behaviour, as it is associated mental underpinnings, has long been ignored in psychology. Spering (2001) proposed some key questions pertaining to psychology:

“What is universal and what is culture specific?”

“What is specific to one cause and what is a general pattern?”

“What is psychological and what is cultural?”

Although research shows an emergence in topics concerning cultural, cross-cultural and indigenous psychology, there are still deficits in the available data in this domain. (Greenfield, 2001; Kim & Berry, 1993).

In South Africa specifically, there is a melting pot of cultural, traditional, racial and religious factors which can influence psychotherapy sessions. These need to be identified so that student and intern psychologists are imbued with an understanding of cultural diversity and are able to use this as a tool in psychotherapy treatment. Cultural differences within the first therapy session may present as challenges in the sense that they may hinder, interrupt or even block the therapy session and outcomes. Delving into the domain of indigenous psychology, one begins to understand that therapy techniques and treatment plans cannot simply be used on all people, all of the time, despite the fact that different groups of people may have similarities in clinical presentation and circumstances. Hence this shows that student and intern psychologists who hold limited therapeutic modalities in their repertoire are under the false assumption that an all-encompassing model or method of treating client will be beneficial and help them in their interactions within the first therapy session.

Enriques (1993) brings to prominence two concepts which underpin the field of psychology in local settings: indigenisation from within and indigenisation from without. Indigenisation from within refers to the use of indigenous information as a primary source of knowledge. Indigenisation from without pertains to the modification of psychological theories in order to fit into the local cultural context.

Heelas (1981) and Sinha (2003) discuss the concept of folk psychology. This refers to ordinary psychological views, preferences, practices, norms, assumptions and theories that are held by the general populace of a particular society. It is a somewhat natural phenomenon that has no scientific basis. This is direct contrast to scientific psychology which encompasses an academically constructed system of psychological knowledge which uses scientific methodology. Kim and Berry (1993) highlight the unique nature of indigenous psychology, noting that it is the study of native behaviour which has not been transported from other regions. It is designed for its people.

When one considers this concept, it is evident that there are perhaps gaping deficits in the manner in which student and intern psychologists are trained. Of course, the academic curriculum is validated by the use of scientific methodology and evidence based practices, however, they are not taught how to incorporate indigenous psychology as a tool in a treatment protocol. This task of incorporating indigenous psychology in the curriculum is proven to be arduous since there is no scientific foundation that can prove its proficiency.

2.11.1 Management of cultural aspects

Rohner (1984) provides a more definitive perspective of culture as a group of meanings which are learned and as shared as well by the people in that population. Culture is transmitted from one generation to the next.

Segall, Lonner and Berry (1998) provide three perspectives to understanding cultural difference within the arena of psychotherapy: Universalism, Particularism and Transcendist.

Universalism, which asserts that psychotherapy, in spite of its multitude of approaches, has common facets such as warmth and understanding, states that cultural differences will not have an impact on the psychotherapy with clients who are of a different race or culture from that of the psychologist. Hence it is not necessary to address these issues.

In contrast to Universalism is the Particularism perspective, which proposes that people from different cultural backgrounds will not be able to understand each other because their culture, race or ethnicity may have a fundamental effect on the person's experience. Thus, cultural differences, when viewed from this perspective are seen as a major and insurmountable obstacle in psychotherapy.

Finally, the Transcendist perspective argues that different cultures, races or ethnicities have different psychological compositions. However, these differences can be transcended.

La Roche and Maxie (2003) provide guidelines that clinicians need to consider when working with clients of different cultural backgrounds. However, they caution against using these guidelines as a definitive problem solving manner.

Cultural differences are subjective, complex and dynamic. Within the arena of psychotherapy, there is a general consensus on which factors compromise cultural differences between a clinician and a client. One may argue that it consist of differences in skin colour, language or accents. Nevertheless, these factors that are associated with cultural differences are subjective. Therefore, the client will attach their own understanding of these differences

in accordance to their experiences. Consequently, the subjective understanding is of more importance than the objective differences of culture.

Cultural differences are complex in nature and can occur in a multitude of variables (for example in sexual orientation, age or religion). Therefore, it is of critical importance to consider all the possibilities in which these differences can occur. White and Epston (1990) argue that the concept of cultural differences between the therapist and the client is never static. Due to the dynamic nature of cultural differences, certain factors may become less important and may be superimposed by other more pertinent factors. As such, it is advisable for the therapist to ensure continuous exploration of the dynamic nature of culture, even when cultural differences may have been understood at an earlier stage of therapy.

The salient cultural difference needs to be addressed first. La Roche and Maxie (2003) propose that cultural differences have varying levels of importance and it is crucial for the clinician to address these directly. Consequently, La Roche and Maxie (2003) argue that when a therapist acknowledges the cultural differences with a client and addresses it, the therapist will facilitate further discussion about the therapy process thereby increasing the chances of a successful outcome.

Similarities should be addressed as a prelude to discussions of cultural differences. Spieght and Vera (1997) establish that the therapist and the client share many similarities. Therefore, the client will profit if the therapist acknowledges and shares the similarities. In doing so, the therapist may reduce the ambivalence of the client has to the cultural difference. Other

benefits of addressing similarities between therapist and client could be that it assists in developing good rapport and increases the client's acceptance of the therapist.

The client's distress levels, in combination with the presenting problem, are the determinants of when and if the cultural differences are discussed. An assessment of the level of emotional distress will be beneficial to the client. Wilkinson and Spurlock (1986) recommend that differences between the therapist and client should not be addressed during crisis intervention as the safety, together with the mental status, of the client is of paramount concern.

2.12 Time management

Time management is an essential issue within the confines of the therapy session. Often, the time frame allocated to the therapy session is disproportionate to the vastness of substance and content that emerges in the time. Student and intern psychologist therefore have to contend with the time constraints and still achieve therapeutic goals. The definition of time management denoted in the Collin's dictionary states the time management is an analysis of the manner in which working hours are spent as well as the prioritisation of tasks to allow maximisation of personal efficacy in a working environment. It is therefore evident that effective time management is an important skill in the therapy session. James (2010) has identified sources of poor time management in the therapy session. These are a lack of directive sign posts to herald the segment of the therapy session, and mismanagement of time causing the therapist to rush and exceeding the prescribed length assigned to the therapy session. Directive sign posts refer to the manner in which the therapist conveys the amount of time that needs to be attributed to each topic and the amount of time left in the therapy

session. In essence, it pertains to the manner in which a therapist directs the structure of the session.

Sue and Sue (2008a) place much emphasis on the effective structuring of a therapy session so as to balance the amount of time with the quality of content. They propose that each therapy session should begin with a check-in routine which should be a maximum of ten minutes in length. Although this is not done within the first therapy session, the check-in routine is used as a means to establish significant events and positive and negative changes that may have occurred since the last therapy session. Once the check-in routine is complete, an agenda should be set for the session. Sue and Sue (2008b) report on the value and purpose of the collaborative efforts of therapist and client in setting an agenda. The items on the agenda can be arranged in order of importance and encompasses current life situations and associated stressors, suicidal feelings and tendencies, therapy-interfering behaviours as well as intervention strategies for current symptoms. The therapist should ensure that the agenda is not extraneous but is rather relevant to the client's presentation and therapeutic goals.

2.13 Résumé

This chapter aids in a deeper understanding of the obstacles faced by student and intern psychologists, by exploring the pertinent literature and other areas of concern regarding this field. In the next chapter, a discussion of the methodological underpinnings of the study will be discussed.

Chapter Three

3.1 Introduction

This chapter expatiates on the research design and discusses how the research instrument was administered. The philosophical underpinnings of phenomenon under study will be examined, as well its assumptions about human understanding. There will follow a critical appraisal, vis-a-vis a substantiation of thematic analysis and its usefulness in a study of this nature.

3.2 Data collection

The semi-structured interview approach was selected for this study. A semi-structured approach as a sort of golden means between the two extremes of interview styles (completely structured and completely unstructured, Welman, Kruger and Mitchell, 2005) can be cautiously manifested to avoid the pitfalls of the latter, two instruments. Semi-structured interviews in the phenomenological context can best be described as an interviewer guide which allows the researcher to focus on certain themes and subtopics, gloss over others, and improvise with yet others if the flow of the interview so demands.

To summarise, Denscombe (2007) states that semi-structured interviews allow for flexibility and latitude which facilitates shifts in focus and encourages the interviewee to speak with freedom and ease, thus expanding and clarifying on the information obtained from the interview.

Austin (1981) found that using personal interviews for data collection can potentially negate the poor response rate associated with a questionnaire survey. Furthermore, a personal interview allows for a deeper exploration of the attitudes, values, beliefs and motives which underpin the personal, professional and philosophical constitutions of the research participants (Richardson, Dohrenwend & Klein, 1965). In addition, Richardson et al. (1965) stress the value of personal interviews by noting that it also allows the research investigator to further analyse the validity of the research participant's response by observing the non-verbal and paralinguistic subtleties that come with face to face interviews. Additionally, the use of semi structured interviews allows for the participants to reveal and discuss their feelings, as well as their thoughts, that they may consider private and confidential.

3.3 Probing questions

A probe can be considered as a means to delve into aspects of the participant's answers by prompting them to think about the underlying issue.

Semi structured interviews permit the use of probes, which in itself can be an important tool to determine the reliability of the data (Hutchinson & Wilson, 1992). They assert that probing enables clarification of issues discussed by the research participant and allows inconsistent responses to be further explored and clarified.

Patton (1990) also maintains that probing contributes to establishing a favourable rapport between researcher and respondent. This minimises the tendency of the respondent to give answers which are socially desirable irrespective of whether they are true or not.

3.4 Records

In order to keep an accurate and detailed account of the interview process in its entirety, an audio recording by means of a Dictaphone was made of each individual interview. Barriball and While (1994) maintain that the value of audio taping of interviews lies in the ability to record an identical replication of interviews which in turn allows for deeper retrospective analysis of the content. They further argue that recording an interview by means of an audio tape, reduces the risk of potential errors on the part of the interviewer. These errors include incorrect recording of the data and cheating by means of logging in answers of unasked questions. Audio recordings of each interview were then transcribed.

3.5 Ethical Considerations

Permission, including ethical clearance, has been sought from the University of Zululand Ethics Committee to proceed with this study. In order to conduct this research at the University of Zululand permission from the Deputy Vice-Chancellor (Research and Innovation) has also been sought. The ethical implications and the objectives of this study had been explained to participants. Only participants who were willing to participate in the study were selected. The participants in this study were willing to openly and honestly discuss the topic. The participants were informed that they were free to discontinue participation in the study at any time if they wished to do so. Informed consent forms were administered to all participants. They were informed of their rights to privacy, and issues of confidentiality were discussed. Interviews were 60 minutes and were recorded on audio tape and transcribed verbatim *mutatis mutandis*. Since the interviews focus on the clinician's personal experience vis-a-vis therapy process, the participants were not considered vulnerable. No confidential information about the client was discussed.

3.6 The Interviewer effect

Denscombe (2007) notes that the manner in which interviewees respond, it can be greatly affected by how they perceive the interviewer. Durrant, Groves, Staetsky and Steele (2010) meanwhile purport an increase awareness of how the actual activities of the interviewer are an important determinant to response errors and also to non-responses. Denscombe (2007) argues that issues such as sex, age or even ethnicity may affect the quality and amount of information gleaned from the interview. As a result, the personal characteristic or identity of the interviewer may have a bearing in the interview process. He adds that, that there are limitations as to what the interviewer can employ to overcome these variables. However he adds that effort can be placed to negate potentially counteracts this. As a result the interviewer placed an emphasis on politeness, punctuality, neutrality and non-judgemental so as to create an environment that the interviewee could feel comfortable.

3.7 Interview setting

The interviews were conducted at a site considered most appropriate and convenient by the research participants i.e. in their office. This was done to ensure that the participants were in an environment in which they felt safe and comfortable so as to maximise the richness and depth of information shared during the interview session. The seating arrangements irrespective of the venue used were of the face to face interview style.

3.8 Funding

This research was self-funded. The expenses included: printing, travelling, binding and editing. Additional expenses included a Dictaphone, which was essential for the recording purpose, internet expenses and printing of transcripts.

3.9 Sample population

Ten participants were used for this study, selected on the basis of their meeting all of the following criteria:

The participants were either student or intern psychologists.

The participants were currently completing a Master's degree in Clinical Psychology.

The participants have had at least one therapy session with a client (not including the first interview).

Participants were selected regardless of gender, race, age, theoretical orientation. As stated previous, the participants were from various universities within South Africa. Purposive sampling was used to access the target population. Purposive sampling is a category of non-probability sampling, the latter being used not on a random basis but where researchers use convenience samples of people who volunteer to participate. Purposive sampling rests on the assumption that participants are representative of the population being studied. In sum, purposive sampling was chosen because it provides a far more acceptable degree of representivity than other sampling techniques, and is ideally suited to the type of research being undertaken (Terre Blanche, Durrheim & Painter, 2006).

3.10 Research paradigm

Terre Blanche, Durrhiem and Painter (2006) state that research has 3 major dimensions, ontology, epistemology and methodology. Research paradigm is all inclusive system of practices and as well as thinking that co-ordinates the nature of enquiry in the three dimensions. Qualitative research uses a naturalistic approach that aims at understanding

concepts within a real world setting (Golafshani, 2003). In addition the researcher does not attempt to influence the findings. Strauss and Corbin (1990) assert that qualitative research is research that produces findings not arrived through the use of statistical means. Qualitative research produces different type of knowledge than quantitative inquiry. One reason for this is that qualitative research argues its results from the underlying philosophical nature within a paradigm. Therefore, methods such as interviews and observations are used in the interpretive paradigm.

Researchers who employ an interpretive paradigm believe that the reality consists of the people's subjective experience of the external world. While Willis (1995) maintains that interpretivists argue that is no one correct route or particular method to knowledge. Therefore Walsham (1993) asserts that within the interpretive tradition there are no correct or incorrect theories but it should be valued in accordance to how interesting they are to the research.

Myers (2009) states that the fundamental idea of interpretive researchers is that access to reality is through social constructions such as language, consciousness and shared meaning.

3.11 Rationale for utilising interpretive paradigm

Interpretive paradigm is driven by observation and interpretation therefore while observing merely collects information, to interpret is to make meaning of the information. Aikenhead (1997) maintains that interpretive paradigm tries to understand phenomena through the meaning that the people assign to them. Therefore it was chosen to explore the obstacles faced by student and intern psychologists whilst conducting their first therapy session.

