# GUIDELINES TO SUPPORT STUDENTS DURING PRACTICUM TRAINING AT A UNIVERSITY IN LIMPOPO PROVINCE, SOUTH AFRICA

**By**

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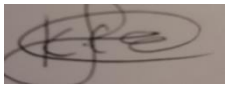
DECLARATION

I, **Khathutshelo Edith Mphephu (11530508),** hereby declare that the thesis for the Doctor of Philosophy degree, entitled "**Guidelines to Support Students During Practicum Training at a University in Limpopo Province, South Africa**" hereby submitted by me, has not previously been submitted for a degree at this or any other University, and that it is my own work in design and execution and that all reference material contained therein has been duly acknowledged.

Signature:  Date: 02/05/2023

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## Dedication

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**Abstract**

Students registered for a Bachelor of Psychology are required to complete a six-month practicum during the second semester in their fourth year of study before they graduate. During their practicum, they are called student registered counsellors. These student registered counsellors also offer counseling to clients suffering from trauma. Counselling trauma clients exposes the students to various challenges which affect their normal functioning, making them less effective when they offer counseling. The aims of this study were to explore the challenges experienced by student registered counsellors during their practicum and develop guidelines that will assist to identify and offer support to affected students while they are caring for trauma clients.

The objectives of the study were to describe the profile of clients counselled by student registered counsellors, to explain the activities and roles played by student registered counsellors during counselling, to determine the effects of counselling trauma clients on student registered counsellors, to explain the mechanisms for identifying student registered counsellors affected during practicum, to identify coping strategies used by students to deal with challenges encountered during practicum training, to explore the kind of support received by student registered counsellors during practicum, and to develop guidelines for supporting students who experience challenges while caring for clients during practicum. The study was qualitative in nature.

A phenomenological research design was used. The population comprised former student registered counsellors who had completed their practicum. Purposive sampling was used to select 12 participants. The former student registered counsellors were asked to come on campus for the interviews after they had completed their practicum. The researcher took into consideration both institutional and external ethical issues. Data was collected using a semi-structured interview guide. The semi-structured interviews were conducted in the researcher's office. Interpretative phenomenological analysis was used to analyse the collected data. The findings of the study outlined several challenges, such as struggles to adjust to a new environment, and countertransference, that were encountered by student registered counsellors during practicum, and which were related to training at the university and the practicum site. The study also helped to identify ways

that can be adopted to deal with the challenges encountered by student registered counsellors. At the end of the study, based on the findings, the researcher was able to develop guidelines that will be used to support student counsellors on practicum.

**Keywords**: Counselling, Guidelines, Practicum, Student, Support, University

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## LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| **ACA** | American Counseling Association |
| **APIL** | Ability, Processing of Information, and Learning |
| **AIDS** | Acquired Immuno Deficiency Syndrome |
| **APA** | American Psychological Association |
| **ASB** | Aptitude for School Beginners |
| **BPsych** | Bachelor of Psychology |
| **BO** | Burnout |
| **CDQ** | Career Development Questionnaire |
| **CF** | Compassion Fatigue |
| **CRTB** | Critical Reasoning Test Battery |
| **CSDT** | Constructivist Self-Development Theory |
| **CT** | Counter Transference |
| **DOE** | Department of Education |
| **DOH** | Department of health |
| **DSM** | Diagnostic and Statistical Manual of Mental Disorders |
| **DSM IV- TR** | Diagnostic and Statistical Manual of Mental Disorders, fourth edition, Text Revised |
| **EST** | Ecological Systems Theory |

| | |
|---|---|
| **FET** | Further Education and Training |
| **15 fq+** | Fifteen Factor Questionnaire Plus |
| **GRADE** | Grading of Recommendations, Assessment, Development and Evaluation |
| **GRT** | Graduate Reasoning Test Battery |
| **GSAT** | General Scholastic Aptitude Test |
| **HCPC** | Health and Care Professions Council |
| **HIV** | Human immune deficiency virus |
| **HPCSA** | Health Professions Council of South Africa |
| **IPA** | Interpretative Phenomenological Analysis |
| **LPCAT** | Learning Potential Computerised Adaptive Test |
| **LTT** | Louis Trichardt |
| **19FII** | Nineteen Field Interest Inventory |
| **NGO** | Non- Government Organization |
| **OIP** | Occupational Interest Profile |
| **OPP** | Occupational Personality Profile |
| **PICO** | Population, Intervention, Comparison and Outcome |
| **PPG** | Paper and Pencil Games |
| **PTSD** | Post Traumatic Stress Disorder |
| **RPM** | Raven's Progressive Matrices |

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|---|---|
| **SETT** | School-readiness Evaluation by Trained Testers |
| **SAVII** | South African Vocational Interest Inventory |
| **SDS** | Self-Directed Search Questionnaire |
| **SII** | Strong Interest Inventory |
| **SAQA** | South African Qualifications Authority |
| **SRC** | Student Registered Counsellor |
| **SSHA** | Survey of Study Habits and Attitudes |
| **STS** | Secondary Traumatic Stress |
| **TRAM** | Transfer, Automatisation and Memory |
| **TPL** | Theory of Planned Behavior |
| **UNIVEN** | University of Venda |
| **WHO** | World Health Organisation |
| **VT** | Vicarious Trauma |

# CHAPTER 1

# INTRODUCTION TO THE STUDY

## 1.1 Introduction and Background of the Study

Practicum training forms part of any holistic curriculum and provides students with the opportunity to apply theoretical knowledge, skills, attitudes, and values in a real work environment (Pill & Pilli, 2013). During practicum training, students learn to apply, adapt, and integrate the theoretical aspects of the profession. Practicum training is critical in preparing students for the complexities and demands of being a prospective counsellor.

The counselling practicum is a supervised clinical experience. Prospective counsellors are supervised to build and enhance their basic counselling skills and to integrate their theoretical expertise with practise. Linking theory and practice is useful for professionals to avoid endangering the lives of the people they serve (Chaminuka & Kaputa, 2014). To conduct an effective counselling process, a skilful counsellor should have some professional skills. These professional requirements include different types of skills such as positive relationships, helping/counselling, case conceptualisation, diagnosis, strategies, and interventions (Cormier & Hackney, 2008). Students on practicum are exposed, likely for the first time, to intense professional expectations while in the meantime they have coursework, research responsibilities, and psychotherapy training. These students are involved in other activities and commitments apart from practicum which can lead them to experience stress due to a great deal of expectations. According to Schwartz-Mette (2009), if this stress is not addressed properly, it puts students at increased risk for impairment, meaning that they may not fully learn what they are expected to do during practicum. The practicum is a critical part of professional education in higher education and takes a variety of forms depending on the field, such as field practicum, block practicum, and clinical practicum (Johnson et al., 2012).

The professional category of Bachelor of Psychology (BPsych) Registered Counsellor was created in South Africa with the aim of delivering psychological services at a primary healthcare level to previously disadvantaged communities (Elkonin & Sandison, 2006).

The Health professions council of South Africa HPCSA has a document called form 258 which consist of the framework for education, training, Registration and Scope of Registered counsellors. Forms 285 informs all the training institutions that offer the BPsych degree on how to train students theoretically and practically. The form outlines the academic, and professional content that student registered counsellors must get training on at various training institutions that offer the degree. It also guides the training institution about practicum training and research that the SRCs must conduct. The general HPCSA training framework offers a guidance on how to best train registered counsellors in South African institutions. The researcher offers functional supervision to SRCs that are placed at various institutions including the student counselling center at the University of Limpopo, what was observed is that the framework on form 258 is taken into consideration at this intuition and at the university of Venda.

Fourth year Bachelor of Psychology students at the University of Venda (Univen) have to complete a six-month counselling practicum during the second semester, that is, from 1 July - 31 December. While they are at the University they are referred to as BPsych students, but when at the practicum site they are referred to as Student Registered Counselors (SRC). These students are placed in different sectors, such as Department of Health (Hospitals), correctional services (Prisons), Department of Education (Technical and vocational education and training, schools, student counselling units at different universities), and non-government organisations, wherein they offer counselling to clients as student registered counsellors. According to Pretorius (2015) registered counsellors work with cases of Human Immunodeficiency Virus (HIV) and acquired immunodeficiency syndrome (AIDS), trauma, woman and child abuse, substance abuse, orphans, and bullying. Huang et al, (2014) defines trauma as experiencing of events that are emotionally and physically harmful or life threatening. Furthermore, these events have a lasting effect on the individuals' mental, emotional and social well-being. The trauma clients that come for counselling experience various forms of trauma which may be physical, psychological, emotional, sexual abuse or other traumatic life event such as loss of a loved one, illness, accidents and disasters (Frazier, 2012). They also work in the context of violence that is defined as using physical force to injure, damage, violate or destroy people or things (Bufacchi, 2005). The categories of violence that SRCs work

with are: Assault (grievous bodily harm, murder etc.); Robbery (hijacking, house/bank robbery etc.); and rape (and other sexual assault) .There is undoubtedly a great need of registered counselors in the profession of psychology in South Africa. BPsych students on practicum are not immune to several challenges related to practicum training due to the nature of the work that they do during training.

The nature of the counselling practice is exhausting and draining, which leaves SRCs prone to experience psychological distress. Researchers have explored the interpersonal reactions between the client and the counsellor (Silveira & Boyer, 2015). When the SRC experiences personal distress, it can negatively impact their professional experience. In other words, stress and impairment negatively impact their ability to work effectively with clients (Schwartz-Mette, 2009). Students' developmental predispositions (e.g., childhood trauma) and problems related to their professional roles (e.g., isolation, emotional overload) may contribute to difficulties for SRCs (Knapp & VandeCreek, 2006). SRCs on practicum are also prone to developing psychological distress due to long working hours, finances and pressures of both formal and informal evaluations. Furthermore, trainee counsellors struggle with issues related to the pressures and stresses of their courses, challenging clients, problems with supervisors, preparing for tests and exams, countertransference issues, and difficulties undergoing emotional changes inherent in counselling training.

In an Australian study by Dunkley and Whelan (2006) of telephone counsellors working with clients who had experienced trauma, it was found that nearly 26% of counsellors had experienced at least one posttraumatic stress symptom, while 8.2% had high levels of trauma indicators. An estimated 82% to 94% of clients seeking counselling at community centres have survived a traumatic event. As a result, student registered counsellors will work with more trauma clients (Williams et al, 2012). Exposure to traumatic life events often results in negative psychological symptoms, which may include intrusive cognitions, images, memories, and emotions related to the original trauma (Garland et al., 2013).

The results of a study conducted by Mansor and Yusoff (2013) in Southeast Asia on the feelings and experiences of students in the counselling internship at the International

Islamic University in Malaysia showed that nervousness, lack of confidence in applying theories, and completing tasks are among the challenges during the internship. In addition, there are some problems and concerns related to counselling diverse clients in the Malaysian context. A study conducted by Jaladin (2013) in Malaysia on multicultural counselling suggested that counsellors need to develop competency in spirituality and religious aspects of counselling in order to successfully and ethically provide multicultural counselling in the Malaysian context.