A key feature of interpretive paradigm is the need to put analysis into context (Reeves & Heedberg, 2003). Thus it attempts to understand the world from a subjective experience of

the participants. Another reason for adopting interpretive paradigm is that it utilizes meaning orientated methodologies for example interviews or participation observation. This relies on subjective relationships between the researcher and the participant. Finally, predefined, dependant and independent variables are not of value in interpretive paradigm. Instead it focuses on the human complexity and making sense of situations as it arises (Kaplin & Maxwell, 1994). In addition Kaplin and Maxwell (1994) argue that interpretative research concerns itself on the full complexity of human sense making as the situation emerges.

3.12 Data analysis

Thematic analysis as a means of analysing and interpreting the data, the latter being suitable for exploration of experiences of a subjective nature, Braun and Clark (2006) describe thematic analysis as a method of identifying, correlating and reporting patterns or themes which emerge within the body of data. Braun and Clark (2006) define a theme as important correlations in the data which are directly related to the proposed research question and is representative of patterned responses or means encompassed within a set of data. Thematic analysis can be differentiated from other analytic methods which also seek to identify patterns within qualitative data, such as grounded theory (Braun & Clark 2006). They argue that thematic analysis is not embedded in theoretical or even in technological knowledge. Therefore it is not attached to any particular theoretical framework, hence allows for more understanding of the analysis by researchers.

The following steps will be used in thematic analysis (Terre Blanche et al. 2006):

3.12.1 Familiarisation and immersion.

This step requires the researcher to immerse themselves in the data material. Terre Blanche et al. (2006), state that the data material could be in the form of texts, transcripts or even field notes. At the end of this step, the researcher will know the data sufficiently, where things are located and the different kinds of interpretations that can be adduced.

3.12.2 Inducing themes.

Terre Blanche et al. (2006) suggest that this step utilises a bottom up approach, in which the material is analysed and organising principals are gleaned instead of utilising preselected categories. In order name categories, Terre Blanch et al. (2006) suggest that the language of the interviews, as opposed to an abstract theoretical language, be used. Secondly, in the selection of themes, Terre Blanch et al. (2006) suggest that one should not only summarise the content, but also look for contradictions, processes and functions etc. in order to organise the material. Thirdly, they suggest that having a few themes are not appropriate for discussion and that an “optimal level of complexity” needs to found. Fourthly, they suggest that there is a need to explore different systems to see the outcome and not settle for one type of system too quickly. Lastly, the main focus of the study should not be lost, in order for only relevant themes to be selected.

3.12.3 Coding

In this step the data is marked in accordance or relevance to a particular theme. Terre Blanche et al. (2006) suggest using different colours to highlight the parts of the data that are relevant to a specific theme.

3.12.4 Elaboration

From the previous step, new themes and categories may arise. These new themes need to be examined more closely, which Terre Blanche et al. (2006) refer to as elaboration. This allows for the examination of things that may have been missed or undetected thus admitting refinement of the coding step. This process should continue until no further changes to the coding occur.

3.12.5 Interpretation and checking

In this final step, the accounts are written while utilising the thematic categories for the headings. It allows for exploration of the interpretation and also for corrections and improvements if necessary. In this step, the researcher's bias can be investigated to determine how it may have interfered with the data analysis.

3.13 Résumé

In this chapter, the methodology that was applied this research was discussed. In the next chapter data analysis, interviews and interpretations will be discussed.

Chapter Four

4.1 Introduction

This chapter entails a presentation of the themes that were ascertained from the responses of the participants regarding the obstacles they encountered whilst conducting their first therapy session. Extracts and quotations of the participant's responses are used in order to substantiate the researcher's findings as well as to provide a first-hand experience of the topics discussed in the literature.

As stated in Chapter 3, this research utilises a phenomenological theoretical orientation and the data will be formulated and structured through thematic analysis. The purpose of this is to provide a detailed description of the data in order to gain a robust understanding of the data, whilst conveying meaningful insights into the participant's views, responses and experiences. A discussion of each theme is also encompassed in the analysis.

4.2 Number of intern and student psychologists who participated in the research

<u>Gender</u>	<u>Intern Psychologist</u>	<u>Student Psychologist</u>
<u>Male</u>	4	1
<u>Female</u>	5	0

Table 1: Demographics of student and intern Psychologists

The population sample consisted of 10 intern or student psychologists and were categorised by gender. Within the Male Category, 4 (four) were intern psychologists and 1 (one) was a student psychologist. The female category consisted of 5 (five) intern psychologists. All participants were registered with the HPCSA (Health Professions Council of South Africa) within their relevant categories, i.e. student psychologist or intern psychologist (supervised practice). The intern and student psychologists were registered for a Master's Degree in Clinical Psychology at various Universities within South Africa. Theoretical orientation was not used as an exclusion criterion for this research. Informed consent was obtained from all participants.

4.3 Key Themes

Upon close inspection and examination of the qualitative data from each participant, key themes were identified. Numerous themes were identified and filtered from the responses of the intern and student psychologist.

Themes	Illustrations
Exploring Incompetence	The feelings of incompetence were described by the clinicians as being overwhelming. The clinicians shared their feelings and emphasised that this awareness of incompetence was only created once they had contact with the client in the therapy session. Often the clinicians lacked awareness of this feeling before the contact with the client.

Empathetic Failures and Counter Transference	The clinicians who experienced empathetic failure often missed or overlooked the implications of this in the therapy session. As a consequence, they also failed to recognise and understand the counter transference feelings it evoked in them.
Anxiety	This theme emerged in several clinicians. Anxiety in the first therapy session was reported by many of the clinicians. It manifested in various ways and developed through numerous means.
Ethics	Numerous clinicians found that ethical issues were a major concern and obstacles for them in the therapy session.
Inappropriate Client Behaviour	This posed a major challenge for the clinicians as they were ill equipped to deal with this obstacle.
The need for more training	Almost all of the participants felt that there was a significant need to be trained more during Masters in psychology. They felt that the training that they did receive did not prepare them to overcome the obstacles that they faced.
Therapeutic Alliance	This emerged as a significant theme. Often the clinicians were ill-prepared to manage the dynamics of establishing and managing an effective therapeutic alliance.
Cultural Dynamics	This was a prominent theme. Even when participants shared many similarities with their clients, they still encountered cultural differences.

Table 2: Main themes elicited from student and intern psychologists**4.4 Discussion of the themes elicited from the interviews of the participants**

The participants' responses together with the themes are provided below.

4.4.1 Exploring inexperience. Inexperience, anxiety and feelings of incompetence are three interrelated concepts that frequently occur in student and intern psychologists. As discussed in the review of literature, feelings of incompetence are deeply rooted and correlated to clinical inexperience of novice psychologists. When feelings of incompetence occur in novice psychologists, it leads them to become anxious about the quality and efficacy of therapy and treatment. Feelings of incompetence and anxiety can also create discomfort for a psychologist in the working environment. This sense could be related to fears of humiliation in front of the client and also fears that the therapist is performing inadequately and not meeting the expectations of the client. The umbrella theme of clinical inexperience and its related sub-categories emerged prominently in this research investigation.

4.4.1.1 Feelings of incompetence. The majority of the participants responded to feeling uncomfortable, uncertain and unsure regarding the exact manner and course of negotiating and conducting a therapy session with a real client. Clinical uncertainty is a branch of clinical inexperience. Participant 1 stated that her source of discomfort was caused by her incompetence and her anxiety levels. Increased anxiety levels have the potential to cause the participants to doubt their abilities and hence question the overall quality of treatment.

Participant 1 reported:

Well I would say especially in the first therapy session, my experience was somewhat uncomfortable. I think that probably links to my not being competent and depending on the case the anxiety level it could be personal so personal anxiety levels depending on what the client has been through might increase my own anxiety.

The concept of feelings of incompetence and clinical inexperience appears to be a recurring theme amongst participants, with participants responding about their subjective feelings in this regard. This is congruent with the findings of Theriault et.al (2009), Theriault et.al (2002) and Theriault and Gazzola (2006) who noted the detrimental effect of feelings of incompetence on the psychologist in a therapy session.

Participant 2:

A particular session comes to mind when I was at the student counselling centre, but I had just started my very first day, very first time and she comes in and the case is dealing with termination of pregnancy and I was so completely out of my depth. I felt literally like a raft in the middle of the ocean you know I felt completely unprepared and like I had absolutely no idea what to do with this person or how to help this person... Feelings of inadequacy and so on and that was my first session and yeah.

And,

Participant 4:

Honestly, looking back, I remember I was nervous. I was doubting and questioning if I know what I'm about to do and you know I was so pre-occupied with you know what questions am I going to ask the patients, you know and in fact even during the session

I kept you know, you know while trying to listen to the clients or the patients and you know trying to actually do your work at the same time. It felt like you know I had to consistently think of what questions are I going to ask next.

This shows that in clinical practice, it is more difficult to attain a balance between fully engaging with a client and simultaneously completing the administrative component (i.e, note taking and completing of required forms) of clinical practice and ensuring a flowing current, as opposed to a mechanical robotic approach in the therapy style.

These feelings of incompetence, accompanied with self-doubt in their therapeutic abilities and anxiety about one's performance, are an inherent part of the development of the student and intern psychologist. These feelings, according to Truell (2001), could arise from a general lack of theoretical and practical skills in addition to having an over or under estimated belief in their own therapeutic ability or an unrealistic assumption about their clients. These feelings of discomfort could also be attributed to the perceived expectation of the client and adopting the psychotherapist role.

Participant 6 provides evidence for this:

During the therapy session, I think again it would be the patient's expectations because you are not sure about what they are looking for and you are not sure if you will be able to deliver but you are trying to find a balance I think, but the expectation is always what was difficult for me. What does the patient expect from me?

Due to the lack of clinical competence amongst student and intern psychologists, one needs to consider the differences between a novice compared to an expert in the profession.

Feltovich, Prietula and Ericsson (2006) formulated the differences between the expert and the novice. They postulate that experts have, as a result of their professional experience in the profession, a vast knowledge base. Hence, when they are faced with a problematic situation they have the ability to remember more information and identify pertinent information whilst discarding irrelevant ones. They are better equipped and faster to response to specific tasks in their domain as compared to novices.

It is pertinent, and at the same time somewhat worrying, to note that only one of the participants who experienced feelings of incompetence and associated anxiety managed to curtail it in the therapy session. The participant made extensive use of self-reflection and relaxation techniques. This participant validated the finding of Varma (1997) who noted the importance of self-reflection and relaxation techniques to aid the psychologist and the importance of having a reservoir of techniques that can be used to combat stress and feeling of incompetence.

Participant 2 reported:

I started keeping it in my mind to remind that I don't always have to keep it together and also I had to master the anxiety feelings and in any session not just the first session. And in particular be aware of my own emotions my own reactions and it can quiet severely impact the client or the session.

And,

I think also giving myself some a little bit of breathing space before the intake.

Also,

I think also form them in particular a certain amount of self-reflection and you know really examining yourself it's a therapeutic relationship and a relationship like any

other. What did I bring to this, what did my client bring to this and try to actually figure out how much of it were you and how much wasn't and you know quite a lot of it would probably be you so you know the client also comes with her baggage you know with a whole lot of anxiety and her own standing that well yes I certainly did contribute to that session and to that client and it's not 100 percent my responsibility.

From the number of participants who exhibited feelings of incompetence, the lack of a deeper understanding of this concept and the general lack of strategies to manage the feelings portrays the vulnerability of the novice psychologist. This highlights an area of concern, as noted by Theriault and Gazzola (2006), that feelings of incompetence have a detrimental effect on the psyche of the therapist. In addition, this brings into prominence a gap and a major deficit in the teaching and training of psychologists and the management of adverse internal reactions and feelings within the novice psychologist. This is in accordance with the research done by Truell (2001) who noted that due to the intense and emotional nature of the work that psychologists perform, it could cause psychological distress. Halleck and Woods (1962) concur with the finding of Theriault and Gazzola (2006) in that they reported that increased levels of anxiety and depression were common amongst psychologists. Therefore, Truell (2001) argues that the negative effects of learning the skills of counselling should be negated first and foremost in the classroom setting so as to ensure that the psychologist does not carry with them any negative aspects of learning psychotherapy into the therapy session. This could lead to contamination of the therapeutic relationship between the psychologist and client and thus lead to negative outcomes in the therapy process.

4.4.1.2 Theoretical competence in contrast to practical competence. The transformation of theoretical knowledge into a practical application is often tumultuous, as

evidenced in the body of literature presented by Theriault and Gazzola (2006). This often causes unbridled feelings including inadequacy and being fraught with uneasiness and difficulty. The expanse of theoretical knowledge that is held by intern and student psychologists is erroneously hailed as a buffer against feelings of inadequacy. These feelings of competence quickly erode when novice psychologists are confronted with a situation where they are challenged or even by simply being placed in a counselling session. The gap between the theoretical capacity and practical knowledge becomes prominent and causes a barrier between the psychologists and clients, thus causing the novice psychologists to question themselves about the actual role that the psychologist plays in the healing and treatment of clients and question about the qualities that they should possess.

Participant 2 said:

So really it felt like while I, you know, I learned about theory and about particular techniques and that sort of thing, I didn't actually know how to help a student. Do I do an intake interview when she's feeling distressed or how do I actually go about being a psychologist. So you know this is what I've been trained for but I'm nowhere near what I should be doing.

This highlights the deficits in appropriately managing a patient and shows that practical application requires discretion about when, how and to whom to apply a particular therapeutic modality to.

Participant 8 stated:

I think that there's so much I need to learn, that maybe I'll be doing injustice to the patient because I'm not competent enough. The theory and practice, the theory is very different. Psychology is designed in a way that you learn so much theory and then you

are supposed to apply the theory. So it did feel like I really didn't know what I was doing at first because I really felt incompetent. The nature of the, the sessions that I had here is quite different from the one's I used to have when I was doing MI. So there are, there are patients of different kinds of diagnosis that I wasn't exposed to when I was doing my MI..... You know there was a time where I link being in therapy with driving cars you can't say that because you've learnt about the theory, what gears, how do you put in a gear or what do you press to brake, what is the clutch and everything, it's very different when you get behind the wheel and actually drive. So you learn the theory of how you drive a car but now you've been put behind the wheel and you're expected to drive. So you do feel that maybe even though I do have the theory but actually driving the car is different from learning the theory. So the exposure that I had in my MI is very different from the one I'm having now. So that means then that I can feel sometimes that I do not know what I'm doing.

This participant analogously compares clinical practice to the action of driving. Driving requires a combination of skills including foresight, judgement, co-ordination, concentration and experience, similarly clinical application requires these attributes. So in this manner, although the intern psychologist has learnt the theoretical foundations that underpin psychological therapy, it is often a tenuous task of converting this theory into practical, usable skills that can cause positive effects and change within the client's psyche. Thus aiding in the psychological recovery of the client.

Stedman and Schoenfeld (2011) questioned the minimal standards of competency in the training of psychologists and proposed the use of the Examinations for Professional Practice in Psychology as a way to examine competency across many domains in psychology. This brings to mind the quandary of a need to assess student psychologists on core competencies

before the start of internship, so as to ensure efficient treatment of clients. While Donovan and Ponce (2009) argue for the transition from a time-orientated model of learning and teaching to that of a competency based model, so as to ensure that the student and intern psychologist has acquired the core competency that are necessary for effective treatment of the client in a clinical setting.

4.4.1.3 Client's knowledge of therapist's feelings of incompetence. The majority of the participants assumed that the negative behaviour of the client within the therapy session was attributed to their client's awareness of the psychologist's feelings of incompetence, lack of experience and clinical skills. This in turn had a negative effect on the psychologist's overall competence and hence their functionality in the therapy session. This perception increased the overall levels of anxiety in the novice therapist. It is well documented that anxiety is indeed a natural component in the training experiences of the novice psychologist. This is in keeping with the literature finding of (Ronnestad and Skovholt, 2003; Skovholt and Ronnestad, 2003). Thus, the research findings of the presence of anxiety is not unexpected, nevertheless what is pertinent to note, is the manifestations and the expressions of anxiety and its effects on the therapy session. Thus, the anxiety may be viewed as developing in an interrelated manner between the personal and professional selves of the psychologist. Therefore, when anxiety arises in the personal self it leads to increased anxiety in the professional self of the novice therapist. This has the propensity to lead to damaging and harmful effects on the first therapy session thus on the therapeutic continuum as a whole, as the client may be acutely aware of the relative lack of experience, expertise and clinical knowledge of the psychologist.

Participant 2 said:

Yeah I think it did because of the anxiety/paranoia, it makes me kind a then more aware of the things I'm actually already aware about and so yeah I'm doing a terrible job, she's turning away from me, she's not engaging because of me.

And,

Participant 10 stated:

I think my clients start seeing me as not competent enough, you know they start seeing me as not being able or competent enough to handle the situation that they bring, it affected what I was going to say next or do next because you know you can definitely feel when a patient doesn't think you're confident enough they start to lose respect for you or the patient can go and not come back so you definitely lose that confidence that you have as a professional.

The psychologist often used the client's verbal and nonverbal behaviours as a reflection of their own performance and judged their ability. The participants overall therapeutic ability and confidence levels were to an extent, largely determined by the clients' reaction to them. Whether this emotional reaction of the client is truly in response to the psychologist ability is questionable. However, another important question arises regarding how intern and student psychologists evaluate their own therapeutic performance. The student and intern psychologists often views this rupture of the therapeutic alliance as being caused by them and their lack of clinical competence, increased levels of anxiety and sense of being overwhelmed by the therapy session.

4.4.2 Empathic failures and counter transference. Empathic failures often arose in the therapy session when the psychologist encountered counter transference feelings toward their client. These empathic failures were recognised, however, most psychologists were not always able to understand the cause and underlying dynamics of this phenomenon and as a result, often attributed their perceived failure to the client's non willingness to engage in the therapeutic encounter.

Participant 10 reported:

And issues of counter transferences how transferences as well, where you would probably get a patient who has the same problem that you have had and you can then begin to disengage with the patient because you feel as though they are not dealing with this the way you dealt with or they could have handled the situation better and then yeah, so there's a lot of tension and anxiety provoking. It definitely did affect the therapy session because as I said, you don't know exactly what you're doing, you're not sure about what you're doing, you're not sure on whether you're competent enough to even do it, so you keep getting worried about that, that lose count of what is happening with the patient and you find yourself asking questions.

Often the therapist, as a means to counteract their disengagement with the client, increases the questions posed to clients. However, there is a realisation on the part of psychologist, that the increased questioning has an adverse effect on the client. This often causes the client's level of discomfort to increase. Therefore, this method that is commonly utilised by novice psychologists to counteracting the empathic failures is inherently ineffective.

Participant 10 said:

Asking the same questions and then you might find that the patient may himself feel uncomfortable.

Mordecai (1991) asserts that these failures are often communicated by the client to the therapist through verbal or affective means. However, Mordecai (1991) cautions that many empathic failures are concealed and obscured by the countertransference that occurs between the psychologist and the client.

Stone (2001) proclaims that psychotherapists cannot be expected to always fully understand their patients. This is a valid point particularly in the case of the novice psychologists, because hearing and listening to a client's story is vastly different from understanding their specific set of issues. Despite theoretical groundings and academic frameworks, there is no set formula or generic management plan that can simply be transposed onto all or any clients who present in a certain manner. This not only relates directly to practical versus theoretical competency and clinical inexperience but also highlights the significance of appropriate patient management. The following responses indicate real instances where patient management was an issue.

Participant 1 reported:

So during the first therapy session mostly because I'm not sure of I've formulated correctly, I'm not sure of the right route so overall the experiences it's probably not as great as it would be if I had knew what I was doing.

Stone (2001) appropriately highlights three specific reasons regarding therapist misunderstanding: over adherence to theory, boundary crossing and inexperience. These reasons are consistent with the previous findings of this research investigation

A closely related concept to empathic failure is the timing of the comment or intervention. As a consequence, the psychologist may be unaware that their interventions actually have an adverse effect of the client and on the therapy process on a whole. Stone (2001) argues that even when the psychologist is well intentioned, their intentions, questions or even observations about a client maybe interpreted by them as un-empathic or to a greater extent, hurtful. In this case, one of the reasons perhaps could be that the comment was ill-timed or perhaps the interpretation by the psychologist was ill-timed.

These slips in the therapy, which is often caused by the psychologist themselves, could potential be due to lack of training or clinical inexperience, feelings of incompetence, anxiety or lack of deeper understanding of the therapy process.

4.4.3 Anxiety

Numerous clinicians reported feeling anxious and overwhelmed by their experience of anxiety. They often report that because of the feeling of anxiousness, it led them to be preoccupied in themselves to the detriment of the client.

4.4.3.1 Self-confidence

Lack of self-confidence on the part of the psychologist emerged as a recurring theme in the research. It surfaced in a myriad of ways amongst individual psychologists.

Participant 1 said:

You don't always know what you're doing, whether you're taking the right route or therapy, selected the right therapy

And participant 3 stated:

Oh I immediately thought what the hell I am doing this for so you know I should just give up now I'm just wasting everyone's time and money. Because I might not be competent. That was my first sort of thought,

Self-confidence can be viewed as a characteristic that greatly influences behaviour in a person. Increased self-confidence is believed to aid the psychologist in their therapeutic abilities and in improving their clinical practice. As evidenced in the quotes from the participants, they often doubted their abilities, their ability to contain and to manage their client appropriately. However, one could argue that when a novice psychologist, or even to a certain extent, a well-seasoned professional begins to question themselves and their professional abilities, it could be considered appropriate or even been seen as sign of self-reflection. In most cases this can be considered to be healthy, however, in the case of the participants, the lack of self-confidence is often disconcerting and leads them to have increased levels of anxiety and therefore negatively affecting themselves and their therapeutic abilities. This is in accordance with the survey of literature in which Skovholt and Ronnestad (2003) claim that novice or in-training psychologists often doubt their abilities and

themselves. These research findings are corroborated with the research findings of Birchhoff (1997) who found that participants felt that they were pretending and feared that their lack of therapeutic abilities would be revealed. In other words, as there is an increase in the levels of anxiety, this leads to a significant decrease of confidence.

Often the therapist wants to meet the expectations of the client so as to avoid being considered as anxious or to appear confident in his or her therapeutic abilities. As evidenced by the participant, winning the approval, receiving praise or criticism has a dramatic impact in the self-confidence of the psychologist.

Participant 6 stated:

You want to meet the expectation of being the fixer and make them like you maybe let them want to come back.

Another concept that is closely linked to self-confidence is self-efficacy. It has been developed from the works of Bandura (1982). Self-efficacy can be understood as the therapist's belief about his or her ability to provide treatment in a competent and effective manner. Therefore, when the therapist believes that he or she is able and has adequate knowledge, then he or she is more likely to be motivated and hence has increased levels of self-confidence.

4.4.3.2 Time management

Another source of anxiety for the student and intern psychologists are issues of time management. This issues a challenge for the psychologists especially whilst conducting their first therapy session. As discussed in the review of literature, the first therapy session was deliberately chosen due to its immense importance in the therapy process. Traditionally, a

typical therapeutic session lasts 50 minutes. Due to this limited time frame, the novice psychologist is often under immense pressure to achieve therapeutic goals.

Participant 10 said:

Maybe issues of time management - Issues of time management, boundary and confidentiality as well... time management, you have certain patients that don't want to leave the session you know when you tell them that time is over that you know bring a new topic so I think managing time is important.

Student and intern psychologists were acutely aware of time constraints within the therapy session and often struggled to contain and maintain the flow of therapy within the allotted time. This is in line with the findings of James (2010) who stated that there was a lack of sign post to distinguish different segments of the therapy session. The participants often had little confidence in themselves to manage new information from the client towards the end of the session. However, novice psychologists were aware of the implications of ineffective time keeping in the session and how to overcome the obstacle of poor time management. As evident in this case, it could constitute an ethical issues of boundary crossing:

Participant 10 stated:

Time management, definitely keeping a watch in the office so you know if it's an hour it's a one hour straight you don't give extra time or else the patient will start thinking that they're special which is not what you want. Just time management making sure you check the time, you're not late as a therapist because that's going to impact on how your patient looks at you.

And participant 8 reported:

The obstacles were I think one of the obstacles was managing time. Some sessions when it is a busy day you have a patient after patient you lose track of time and after the next patient someone is waiting for you and your here and they already feel that they have waited for you for quite some time. So managing time it's something that you becomes part of your therapy session.

However, the fixation on time management seems also to be a distraction in the therapy session and may have an adverse effect on the client- therapist relationship as the novice psychologist often became preoccupied with the time at the detriment of the relationship. What is pertinent to note is that the underlying issue was the inability of the novice psychologist to correctly manage the therapy session effectively and delineate sectors of the therapy session to specific task as noted by (Sue & Sue, 2008a).

4.4.3.3 Communication and language

The verbal and the nonverbal communication of the client emerged as a subtheme that caused the psychologists' anxiety. In addition, participants found difficulty in translating certain psychological terms into another language. The mannerism in which the client communicated was interpreted by the psychologists as a signal that the client was unwilling to participate in the therapy process. This posed a significant challenge to the psychologists as their quality of the therapy was affected and as a result, their anxiety levels increased which had an adverse effect on the therapy session.

Participant 7 stated:

I know I'm Zulu speaking myself but you know having to speak about psychology to a Zulu speaking person it was quite a challenge.

And participant 9 said:

I've seen I'm Zulu speaking also I speak English and a little bit of Xhosa and I've seen some Xhosa speaking patients who speak really deep Xhosa and you know my Xhosa is basic in such an attempt that whatever you try to say they understand differently. Even if you try and mix them up with your Xhosa it is still not enough. So in such sessions you end up missing a lot a whole lot, but I believe I miss a whole lot acquired from someone where we talk the same language, so the issue of language and not only language and culture being attached.

Within the South African context, this poses a significant challenge for the psychologist due to the number and variety of languages. The appropriate use of a qualified interpreter could act as a buffer to this challenge, however, the use of an interpreter has its own set of unique challenges. The reliability of the interpretation could be questionable. This has the potential to transgress ethical codes of conduct and confidentiality. However, participants found that the use of an interpreter changed the therapeutic dynamic of the session.

Participant 1 stated:

The biggest thing is the language barrier it's a big thing for me. The patients of mine a lot of times there was somebody that Zulu and Afrikaans are the big ones but Zulu more predominantly than Afrikaans. And if I don't know what they are saying then what am I going to do. So I get an interpreter and that just adds a third dimension

which doesn't work. I don't like having interpreters, so it just is a barrier a big big barrier is the language.

4.4.3.4 Nonverbal communication. Participants perceived the nonverbal communication of the clients as indifference towards the therapeutic process. As a result they felt judged, intimated or fearful of the client. Participants erroneously interpreted the body language of the clients to be hostile.

Participant 1 said:

He'll sit forward quite a bit like and when there's a patient that makes you feel uncomfortable if they and funny how you say it's like forward. It's just when an older male presenting with what he presented with you know those nonverbal things, just, yes it negatively, I don't know, negatively impacted on the session. For him I don't think he realised I don't think he realised that giving me a hug and kissing me on the cheek or the way he does I don't think that he notices or realises that it could probably impact me and then impact the session as well. So it didn't really impact the session but it impacted myself and which all in all it affects the therapy..... I wouldn't say that led me to feel incompetent. I would say at the end of the day a lot of the things that we had spoken about if you quite think about it again I think about incompetence because I think oh well if I was experienced maybe somebody else or maybe then it would have been handled completely differently.

The nonverbal communication was perceived by the therapist as evidence that the client was aware of their incompetence or had negative feelings towards the therapist. In addition, this brought to the awareness of the psychologist of the subtle resistance of the client.

4.4.3.5 Silent moments have meaning

It is pertinent to note that the silent moment cause the psychologist to have increased levels of anxiety.

Participant 4 stated:

I felt like okay I don't know what I'm doing. If there was a silent moment especially for a longer period I felt like I don't know what I'm doing there. That's why I felt okay I need to think about something to say.

This is congruent to the findings of Scott and Lester (1998) who stated that the experience of silence in the therapy session is extremely anxiety provoking for the therapist. Some of the participants experience significant value in the silent moments.

Participant 4 reported:

Like the silent moment, I didn't think you should have that, I didn't you know it's only later that I realised those are actually important and they mean something, but at that time I felt that, that shouldn't happen

And participant 4 continued:

...to treasure the silent moment, in that very, very, very first session that I had, It's through its yeah I would have definitely treasured those silent moments because knowing what I know now I would have understood better and to observe what my clients were actually communicating to me in those silent moments instead of being quick in something to say.

Participant 3 stated:

She didn't speak, she spoke little most of about her she is very quiet silent she just sat very withdrawn in the chair, she didn't look at me

And participant 4 said:

What question can I ask next to avoid that silent moment between you and the patient. felt like you know the silent moment it was awkward, I didn't feel that I was anything good or it symbolised anything at the time. I felt like I need to keep going with questions and answering, questions and responding, questions and responding.

And participant 10 reported:

I've never experienced a silent moment before so now how do I respond to this, how do I act to this, you know and we just kept quiet and there was some awkwardness in that silent moment the patient looked at me I looked at the patient, I didn't know what to do.

4.4.5.3.1 Management of silent moments

Participants used various strategies to avoid or to manage silent moments.

Participant 4 reported:

Also I remember was one of my keys when I felt like here's a silent moment coming in I reflected on what she said you know to kind of make sure I actually understood.