In the sub-Saharan region, a study by Chaminuka and Kaputa (2014) of experiences during practical training at the Zimbabwe Open University in Harare concluded that challenges faced by trainees included issues such as burnout and lack of empathy, as well as compassion for clients. Participants also indicated that they faced time constraints, i.e., limited time, while others indicated that work pressure was a problem at some sites, as they had to manage a heavy workload and had little time to reflect on their sessions. Some of the students complained that they even felt exploited most of the time (Chaminuka & Kaputa, 2014). The biggest challenge with practical training is organising it in a way that is successful and meaningful for everyone involved (Pill & Pilli, 2013). Student counsellors in Kenyan universities and colleges must apply the knowledge and skills acquired in the classroom. Applying the above knowledge and skills in practice is a major challenge for trainees and newly qualified counsellors (Misigo, 2014). Misigo (2014) further pointed out that these students face the challenge of knowing how to apply different counselling techniques when dealing with a variety of problems presented to them by their clients. Counsellors may feel insecure in their role because their training has not equipped them for their current practice.

South Africa in the post- apartheid era is one of the countries with high rates of violence (Souverein, 2015). South Africa's changing sociocultural context demands greater urgency for mental health interventions at the primary prevention level (du Preez & Roos, 2008). Interpersonal violence is widespread, and access to public mental health care is limited. This is evident from a study by Ortlepp and Friedman (2002), which found that at least 10% of lay trauma counsellors trained to counsel bank employees after bank robberies in South Africa reported experiencing secondary traumatic stress symptoms at

extremely high levels. Volunteer crisis workers play an important role in supporting survivors of violence (Howlett & Collins, 2014). The diversity of the South African population requires counsellors who can promote the mental health of all who express a need for these services.

In clinical learning, students encounter a difficult, multidimensional, and unfamiliar world where social and cultural realities and rules may be different than in the university setting. Several professional education programmes have found that students are impaired during training due to the constraints associated with the demands of counselling (Rosenberg et al., 2005). Vocational education programmes have an ethical responsibility to respond appropriately to identified impairments in their trainees. Fitch and Marshall (2002) also agree that trainees in counselling practicum face many self-defeating thoughts and fears. Much of the research on counselling trainees focuses on supervisors' perceptions of the internship, whereas the present study focuses on trainees' perceptions.

### 1.2 Problem statement

Student Registered counsellors experience several challenges during practicum training. These students are placed at different sectors where they are expected to be working daily with compassion and connection, which might lead to challenges as discussed below.

During practicum training, SRCs receive clinical and functional supervision from supervisors at the practicum placement site and from their lectures who monitor their performance. It was observed that some of them were not coping especially after counselling trauma clients. SRCs each year would complain that they are not coping with the practicum training due to several factors that range from struggling to strike a balance between ongoing academic research projects and the clinical practicum, to a lack of knowledge about how to deal with certain clients. Some SRCs would even report that they feel like they have chosen the wrong career path due to the nature of the content that the clients shared with them.

SRCs are expected to undergo two oral examinations. The examinations are carried out to test their competency during practicum training, the first oral exam is done within the first three months after commencement of practicum then the second is done in the sixth month before they complete the practicum. Should they fail these examinations, it indicates that they are not grasping the practical component of this degree and may result in an extension of their practicum. Almost each year, some of the students will get a three-month extension on their practicum because they are failing their oral examination. This indicates that there is a problem that they encountered during training. Some of the students indicated that the clients' traumatic events were too painful for them to deal with, and that they were affected for some days afterwards, and as a result they could not execute their duties as SRCs effectively.

During their training at the university, for three and a half years, they are exposed to theory, and during community outreaches they design and implement mental health awareness campaigns. These students only start to come into contact with actual clients during the second semester during the practicum. As a result, most of the students find it challenging to link theory and practical (not knowing exactly which theory or counselling technique to apply to a real client's situation). SRCs may become less motivated to continue with their practicum training due to the challenges they encounter during training. In addition, there may be limits to what they can learn during their professional training. The present study focused on the challenges encountered by the students during practicum training.

### 1.3 Aims of the study

1.3.1 To explore challenges experienced by SRCs during practicum.

1.3.2 To develop guidelines to support students during practicum training at a selected University in Limpopo Province, South Africa

### 1.4 The study was guided by the following objectives:

- To describe the profile of clients counselled by SRCs.
- To explain activities and roles played by SRCs during practicum.

- To determine the effects of counselling trauma clients on SRCs.
- To explain mechanisms for identifying SRCs affected by offering counselling during practicum.
- To identify coping strategies used by students to deal with challenges encountered during practicum training.
- To explore the kind of support received by SRCs during practicum.
- To develop guidelines for supporting students who experience challenges while caring for clients during practicum.

### 1.5 Main research question

What are the challenges faced by SRCs during their practicum training?

### 1.6 Rationale of the study

While many studies have been conducted previously on the challenges faced by mental health workers in relation to offering counselling (see Pill & Pilli, 2013; Adams, Boscarino, & Figley, 2006; Figley, 1999; Pearlman & Saakvitne, 1995), few studies have focused on practicum for SRCs and how to assist them with challenges experienced such as burnout, counter transference, VT and others. Another qualitative study by Ling et al, (2014) examined factors that helped counsellors exposed to indirect trauma succeed personally and professionally but did not focus on the experience during the internship. Ortlepp and Friedman (2002) conducted a study to identify the prevalence of secondary traumatic stress experienced by trauma counselors at work and indicated the presence of psychiatric symptoms coupled with negative psychological well-being that had been reported by trauma counsellors. Goodman (2015) indicated that the awareness about the need for counsellors to be prepared for trauma work has increased since the late 1970s and early 1980s however not much literature has been accumulated with regard to SRCs, within the South African context, and only a few studies have focused on the experiences of registered counsellors during practicum (Rouillard et al., 2016).

Although experienced psychologists are better able to deal with the interplay of personal and professional experience in the delivery of psychotherapy, students encountering the

world of work for the first time often find the task difficult and confusing (Schwartz-Mette, 2009). The current study will reveal the experiences that are encountered by SRCs during their practicums when they treat clients. In South Africa, there is little research on the support needs of workers or students trained in organisations that deal with trauma cases (Couper, 2000). The present study will help to identify strategies for assisting SRCs who experience challenges during practicum training.

### 1.7 Significance of the study

This study is important as it specifically focuses on how the SRCs are affected by offering counselling to clients during their practicum. SRCs on practicum placements are exposed to the same clients as professional psychologists and registered counsellors in terms of the problems they present. As a result, they can also be affected in the same way as fully trained psychologists. This study revealed the challenges that are encountered by students during practicum training when they treat various clients. In addition, the study revealed what needs to be done to identify students who are affected. This study helped to develop guidelines that can be used to assist students on the practicum to deal with several challenges associated with practicum training. This study will also benefit the University of Venda as well as other universities offering the BPsych degree because they will understand the experiences of their students while they are doing their internship and can ensure that they are properly prepared to deal with challenges experienced during practicum training.

The clients that the students counsel will benefit as well because they will be assisted by students who are mentally prepared to help them. Placement sites such as hospitals, Further Education and Training (FET) colleges, schools, and non-government organisations (NGO's) will benefit as they will have students who are delivering quality services to clients. All BPsych students will benefit from the study as it will reveal challenges, they may come across during practicum training, and ways of dealing with them.

This study will also benefit the Health Professions Council of South Africa (HPCSA), as it will have registered students who are emotionally fit to execute the duties of a SRC. In

so doing, the students will be protecting the public from harm. The present study mostly benefits students who are counselling clients during their practicums. Novice or beginning counsellors will be in much need of help regarding the structuring of their work (Krige & Fritz, 2006).

## 1.8 Definitions and operational definitions of concepts

**BPsych**

Bachelor's Degree in Psychology (leading to Registered Counsellor qualification) (Fisher, 2017).

**Counselling**

Counselling is defined as a principled relationship that involves the application of one or more psychological theories and the use of a set of communication skills modified by experience, intuition, and other interpersonal factors to address clients' intimate concerns, problems, or desires (Gladding, 2004).

**Practicum**

This is also called work placement; it is designed to give students supervised practical application of a previously studied theory. This is a course with activities that emphasise the practical application of theory, specifically a course in which a student gains 'on-the-job' experience in an area of study (Harcourt, 2010). In this study, the words practicum, practice and practical will be used interchangeably.

**Registered counsellor**

Refers to a counsellor that provides short-term counselling that is supportive in nature, psychoeducation, and various psychological assessments, e.g., intellectual, or scholastic abilities, aptitude, interests, career placement, personality profiling at a primary level (Pretorius, 2015).

**Support**

In this study, the term support refers to an activity or function required for the successful completion of a process, program, or project.

**Trauma**

Trauma is “an emotional response to a terrible event like an accident, rape, or natural disaster” (American Psychiatric Association, 2013).

## 1.9 Demarcation of the study

### 1.9.1 Chapter 1: Introduction to the Study

Chapter one comprises an introduction and background of the study. It gives an insight into the BPsych degree and the practicum requirements. The first chapter also provides a discussion about the work that SRCs do and the challenges that come with offering counselling to a variety of clients.

### 1.9.2 Chapter 2: Literature Review

The second chapter covers the literature about the rationale for the BPsych qualification, and the requirements for completion of the degree. The literature review also entails a detailed discussion about several challenges that are experienced by mental health workers which the SRCs are not exempted from; the discussion also covers ways that can be used by SRCs in order to overcome the challenges they may encounter during practicum.

### 1.9.3 Chapter 3: Theoretical Framework

This chapter looks at three theories that are applicable to the study. The theories discussed are the constructivist self-development theory, that explains how exposure to traumatic material disrupts the SRCs’ sense of safety and trust which in turn affects their

learning during practicum. The second theory discussed is the Bronfenbrenner's Ecological Systems Theory (EST), that explains how the learning of SRCs is influenced by both psychological and social factors in their environment. The third and last theory discussed in this chapter is the Theory of Planned Behavior (TPB) which focuses on understanding the planned behavior of individuals and causes.

### 1.9.4 Chapter 4: Research Methodology

This chapter is about the research methodology that is used in the study. The chapter is divided into two phases namely, Phase one and Phase two. Phase one is the empirical phase that focuses on the research approach, the research design, population and setting, sampling and sample size, research instrument, pre-testing, data collection, data analysis, and trustworthiness, and lastly a discussion about the ethical codes that will be considered in the study. The second phase is guideline development, and a detailed discussion about the guidelines that will be developed and validated.

### 1.9.4 Chapter 5: Presentation of findings

Chapter 5 provides a discussion of the findings after data was collected and analysed. This chapter describes the characteristics of the participants and gives a discussion of their responses to the questions that were asked during data collection

### 1.9.5 Chapter 6: Discussion of Findings

The discussion of findings chapter focuses on what the participants reported, and the researcher's understanding of the data. The topics discussed in this chapter comprise: the profile of clients to whom Former Student Registered Counsellors (FSRC) offered counselling; preparedness to offer counselling; challenges experienced during practicum training; experiences of counselling trauma clients; the effects of counselling trauma patients; support received during practicum training; and ways to assist students who experience challenges while on practicum training.

### 1.9.6 Chapter 7: Recommendations and Limitations of the Study

This chapter entails a discussion about the suggested recommendations based on the findings of the study. Another aspect that is discussed in this chapter is the limitations that were encountered in this study.

### 1.9.7 Chapter 8: Guidelines Development

The last chapter contains a detailed discussion about the steps that were followed in the process of guideline development. A discussion about all the people who were involved in developing and validating the guidelines is given in this chapter. The developed guidelines are listed and explained in detail.

## 1.10 Summary

This first chapter introduced the study focusing on the background of the study, the rationale for the study, its significance, and the problem statement. Furthermore, the aim and objectives of the study were described. This chapter also offered the research question and definition of key concepts in the study. Lastly there was a discussion about how the chapters are organised and the focus of each chapter.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 Introduction

To fully capacitate SRCs for their professional roles, practicum training is pivotal. However, there are challenges experienced in the learning process and facilitation of the programme as highlighted in the previous chapter. In this section, the researcher presents a review of the literature. The review was aimed to gain a broad understanding of the available information related to the practicum experiences of SRCs as Burns and Grove, (2003) propose. This will be achieved by looking at the purpose of the qualification; the current structure/curriculum of the B Psych programme; the practicum training; profiles of clients that the SRCs offer counselling to; and roles of students during practicum. In addition to this, the researcher will discuss challenges experienced by mental health workers (full-time and in-training) as well as their coping strategies. Relevant literature was searched for from various databases including, Science Direct; Ebscohost; Sage; JSTOR; Emerald; Directory of open journals; SA-e journals; Springer; Global books in print; Sabinet; Medline; Newspapers source; Econlit; and Health source (Nursing/academic edition). To get information related to the topic of interest, the researcher used keyword searches, which included: practicum; challenges during practical training; BPsych; challenges during counselling; and vicarious trauma.

## 2.2 Purpose of the BPsych Qualification

The purpose of the BPsych qualification is to produce qualifying practitioners who will be registered with the HPCSA to offer psychological services focusing on prevention and primary intervention for psychological challenges in a diverse community context.

In addition, the aim is to promote psychosocial health while working within the scope of practice for Registered Counsellors (RCs) as defined under the Health Professions Act, 1974 (Act 56 of 1974). The Registered Counsellor registration category was created by the Professional Board for Psychology of the HPCSA and enacted by the late South African Minister of Health, Dr. Manto Tshabalala-Msimang in December 2003. The

category RC was intended to improve access to and delivery of mental health services nationally (Fisher, 2017). In addition, this category was developed to provide basic primary mental health counselling services to communities in South Africa that were previously disadvantaged (Elkonin & Sandison, 2006). Form 258 of the HPCSA indicates that the goal of the qualification is to train professional and competent practitioners to provide basic psychological services in a variety of contexts and to promote the psychological well-being of the public. The registered counsellor "must provide formalised, structured, and short-term interventions" at the primary curative or preventive level using "specific and predetermined decision rules" (Health Professions Council of South Africa, Professional Board for Psychology, 2005).

Registered counsellors are responsible for making psychological services available to the South African population. They also provide psychological and preventive interventions focused on supporting and promoting improved well-being in communities. This applies to individuals, families, groups, and communities. RCs differ from other categories of psychology in that their primary function is prevention, promotion, intervention, and appropriate referral.

Form 258 of the HCPSA indicates that students must complete a 4-year BPsych or Honors degree in Psychology accredited by the board as an equivalent to the BPsych degree. It is important to understand the differences and the links between a B degree, a BPsych degree and a BPsych equivalent. The discussion that follows looks into the three categories in detail.

A Bachelor's Degree (B degree) in Psychology offers training to students who aim to develop psychological knowledge and people skills and serves as a foundation for building a professional qualification in psychology. The B degrees are done full-time over three years in which students must accumulate 360 credits to meet the regulation by the South African Qualification Framework (SAQA) as part of the National Qualification Framework (NQF). The B degrees are Bachelor of Arts; Bachelor of Science; Bachelor of Social Science; or Bachelor of Human Science etc. These Bachelor's degrees are at NQF level 7 and are purely academic without a practicum component, meaning that the

student does not qualify for any professional registration in South Africa and cannot practice as psychologists or registered counsellors (Benyon, 2019).

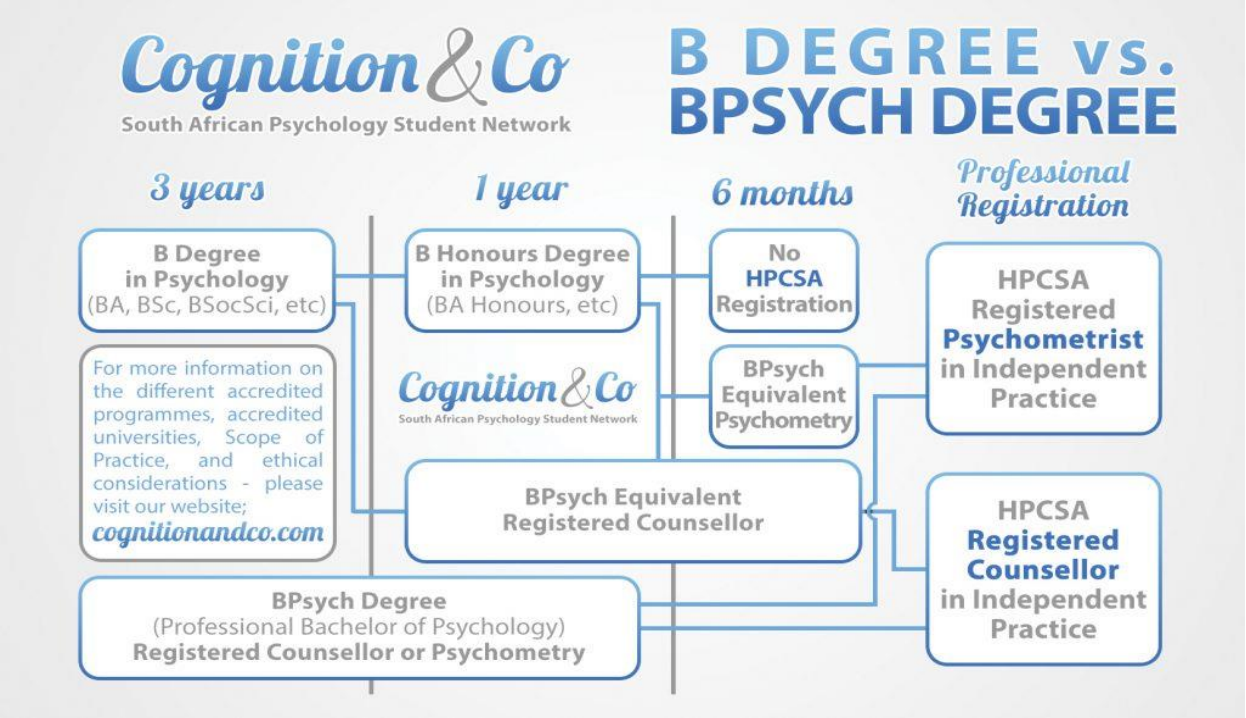
The 4-year BPsych degree like the B degree is an undergraduate programme. However, it differs from the B degree in that it incorporates a six-month, or 720 hour supervised face-to-face practicum. Students doing the BPsych degree are required to accumulate 480 credits to acquire a degree with an NQF level 8, which according to SAQA is the same level as a Bachelor of Arts degree (HPCSA, 2019). The BPsych degree is completed through an HPCSA accredited institution, and is a Bachelor of Arts in Psychology, combined with an Honours degree in Psychology. In terms of the Government Notice No 287 of 9 October 2012, all students enrolled at an institution that is accredited to offer training of RCs are required to register with the HPCSA under the category "student registered counsellor" from the first year of study. Students who complete the BPsych degree with an accredited institution are then eligible to be registered with the HPCSA under the category 'Registered counsellor' upon passing the board examination.

Upon completion of the 4-year degree, students must write a board examination in which they must pass with 70 marks, after which they qualify to register with the HPCSA as RCs (HPCSA, 2019). The national board examination is written to determine if a student has sufficient professional knowledge, skills, and competencies required to practice their profession. Graduates must register as RCs within a three (3) year period after completing their academic and practical training (HPCSA, 2019). Graduates who exceed the designated time frame for registration by more than three to five years must complete an additional three-month practicum. Those who exceed the time frame by five to seven years must complete six months practicum. those graduates who exceed the time frame for registration by eight years or more are required to complete an 11month internship. In addition, an evaluation report from the university or training institution must be submitted indicating that the university or institution has evaluated the candidate and was satisfied/not satisfied with his/her theoretical work.

The BPsych Equivalent is an additional degree that allows students with a B degree and a B Honours degree to obtain professional registration with the HPCSA upon completion.

There are two categories of BPsych Equivalent programmes namely: Psychometrist and Registered counsellor. The BPsych Equivalent for registered counsellor is a full-time practical programme that is done over a period of 18 months. After completion of this programme, legal and ethical counselling of clients can be done within a limited scope, which is described and regulated by the HPCSA (Benyon, 2019).

Figure 2.1 Comparison of the B degree, BPsych degree and BPsych Equivalent.




Source: Cognition & Co (2019).

2.2.1 Academic Training Requirements

The Professional Board for Psychology outlines the admission requirement for an accredited Bachelor of Psychology (BPsych) degree programme. The applicants must be in possession of a National Senior Certificate or an equivalent; and must satisfy other requirements as stipulated by the training institutions in which they are applying to study (Health Professions Council of South Africa,2019). Regulations relating to the registration of SRCs published in terms of Government Notice No 287 of 9 October 2012, indicates

that “all students registered at an accredited institution offering education and training as Registered Counsellors have to be registered as students as from the first year of study” (Form 258 - Scope of a Registered Counsellor, 2013).

Form 258 of the Health Professions Council of South Africa (2013) highlights the following content as forming part of the academic training:

- Psychopathology - involves the study of the types of abnormal behaviours.
- Developmental Psychology -is the study of human development from birth to death (life span).
- Therapeutic Psychology- n which students study different psychological therapies and counselling techniques.
- Research Psychology- is concerned with the study of qualitative and quantitative and or mixed research methods.
- Psychometric and psychological assessment - has to do with the module study of different assessment tests relevant to the student’s scope of practice.
- Personality Psychology – refers to the study of personalities of individuals.

### 2.2.2 Professional Training Requirements

The professional training of SRCs is crucial to make certain that they are prepared for the workplace. The Framework for RC Education, Training, Registration, and Scope states that professional training for BPsych students includes, but is not limited to, the following professional content:

Professional ethics and conduct; interviewing techniques; client observation skills; basic counselling skills; prevention and development programme development; report writing; conceptualization skills; biopsychosocial and systems theory appropriate for community interventions; structured trauma counselling; Community understanding and intervention; psychometric competencies (within their scope of practice); cultural beliefs and diversity; language sensitivity; entrepreneurial skills; psychoeducational skills; and a thorough

grounding in the Code of Ethics, Bill of Rights, and other relevant laws (Form 258 - Scope of a Registered Counsellor, 2013).