And participant 10 stated:

It was after the first session that I knew how I could handle a silent moment which would be by reflecting on the silent moment and not just ignoring it, just reflecting on that silent moment.

This strategy seemed to be appropriate in management of silent moments.

4.4.3.6 Professional identity. According to Tahim (2015) professional identity is an important factor in the trainee's development in health care. It provides trainees with a sense of belonging which has an enabling and motivational effect. Ibarra (1999), postulates that professional identity is a stable collection of attributes, beliefs, values, motives and experiences. These experiences are constant over time. Ibarra (1999) goes on to state that that professional identity is a term in which people define themselves in a professional role. Friedlander, Keller, Peca-Baker and Olk (1986) make relevant statements regarding the duality of being a trainee psychologist. They propose that trainee psychologists have a dual function in that they are superior to their client, yet simultaneously are subordinates to their supervisors. To effectively grasp the dichotomous parallels of being both a superior and a subordinate alike, they would require a strong sense of who they are. In order to maintain professionalism on both fronts, they would need to understand and accept the dynamic of both types of relationships. This is where professional identity comes into effect.

Professional identity has a reciprocal relationship with clinical experience. To elaborate, a person gains more clinical insight and a heightened sense of professionalism, and professional identity also increases and solidifies. However, the development of professional identity is by no means a static or finite process. Rather, it is an on-going process that

changes and evolves throughout the duration of one's professional career (McElhinney, 2008).

From the interviews conducted, it became obvious that the trainees often forgot the crucial role they had to play in facilitating the healing of their clients because they were plagued by their own sense of inadequacy and self-doubts. Excerpts from the interviews demonstrate this point.

Participant 4 reported that:

I think I was trying to be perfect. I think for me that was my biggest challenge I was trying to do a good job at the very first time and yah feeling like am I connecting with her, does she understand me

And participant 6 stated:

...not being able to be comfortable with the psychologist's role at first because people always want an answer they want a way forward they always come with issues that have possibly escalated to something big and they want an answer and want someone to fix it. I think at the beginning psychologists you are not always comfortable with the fact that you not just going to fix this. You want to meet the expectation of being the fixer and make them like you maybe let them want to come back.

And participant 4 said:

I actually found that I had not understood who I was as someone who was aspiring to be a psychologist at the time. You know like I didn't really know who I was; I wasn't really comfortable in my skin. I didn't really, I've haven't adopted what it means to be

a psychologist that role. I just had ideas about how psychologists should be these are the skills that we need to have, this is what you do but I had not really practiced that before or basically just become comfortable just being myself as who I am and also being a psychologist and combining those two.

It has been established that a certain degree of self-doubt, paired with clinical inexperience, is only but natural during the early stages of one's career. Professional identity should not be pushed to the periphery. Instead, it should be constantly reinforced so as to buffer or negate the tendency for novice therapists to become preoccupied with their own clinical inexperience and assert themselves to the best of their abilities within the therapeutic relationship.

4.4.4 Ethics

The student and intern psychologists were faced with ethical problems.

4.4.4.1 Mandated therapy

Traditionally when one thinks of therapy, it conjures up images of the voluntary endeavours, where the client and the psychologist engage in a therapeutic exchange and where both parties have mutually consented to participate. According to Tohn and Oshlang (1996), mandated clients are sent or brought into therapy by someone else. Berg and Shafer (2004) state that many clients are referred into therapy by the justice system and therapy is often viewed as a more cost effective manner for rehabilitation than imprisonment. Therefore, when mandated therapy is viewed from this light, clients may erroneously perceive the psychologist as just another part of the legal process and see the psychologist as punitive. The

research participant's experience is that when a client was ordered into therapy, the resultant effect of this was detrimental to the therapy, as well as the therapeutic relationship.

Participant 2 stated:

You know looking back I'm not sure she was, she was in a crisis situation she wasn't she had being suggested that she attend therapy she was almost ordered to by a nurse or someone who sent her off and so that's why I think she wasn't engaged, she would have benefited immensely. This was not something she was looking forward to or not something she was planning to do. And yeah not to me that she was willing to engage.

and participant 3 reported

In the beginning she was very uncomfortable, and she didn't want to be there. She sort of warmed a little bit as it went on. I think the damage had been done almost in a way I wasn't able. Too much damage had been done for someone with my abilities to repair.

This poses a challenge to the psychologist, in that although the client has consented to therapy, their levels of commitment and interest in the healing and therapy process is questionable. The psychologist begins to question the ethical considerations of this and as result effects the therapy session by causing the therapist to question the ethical implications around this issue.

A number of clinicians reported that they had ethical concerns in the session. As a consequence of the ethical dilemmas encountered, the clinician feared a break in the therapeutic relationship that they had established with the client.

4.4.4.2 Confidentiality

A Participant questioned herself about issues of confidentiality. She expressed her concern about divulging information about her client as she feared that it would be to the detrimental to her client.

Participant 10 reported:

maybe confidentiality not knowing what to actually say, because you know when you have a patient, you have that in the first session, you speak about confidentially and you should maintain confidentiality as a psychologist but now you know when you go to your supervisor you don't know exactly what to present or even do the MDT. You don't know what you should say about the patient and if you say it, would they look at the patient differently, will it impact on the patient.

Participant 10 continued saying:

...when it comes to the supervisor, there's something that you feel as a psychologist in training that you shouldn't be speaking about it will impact at the way they look at the patient and so forth, so you have to be-careful about confidentially especially working with children. I think it's very tricking when working with kids because there are something's that the kids tell you and then you know you have to breach confidentiality that after you have done so you find that the kids won't trust you again or won't come back to therapy you know so it's definitely an obstacle that you know we face on a daily basis.

Throughout ones professional career, psychologists are faced with ethical dilemmas. Davis (2000) asserts that when psychotherapy occurs in an organisation, such as a hospital, it does

not occur within a dyad, with just the clinician and the client, but that it occurs in a triad between the clinician, the client and the organisation. Therefore the clinician needs to be aware of the ethical implications of this and how it effects their interactions with the client.

While participant 7 stated that

In a way the things that are stated in the ethics it helps address the client's anxiety as well especially the issue of informed consent the confidentiality. At some point you feel that once you explained that the person is more at ease and they are willing to divulge.

Thus when confidentiality has been guaranteed, this has the potential to make the client feel more at ease with the student and intern psychologist. Thus allowing for the establishment of rapport and a solid therapeutic relationship.

4.4.4.3 Informed consent

A clinician had concerns about not obtaining informed consent from his client.

Participant 7 stated:

You know for the first one, the first few sessions sometimes you forget about ethics, more especially the informed consent. At some point you walk in there so preoccupied with the thoughts in your head that you even forget that they are not done. You even forget that there are things you got to explain to them before you go on. Sometimes you do forget to do those things. So it would be more ethics than anything those lines of informed consent more specifically

Participant 7 continued:

...Ethics it helps address the client's anxiety as well especially the issue of informed consent the confidentiality. At some point you feel that once you explained that the person is more at ease and they are willing to divulge.

The clinician was aware of the repercussion of not obtaining informed consent and the consequences of it in the therapy session.

Participant 4 stated:

Something that important to notice or to do you know when you have an introductory session with the patient you know how you introduce yourself, this is my name if you're under supervision this is my supervisor so and so I work here and things like that and introducing the ethics and things like that like you know privacy and informed consent and all those things and the you know permission for them to feel comfortable or to know that whatever you talk about is confidential I think that's very important because I've often found that sometimes I remember when we were still training when you missed certain things like;

Zur (2004) asserts that the therapist must ensure that the risks and benefits of the treatment, including the nature of the treatment procedure, are communicated to the client. Included in this communication is the authorisation of the therapist to release information or to record the session. At this stage, the client must be given the opportunity to ask questions and be allowed to engage in discussions with the therapist about the treatment.

The therapist has to evaluate if the client has the capacity to understand the information pertaining to the consent and to make decisions regarding their health and treatment.

Lastly, the client has to acknowledge that they have been given the information and in doing so must express their consent and understanding either verbally or through written consent.

4.4.5 Inappropriate patient behaviour

In a clinical setting, a therapist may be exposed to a variety of complex and uncomfortable situations which require quick-thinking, tact and appropriate action to be managed effectively. One such situation is inappropriate sexual behaviour directed at the therapist by a client. Sexual impropriety is a relatively common occurrence in a clinical setting and has negative ramifications for the therapeutic process (Hartl, Zelss, Marino, Zelss, Regev & Leontis, 2007).

Inappropriate patient sexual behaviour by definition entails an act, explicit or perceived, physical or verbal advancement which incongruous to the clinical context (Johnston, Knight & Alderman, 2006).

Cambier (2013), reports that sexual inappropriateness is experienced by approximately 85% of therapists at some point in their career. This can manifest as suggestive remarks, staring, indecent exposure, romantic gifts, unnecessary touching, sexual assault and threats. Johnston et al. (2006) contribute to delineating the spectrum of inappropriate patient sexual behaviour by adding unsuitable physical proximity and rape.

Friedman (2007) notes that clients' inappropriate sexual behaviour may stem from long standing sexual dysfunction including fear or loss of sexual function, neurological dysfunction, fear, hostility, misinterpretation of the therapist intentions or even an attempt to control or create a diversion from the therapy process. Cambier (2013) delves deeper into

investigating the clinical and cognitive reasons for inappropriate patient sexual behaviour. Clinical conditions related to inappropriate patient sexual behaviour include delirium, dementia, bipolar mood disorder, substance abuse and schizoaffective disorder. Cognitive impairments related to medical conditions include impulsiveness, impaired problem solving and judgement, generalised disinhibition, and the inability to determine and comprehend what is socially appropriate. Other reasons for perpetrating inappropriate sexual behaviour in cognitively intact clients are boredom, loneliness or being unaware of professional boundaries, the need for reassurance regarding attractiveness or even re-establishing gender dominance, e.g. in the case of female therapists and male patients.

Sarkar (2004) reports that only serious sexual boundary violations are likely to be reported and that minor or less physical forms of boundary violations are prone to being underreported. This could be due to feelings of guilt and shame associated with reporting and acknowledging these experiences

4.4.5.1 Stalking

Stalking refers to the wilful and malicious harassment of a person that threatens their right to feel safe and protected. Stalking generally infers a repeated offence (Meloy & Gothard, 1995). It is a complex interaction between a victim and perpetrator. Meloy (1998) refers to the act of stalking as an “obsessional following”.

Meloy (1996) provides clinical insight into the psychological profile of individuals who engage in stalking, noting that most of these people have a history of criminal behaviour,

psychiatric disorders or substance abuse. There is no stereotypical profile that can be used to identify and recognise a stalker.

Participant 10 reported:

You know you start, you start having fears of this you start fearing your patients because a patient is actually stalking you. I have an example with a patient stalked me at work and my personal phone details, the patient would follow me in the car park and you know this became very difficult during the sessions that was definitely because now I start fearing this patient if this patient can stalk me, what else can this patient do, you know and that is very anxiety provoking as well during a session.

Stalking is considered to be a form of antisocial behaviour mainly perpetrated by angry or psychotic individuals (Meloy, 1996). Stalking is a progressive phenomenon. It usually begins with mild manifestations such as unwanted phone calls, or other forms of communication, frequent visits (which may be perceived as threatening) and unwanted invitations. Thereafter, the stalker may become more bold and forceful in their endeavours to a point of legal violations.

Although only one participant reported that she was stalked by a client, it was included in this research investigation, as it shows one of the extreme dangers of a boundary violation.

Within the domain of the psychotherapy session, stalking can be considered as an extreme form of boundary violation. Therefore, it is prudent that the psychologist identifies and deals with the patient's inappropriate behaviour as and when it occurs so as to re-establish

professional boundaries and to analysis the breaking of boundaries within a wider clinical framework, which could be beneficial to the client and aid their recovery.

4.4.5.1.1 Management of stalking

Meloy (1996) recommends a multi-disciplinary approach to managing stalking. This team approach is aimed at providing support of different levels for the victim. The team should ideally consist of the following:

Support companion- for emotional support.

Mental health professional- psychological support

A local police officer- for protection and

local prosecutor- for local support.

Furthermore, depending on the severity, necessity and economic restraints, a private investigator or security guard may be considered. Meloy (1996) maintains that it is imperative that a victim of stalking acknowledges that they have a central role to play regarding their own safety. This concept is indeed daunting as it places the burden of responsibility upon the victim. This may provoke feelings such as anger, denial, and increased fear and anxiety.

4.4.6 The need for more training

There is international consensus on the fact that training and experiential based training are crucial factors in the development of competent and professional psychologists. However, the exact type and the execution of the training are still open to discussion.

It is surprising, and also of concern, that none of the participants reported that they felt that they were adequately trained to handle the obstacles that they faced in the therapy session. The participants either felt that they had not received sufficient training to deal with the obstacles or were in a state of ambivalence with regards to their training.

Participant 1 stated:

Here there are things popping out from all over the place, things that you have never done before, forms that you never fill out before. Even some assessments that you use maybe learned briefly but now you doing a whole lot more, more interpretation, the pace, the work load it's like you're not prepared for everything so at the end of the day it's the training is not enough because they don't prepare you for the pace, the workload the spectrum of clients your re going to see, so I would say no.

And participant 2 acknowledged:

Not at all, like I mentioned I think its there's a lot of there's so much happens in the M1. All the theory and all the practical and I don't know how else it can be structured... You know I think it's something that's certainly lacking in the training. In practical's this is how we do.

In addition participant 6 stated:

I don't think the training is enough. You need to be trained more to rely on intuition. Your skills as a therapist which also can't be thought, you have to practice them. So no I don't think so...

While participant 8 believed:

Not really, I don't feel when I came here I felt like I knew nothing like almost nothing so I don't feel, I don't that the training that I received in M1 if it was sufficient would

it make me feel like that when I came here. I feel that most of the obstacles that I encountered here, that I'm dealing with that the only strategies that I use to deal with them are what I've learnt here. So the training according to M1 and exposure that I got there I don't think it was sufficient

And participant 3 reported:

Yes and no. I don't know. My own experience although, we were given a lot of theory and we were told everything we needed to know but I don't think we were given. I think supervision is better, I think it would have been better if there were more emphasis on supervision and more emphasis on just practical stuff

And participant 10 stated:

I don't think university trains you for these things and even thou it's what they tell us you know, you don't get a patient, every patient is different so sometimes you just forget everything that you read in the book when actually a real session is happening but otherwise you're not trained for such, you know we encounter so many different things that material we do still doesn't cover so no.

All the participants emphasised a need for more training during their Master's year. They often suggested various aspects that they would like to be trained in, ranging in more practical exposure and supervision, to more case studies.