Research Project

SRCs are expected to conduct a research project that is applicable to the field of psychology. The research project of interns or SRCs has to be conducted in a community setting (Form 258 - Scope of a Registered Counsellor, 2013). The minimum standards for the training of RCs document of the HPCSA (2019) outlines the following requirements in relation to the research project:

- The SRC must demonstrate proper theoretical engagement and the ability to evaluate and apply the appropriate research design, methodology and analysis.
- The SRC must conduct independent self-managed learning and must conduct and report on research proceedings under supervision.
- They must be able to conduct and complete a research project which is community- based either individually or in groups.
- In addition to the abovementioned requirements, the SRC must apply knowledge and understanding of research methodology, conduct research projects that are ethically compliant, and keep records.

## 2.3 The BPsych Practicum

According to the HPCSA (2005), the practicum involves a field experience that is supervised and allows students to develop counseling skills and professional knowledge. Practicum for SRCs is part of a Board-accredited BPsych program. The duration of the internship is six months full-time or the equivalent of no more than 12 months part-time. The BPsych practicum may not be completed in a private practice or in a mental health facility. The practical training shall be completed during the four-year training period and shall not exceed three months in case of extension. Extension of practicum can be given in circumstances wherein a student is not found to be competent or was not complying with the requirements of the practicum training. In other instances, extensions can be

granted due to personal reasons, such as illness, that occur during training ( Form 258 - Scope of a Registered Counsellor, 2013).

The practicum takes place after students have completed their coursework in the counsellor preparation programme (Misigo, 2014). Students are taught a variety of courses by different instructors, and the practicum provides trainees with the opportunity to integrate these different courses. However, some researchers report that applying theory to practice during the practicum can be a difficult task (Rebekah & Bradley, 2013). Burant and Kirby (2002) noted that structures need to be put in place to encourage reflection and evaluation by trainees so that they do not experience the practicum as an experience that is not important and detracts from the quality of the training. Linking theory to practice helps professionals avoid compromising the lives of the people they serve. Counsellors are expected to help people overcome their concerns. It is invaluable for a counsellor to have completed an internship (Chaminuka & Kaputa, 2014).

The discussion on sections 2.2 and 2.3 above focused on the training requirements of SRCs according to form 258 (Framework for Education, Training, Registration and Scope of Registered Counsellors) of the HPCSA. The framework has strength in that it clearly outlines the academic, professional, research and practicum training that is required for training SRCs. This informs and gives clarity to all providers of the qualification about how to train SRCs until they complete their studies and register with the HPCSA. Furthermore, the framework offers timelines about when the SRCs should complete their practicum and the acceptable period of the extension thereof. Even though form 258 offers clear instructions on how to train SRCs it lacks instructions on ways to monitor the 20 hours supervision indicated on the form. The researcher has observed that each training institution has their own unique supervision forms and that most times supervisors do not sign the code of conduct and confidentiality as indicated in form 258. This results in unequal supervision hours for students as supported by the study findings which revealed that some of the former SRCs did not get adequate supervision during practicum. This inequality of supervision hours can be addressed by developing a strategy that will be used by all training institutions to monitor supervision.

The SRCs conduct a research project as part of their training, form 258 offers a timeline on their practicum but does not give guidance on when they should complete their research projects. This puts the SRC at risk of not acquiring their qualification in time. The researcher is of the view that form 258 should put a timeline of when the SRCs should finalise their research projects as it is indicated for practicum. Former SRCs that were interviewed in this study reported that it was challenging for them to strike a balance between their research work and practicum. Due to the demanding nature of practicum work the researcher observed that the SRCs tend to neglect their research work and focus more on practicum. In summary, training of SRCs is guided by form 258,however they still experience challenges that are related to the practicum that can be resolved by monitoring of supervision and allocating timelines to activities. The next paragraph provides a description of the clients that SRC offer counselling.

**2.4 The Profile of clients that the students counsel.**

The discussion above described the BPsych degree and the training requirements. However, it is necessary to understand the profile of clients to whom SRCs offer counselling. Form 258 of the HPCSA (2013, p.9) indicates that “Registered Counsellors work in a variety of community contexts including SAPS and SANDF; the Department of Labor; mortuary services; schools; student counselling centres; Early Child Development centres; NGOs; TVET Colleges; correctional facilities; Employee Assistance Programs; Primary Health Care Centers; District Hospitals; hospices; and NPOs”. RCs work with clients of all genders and age groups ranging from children, adolescents, and adults to the elderly. It is important to note that SRCs are exposed to the same clients during practicum, they work with individuals, families, and groups of people. They offer counselling services to clients with a diversity of cultures and academic backgrounds.

SRCs work with clients from different contexts who present with a variety of challenges such as being victims of sexual abuse, victims of incest, and sexual abuse survivors. Leonard (2020) mentioned that trauma counselling entails offering counselling to clients who have experienced various forms of bullying, life-threatening illness, psychological or sexual abuse, sexual assault, traffic accidents, childbirth, physical abuse, sudden loss of a loved one, assault, kidnapping, terrorism, natural disasters, and war.

## 2.5 The role of registered counsellors

After discussing the profile of clients with whom SRCs work during practicum, it is of paramount importance to talk about the roles played by counsellors. Although the Health Professions Council of South Africa (2013) in Form 258 highlights the roles and responsibilities of RCs, SRCs are also guided by this document during practicum. “Counseling is a distinct profession. It is concerned with wellness, prevention, development, and situational difficulties as well as with helping persons with psychological disorders” (Gladding, 2013). Form 258 of the Health Professions Council of South Africa (2013) states the primary role of RCs as being at a preventative and promotional level. RCs make psychological services available to the diversity of the South African population. They provide psychological interventions focusing on supporting and promoting the wellbeing in community contexts (individuals, families, groups), The role of RCs differs from that of other categories of psychology in that they do not offer psychotherapeutic intervention; their primary function is to prevent, promote, intervene, and appropriately refer.

The HPCSA Framework for Education, Training, Registration and Scope of Registered Counsellors (2019) states the following roles of registered counsellors:

2.5.1. Providing preventative, developmental counselling services and interventions.

This first role implies that RCs are expected to offer their counselling services and intervene where counselling is required to prevent further development of psychological problems.

2.5.2. Screening and identification of mental health challenges.

Secondly, RCs must do screening for the purpose of identifying clients who may be faced with mental health challenges so that they can get assistance.

2.5.3. Competence in psychometric assessments that fall within the scope of practise described in this form as set forth in this form.

Psychometric assessment is another important responsibility of RCs. However, it is important that they know the limitations set by the HPCSA on the tests they can use. HPCSA Form 528 (2013) lists the psychometric tests that can be used by registered counsellors as follows:

Intelligence Tests: Cattell Culture Fair Intelligence Tests; Raven's Progressive Matrices (RPM); and School-readiness Evaluation by Trained Testers (SETT).

Ability tests: Critical Reasoning Test Battery (CRTB1) (CRTB2); Figure Classification Test; General Reasoning Test Battery (GRT2); Graduate Reasoning Test Battery (GRT1); Paper and Pencil Games (PPG).

Aptitude Tests: General and Graduate Test Batteries; General Scholastic Aptitude Test (GSAT); and Aptitude for School Beginners (ASB).

Learning Potential: Ability, Processing of Information, and Learning (APIL); Learning Potential Adaptive Test (LPCAT); Transfer, Automatisation and Memory (TRAM -1 and TRAM -20).

Personality Test: Personal, Home, Social, and Formal Relations Questionnaire, Occupational Personality Profile (OPP), Fifteen Factor Questionnaire Plus (5 fq+).

Interest tests: Career Development Questionnaire (CDQ); Nineteen-Field Interest Inventory (19FII); Occupational Interest Profile (OIP); Self-Directed Search Questionnaire (SDS); South African Vocational Interest Inventory (SAVII); and Strong Interest Inventory (SII).

Study Habits: Survey of Study Habits and Attitudes (SSHA).

Developmental measures: (not for projective purposes) Goodenough-Harris drawing test; and Bender.

Scholastic: reading and spelling tests.

2.5.4. Containment of presenting difficulties, i.e., the alleviation of distress.

RCs are expected to play the role of containment (especially emotional containment) when their clients are experiencing difficulties. Containment of emotion and content presented by the clients is crucial and plays a huge role in reducing the stress experienced by clients.

2.5.5. Support to assist in the restoration of a previous/more adaptive level of functioning.

The RCs do not only provide containment of presented difficulties, but they also offer supportive counselling and assist the client to go back to the health level of functioning before the distress.

2.5.6. Psychoeducation and mental health promotion.

Psychoeducation is of importance as it helps the client understand their symptoms and reaction to their stressors much better. RCs are responsible for psycho-educating their clients and to promote their mental health.

2.5.7. Promotion of primary psychosocial wellbeing.

Another crucial role performed by RCs is that of promoting psychosocial wellbeing of clients.

2.5.8. Working with interdisciplinary professional teams.

RCs work with other professionals in other disciplines such as nurses, social workers, dietitians, and the SAPS. The RCs must familiarise themselves and work within an interdisciplinary context with the aim of providing the best/ complete services for clients.

2.5.9. Referral to appropriate professionals or other appropriate resources according to the guidelines of good practice in the health professions.

Lastly, RCs must refer their clients to other professionals if they see the need for that individual to get further assistance by someone else. Referral of clients is good practice and demonstrates caring for the client. (Form 258 - Scope of a Registered Counsellor, 2013).

## 2.6 Challenges experienced by SRCs during practicum

The discussion above focused on the roles that SRCs have to perform. After discussing the roles, it is important to talk about the challenges of working with trauma clients. Mental health workers, including counsellors, regularly provide counselling to trauma victims in a variety of work settings. This interaction with trauma clients leads professionals to experience the effects of trauma themselves (Culver et al, 2011). SRCs are not immune to the challenges that are experienced by counselors in other categories; they can experience similar challenges experienced by practicing professionals combined with their own challenges related to finalising their academic work. These students also offer counselling to trauma clients and working with trauma clients can result in conditions such as vicarious trauma, professional burnout, counter transference, and compassion fatigue (Newell & MacNeil, 2010).

### 2.6.1 Exposure to Vicarious trauma

It is important to highlight the difference between trauma and vicarious trauma. Trauma is an event in which one's physical integrity or that of another is threatened and is experienced by the person as frightening, overwhelming, or horrifying (American Psychiatric Association, 2000). Trauma clients experience the threat of death or serious injury. According to the current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR) (American Psychiatric Association (APA), 2000), trauma can be an “emotional response of fear, helplessness, or horror at the time of the precipitating event”. Trauma can also be a result of experiencing other “painful and stressful events that constitute the normal vicissitudes of life, such as divorce, loss, serious illness, and financial misfortune” (McHugo et al, 2005). The impact that trauma work has on counsellors must be considered, as neglecting this impact can also be harmful to clients (British Psychological Society, 2009).

The term vicarious trauma (VT) refers to a unique collection of negative experiences of therapists treating trauma survivors, such as numbing, safety concerns, social withdrawal, feeling emotionally overwhelmed, and hopelessness (Kadambi & Ennis, 2004). The term is used to refer to changes that occur in professionals' views of

themselves, others, and the world that are harmful and result from contact with traumatic material from their clients (Baird & Kracen, 2006).

2.6.1.1 Symptoms of vicarious trauma

Like any disease, VT has its own symptoms. Symptoms may include immediate reactions such as intrusive images, nightmares, and fears for one's own safety and that of loved ones. In addition, a person suffering from VT may avoid violent stimuli in the media, have difficulty listening to clients' accounts, feel irritable, and be emotionally numb. Long-term reactions may include a sense of hopelessness, emotional and physical exhaustion, and an altered worldview that leads to viewing others with suspicion and cynicism (Iliffe & Steed, 2000). Symptoms of VT may also take the form of changes in personal identity, social withdrawal, lack of trust in others, mild emotional overwhelm, atypical feelings toward people and events, hypervigilance, and difficulty feeling pleasure (Iqbal, 2015). Some of the common symptoms of VT are anger and frustration (Mouldern & Firestone, 2007). While the symptoms of VT are discussed, it is also important to understand the different causes of VT as discussed below.

VT is associated with disruptions to schemas in five areas: namely, safety, trust, esteem, intimacy, and control (Baird & Kracen, 2006). Culver, McKinney, and Paradise (2011), in their study of mental health professionals' experiences of VT in post–hurricane Katrina in New Orleans, found that clinicians' perceptions of others and worldview was affected because of seeing trauma clients. SRCs are at risk of experiencing a disruption in their frame of reference and cognitive schemas (Jankoski, 2010). The shift in cognitive schemas occurs when an individual is affected by trauma work and it causes a change in their perception of self, others, and the world. This shift may sometimes affect the therapist's relationship with others, which will have implications on their ethical and professional practice (Iqbal, 2015). Cunningham (2003) found that clinicians who regularly treated trauma clients had major disruptions in their own ability to see others as safe and trustworthy. The disruption of schemas can create distrust and doubt in the counsellor's ability to effectively assess and intervene with their clients' feelings of withdrawal, avoidance, or excessive control (Măirean, & Turliuc, 2013). This is an indication that should mental health workers (in this case SRCs) be exposed repeatedly

to client's trauma content they may experience significant adverse effects in core aspects of themselves, including perceptions of themselves, others, and the world (Rasmussen, 2005). The disruption in SRCs' cognitive schemas implies that their learning is impaired during the internship. They may not learn everything they should learn during practicum.

2.6.1.2 Causes of vicarious trauma

There are several factors that can cause VT: namely the counsellor's history of previous trauma, caring for trauma clients, and an increased workload. Various causes of mental disorders in trauma patients have been pointed out. These include pain and the sudden and unexpected nature of events (Mohta et al., 2003).

a. The counsellor's history of previous trauma

Two of the SRCs in this study indicated that they were reminded of their previous trauma when the client presented their problem. According to Devilly et al. (2009) a personal history of trauma predisposes the therapists to VT. A person's history of past stressors is said to affect the current levels of distress (Lerias & Byrne, 2003). Having a history of trauma appears to confer risk for other stress-related problems (Borelli & Sbarra, 2011). In a study by Dunkeley and Whelan (2006) it was found that counsellors with a personal trauma history coupled with current life stressors and attachment style were at greater risk of developing VT. Counsellors bring their unique qualities and life experiences to each therapeutic session, in addition to all their theoretical and practicum training at school which is the reason why it is easy for them to be affected by VT. It is important that counsellors should be aware of their own personal needs and unresolved conflicts, so that they are able to promote growth and change in their clients (Corey et al., 2003).

b. Providing counselling to trauma clients

In addition to a history of trauma, helping people cope with trauma significantly reduces professionals' emotional energy and coping resources (Adams & Riggs, 2008). The growing clinical evidence suggests that health professionals working with survivors of traumatic events are at risk of developing traumatic symptoms themselves (Crumpei & Dafinoiu, 2012). This is consistent with a study conducted by Iyamuremye and Brysiewicz

(2012) in Rwanda, which revealed that mental health workers experience feelings of pressure, loss of control, anger and frustration, emotional and physical fatigue, and numb and dysfunctional relationships as a result of working with traumatised clients. The negative functioning of counsellors can range from distancing themselves from clients to becoming overly involved and intrusive in working with clients (Taylor & Furlonger, 2011). VT may develop as an unavoidable consequence of caring for traumatised persons (Elkonin & Van der Vyver, 2011). Traumatic events do not only affect the victims, but also those who witnessed and subsequently engaged with survivors of trauma (Howlett & Collins, 2014).

Repeated exposure to a client's traumas may cause professionals to experience negative effects in important aspects of themselves (Măirean & Turliuc, 2013). In a study conducted by Regehr et al. (2002), of 173 child welfare workers exposed to traumatic images through client narratives and direct exposure to trauma such as violence and threats, 46.7% reported traumatic stress symptoms in the severe range.

Counsellors intervention in severe crises or witnessing human tragedy can take its toll on the individual (Lerias & Byrne, 2003). Bearing witness to an event or listening to explicit accounts of traumatic events from clients has been shown to cause serious prolonged anxiety (APA, 2000). Altruism and compassion can leave practitioners susceptible to VT which can contribute to their complete departure from the field (Tompson, 2011).

c. Counsellors' Increased workload

The section above explained how caring for trauma clients contributes to the counsellors experiencing VT. VT is one of the most extreme effects of working with traumatised clients (Williams et al., 2012). Increased workload wherein the counsellor is exposed to more trauma client may result in VT. Higher levels of exposure to traumatised clients is a significant predictor to VT. Wang, Strosky and Fletes (2014) identified increased workload and severity of client trauma symptoms as risk factors for the therapist to develop VT. Higher caseloads increase exposure to traumatic material, which increases the chances of a trauma worker being affected by VT (Steed & Bicknell, 2001). Taylor and Furlonger (2011) indicated that aspects of work such as high caseloads and experience with the

work can cause VT. Work ethics such as maintaining confidentiality may also limit a counsellor's ability to share the difficulties, they may experience at work freely with others (American Counseling Association (ACA), 2005). Concealing traumatic experiences leads to negative consequences such as higher risk of illness (Pennebaker, 2004). Preventing counsellors from sharing their work difficulties with others can lead them to keep negative feelings to themselves (Grey, 2009). There is no doubt that counsellors who work primarily with trauma survivors experience a greater degree of VT than counsellors with general caseloads who see fewer trauma clients (Trippany et al., 2004).

### 2.6.2 Professional burnout experienced at work

The second challenge SRCs may encounter during practicum is burnout. Professional burnout is a state of physical, emotional, spiritual, and psychological exhaustion resulting from chronic exposure to suffering clients (Newell & MacNeil, 2010). Burnout results in low morale, depression, anxiety, sleep disturbances, and headaches (Barford & Whelton, 2010). Burnout is a serious problem that results from trying to cope with excessive pressure. The helping professions, such as health care workers, are at greater risk for burnout due to their intense interaction with the patients/clients they serve (Schaufeli et al., 2009). In a study by Peltzer et al (2014) of counsellors working with HIV clients, contact with more HIV counselling and testing clients and high levels of life trauma were reported to be associated with occupational burnout.

Burnout is regarded as an occupational illness due to its high prevalence in certain professions and the problems that it generates for workers and their organisations. Burnout, like other pathologies is a formal medical diagnosis (Schaufeli et al., 2009). Burnout is also included in the International Diseases Classification of the World Health Organization, it is categorised as a life-management difficulty (World Health Organization (WHO), 2015). The risk factors of burnout most often studied are related to the workplace environment (Sinclair et al., 2015).

Occupational burnout is thought to be related to occupational factors such as workload and reward rather than personal relationships (Whitebird et al., 2013). Individuals who have a certain level of perfectionism and feel guilty when they underperform tend to be

at risk for burnout. The above mindset could cause imbalance in work-related situations and lead to long-term absenteeism (van Mol et al., 2015). The symptoms of burnout are like steps a person goes through on the way to total burnout. In total burnout, burnout symptoms usually occur in the following order: Irritability, Anxiety, Fatigue, Exhaustion, and Total Burnout.

- Irritability

As an individual struggles to cope with the overload, they are constantly on edge. The person becomes emotionally drained but fails to take the time to restore emotional balance. The individual becomes emotionally stressed and is ready to snap at any moment. “Irritability is persistent anger, a tendency to respond to events with angry outbursts or blaming others, an exaggerated sense of frustration over minor matters” (APA, 2013).

- Anxiety

Anxiety is experienced when the overload is prolonged, and the stress levels grow, an individual becomes more and more anxious. It is an emotion concerned with feelings of tension, worried thoughts, and physical changes like increased blood pressure. (APA, 2013).

- Fatigue

Fatigue is one of the most observable of the symptoms of burnout. Fatigue is lack of energy and feeling tired most days. The fatigued person feels drained and feels a sense of dread about what lies ahead (Ma, 2016). Insufficient rest time to recover from the pressures experienced at work may cause fatigue and in turn cause performance levels to drop.

- Exhaustion

Increased pressure, increased working hours, and reduced rest time, is a recipe for disaster. The fatigue levels continue to grow until the person is completely exhausted.

Furthermore, exhaustion includes loss of enthusiasm for work or feeling drained (Schrijver, 2016).

### 2.6.3 Exposure to Countertransference

SRCs are likely to experience countertransference during practicum. Literature provides various definitions for Counter Transference (CT), and two of these definitions will be adopted to discuss CT. The first definition is by Gelso and Hayes (2007), who described CT as “the therapist’s internal and external reactions that are shaped by the therapist’s past or present emotional vulnerabilities and conflicts”. Secondly, CT is said to refer to a therapist’s response to the client based upon his or her own unresolved experiences (Vachon, 2010).

CT is common and can happen regardless of years of experience; it needs to be identified and managed. Unmanaged CT can hinder a beneficial counselling relationship with a suicidal client (Richards, 2000). Counsellors experiencing CT bring their outside experiences into the session, leading to a loss of focus which in turn harms the client (Overstreet, 2018). A lack awareness in CT may be negligent and unprofessional for counselors working in various contexts with various populations (Gelso & Hayes, 2007). Counsellors may experience occupational risks such as depression, anxiety, substance abuse, and relationship problems (Gilroy et al., 2002).

There is no doubt that failure to manage the counsellors’ CT has the potential for harming the client. However, experiencing CT is a reminder that counsellors are human beings with feelings and emotions (Overstreet, 2018). According to Sledge (2002), CT can result in prolonged inability to understand the material presented by patient’s, feelings of depression, anxiety before a session, trying to impress the patient, and arguing with the patient etc. Once CT is recognised, it is important for the counsellor to acknowledge and work through those feelings to ensure that they have successful sessions with their clients. Apart from countertransference, SRCs are at risk of experiencing compassion fatigue.