4.4.7 Therapeutic alliance

The therapeutic alliance and collaborative approach have been discussed at length at various points in this research investigation. However, the information gleaned from the respondents indicates that there are considerable difficulties in establishing and maintaining a solid

therapeutic relationship. Whilst the literature is richly detailed regarding the requisites and nature of an effective therapeutic alliance, there is relatively sparse data on how to actually go about creating this relationship. This is perhaps because there is no set, methodical manner in establishing a relationship that is of sound quality.

Participant 2 supported this view:

...as the session kind of went on I felt more and more lost and more and more unhelpful and it seemed to me that she became cut off.

While participant 3 added:

In the beginning she was very uncomfortable, and she didn't want to be there. She sort of warmed a little bit as it went on. I think the damage had been done almost in a way I wasn't able. Too much damage had been done for someone with my abilities to repair.

4.4.7.1 Therapeutic ruptures

A rupture in the therapeutic alliance, as defined by Safran and Muran (2006), occurs when tension, which takes the form of conflict or even a misunderstanding, occurs between the therapist and the client. This definition is in congruence of Bordin (1979) who defined a therapeutic rupture as when the client and the therapist disagree on the goals of the therapy and the task of the therapy. The participants in the research were confronted with ruptures in the therapy session, although they were unaware of it at times.

Participant 1 recalled:

You can say quite defensive, so maybe I could say he was quite his reaction during the first therapy session was probably quite defensive because I was now challenging him.

4.4.7.2 The therapist in psychotherapy

In a clinical context, a psychotherapist is more than merely a facilitator of a healing process. His or her attitude, demeanour, values, mannerisms and personality in general have a direct bearing on the therapy process. Ackerman and Hilsenroth (2003) found that qualities such as flexibility, honesty, confidence, warmth, interest, respectfulness and especially trustworthiness have a positive impact on the therapeutic alliance.

Lambert and Barley (2001) systemised factors which influence client outcome in therapy into 4 broad categories: extra therapeutic factors, expectancy factors, specific therapy techniques and common factors. Extra therapeutic factors pertain to the positive outcomes of therapy as a result of the client's social support. Expectancy factors refer to the placebo effect. While specific therapy techniques refers to the actual techniques employed by the clinician such as systematic desensitisation. Common factors pertain to the interpersonal skills and inherent personality traits such as warmth and empathy of the therapist. Lambert and Barley (2001) ascertain that the therapy process itself is an interpersonal process in which the nature and dynamics of the therapeutic process is a primary curative component. Furthermore, they found that psychotherapy can be improved by the therapist conscientious efforts to improve their abilities to relate to client in an individualised and meaningful manner. Participants in the research study found that once there was a rupture in the therapeutic alliance, their expectations of the therapy had decrease to a level where they felt that their ability and the therapy was no long helpful to the client.

Participant 3 related this experience:

I was feeling exactly how she felt and I was, she didn't want to talk, she didn't want to be there at all and once she started crying I felt I didn't want to be here either. I'm done.

In alignment with the idea of therapist's character traits within the therapeutic alliance is the concept of expectation. Both the client and clinicians have expectations of the therapy process. These expectations have a profound impact on the efficacy of it. Greenburg, Constantin and Bruce (2006), state that expectations as a clinical component have been undervalued.

4.4.7.3 Client Expectations

Client expectations are a major proponent in receptivity to treatment as well as positive resolution and therapy outcomes. Grief (2006) indicates that when a client enlists the help of a psychotherapist, he or she already formulates pre-conceived notion of expectations that may or may not be met at the commencement or duration of therapy. Grief (2006) goes on to note that discrepancies between pre-therapy expectations and the actual therapeutic process can impact a client's responsiveness to treatment. Client expectations are varied and individualised but commonly includes perception of what the therapist will be like and the manner in which they will relate to each. A participant found it difficult to relate to clients who have low expectations of the therapy session.

Participant 2 related his experience:

There were times also where she came in almost quiet cut off almost like she didn't want to connect with the situation and yeah it was a very difficult situation for her.

However, when the client's expectation levels were increased, the participant reported that it had a positive influence on the therapy session.

Participant 7 recalled his experience:

I think after that they expected that I make them feel better. But then since I have explained to them ,it's not a matter (although not how I'm explaining it now)I've explained ,we are going to be working together. With them doing most of the work. I think because they came up with that, they expected to feel better. Some of them, few of them reportedly to be better and some of them looked relieved and some of them feeling better.

Arnkoff, Glass and Shapiro (2002), mention that when a client initially enters therapy, they have assumptions about the goals that will be set, and the methods which will be utilised, as well as the expected outcomes. Orchowski, Spickard and McNamara (2006) highlight the impact of stereotypes and social influences by stating that media representations can have an effect on a client's perception of psychotherapy. Furthermore, a client can also be influenced by a friend's or relative's experience of counselling and thus construct expectations based on this. As Deane, Skogstad and Williams (1999) aptly note, past psychotherapy and counselling experiences also have a bearing on the current counselling experience. These factors are all determinants in establishing and acting on expectations in psychotherapy.

Psychotherapy cannot continue indefinitely. This is perhaps why goal-orientated therapy sessions are so important- to measure progress, resolution and change. This is where duration of therapy comes into effect. Greenberg, Constantino and Bruce (2006) point out that client

expectations regarding therapy duration is in fact a broad domain. In an investigation conducted by Pekarik and Wierzbicki (1986) on patient expectations about duration of therapy, 50% of participants stipulated that they anticipated attending five or less therapy sessions. This differed greatly from the therapist's prediction of the duration of therapy. Therapist anticipated at least fifteen or more therapy sessions. This brings to prominence another variable in the spectrum of challenges faced by psychotherapists as clients may be grossly unrealistic in their expectations of the time in which the benefits of therapy can be felt and verified.

Tsai, Ogrodniczuk, Sochting and Mirmiran (2014) highlight yet another key concept found in their investigation of patient expectations. Tsai et al. (2014) found that patients who have a significant hopeless or demoralised clinical presentation are likely to have a low expectation regarding a positive outcome for treatment.

Considering that a substantial percentage of clients who present to psychotherapist are in this frame of mind (e.g. depressed or suicidal), this would inferentially mean that a major portion of clients do not expect to recover. This low expectation in itself creates a barrier to the receptivity of treatment and thus the therapeutic outcomes.

Tsai et al. (2014) maintain that efforts should be made during the first few therapy sessions to mobilise a patient's hope and expectations of success. This can be done by creating an optimistic outlook on probability of treatment success through developing a strong working relationship between client and the clinician. It is at this clinical juncture that a collaborative rather than an authoritarian approach is particularly important.

4.4.8 Cultural Dynamics

South Africa is well known for being culturally diverse. With eleven official languages and a wide variety of cultures, racial and traditional groundings, cultural diversity can in fact become an impediment to the therapy process.

When the psychologist is from a different cultural background from that of their client, the psychologist may experience difficulty in identifying with the client. This has the potential to disrupt the therapy session and present as an obstacle to the novice psychologist.

Participant 9 related his experience:

The different language I experience that, the issue of gender differences I experienced that, the issue of race I experienced that and the issue of age I experienced that as well.

Participant 9 continues:

So in such sessions you end up missing a lot a whole lot, but I believe I miss a whole lot acquired from someone where we talk the same language, so the issue of language and not only language and culture being attached.

And he goes on to state:

It was hard to get that, it was not only language also a cultural barrier and behind language that is also a challenge.

Cultural norms have a major impact on the therapy session. One such “norm” in the African culture is viewing those who are of a younger age as being a child. This notion could imply a

lack of knowledge and lack of experience on the part of the younger person. The following extract portrays this

Participant 10 provides evidence for this:

Clients that come that are older than you and then when they come into the session, they belittle you they say that I don't think my child that's what they call you "my child" I don't think you're old enough to understand what I'm going through, can I get another therapist whose older and understands, you know that makes me feel that I'm not competent enough to do my job.

This has had implications for the psychologist as she felt that the client was degrading her and her expertise and therefore interrupted the therapy session.

Participant 4 recalled:

And also age for me, because I remember my first patient was quite it was a grown women I think she was in her late forties or maybe fifties and also we had racial differences, so you know I had to consider those things and I felt like you know I felt a little bit uncomfortable at times because I was asking certain questions to an older woman it was more like some who is my mum's age, so there are things that as an African woman you find that you know it's a bit awkward to ask certain questions you know especially to someone whose like your mums age even thou she a different race. So I experienced that as well with her the age difference.

Participant 4 goes on:

...Maybe that creates some boundary or you feel she sees me as this young child you know and I wonder if she's going to take me seriously is she really going to value what I'm saying has I'm younger in terms of age.

Robiner and Stovandt (1983) assert that the effects of the therapist's age on the outcomes of psychotherapist is difficult to quantify or even estimate given that counselling experience often comes with an increase in the therapist age. However, Karasu, Stein and Charles (1979) argue that the age of the therapist in relation to the age of the client is an important factor in the early stages of the therapy. These cultural norms have emerged as an obstacle in the therapy session. One reason for this could be that psychology is based on a Western model and therefore students are not made aware of the cultural values. Therefore, the psychologist may not know how to understand and respond to the cultural differences. Pedersen, Dragun, Lonner and Trimble (1996) assert that when there is a significant difference of culture between the psychologist and the client, the more noticeable is this difference and therefore, this difference has a more obtrusive role in the counselling process. Thus, this cultural difference raises the likelihood of negative experiences such as clashes pertaining to expectations of counselling, and more misunderstanding of intentions in the therapy process.

However, cultural differences are not confined to the individuals who have differences in culture. It also occurs in individuals who share the same culture. The psychologist found that although he shared the same culture as his client, he still found subtle differences in their home environment which constituted an obstacle.

Participant 7 related his experience:

You know in fact that you grow up in a household where you are taught, you don't maintain eye contact with an adult, you don't argue with an adult. No disagreeing with an adult. So that came into play in that therapy session and when you meeting

patients of other cultures even with the Zulu culture you know at some point it becomes difficult because the belief system is different. I maybe a Zulu and my patient is a Zulu as well but the way they do things in his household may be different from how we do things in my household and that may clash in the therapy you know.

This brings into prominence the uniqueness of the human culture, and the implausibility of understanding every client even though there are commonalties between the therapist and the client.

Therapists, when engaging in interracial therapy must display flexibility and encompass in their repertoire of approaches to clients, a variety of techniques that is appropriate to the worldview of their client.

4.5 Résumé

This chapter entailed a detailed description of the themes that were ascertained from the research investigation. In the subsequent chapter, the conclusion will be discussed, as well as limits of the study and recommendation for future research will be made.

Chapter Five

5.1 Introduction

In the previous chapter, a detailed discussion of the key themes in the research investigation was presented. In this chapter, the focus is on avenues that could be investigated in future research, and methodological limitations, so as to expand the body of existing knowledge and hopefully lead to improvements in the academic infrastructure and service delivery of South African Psychology.

5.2 Summary

It has been well established that the obstacles and challenges encountered by student and intern psychologists are both prevalent and interrelated to each other. Intern and student psychologists, by virtue of their professional status, are susceptible to a multitude of obstacles. Obstacles and challenges are a component of the student and intern psychologists' professional career and depending on how these obstacles and challenges are managed and negotiated, it can either enhance or hinder their professional identity and the capacity to effect change in their client. The major themes which have emerged in this research study are consistent with those obstacles and challenges that have been identified in the international platform by other researcher in the review of literature. This indicates the universal nature of the obstacle and challenges within the domain of psychotherapy. However, despite the fact that these obstacles and challenges are prevalent on a global scale, the international findings and management of the obstacles needs to be extrapolated to the South African context with caution.

Clinical inexperience and deficits in clinical insights seem to underpin most of the obstacles encountered by the student and intern psychologist whilst conducting their first therapy session. This, however, does not mean that experience alone is sufficient to negate the challenges that arise in the psychotherapy session. Clinical inexperience is not a finite process; it is ongoing and dynamic.

These represent the major obstacles in this sample population and do not represent all the obstacles that potentially could be faced by all intern and student psychologists. Challenges may be determined by the uniqueness of the client presentation. However, the intrapsychic dynamics of the psychotherapists cannot be discarded, because the intricate, inner workings of the psychologist's mind have a profound impact on the quality of the process and outcome of therapy.

The onus also falls upon the student and intern psychologist to accept and honour the role as a professional. Therefore, they must not simply masquerade behind the pretext of being novice. To elaborate, it is an easy retort or counter argument that since they are novice psychologists, they lack the clinical knowledge and this excuses them from the mismanagement of their clients. That is not acceptable.

5.3 Limitations

Various limitations were identified whilst conducting and analysing this research investigation. It is prudent to take cognisance of these limitations for future research in this domain.

The sample population consists only of clinical psychologists. Furthermore, the sample population is comparatively small, consisting of only ten participants. Demographic representation is also limited.

The research findings are exclusive to the sample population. Therefore, any attempts to generalise the findings to other categories of psychology should be done with caution.

In order to establish a broader understanding of the obstacles faced by psychologists, the participation of other categories of psychologists needs to be included.

The literature presented in this review were predominately from America and Europe and therefore presents a gap in the South African academic arena with regards to issues pertaining to the training and recommendation to aid South African psychologists with the obstacles that they face.

5.4 Future Research

This research investigation provides a detailed description of the obstacles faced by student and intern psychologists. However, it also highlights areas where future research could be conducted.

Future research could investigate the relationship that the intern psychologists have with the affiliated university and the role that the university has in mentoring and monitoring their

intern psychologists who are placed outside of their academic institution thus helping to ameliorate some of the obstacles the intern psychologists encounter.

Research should also be focused on the transition and developmental of their professional identity from undergraduate psychology academia to postgraduate and professional psychology.

As mentioned in the limitations, the participants of the research study were clinical psychology student and interns. Therefore, future studies could aim to duplicate this research investigation which utilises other criteria of psychologists (i.e. counselling and educational psychologists).

Since professional psychology does not only rely on psychotherapy to provide assistant to clients, research should also be conducted on the obstacles faced by intern and student psychologists whilst conducting psychological assessments.

Research could concentrate the effectiveness of techniques used to overcome the obstacles encountered by novice therapists. Despite the body of literature emphasising the role of supervision, there is a scarcity of literature regarding personal techniques used by psychologists to overcome their obstacles.

5.5 Conclusions

From the review of literature and clinical findings, it is evident that obstacles in therapy, particularly in the first therapy session, is indeed prevalent amongst student and intern psychologists both within South African health care system and the broader context. It has emerged that these obstacles are not always addressed effectively but, this research investigation has fulfilled its objective in bringing these challenges to the fore, for student and intern psychologists. This alludes to the fact that clinicians should be aware of their own limitations in the counselling process with specific reference to their relative lack of clinical experience. It also calls attention to a therapist emotional states and reactions and the subsequent impact of these on the first therapy session and therapeutic continuum in its entirety.