### 2.6.4 Experiencing Compassion Fatigue at work

SRCs may experience compassion fatigue (CF), which refers to a progressive psychological disruption that is experienced by therapists (Sprang et al., 2007). CF could interfere with the counsellor's performance if not dealt with. CF results in reduced capacity for empathy or client interest which manifest through behavioural and emotional reaction from exposure to the traumatic experiences of others (Adams et al., 2008). It comprises the loss of compassion as a result of repeated exposure to suffering during work. CF has also been defined as a state of physical or psychological distress in caregivers, which occurs due to an ongoing process in a demanding relationship with needy clients (Nimmo & Huggard, 2013). CF is caused mainly by deep involvement with a primarily traumatised person, because of the 'more friendly framing'. From this time on, CF has interchangeably been referred to as secondary- and posttraumatic stress (S/PTS) or vicarious trauma (VT) (Jenkins & Warren, 2012).

SRCs are required to work with clients empathetically, which exposes them to CF. This is supported by Sabo (2011) who indicated that individuals who display high levels of empathy towards a client's pain and traumatic experience are more vulnerable to experiencing CF. Furthermore, Figley (2002) points out that empathy and emotional energy are the critical elements for the formation of a therapeutic relationship and a therapeutic response. An individual's capacity for empathy and ability to enter a therapeutic relationship is considered to be central to CF. Empathetic connections are undoubtedly an invaluable aspect of therapeutic relationship building. However, if counselors do not practice self-care, these connections can come with debilitating consequences (Tompson, 2011).

As indicated, exposure to a client's pain and suffering triggers an empathic concern on the part of the registered counsellor resulting in CF. The risk of CF increases with ongoing exposure to clients' suffering, memories about emotional response, or unexpected disruptions in her/his life (Figley, 2002). It is without question that SRCs are at risk for developing CF during practicum because they are exposed to trauma clients. CF affects the work of counsellors. It is therefore important for SRCs to be aware of CF and seek help if they feel affected.

## 2.7 Mechanisms for identifying and preventing challenges during practicum

The paragraphs above highlighted challenges experienced during practicum. This section entails a discussion of how these challenges can be prevented and / or identified and reduced. SRCs are required to go for supervision during practicum. The minimum standards for the training of RC document of the HPCSA (2017) indicates that SRCs must undergo practical assessments as part of their formative assessment. During supervision and practicum assessments, students who are having personal challenges and those related to the practicum can be identified.

Identifying students who are having challenges during practicum is crucial and helps in preventing some of the challenges from recurring. According to Helm (2010), prevention and intervention when experiencing VT should be done through wellness, organisational, educational, and supervisory dimensions. Intervention strategies may be more effective if they are organised according to individuals' underlying personality dispositions, rather than according to the nature of an event itself (Moos, 2002). Some of the prevention strategies are self-care, management of caseload, education and training, and personal coping mechanisms.

### 2.7.1 Self-Care and Personal coping mechanisms

- Self care

Self- care is imperative for counsellors because the most important instrument is who they are and their ability to model realness (Corey, 2005). Mental health professionals working with traumatised clients have to practice self-care by examining themselves and find out if there are any unresolved trauma issues of their own (Iyamuremye, & Brysiewicz, 2012). Counsellors can maintain their clinical efficacy and personal wellbeing by prioritising and attending to self-awareness and self-care (Warren et al., 2010). According to the ACA (2005), it is an ethical and professional responsibility for counsellors to engage in self-care. Self-care can be practiced by engaging in the 'wellness days' provided by the organisation in which the individual is working, and according to Howlett

and Collins (2014), wellness days do not only provide stress-relieving activities such as walking and yoga, but also allow the individuals an opportunity to meet and speak to each other.

Mental health professionals who work with trauma must learn to maintain a balance of work, play, and rest. This balance includes socialising with significant others, being physically active, and involvement in creative activities. Participating in the mentioned activities may promote the preservation of a sense of personal identity. Rest and leisure activities are also important in decreasing the effects of VT because of their restorative nature. In addition, VT may affect the ability to feel trust and therefore a strong social support network can assist to prevent or soothe its effects. Lastly, participating in various activities, such as journaling, counselling, meditation, and emotional support from significant others, allow for a natural reconnection to emotions.

Some workers do not always take regular breaks from the work because they are committed to their work/clients. They feel an obligation to their clients and believe that they are being selfish or abandoning them if they take holidays breaks. It is because of these reasons that counsellors will often not go for regular breaks, resulting in their vulnerability to develop psychological distress.

- Personal coping mechanisms

Learning how to stay well is the counsellor's responsibility (Hendricks et al, 2009). Counsellors bring their human qualities and life experiences to every therapeutic session, in addition to all their theoretical and practicum training at school (Abdullah et al, 2012). Engagement in personal wellness practices, such as exercise, decrease the risk of being affected by VT (Williams et al., 2012). Peer consultation, supervision, and professional training to reduce the sense of isolation and increase feelings of efficacy are suggested (Dane, 2000). Some of the strategies for self-care that mental health workers use include verbalisation and letting go, a sense of humor and personal hobbies (Osofsky et al, 2008).

### 2.7.2 Management of caseload

Managing one's caseload can be used as a way of preventing several challenges such as professional burnout during practicum. Caseload has to do with the number of cases/clients handled in a given period of time by an individual. Overload of work is another factor that contributes to burnout. The pressures which are placed upon an individual, or which the person perceives to be placed upon them, exceed the level of pressure which they can cope with or, which they perceive that they can cope with. It is important to note that the perception of the pressures and perceptions of the ability to cope are as important as the actual pressures and the actual capabilities. The management of caseloads through limiting the number of clients per week and the number of 'intensely traumatic' cases may be a way of minimising the potential vicarious effects of working in this field (Trippany et al, 2003). It is important for counsellors to have realistic expectations of caseloads. Stemming from the association between exposure and symptoms, reducing the number of trauma cases is frequently suggested (Hesse, 2002). Offering support to counsellors may include determining the workload and the work environment's educational and group support (Bell et al, 2003).

## 2.8 Coping strategies used by student registered counsellors during practicum

The discussion above focused on ways that can be adopted to identify SRCs experiencing challenges and ways of preventing/reducing the problems that accompany practicum. This section entails a discussion about strategies that can be used to address challenges during practicum. Literature outlines several ways that can be employed to help SRCs cope with the demands and challenges that accompany practicum. Methods such as peer support (in which students can talk to each other about challenges experienced and ways of overcoming them); clinical supervision (supervisors make time to listen to students talk about their practicum experiences and offer assistance); and consultation and personal therapy (SRCs who are struggling during practicum go to RCs or clinical psychologists for counselling); have been suggested as methods of dealing with challenges encountered by counsellors (Phelps et al., 2009). Another method discussed in this section is 'spirituality'. It explains how counsellors can turn to prayer, meditation, etc. as a way of dealing with challenges they may encounter during practicum.

### 2.8.1 Psychotherapeutic intervention

The first and most important way of addressing the challenges encountered during practicum is seeking psychotherapeutic assistance with CT or other issues related to unresolved events in ones' personal history; addressing secondary trauma could help to deal with VT. This act of self-care is necessary for a successful practicum. It appears that mental health workers who have more time to sustain relationships and engage in basic self-care seem to be at lower risk of experiencing the negative effects of work-related stress (Badger et al., 2008). Getting psychotherapeutic treatment as a way of self-care is important both ethically and practically; utilising interpersonal relationships and undergoing personal therapy are ways that counsellors can use to promote self-care (Abdullar et al., 2012).

### 2.8.2 Support from supervisors

The second strategy that is useful in dealing with challenges associated with practicum is going for regular supervision. Each trauma worker is responsible for their wellbeing and should avail themselves for frequent and regular supervision (Iqbal, 2015). Supervision plays a vital role in coping with the stress of working with trauma clients (Kinsel & Nanson, 2000). It is for this reason that Etherington (2009) highlighted the importance of supervisors who are supporting students to have a good understanding of trauma theories which are constantly being updated. Furthermore, CF workshops and VT treatments are being offered to therapists who work with trauma population (Devilly et al., 2009). According to Gumani, Fourie, and Terre Blance (2013), organisations set expectations about how trauma will be experienced and should be dealt with by the worker, both individually and professionally, by offering support and helping workers deal with trauma. In a study by Bober and Regehr (2005) about coping strategies used by mental health workers, it was however stated that even though therapists believed that recommended coping strategies such as involvement in leisure activities, self-care activities and supervision are helpful, these beliefs did not translate into time devoted to engaging in the activities. Supportive environments are necessary to reduce VT, social support such as professional supervision or informal support such as peer supervision,

family, and the community have important roles in altering the impact of negative outcomes (MacRitchie & Leibowitz, 2010).

Peer supervision groups also serve as important resources for trauma counsellors as these offer social support and normalisation of VT experiences (Trippany et al., 2004). Supervision provides a facilitative environment for counsellors to process their response to trauma work and develop self- awareness and professional boundaries Taylor & Furlonger, (2011). Peer supervision, one-to-one or group peer supervision are important resources for any mental health professionals, especially those who work with trauma clients. Sharing experiences of how the work is affecting work and personal life offers social support and normalisation of the therapist's own experience. There are positive outcomes for counsellors who engage in supervision or consultation (Wheeler & Richards, 2007).

### 2.8.3 Spiritual interventions

The third strategy for dealing with challenges experienced while offering counselling to trauma clients is spirituality. Spirituality has also been suggested as a protective factor for VT (Trippany et al., 2004). Spiritually based interventions such as rest taking, spiritual collaboration, pro-spiritual support and supervision, meditation, spending time in nature, and prayer are also recommended for dealing with VT (Dombo & Gray, 2013). In a study by Abdullar et al., (2012) about self-care among Malaysian counsellors, spirituality development as a way for caring for oneself was highly recommended by the participants. "A strong sense of spirituality in the workplace promotes positive attitudes, health, happiness, empowerment, inner peace, truth, and healthy relationships" (Tovar, 2011).

## 2.9 Positive outcomes of counselling trauma clients

While the previous sections emphasised the negative outcomes of counselling trauma clients, it is good to know that there can be positive outcomes related to trauma work. South Africa in the post-apartheid era is one of the countries with high rates of violence (Souverein et al., 2015). Moreover, the COVID-19 pandemic has resulted in an increase in gender-based violence against women and girls in South Africa (Muchena, 2021). This suggests that SRCs will be exposed to clients that experienced trauma at some point;

however, literature indicates that there are also positive effects to counselling trauma clients as discussed below.

According to Hernandez, Gangsei and Engstrom (2007), trauma work might also present positive effects, namely vicarious resilience. Resilience refers to the ability to process overwhelming experiences, and not becoming caught in them or becoming dysregulated by them (Randall & Haskell, 2000). Counsellors are likely to see their own strengths as human beings and healers when they realise that their clients have developed attitudes of hope, strength, resilience, and growth potential (Silveira & Boyer, 2015). The concept of vicarious resilience refers to the therapist's emotional growth that occurs as a result of therapeutic engagement with traumatised clients (Tassie, 2015). Counsellors receive a sense of reward from knowing that they assisted in reinforcing their client's strength. In addition to counsellors receiving a sense of reward from assisting clients, Hunter (2012) also suggested that working with trauma clients caused counsellors to permit themselves to feel their clients' sadness and hopelessness as well as to feel personally proud of their clients' victories.

Listening to clients talk about horrific events can have both negative and positive consequences; positive outcomes are called vicarious posttraumatic growth (Brockhouse et al., 2011). Therefore, positive consequences associated with trauma work may include personal growth, spiritual connection, hope, and respect for human resilience (Friedman & Ortlepp, 2002). The mental health practitioner can also experience compassion satisfaction. Compassion satisfaction experienced in higher levels can protect the worker against burnout and secondary trauma (Conrad & Kellar-Guenther, 2006). In a New Zealand study of 22 counsellors working as trauma therapists, it was reported that the experience of VT generated a search for meaning enabling counsellors to come up with strategies and ways of being that effectively fostered personal and professional resilience (Pack, 2014).

### 2.10 Conclusion

The literature review showed the importance of counselling and highlighted various challenges and positive aspects that accompany counselling during practicum. This

chapter gave an insight into how counsellors can identify and solve the problems that may arise because of caring for trauma clients during practicum.

# CHAPTER 3

# THEORETICAL FRAMEWORK

## 3.1 Introduction

While the previous chapter provided literature on the training and challenges of RCs, this chapter presents three theories that are applicable to the study namely, the constructivist self-development theory, the Bronfenbrenner's EST, and the Theory of Planned Behavior (TPB). These theories offer the best explanations as to how practicum affects the SRCs. Each of these theories are discussed and their applicability to SRCs is also highlighted.

## 3.2 The Constructivist Self-Development Theory

The first theory that guided the present study was the Constructivist Self-Development theory (CSDT). This theory refers to the process of disruption to one's sense of safety, control, trust, and intimacy because of continuous exposure to traumatic material over time during trauma work with clients (Sprang & Craig, 2015). According to Millera et al. (2010), the CSDT has been used to study trauma victims and counsellors. According to the CSDT, trauma can disrupt a person's schema across five areas of fundamental psychological needs, namely: safety, dependency/trust, power, esteem, and intimacy.

Pearlman (2013) indicated that the areas that are affected by trauma include self-capacities (abilities that enhance self-regulation); ego resources (skills to manage the interpersonal world); psychological needs (such as security, trust, esteem, intimacy, and control); related cognitive schemas; frame of reference (including identity, world view, and spirituality); and body and brain. A central aspect of this theory is that psychological needs may be disrupted by exposure to traumatic events or conditions (Varra et al., 2008). The theory also stipulates that through empathic engagement with trauma survivors, therapists may also experience similar and permanent disruptions (McCann & Pearlman, 1990). The CSDT represents one theoretical perspective that has been of great use in examining reactions to stress and traumatic events (Dunkley & Whelan, 2006).

The CSDT identifies five need areas that are said to be specifically affected by the experience of trauma (Pearlman, 2013). These needs are that of safety, trust, esteem, intimacy, and control. Each need/schema is experienced in relation to self and other which means that we all have the need to believe the world is safe – that we are relatively safe from harm by ourselves and by others. Counsellors are expected to be empathetic towards their clients for counselling to be effective, however counsellor traits of commitment and responsibility require close attention to ensure healthy boundaries are maintained in the working relationship (Hesse, 2002). Evidence suggests that unprocessed counsellor's response to empathic engagement can result in mental challenges but if there is an early intervention, positive growth can occur for both client and counsellor (Pearlman & Caringi, 2009). The resulting changes to therapists' cognitive schema of self, other, and world are pervasive, cumulative, and permanent (Baird & Kracen, 2006).

The CSDT is based on a constructivist foundation, the belief is that individuals construct their own personal realities based on the complex cognitive schemas that they use to interpret and make sense of life experiences (Pearlman & Saakvitne, 1995). Individuals recreate and restructure their realities and perceptions during the process of self-development, this is done based on their experiences (McCann & Pearlman, 1990). According to the CSDT, counsellors who work with traumatised clients actively recreate and restructure their perceptions based on the interaction between client stories of trauma and their own frames of reference (Pearlman & Saakvitne, 1995). As a result of continued exposure to traumatic material, counsellors are said to adapt their belief systems and worldviews to extract meaning from these events (McCann & Pearlman, 1990).

The SRCs on practicum training are also exposed to trauma clients, and as a result they face the above-mentioned challenges. These students will also restructure and recreate their realities and how they perceive the world based on the interaction they have with the clients, coupled with their own personal experiences. Should the student's belief be disrupted in relation to safety, dependency/trust, power, esteem, and intimacy, this will

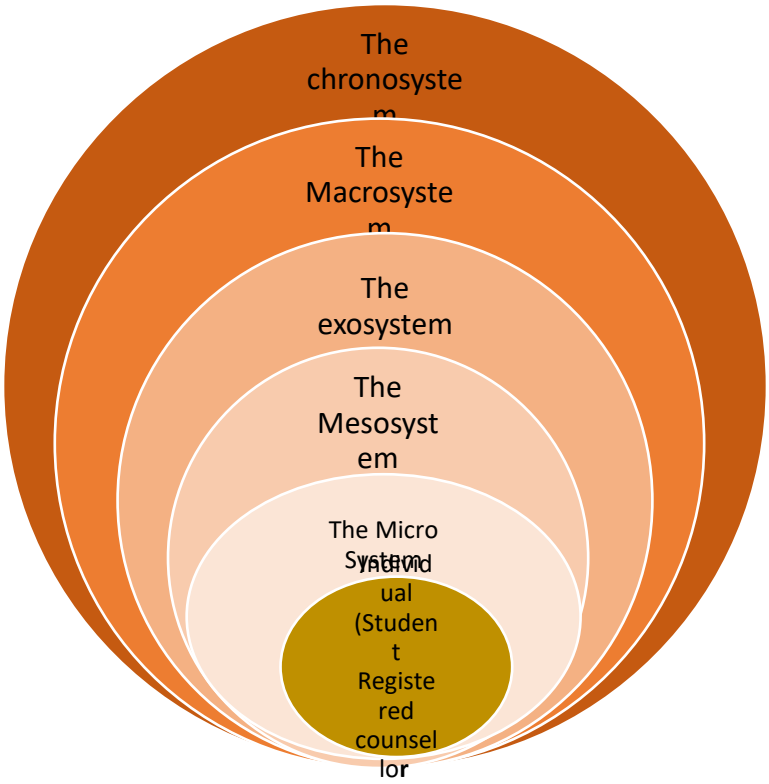
then affect how much they learn during their practicum and their commitment to work during training.

### 3.3 Bronfenbrenner's Ecological Systems Theory

The second theory which guided the study is the Ecological Systems Theory (EST) which stresses that learning is influenced by both psychological and social factors. The EST was developed by psychologist Urie Bronfenbrenner (1993). It states how human development is influenced by different environmental systems. Hayes et al. (2017) added that the EST provides a holistic approach that comprises all the systems in which children and their families are involved. It further states that people encounter different environments throughout their lifespan that may influence behaviour in varying degrees. Bronfenbrenner also indicated that in order to understand the effects of the processes on development, the focus must be on the person, context, and developmental outcome (Bronfenbrenner & Evans, 2000).

People are said to be able to create environments that are beneficial and that they can control. Bronfenbrenner proposes four types of interrelated ecological systems, namely, the micro, meso, exo, and macrosystems. In terms of professional identity construction of the RCs, the EST acknowledges that being human occurs within a context and that people are found within a multi-layered dynamic context (Fisher, 2017). The EST provides an understanding of the influences in a person's life and how these influence other parts of their development, including professional development. The EST also helps to understand how aspects such as time or culture exert influence on individual development. The layers are discussed below:

Figure 3.1 The ecological systems theory




Source: Fisher (2017).

1. The Micro system

The first layer which is the micro system's setting is the direct environment people have in their lives; it consists of family, friends, classmates, teachers, neighbours, and other people who have a direct contact with an individual (Sincero, 2012). The first layer includes the settings in which individuals directly interact. The microsystem pays attention to the relations between the individual and their immediate environment, such as the home, school, and workplace. These refer to the family members or relatives, supervisors, and friends that the SRCs have and are in direct contact with.

2. The Mesosystem

This involves the relationships between the microsystems in one's life. Mesosystems have to do with social interactions found between two of the individual's settings (Neal &

Neal, 2013). This means that the family experience may be related to practicum experience. Leventhal and Brooks-Gunn (2000) have argued that there is limited research examining the mesosystem of the EST, making it unclear to what extent these systems can shape child development. However, Culpepper and Killion (2016) argue that the mesosystem is useful in describing processes and immediate interactions and interconnections between the microsystems that impact professional development. It involves linkages between home and school, between peer group and family, or between family and church. Furthermore, it involves processes that occur between the multiple microsystems in which individuals are embedded. The mesosystem comprises interrelations between major settings containing an individual, such as relations between home and school, home and peer-groups, etc. For example, if a SRC is having problems with parents at home, he or she may have problems concentrating at the office. These interactions should assist in forming professional goals and aspirations. This implies that it is of utmost importance that SRCs should maintain positive interactions with different people as this affects them and how learning occurs during practicum.

3. The Exosystem

The exosystem is a setting in which there is a link between the contexts in which the individual does not have any active role (Neal & Neal, 2013). The exosystem is the outermost level which includes the microsystems in which individuals are involved but not directly embedded. The exosystem focuses on the links and interactions between the mesosystem and the broader ecosystem. These may include admiration and encouragement significant others all who have supported the journey of professional construction. The word has changed since the EST was introduced, as there are technological developments. This implies that the exosystem could be expanded to include social media, and other modern-day interactions within the ecological system (Guy-Evans, 2020). The ecological systems are still valid in explaining development today, however, there should be an expansion that is inclusive of modern developments. The exosystem has to do with SRCs being influenced to develop through other people involved in their lives. The exosystem focuses on social structures or interactions such as colleagues at work, the media, and the public in general.

4. The Macrosystem

The Macrosystem setting refers to the actual culture of an individual (Sincero, 2012). The outermost system is called the macrosystem, which is comprises beliefs, values, and norms, in the cultural, religious, and socioeconomic organisation of society. The cultural contexts may involve the socioeconomic status of the person and/or his/her family, ethnicity or race. This implies that a culture that a person is part of may influence their beliefs and perceptions about events that transpire in life (Guy-Evans, 2020). A proper example will be of a SRC who comes from a poor background, he/she will work harder because of wanting to make it in life and change their family living conditions. This layer suggests that the attitudes and culture of a SRC will have an impact on their professional construction. The macrosystem influences development within all other systems and serves as a filter through which the SRC interprets future experiences.

5. The Chronosystem

The chronosystem is the fifth and final system that comprises all of the experiences that a person endures throughout their lifetime; the experiences vary from environmental events, major life transitions, to historical events. It incorporates the concept of time into the ecological system of human development (Crawford, 2020). It comprises the socio-historical circumstances and transitions that have an impact on the development of a student (Edelen et al., 2020).