In keeping with the primary objectives of this study, personal and professional obstacles were identified and explored. Personal obstacles included feelings of incompetence, anxiety and lack of professional identity. These personal obstacles are three fold: firstly, it has potential to adversely affect the student and intern psychologists, secondly, the therapeutic process and outcomes and consequently the client themselves. Professional obstacles consist of ethical dilemmas, ruptures in therapeutic alliance, management of inappropriate patient behaviour and negotiating cultural dynamics. Like personal obstacles these professional obstacles also hinder successful therapeutic outcomes.

It was also established that despite the fact that a repertoire of pre-existing coping strategies are available to the student and intern psychologist, there is still a relative deficit in appropriate management of obstacles on the part of the therapist.

Further research would be of practical relevance in this domain. However setting collaborative goals as a strategy may alleviate the counsellor's anxiety levels in the therapeutic process. These collaborative goals need to be realistic in terms of time frame and achievability, whilst taking into consideration the client's situation. Participating in role plays

with fellow counsellors and supervisors could also help. The gap between theory and practical counselling needs to be bridged with the use of micro counselling skills, including verbal and nonverbal skills, These coping strategies are likely to assist them build confidence for interaction with clients in a counselling session.

5.6 Résumé

This chapter entailed a summary, limitations, avenues for further research and a conclusion.

References

- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, 23(1), 1-33.
- Aikenhead, G. S. (1997). A Framework for Reflecting on Assessment and Evaluation. *Headliner, Symposium 4: Assessment Strategies*. Retrieved from <http://www.usask.ca/education/people/aikenhead/seoulassest.htm>. Downloaded on 10 December 2015 at 23h25.
- Allan, A. (2008). *Law and Ethics in Psychology: An International Perspective*. Somerset West: Inter-Ed.
- Aravind, V. K., & Krishnaram, V. D., & Thasneem, Z. (2012). Boundary crossing and violation in clinical setting. *Indian Journal of Psychological Medicine*, 34(1), 21-24.
- Arnkoff, D. B., Glass, C. R., & Sharpiro. (2002). *Expectations and preferences. In psychotherapy relationships that work: therapist contributions and responsiveness to patients*. New York: Oxford University Press.
- Austin, E. K. (1981). *Guidelines for the Development of Continuing Education Offerings for Nurses*. New York: Appleton-Century-Crofts.
- Baber, T. (2009). *Newly qualified counsellors' experience of silence within the therapeutic setting*. Unpublished Master's Thesis, Roehampton University.
- Bandura, A. (1982). Self efficacy mechanism in human agency. *American Psychologist*, 37, 122-147.

- Baer, R. A., Smith, G. T., Hopkins, J., Kreitemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment, 13*, 27-45.
- Barribal, K. L., & While, A. (1994). Collecting data using semi-structured interviews: A discussion paper. *Journal of Advanced Nursing, 19*(2), 328-335.
- Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and Beyond*. New York: The Guilford Press.
- Berg, I. K., & Shafer, K. C. (2004). Working with mandated substance abusers: Language of solutions. In S. Straussner (Ed.), *Clinical work with substance abusing clients* (2nd ed., pp. 82-102). New York: Guilford Press.
- Betan, E., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry, 162*(5), 890-898.
- Birnbaum, L. (2008). The use of mindfulness training to create an “Accompanying Place” for social work students. *Social Work Education, 27*, 837–852.
- Bischoff, R. J. (1997). Themes in therapist development during the first three months of clinical experience. *Contemporary Family Therapy, 19*(4), 563-580.
- Bloom, S. L. (2003). Caring for the caregiver: Avoiding and Treating Vicarious Traumatization. In A. P. Giardino, E. M. Datner, & J. B. Asher. (Eds). *Sexual Assault: Victimization Across the Life Span- A Clinical Guide*. (pp. 459-470). St. Louise: G. W Medical Publishing Inc.
- Blunt, D. R. (2006). *Confidentiality, informed consent and ethical considerations in reviewing the client’s psychotherapy records*. Unpublished doctoral thesis, Walden University.

- Bordin, E. S. (1979). The generalization of the psychoanalytic concept of the working alliance. *Psychotherapy: theory, Research, Practice, Training*, 16(3), 252-260.
- Borys, D. S., & Pope, K. S. (1989). Dual Relationship between therapist and client: A national survey of psychologist, psychiatry and social worker. *Professional Psychology, Research and Practice*, 20(5), 283-293.
- Braun, V., & Clark, V. (2006). Using thematic analysis in Psychology. *Qualitative research in psychology*, 3(2), 77-101.
- Cambier, Z. (2013). Preparing new clinicians to identify, understand and address inappropriate patient sexual behaviour in the clinical environment. *Journal of Physical Therapy Education*, 27(2), 7.
- Carr, S. J. (2004). Assessing clinical competency in medical senior housing officers: how and why should we do it? *Postgraduate Medical Journal*, 80(1), 63-66.
- Caruth, E. G. (1987). Language in intimacy and isolation: Transitional dilemma, transformational resolution. *Journal of the American Academy of Psychoanalysis*, 15(1), 39-49.
- Castronguay, L. G., Constantino, M. J., & Grosse-Holtforth, M. (2006). The working alliance: where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training*, 43, 271-279.
- Chambers, R., Lo, B. C. Y., & Allen, N. B. (2008). The impact of intensive mindfulness training on attentional control, cognitive style, and affect. *Cognitive Therapy and Research*, 32, 303-322.
- Cohen, M. B. (1952). Countertransference and Anxiety. *Psychiatry: Interpersonal and Biological Processes*, 15(3), 231-243.

- Corey, G. (2009). *Theory and Practice of Counseling and Psychotherapy*. (8th ed.). Belmont: The Thomson Corporation.
- Cutler, R. L. (1958). Countertransference effects in psychotherapy. *Journal of Consulting Psychology*, 22(5), 349-356.
- Davis, L. (2000). Private work in public places: Confidentiality and role tension in a university counseling service. *Psychodynamic Counseling*, 6(1), 65-78.
- Deane, F. P., Skogstad, P., & Williams, M. W. (1999). Impact of attitudes, ethnicity and quality of prior therapy on New Zealand male prisoner's intention to seek professional psychological help. *International Journal for the Advancement of Counseling*, 21(1), 55-67.
- Denscombe, M. (2007). *The good research guide for small scale social research projects* (3rd ed.). Berkshire: Open University Press.
- Donovan, R. A., & Ponce, A. N. (2009). Identification and measurement of core competencies in Professional Psychology: Areas of consideration. *Training and Education on Professional Psychology*, 3(4), 46-49.
- Doverspike, W. D. (2008). Dual relationship and psychotherapy. *Georgia Psychologist*, 62(3), 7.
- Dreifuss, A. (1990). A phenomenological inquiry of six psychotherapists who practice Buddhist meditation. *Dissertation Abstracts International: Section B: Science and Engineering*, 51, 2617.
- Duncan, R. E., Williams, B. J., & Knowles, A. (2012). Adolescents, risk behaviour and confidentiality: When would Australian psychologist breach confidentiality to disclose information to parents? *The Australian Psychological Society*, 48(6), 408-419.

- Durrant, G. B., Groves, R. M., Staetsky, L., & Steele, F. (2010). Effects of interviewer attitudes and behaviours on refusal in household survey. *Public Opinion Quarterly*, 74(1), 1-36.
- Edwards, J. K., & Bess, J. M. (1998). Developing effectiveness in the therapeutic use of self. *Clinical Social Work Journal*, 26(1), 89-108.
- Ehrlich, F. M. (2001). Levels of self-awareness: countertransference in psychoanalysis, Couple, and Family Therapy. *Contemporary Psychoanalysis*, 37(2), 283-296.
- Enriquez, V. G. (1993). *Developing a Filipino psychology*. In Kim, U., & Berry, J. W. (Eds.), *Indigenous Psychologies, Research and experience in cultural context*, Newbury Park: Sage Publishers.
- Epstein, G. N., Steingarten, J., Weinstein, H. C., & Nashel, H. M. (1977). Panel report: Impact of law on the practice of psychotherapy. *Journal of Psychiatry & Law*, 5(1), 7-40.
- Epstein, R. M., & Hundert, G. M. (2002). Defining and assessing professional competence. *The Journal of the American Medical Association*, 287(2), 226-235.
- Fatter, D. M., & Hayes, J. A. (2013). What facilitates countertransference management? The role of therapist mediation, mindfulness and self-differentiation. *Psychological Research*, 23(5), 502-513.
- Feltham, C., & Dryden, W. (1993). *Dictionary of Counseling (2nd ed.)*. London, Whurr.
- Feltovich, P. J., Prietula, M. J., & Ericsson, K. A. (2006). Studies of expertise from psychological perspective. In K. A. Ericsson, N. Charness, P.J. Feltovich, R. R. Hoffmann. *The Cambridge Handbook of Expertise and Expert Performance* (Eds.). Cambridge University Press.

- Fisher, B. L. (1989). Differences between supervision of beginning and advanced therapists: Hogan's hypothesis empirically revisited. *The Clinical Supervision*, 7(1), 57-74.
- Fontaine, J. H., & Hammond, N. L. (1994). Twenty Counseling Maxims. *Journal of Counseling and Development*, 73, 223-226.
- Frankel, T. (2011). *Dictionary of Economics and Law*. Retrieved from <http://cyber.law.harvard.edu/trusting/unit5all.html>. Downloaded on 1 March 2015 at 21h00.
- Frankel, T. (2011). Fiduciary law in the twenty-first century. *Boston University Law Review*, 91(3), 6-22.
- Freud, S. (1910). The Future of prospects of psycho-analytic therapy. *Collected Paper*, 2, 289.
- Friedlander, M. L., Keller, K. E., Peca-Baker, T. A., & Olk, M. E. (1986). Effects of role conflict on counsellor trainees' self-statements, anxiety level and performance. *Journal of counseling Psychology*, 33(1), 72-77.
- Friedman, J. D. (2007). Inappropriate patient sexual behaviour. *Advanced Healthcare Network*, 23(20), 40.
- Fussell, S. R. (2014). *The verbal communication of emotions: Interdisciplinary perspective*. New York: Routledge.
- Gabbard, G. (2004). *Long-term psychodynamic psychotherapy: A basic text*. Arlington: American Psychiatric Association.
- Germer, C. K., Siegel, R. D., & Fulton, P. R. (2005). *Mindfulness and psychotherapy*. New York: Guilford Press.
- Geslo, C. J., & Hayes, J. A. (2011). Countertransference management. *Journal of Psychotherapy*, 38(4), 418-422.

- Golafshani, N. (2003). Understanding reliability and validity in Qualitative research. *The Qualitative Report*, 8(4), 597-607.
- Green, A. L., & Oei, T. P. S. (2008). The satisfaction with therapy and therapist scale revised (STTS-R) for group psychotherapy: Psychometric properties and confirmatory factor analysis. *Professional Psychology: Research and Practice*, 39(4), 435-442.
- Greenberg, R. P., Constantino, M. J., & Bruce, N. (2006). Are patient expectations still relevant for psychotherapy process and outcome? *Clinical Psychology Review*, 26(6), 657-678.
- Greenfield, P. M. (2001). Three approaches to the psychology of culture: Where do they come from? Where do they go? *Asian Journal of Social Psychology*, 3, 223-240.
- Greenson, R. R. (1993). On silence and sounds of the analytic hour. *Journal of the American Psychoanalytical Association*, 9(1), 79-84.
- Grief, D. C. (2006). *Alliance expectations and alliance as a predictor of therapy engagement outcome*. Unpublished Master's Dissertation. Antioch University New England.
- Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical risk- management. *American Journal of Psychiatry*, 150(2), 188-196.
- Hadfield, D., & Booton, N. (2003). Clinical supervision: supervisee reflections. *Nursing in Practice*, 10, 60-61.
- Hakim, E. A. (2008). The Importance of Continuing Professional Development in South Sudan. *South Sudan Medical Journal*, 1(2), 26-29.
- Halgin, R. P. (1999). Clinical Training: Challenges for a New Millennium. *Journal of Clinical Psychology*, 55, 405-409.

- Halleck, S., & Woods, S. (1962). Emotional problems of psychiatry residence. *Psychiatry*, 25, 339-346.
- Hartl, T. L., Zelss, R. A., Marino, C. M., Zelss, A. M., Regev, L. G., & Leontis, C. (2007). Client's sexually inappropriate behaviour directed toward clinicians: Conceptualization and Management. *Professional Psychology*, 38(6), 674-681.
- Hayes, J. A. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychological Research*, 14(1), 21-36.
- Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy*, 48(1), 88-97.
- Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. R., Harp, J. S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. *Journal of Counseling Psychology*, 45, 468-482.
- Heaven, C., Clegg, J., & Maguire, P. (2006). Transfer of communication skills training from workshop to workplace: the impact of clinical supervision. *Patient Education and counseling*, 60(3), 313- 325.
- Heelas, P. (1981). Introduction: Indigenous Psychologies. In *Indigenous Psychologies. The Anthropology of the self*. P. Heels and A. Lock (Eds.). London: London Academic Press.
- Heimann, P. (1950). On countertransference. *The International Journal of Psychoanalysis*, 33(1), 81-84.
- Helm, H. (2010). *Managing Vicarious traumatization and compassion fatigue*. Retrieved from http://lianalowenstein.com/artcile_helm.pdf .Downloaded on 15 March 2015 at 14h30.

- Herlihy, B., & Corey, G. (1996). Confidentiality. In B. Herlihy & G. Corey. *ACA Ethical Standards Casebook (5th ed.)*. Alexandria: American Counseling Association.
- Hill, C. E., & Thompson, B. J. (2003). Therapist's use of silence in therapy: A survey. *Journal of Clinical Psychology, 59*(4), 513-524.
- Hill, C. E., Sullivan, C., Knox, S., & Schlosser, L. Z. (2007). Becoming a Psychotherapist: Experiences of Novice Trainees in Beginning Graduate Class. *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 434-449.
- Hines-Martin, V., & Robinson, K. (2006). Supervision as professional development for psychiatric mental health nurses. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice, 20*(6), 293-296.
- Hogan, R. A. (1964). Issues and approaches in supervision. *Psychology Research and Practice, 1*, 139-141.
- Holmes, C. (1998). *There is no such thing as a therapist*. London: Karnac Books.
- Horowitz, M., Wilner, N. C., & Alvarez, W. (1974). Impact of events scale: A measurement of subjective stress. *Journal of Biobehavioural Medicine, 41*(3), 209-218.
- Horvath, A. O. (2000). The therapeutic relationship: From Transference to alliance. *Journal of Clinical Psychology, 56*(2), 163-173.
- Hutchinson, S., & Wilson, H. S. (1992). Validity Threats in Scheduled Semi structured Research Interviews. *Nursing Research, 41*(2), 117-119.
- Hyrkas, K., & Paunonen-Ilmonen, M. (2001). The effects of clinical supervision on the quality of care: examining the results of team supervision. *Journal of Advanced Nursing, 33*(4), 497-502.

- Ibarra, H. (1999). Provisional selves: experimenting with image and identity in professional adaptation. *Admin Scientific Quarterly*, 44(4), 764-791.
- Jacob, S., & Powers, K. E. (2009). Privileged communication in the school Psychologist-Client relationship. *Psychology in the schools*, 46(4), 307-318.
- Jacobsson, G., Lindgren, T. E., & Hau. S. (2012). Rites of passage: Novice student's experience of becoming a psychologist. *Nordic Psychology*, 64(3), 192-202.
- James, A. I. (2010). *Cognitive behavioural therapy with older people*. Philadelphia: Jessica Kingley Publisher.
- James, J. W., & Haley, W. E. (1995). Age and health bias in practicing clinical psychologists. *Psychology and Aging*, 10(4), 610-616.
- Jensen, V. (1973). 'Communicative functions of silence,' *ETC*, 30(1), 249- 257.
- Johnson, C., Knight, C., & Alderman, N. (2006). Challenges associated with definition and assessment of inappropriate sexual behaviour amongst individuals with an acquired neurological impairment. *Brain Injury*, 20(7), 687-693.
- Kaplan, B., & Maxwell, J. A. (1994). Qualitative research methods for evaluating computer information systems. In J. G. Anderson, C. E. Aydin & S. J. Jay (Eds.), *Evaluating Health Care Information Systems: Methods and Applications*, (pp. 45-68). Thousand Oaks, CA: Sage.
- Karasu, T. B., Stein, S. P., & Charles, E. S. (1979). Age factors in patient- therapist relationship. *The Journal of Nervous and Mental Disease*, 167(2), 100-104.
- Kim, U., & Berry, J. W. (1993). *Indigenous Psychologies, Research and experience in cultural context*. Newbury Park: Sage Publishers.

- Kinsinger, F. S. (2009). Beneficence and the Professional's morals imperative. *Journal of Chiropractic Humanities*, 16(1), 44-46.
- Kirschner, S. (2007). Culture, psychotherapy and counseling: Critical and Integrative perspective. *Journal of Theoretical and Philosophy*, 27(1), 182-190.
- Kleinman & Maeder cited in Bustos 1999. Bustos E. Stellvertretende Traumatisierung, verwundete Heiler oder die unvermeidbare intersubjektive Erfahrung in der psychotherapeutischen Arbeit mit traumatisierten Flüchtlingen. Lecture at conference of the BAFF, Berlin, 1999. (Unpublished).
- Kottler, J. A. (1993). *On being a Therapist*. San Francisco: Jossey- Bass.
- Kurzon, D. (1992). When silence means power. *Journal of Pragmatic*, 18(1), 92-95.
- Kurzon, D. (1995). The night of silence: A socio-pragmatic model of interpretation. *Journal of Pragmatics*, 23(1), 55-69.
- La Roche, M. J., & Maxie, A. (2003). Ten considerations addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice*, 32(2), 180-186.
- Ladany, N., Hill, C., Thompson, B., & O' Brien, K. (2004) Therapist perspectives on using silence in therapy: A qualitative study. *Counseling and Psychotherapy Research*, 4(1), 80-89.
- Lambert, M. J., & Barley, D. E. (2001). Research summary and the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 357-361.
- Lasky, G. B., & Riva, M. T. (2006). Confidentiality and Privileged Communication in Group Psychotherapy. *International Journal of Group Psychotherapy*, 56(4), 455-476.

- Lazovsky, R. (2008). Maintaining confidentiality with Minors: Dilemmas of school counsellors. *Professional School of Counseling*, 11(5), 335-346.
- Leahy, R. L. (2007). Schematic mismatch in the therapeutic relationship: A social cognitive model. In P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in cognitive-behavioural therapies*. London: Routledge.
- Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioural therapy. *Behavioural and Cognitive Psychotherapy*, 36(6), 769-777.
- Liegner, E. (1974). The silent patient. *Psychoanalytic review*, 61(2), 229-245.
- Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *Counseling Psychologist*, 10, 3-42.
- Lovelady, H. V. (2005). *The role of silence in the counseling relationship*. Retrieved from <http://www.workingpaper.ctpdc.co.uk/hl.pdf>. Downloaded on 27 January 2014 at 20h30.
- Luborsky, L. (2000). A pattern-setting therapeutic alliance study revisited. *Psychotherapy Research*, 10, 17-29.
- MacEwan, G. H. (2009). *The Efforts of therapists in the first session to establish a therapeutic alliance*. Unpublished Masters Dissertation. University of Massachusetts-USA.
- Maillacheruvu, P., & Mc Duff, E. (2014). South African return to primary care: The struggles and strides of the primary health care system. *Journal of Global Health*, 4(1), 10-15.
- Maslach, C. (1996). *The Maslach Burnout Inventory (3rd ed.)*. Palo Alto: Consulting Psychologist Press.

- Myers, M. D. (2009). *Qualitative Research in Business & Management*. London: Sage Publications.
- McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Trauma Stress*, 3(1), 131-149.
- McClintock, A. S., Anderson, T., & Petrarca, A. (2015). Treatment expectations, alliance, session positivity and outcome: An investigation of a three path Mediation Model. *Journal of Clinical Psychology*, 71(1), 41-49.
- McElhinney, R. (2008). *Professional identity development: A grounded theory study of Clinical Psychology trainees*. Doctorate in Clinical Psychology. The University of Edinburgh.
- McMahon, M., & Knowles, A. D. (1995). Confidentiality in psychological practice: A decrepit concept? *Australian Psychologist*, 30(3), 164-168.
- Meichenbaum, D. (2012). *Roadmap to Resilience: A Guide for Military, Trauma Victims and Their Families*. New York: Institute Press.
- Meloy, J. R. (1996). Stalking (obsessional following): A review of some preliminary studies. *Aggression and Violent Behavior*, 1(2), 147-162.
- Meloy, J. R. (1998). *The psychology of stalking: Clinical and Forensic Perspectives*. New York: Academic Press.
- Meloy, J. R., & Gothard, S. (1995). Demographic and clinical comparison of obsessional followers and offenders with mental disorders. *American Journal of Psychiatry*, 152(2), 258-263.

Meyer, J. (n.d.). *Fresh Legal perspectives: psychologists in dual relationships*. Retrieved from: https://www.pdfFiller.com/en/project/32964803.htm?form_id=30339136.

Downloaded on 26 February 2015 at 19h32.

Moore, A., & Malinowski, P. (2009). Meditation, mindfulness and cognitive flexibility. *Consciousness and Cognition*, 18, 176–186.

Mordecai, E. M. (1991). A classification of empathetic failures for psychotherapists and supervisors. *Psychoanalytic Psychology*, 8(3), 251-262.

Morissette, P. J. (2004). *The pain of helping: psychological injury of helping professionals*. New York: Brunner-Routledge.

Natiella, P., & Wyckoff, N. J. (1994). The collaborative relationship in psychotherapy. *The Person-Centred Journal*, 1(2), 11-17.

National Health Service Management Executive (1993). *Nursing in Primary Care – new world, new opportunities*. Leeds: NHSME.

Newton, N. (2010). *The use of semi-structured interviews in qualitative research, strengths and weakness*. Unpublished Doctorial thesis. University of Bristol.

Norcross, J. C. (2001). Introduction: in search of the meaning and utility of countertransference. *Journal of Clinical Psychology*, 57(8), 981-982.

Openshaw, L. (2012). *Challenges in Clinical Supervision*. Retrieved from www.nacsw.org/Publications/Proceedins2012/OpenshawchallengesFINAL.pdf.

Downloaded on 9 December 2015 at 1h36.

Orchowski, L. M., Spickard, B. A., & McNamara, J. R. (2006). Cinema and the valuing of psychotherapy: Implication for clinical practice. *Professional Psychology, Research and Practice*, 37(5), 506-514.

- Orlinsky, D. E., & Rønnestad, M. H. (2003). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC: American Psychological Association.
- Orlinsky, D. E., & Howard, K. (1997). The therapist's experience of psychotherapy. In Gurman, A. S. & Razin, A. M. (Eds.), *Effective psychotherapy: A handbook of research*. Oxford: Pergamon Press.
- Orlinsky, D. E., Rønnestad, M. H., Ambuhl, H., Willutzki, U., Botermans, J., Cierpka, M., Davis, J., & Davis, M. (1999). Development of Psychotherapists: Concepts, Questions, and Methods of a Collaborative International Study. *Psychotherapy Research*, 9(2), 127-153.
- Overholser, J. C., & Fine, M. (1990). Defining the boundaries of professional competence: Managing subtle case of clinical incompetence. *Professional Psychology: Research and Practice*, 21(6), 462-469.
- Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods*. California: Sage Publications.
- Pearlman, L. A. (1996). Psychometric review of TSI Life Events Questionnaire (LEQ). In B. H. Stam (Ed.). *Measurement of stress, trauma and adaption*. Lutherville: Sidron Press.
- Pedersen, P. B., Dragun, J. G., Lonner, W. J., & Trimble, J. E. (1996). *Counseling across cultures (4th ed.)*. London: Sage Publications.
- Pekarik, G., & Wierzbicki, M. (1986). The relationship between client's expectation and actual treatment duration. *Psychotherapy: Theory, Research, Practice, Training*, 23(4), 532-534.

- Prasko, J., & Vyskocilova, J. (2010). Countertransference during Supervision in Cognitive Behavioral Therapy. *Activitas Nervosa Superior Rediviva*, 52(4), 253-262.
- Pross, C. (2006). Burnout, vicarious traumatization and its prevention. What is burnout, what is vicarious traumatization? *Torture*, 16(1), 1-9.
- Reeves, T., & Hedberg, J. G. (2003). *Interactive learning systems evaluation*. Englewood Cliffs: Educational Technology Publications.
- Reivich, K., & Shatte, A. (2002). The resilience factor: 7 essential skills for overcoming life's inevitable obstacles. New York: Broadway Books.
- Rew, L., Taylor-Seehafer, M., & Thomas, N. (2000). Without parental consent, conducting research with homeless adolescents. *Journal of the Society of Paediatric Nurse*, 5(3), 131.
- Richardson, S. A., Dohrenwend, B.S., & Klein, D. (1965). *Interviewing: Its Forms and Functions*. New York: London.
- Robiner, W. N., & Stovandt, M. (1983). Client perceptions of the therapeutic relationship as a function of client and counsellor age. *Journal of Counseling Psychology*, 30(1), 96-99.
- Rochat, P. (2003). Five levels of self-awareness as they unfold in early life. *Consciousness and Cognition*, 12(4), 717-731.
- Rohner, R. P. (1984). Towards a conception of culture for cross-cultural psychology. *Journal of Cross-cultural Psychology*, 15(2), 111-138.
- Ronnestad, M. H., & Skovholt, T. M. (1993). Supervision of beginning and advanced graduate student of counseling and psychotherapy. *Journal of Counseling & Development*, 71(4), 396-405.

- Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counsellor and therapist: research findings and perspectives on professional development. *Journal of Career Development, 30*(1), 5-44.
- Rosenberger, E. W. (2002). Origins, consequences and management of countertransference: A case study. *Journal of Counseling Psychology, 49*(2), 221-231.
- Rosenberger, E. W., & Hayes, J. A. (2002). Therapists as subjects: A Review of the Empirical Countertransference Literature. *Journal of Counseling and Development, 80*(3), 264-270.
- Rubanowitz, D. E. (1987). Public attitude towards psychotherapist-client confidentiality. *Professional Psychology Research and Practice, 18*(6), 613-618.
- Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: W.W. Norton.
- Safran, J. D., & Muran, J. C. (2006). Has the concept of therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 286-291.
- Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford.
- Sarkar, S. P. (2004). Boundary violation and sexual exploitation in psychiatry and psychotherapy. *Journal of Continuing Professional Development, Advances in Psychiatric Treatment, 10*(4), 312-320.
- Schaeffer, J. A. (2006). *Transference and countertransference in non-analytic therapy: Double edge swords*. Retrieved from <http://www.continuinedcourses.net/active/courses/course076.php>. Downloaded on 1 March 2015 at 15h35.

- Scott, V., & Lester, D. (1998). Listening to Silence. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 19(3), 105-108.
- Schröder, T., Wiseman, H., & Orlinsky, D. (2009). "You were always on my mind": Therapists' intersession experiences in relation to their therapeutic practice, professional characteristics, and quality of life. *Psychotherapy Research*, 19, 42-53.
- Segall, M. H., Lonner, W., & Berry, J. (1998). Cross-cultural psychology as a scholarly discipline: On the flowering of culture in behaviour research. *American Psychologist*, 53(10), 1101-1110.
- Segall, M. H., Dasen, P. R., Berry, J. W., & Poortinga, Y. H. (1999). *Human behaviour in global perspective (2nd ed.)*. Boston: Allyn and Bacon.
- Shah, S. A. (1969). Privileged communications, confidentiality and privacy: Privileged communications. *Professional Psychology*, 1(1), 59-69.
- Sharkin, B. S. (1995). Strains on confidentiality in College-students psychotherapy: Entangled Therapeutic relationships, incidents encounters and third party inquires. *Professional Psychology: Research and Practice*, 26(2), 184-189.
- Sharply, C. F. (1997). The influence of Silence on client-perceived rapport. *Counselling Psychology Quarterly*, 10(3), 237.
- Sherman, P. (1965). Peripheral cues and the invisible countertransference. *American Journal of Psychotherapy*, 19(1), 280-291.
- Short, F., & Thomas, P. (2015). *Core approaches in counseling and psychotherapy*, New York: Routledge.
- Siegel, D. J. (2007). Mindfulness training and neural integration: differentiation of distinct streams of awareness and the cultivation of well-being. *Social Cognitive and Affective Neuroscience*, 2(4), 259-263.

- Sinha, I. B. P. (2003), Trends towards indigenization of psychology in India. In K. S. Yang, K. K. Hwang, P. B. Pedersen and I. Daibo (Eds.), *Progress in Asian Social Psychology: Concepts and Empirical Contribution*. 11-27, Westport: Praeger.
- Skovholt, T. M., & McCarthy, P. M. (1988). Critical incidents in counselor development. *Journal of Counseling and Career Development*, 67, 69-72.
- Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the Novice Counsellor and Therapist. *Journal of Career Development*, 30(1), 45-58.
- South Africa (1974). *Health Professions Act No. 56 of 1974*. Pretoria: Government Printer.
- Speight, S., & Vera, E. (1997). Similarities and differences in multicultural counseling: considering the attraction and repulsion hypothesis. *The Counseling Psychologist*, 25(2), 280-298.
- Spering, M. (2001). *Current issues in cross-cultural psychology: Research topics, applications and perspectives*. Unpublished Doctorial thesis. University of Heidelberg, Germany.
- Stedman, J. M., & Schoenfeld, L. S. (2011). Knowledge competence in Clinical and Counseling training and readiness for Internship. *Journal of Clinical Psychology*, 65(1), 1-5.
- Stephenson, B., & Wicklund, R. A. (1983). Self Directed attention and taking the other's perspective. *Journal of Experimental Social Psychology*, 19(1), 58-77.
- Stevenson, C. (2008). Psychotherapy: A Queer Space. *Smith College Studies in Social Work*, 78(2-3), 243-262.
- Stone, W. N. (2001). The role of the therapist's affect in the detection of empathic failure, misunderstanding and injury. *Eastern Group Psychotherapy Society*, 25(1), 3-19.

- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park: Sage Publications, Inc.
- Strean, H. S. (1969). Non verbal intervention in Psychotherapy. *Psychotherapy: Theory, Research, & Practice*, 6(4), 235- 237.
- Strein, W., & Hershenson, D. B. (1991). Confidentiality in non-dyadic counseling situations. *Journal of Counseling and Development*, 69(4), 312-316.
- Stromme, H. (2010). *Confronting helplessness. A study of psychology students' acquisition of dynamic psychotherapeutic competencies*. (Doctorial Dissertation). University of Oslo.
- Sue, D. W., & Sue, D. (2008a). *Counseling the culturally diverse: Theory and practice*. (5th ed.). New York: John Wiley and Sons.
- Sue, D. W., & Sue, D. (2008b). *Foundations of counseling and psychotherapy: evidence based practice for a diverse society*. New York: John Wiley and Sons.
- Szumacher, E., Catton, P., Jones, G. A., Bradley, R., Kwan, J., Cherryman, F., Palmer, C., & Nyhat-Young, J. (2007). Helping learners in difficulty - the incidence and effectiveness of remedial programme of medical radiation science programme at University of Toronto and Michener. *Annals of Academic Medicine*, 36(9), 725-735.
- Tahim, A. (2015). Who are we? A qualitative evaluation of trainees' perspectives on professional identity in oral and maxillofacial surgery. *Prospect Medical Education*, 4(1), 33-38.
- Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in Practice: Applied Methods for the Social Sciences*. (2nd ed.). Cape Town: UCT Press.

- Theriault, A., & Gazzola, N. (2005). Feelings of inadequacy, insecurity, and incompetence among experienced therapists. *Counseling and Psychotherapy Research*, 5, 11-18.
- Theriault, A., & Gazzola, N. (2006). What are the sources of feelings of incompetence in experiences therapists? *Counseling Psychology Quarterly*, 19(4), 313-330.
- Theriault, A., Gazzola, N., & Richardson, B. (2009). Feelings of incompetence in novice therapists. Consequences, coping and correctives. *Canadian Journal of Counseling*, 43(2), 105-119.
- Thomas, A. (1994). *Psychology and multicultural society: analysis and problem solving*. Retrieved from <http://epub.uni-regensburg.de/19036> on 16 March 2015 at 22h15.
- Tindall, R. H., & Robinson, F. P. (1949). The use of silence as a technique on counseling. *Journal of Clinical Psychology*, 3(2), 136-141.
- Tjeltveit, A. C., & Gottlieb, M. C. (2012). Avoiding ethical missteps. *Psychotherapy Theory, Research, Practice, Training*, 41(1), 68-73.
- Tohn, S. L., & Oshlang, T. A. (1996). Solution focused therapy with mandated clients: co operating with the unco-operative. In S. Miller, M. Hubble, & B. Duncan (Eds.), *Handbook of solution focused brief therapy*. San Francisco: Jossey- Bass.
- Trad, P. V. (1993). Silence: The resounding experience. *American Journal of Psychotherapy*, 47(2), 167-170.
- Triandis, H. C. (2001). Individualism-collectivism and personality. *Journal of Personality*, 69(6), 907-924.
- Truell, R. (2001). The Stresses of Learning Counseling: Six Recent Graduate comments on their personal experience of learning counseling and what can be done to reduce associated harm. *Counseling Psychology Quarterly*, 14(1) 67-89.

- Truscott, D. (2010). *Becoming an Effective Psychotherapist: Adopting a Theory of Psychotherapy That's Right for You and Your Client*. Washington: American Psychological Association.
- Tsai, M., Ogrodniczuk, J. S., Sochting, I., & Mirmiran, J. (2014). Forecasting success: patients' expectation for improvement and their relations to baseline, process and outcome variable in group cognitive-behavioural therapy for depression. *Clinical Psychology and Psychotherapy*, 21(2), 97-107.
- Vailant, G. E., Sobowale, N., & McArthur, C. (1972). Some psychological vulnerabilities of physicians. *Journal of Medicine*, 287(8), 372-375.
- Van Deurzen, E. (2014). Structural existential analysis: A phenomenological research methods for counseling psychology. *Counseling Psychology Review*, 29(2), 54-66.
- Van Wagoner, S. L., Gelso, C. J., Hayes, J. A., & Diemer, R. A. (1991). Countertransference and the reputedly excellent therapist. *Psychotherapy: Theory, Research, Practice, Training*, 28(3), 411- 421.
- Varma, V. P. (1997). *Stress in psychotherapists*. New York: Routledge.
- Vogel, D. L., Wade, N. G., Wester, S. R., Larson, L., & Hackler, A. H. (2007). Seeking help from a mental health professional: The influence of one's social network. *Journal of Clinical Psychology*, 63(3), 233-245.
- Wahass, S. H. (2005). The role of psychologist in health care delivery. *Journal of Family Community Medicine*, 12(2), 63-70.
- Walsham, G. (1993). Interpretive case studies in IS research: nature and method. *European Journal of Information Systems*, 4, 74-81.
- Welman, C., Kruger, F., & Mitchell, B. (2005). *Research Methodology*. South Africa, Oxford University Press.

- Welsh, D. T., Ordenez, L. D., Snyder, G. D., & Christian, M. S. (2015). The slippery slope: How ethical transgressions pave the way for larger future transgressions. *Journal of Applied Psychology, 100*(1), 114-127.
- Welsh, R., & Sharpiro, S. L. (2006). The meaning of meditative disciplines and western psychology: A mutually enriching dialogue. *American Psychologist, 61*(3), 227-239.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- Wilkinson, C. B., & Spurlock, J. (1986). The mental health of Black Americans: Psychiatric diagnosis and treatment. In C. B. Wilkerson (Ed.), *Ethnic Psychiatry* (pp. 13-59). New York: Plenum.
- Williams, E. N., Hayes, J. A., & Fauth, J. (2008). Therapist self-awareness: Interdisciplinary Connections and future directions. In S. Brown & R. Lent (Eds.), *Handbook of counseling psychology*, New Jersey: Wiley.
- Williams, E. N., Hurley, K., O'Brien, K., & DeGregoria, A. (2003). Development and Validation of the Self-awareness and management strategies (SAMS) scales for therapists. *Psychotherapy: Theory, Research, Practice, Training, 40*(4), 278-288.
- Williams, E. N., Judge, A. B., Hill, C. E., & Hoffman, M. A. (1997). Experiences of novice therapists in pre-practicum: Trainees', client's and supervisors' perceptions of therapists' personal reactions and management strategies. *Journal of Counseling Psychology, 44*(4). 390-399.
- Willis, J. (1995). A recursive, reflective instructional design model based on constructivist interpretivist theory. *Educational Technology, 35* (6), 5-23.
- Wilson, J. P., & Lindy, J. D. (1994). *Countertransference in the treatment of PTSD*. New York: Guildford Press.

- Winnicott, D. (1949). Hate in the countertransference. *The international Journal of Psychoanalysis*, 30, 69-75.
- Woods, K. M., & McNamara, J. R. (1980). Confidentiality: its effects on interviewee behaviour. *Professional Psychology*, 11(5) 714-721.
- Yang, K. (2012). Indigenous Psychology, Westernized Psychology and Indigenous Psychology: A non-westernized Psychologist's view. *Gung Journal of Humanities and Social Science*, 5(1), 1-32.
- Zur, O. (2004). To cross or not to cross: Do boundaries in therapy protect or harm? *Psychotherapy Bulletin*, 39, 27-32.

APPENDICES

Appendix A – Letter of request

University of Zululand
Private Bag
KwaDlangezwa
3886

Dear Student/ Intern Psychologist

I am currently pursuing a Master's degree in Clinical Psychology at the University of Zululand. My research will focus on the obstacles faced by student and intern psychologists during their first therapy session.

I would be grateful if you would kindly participate in a personal interview which is necessary for the research. This interview would be conducted within an hour. Your permission will be sought to voice record the interview.

Your responses, I assure you, will be treated with scrupulous confidentiality. You will remain anonymous to ensure that your comments can in no way be traced back to you. Your responses will be kept by the Department of Psychology.

Your participation in this study is entirely voluntary, and, further, you may discontinue participation at any time. The findings of this study may be used for publication in journals or presented at conferences. In order to participate in this study you must:

1. Be a trainee psychologist.
2. Be at postgraduate level.
3. Have had at least one therapy session with a client.

I thank you for your contribution to this study.

Yours sincerely

Mr Jeethen Ramnanan

University of Zululand

Appendix B – Informed consent declaration

INFORMED CONSENT DECLARATION

Project Title: Obstacles Faced by Student and Intern Psychologists Whilst Conducting Their First Therapy Session

Jeethen Ramnanan from the Department of Psychology, University of Zululand has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project, and of this informed consent declaration, have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project is to explore the Obstacles Faced by Student and Intern Psychologists Whilst Conducting Their First Therapy Session.
2. The University of Zululand has given ethical clearance to this research project and I have seen/ may request to see the clearance certificate.
3. By participating in this research project I will be contributing towards the exploration of the obstacles faced by student and intern psychologists whilst conducting their first therapy sessions, how these obstacles affect the therapy session and how student and intern psychologists overcome these obstacles.
4. I will participate in the project by responding copiously, frankly and honestly to the questions put to me in the interview.
5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences.
6. I will not be compensated for participating in the research, but my out-of-pocket expenses will be reimbursed.
7. There may be risks associated with my participation in the project. I am aware that
 - a. the following risks are associated with my participation: my integrity could be compromised if my responses are not treated with confidentiality.
 - b. the following steps have been taken to prevent the risks: I have been assured by the researcher that my contribution will be treated with the strictest confidentiality

- c. there is a <5% chance of the risk materialising.
8. The researcher intends publishing the research results in the form of a dissertation, and peer reviewed journal articles. However, confidentiality and anonymity of records will be maintained and that my name and identity will not be revealed to anyone who has not been involved in the conduct of the research.
 9. I will not receive feedback regarding the results obtained during the study.
 10. Any further questions that I might have concerning the research or my participation will be answered by Jeethen Ramnanan.
 11. By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.
 12. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I,have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

.....

Participant's signature

.....

Date

Appendix C – Ethical clearance certificate

**UNIVERSITY RESEARCH ETHICS
COMMITTEE**
(Reg No: UZREC 171110-30)



UNIVERSITY OF ZULULAND
Website: <http://www.unizulu.ac.za>

Private Bag 31001
KwaDlangezwa 3886

Tel: 035 902 6387
Fax: 035 902 6222
Email: ManqaleS@unizulu.ac.za

ETHICAL CLEARANCE CERTIFICATE

Certificate Number	UZREC 171110-030 PGM 2013/80				
Project Title	Obstacles faced by student and intern psychologists whilst conducting their first therapy session				
Principal Researcher/ Investigator	J Ramnanan				
Supervisor and Co- supervisor	Prof. JD Thwala		Mrs. C Hermann		
Department	Psychology				
Nature of Project	Honours/4 th Year	Master's	<input checked="" type="checkbox"/> x	Doctoral	Departmental

The University of Zululand's Research Ethics Committee (UZREC) hereby gives ethical approval in respect of the undertakings contained in the above-mentioned project proposal and the documents listed on page 2 of this Certificate. Special conditions, if any, are also listed on page 2.

The Researcher may therefore commence with the research as from the date of this Certificate, using the reference number indicated above, but may not conduct any data collection using research instruments that are yet to be approved.

Please note that the UZREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the documents that were presented to the UZREC
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UZREC in the prescribe format, where applicable, annually and at the end of the project, in respect of ethical compliance.

The table below indicates which documents the UZREC considered in granting this Certificate and which documents, if any, still require ethical clearance. (Please note that this is not a closed list and should new instruments be developed, these may also require approval.)

Documents	Considered	To be submitted	Not required
Faculty Research Ethics Committee recommendation	X		
Animal Research Ethics Committee recommendation			X
Health Research Ethics Committee recommendation			X
Ethical clearance application form	X		
Project registration proposal	X		
Informed consent from participants	X		
Informed consent from parent/guardian			X
Permission for access to sites/information/participants	X		
Permission to use documents/copyright clearance			X
Data collection/survey instrument/questionnaire	X		
Data collection instrument in appropriate language		Only if necessary	
Other data collection instruments		Only if used	

Special conditions: Documents marked "To be submitted" must be presented for ethical clearance before any data collection can commence.

The UZREC retains the right to

- Withdraw or amend this Certificate if
 - Any unethical principles or practices are revealed or suspected
 - Relevant information has been withheld or misrepresented
 - Regulatory changes of whatsoever nature so require
 - The conditions contained in this Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project

The UZREC wishes the researcher well in conducting the research.



Professor Rob Midgley
 Deputy Vice-Chancellor, Research and Innovation
 Chairperson: University Research Ethics Committee
 11 November 2013

CHAIRPERSON
 UNIVERSITY OF ZULULAND RESEARCH
 ETHICS COMMITTEE (UZREC)
 REG NO: UZREC 171110-30

11-11-2013

RESEARCH & INNOVATION OFFICE

Appendix D – Format of the semi structured interview

1. How would you describe your experience during the therapy session?

Probes:

How would you describe your client's reaction during the therapy session?

Discuss any subjective feelings you might have experienced during the therapy session.

Did your client engage in any nonverbal expressions or gestures that could have negatively impacted on the session?

2. What were some of the obstacles you experienced during the therapy session?

Probes:

Do you think you met the client's expectations during the therapy session?

Did you experience any barriers in the therapy session such as culture, socio-economic status, etc.?

When you encountered these obstacles, did you notice any reaction by the client?

How do you think the client perceived you at this stage?

3. What were some of the strategies that you used to overcome these obstacles?

Probes:

Do you think you were trained sufficiently to overcome any obstacles that you encountered in the therapy session?

If you could redo the therapy session, what would you do differently?