The applicability of the EST in the 21st century has been questioned. Guy-Evans (2000) indicated that the world has changed a lot since the EST was introduced in the 20th century. This suggests the question of whether the EST theory is still valid to explain behaviour in the 21st century. Kelly and Coughlan (2019), in their study, used constructivist grounded theory analysis to develop a theoretical framework for youth mental health recovery. They discovered many links to Bronfenbrenner's EST to their theory which is recent. This is an indication that even though EST was developed in the

20th century, it can still be used in the 21st century to explain how the experiences of practicum can influence the behaviours of SRCs during training.

### 3.4 The Theory of Planned Behavior (TPB)

According to Ajzen (1991), the Theory of Planned Behavior (TPB) is useful in the prediction of an individual's intention to engage in a certain behavior at a specific time and place. This theory indicates that an individual will have certain intentions that influence their behavior. The TPB stipulates that human behaviour is guided by three aspects: the first being the beliefs about the likely consequences of the behaviour (behavioral beliefs); secondly, the beliefs about the normative expectations of others (normative beliefs); and the third and last aspect is beliefs about the presence of factors that may facilitate or restrict performance of the behaviour (control beliefs) (Bosnjak et al., 2020).

The TPB is applicable to different fields and industries such as politics, healthcare, and general businesses and organisations. The focus of this theory is on three determinants of intention that are: an individual's attitude toward behaviour; subjective norms; and perceived behavioural control (Ajzen, 1991). The three determinants of intention equal behavioural intention which refers to an individual's motivation and / or decision to engage in a certain behaviour (Conner & Armitage ,1998). The stronger the behavioural intention, the more likely the individual will perform the behaviour (Asare, 2015).

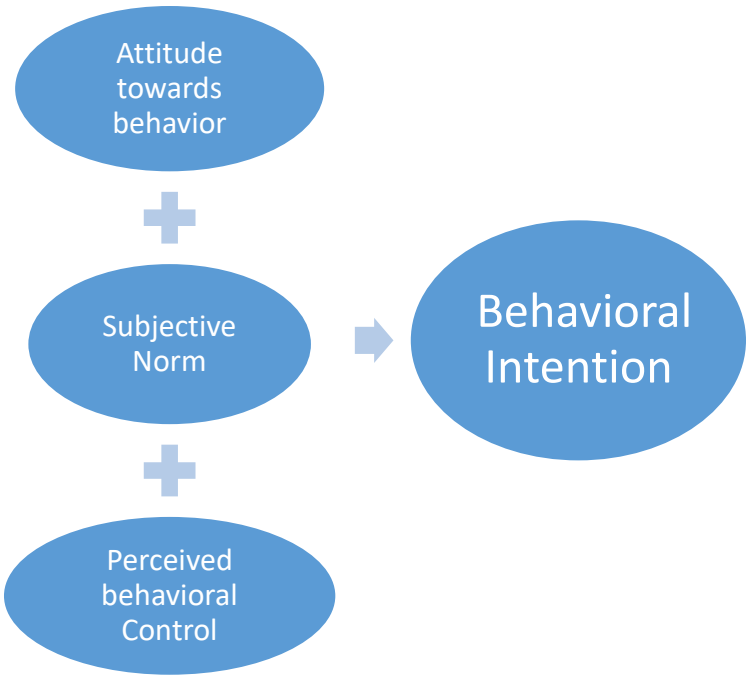
As mentioned above, behavioural intention is influenced by attitude toward behaviour. Cheon et. al. (2012) in a study about planned behavior of college students, referred to attitude as the degree to which a person has a favourable or unfavourable feeling about performing a particular behaviuor. The attitude that the individual has towards the behaviour can be negative or positive. The person considers the results of performing the intended behaviour. This implies that a SRC will be less likely to perform a behaviour that is perceived to yield negative results. They will have a negative attitude towards that behaviour because it yields unpleasant results. SRCs in this study indicated that even

though they understand the importance of the practicum, there are times when they felt overwhelmed by the trauma content presented by clients during sessions. This implies that the negative outcomes experienced by SRCs during sessions may trigger a negative attitude towards the behaviour of counselling clients.

Another element of behavioural intention is the subjective norm. Subjective norm is crucial as it refers to an individual's belief about significant others and their views about whether the person will be able to perform the expected behaviour. Previous studies have indicated that peer students and instructors (supervisors) are relevant referent groups (Liu, 2008). The SRCs are concerned about how their behaviour will be seen in the social environment; this refers to their fellow SRCs and functional and clinical supervisors. The social environment that the SRCs are concerned with will then refer to the workplace and communities in which they work. SRCs reported that they felt that some supervisors sent them on errands that are not practicum-related resulting in them not getting enough exposure to counselling clients, however they performed these duties because it was important that their supervisors are happy with them, and they can help them to be able to perform counselling at the end of the practicum.

The last determinant of behavioural intention mentioned by Ajzen (1991), is perceived behavioural control which refers to how easy or how difficult the behaviour is, according to the person who is supposed to perform it**.** It is important to note that the individual is more likely to perform a certain behaviour if they realise that they have the necessary resources and confidence (Lee & Kozar, 2005). SRCs will be more willing to offer counselling to clients if they view the role of counselling as easy, however if there are challenges related to the practicum, they may be less likely to do so. This study revealed that SRCs will do well during practicum if they have the necessary resources such as adequate office space to help them perform their duties well. Another motivation for SRCs to perform well during practicum is knowing that they are doing well during counselling sessions; this gives them confidence to continue counselling more clients.

**Figure 3.2 Theory of Planned Behavior**




Adapted from (Ajzen, 1991)

### 3.5 The Coping Theory

The theories discussed above namely the Constructivist Self-Development Theory, Bronfenbrenner's Ecological Systems Theory and the theory of planned behaviour explained how individuals, in this case SRCs are likely to behave in various situations. The theories helped with understanding how the challenges experienced during practicum impacts SRCs in various ways and how their functioning as individuals will be affected. The coping theory was used to understand how SRCs deal with the stress that they encounter during practicum due to various challenges.

The pioneers of the coping theory are Lazarus and Folkman (1984). They defined coping as constantly changing cognitive and behavioral efforts to manage specific external and

internal demands that are appraised as taxing or exceeding the resources of the person. The coping theory has three important aspects that are emphasized namely, stress, appraisal, and coping. An individual experiences stress when the demands they have exceed their social and personal resources (transactional model of stress and coping). In addition, the effect that the stress will have on an individual is based on how they perceive the stressor (whether they will be able to cope, feel threatened, vulnerable etc.) rather than on the event itself (Gunawan, 2013). This implied that even though the former SRCs were exposed to various stressors during practicum they were affected by how they perceived the stressful event. This was evident in the finding when one of the former SRCs indicated that they were struggling to strike a balance between research and practicum. The SRC was stressed because they perceived themselves as not having enough coping skills to cope with the demand from practicum and research.

The second aspect in the coping theory is cognitive appraisal which states that an individual response to stress is related to how threatening they see the stressor and whether they have the resources that are required to minimize the stressor. In addition, cognitive appraisal enables an individual to decide whether a situation is stressful or not (Litwic-Kaminska, 2020). This happens through primary appraisal (people ask how the stressor influence them/its meaning) and secondary appraisal (Involves feelings that are related to the stressor) which occur simultaneously. Cognitive appraisal was used by former SRCs when they determined which aspects of their practicum were stressful.

The third and last aspect of the coping theory which crucial is coping. Coping is when an individual manages external and internal demands that are seen/appraised as stressful by changing their cognitions and behavioural efforts. The two types of coping are problem-focused coping and emotion focused coping. Problem focused coping proposes four steps that are used when dealing with stress. The steps are to defining the problem, generating alternative solutions, learning new skills to deal with the stressor, and reappraising and finding new standards of behaviour. Emotion focused coping is used when an individual feel that they cannot manage the source of the problem. There are five ways in which individuals commonly use emotion focused coping namely, gaining

strategies for regulating stress, avoiding the stressor, distancing oneself from the stressor, acceptance of the stressful event, seeking medical support, turning to substance use (Gunawan, 2013).

The findings indicate that former SRCs utilised both problem-focused and emotion focused coping during practicum in order to deal with the challenges and stressors that were encountered. The two coping methods are useful in helping SRCs deal with challenges encountered during practicum and the emotions that experienced. However, problem focused coping is more useful in helping an individual to find ways of dealing with the stressors, on the other hand, those who use emotion focused coping tend use strategies such avoidance of the stressor which offer a temporary solution but does not deal with the root cause of the stressor.

### 3.6 Conclusion

The three theories discussed in this chapter did justice in explaining various causes of problems experienced by the SRCs during practicum. The theories gave an insight into how the different environments in which the SRCs function influence their growth and performance. Another point made is how working with trauma clients affects the SRC as an individual. The theories offer a way of predicting how SRCs will behave during practicum. This knowledge is vital for planning interventions for those SRCs that may be affected.

# CHAPTER 4
# RESEARCH METHODOLOGY

## 4.1 Introduction

Chapter three gave a detailed discussion of the theories that best explain the behavior of RCs during practicum. The current chapter focuses on the research methodology that was applied in this study. The relevant research methodology as pointed out by Creswell (2014) includes the whole framework regarding data collection, data analysis, and data interpretation. The research methodology is discussed in two phases namely, Phase A (Empirical phase); and Phase B (Guideline Development). Phase A comprises a discussion about the research approach; the research design; population and setting; sampling and sample size; research instrument; pre-testing; data collection; data analysis; trustworthiness; and lastly a discussion about the ethical codes that were considered in the study. Phase B comprises a discussion about the research methods that were applied in the process of guideline development.

**Phase 1: Empirical phase**

## 4.2 Research approach

Alharahsheh and Pius (2020) state that a research paradigm is inclusive of the ontology, epistemology, and methodology applicable to a study. In addition, researchers must understand ontological and epistemological assumptions related to their study because this helps in the selection of appropriate methodology. The researcher understands ontology to be concerned with a phenomenon as it exists whereas epistemology has to do with how the researcher gets to know about the phenomenon of interest. Epistemology was useful in this study when the researcher did manage to get an in-depth understanding of SRCs during practicum. Obtaining in depth information about the experiences of practicum was possible by applying the correct research methodology.

The researcher was influenced by the interpretive paradigm. Applying this paradigm to the study enabled the researcher to gain deeper understanding of each of the former SRCs experiences taking into consideration their unique characteristic and differences rather than looking only at how they were all affected by the practicum. Saunders et al. (2012) adds to say interpretive paradigm provides link between the research and research subjects; humans cannot be divided from their knowledge (subjective epistemology). Furthermore, reality is perceived through consideration of meanings and understanding of social and in the research (relativist ontology) (Saunders et al., 2012).

Collecting data for this study was a great experience for the researcher. It was important to avoid leading questions because some of the challenges which were observed during functional supervision were known to the researched. The researcher was able to get a full understanding of the practicum experiences because the questions were designed to allow participants to give in depth information about their experiences, by doing so the objectives of the study were addressed. Furthermore, the use of semi structured interview guide allowed the researcher to probe in order to get the SRCs to share their experiences without being limited. The use of a qualitative approach was helpful in this study.

Qualitative researchers explore a scientific phenomenon, looking for and seeking to recognise and understand insights as compared to quantitative researchers who collect information and measure data. Quantitative researchers do not explore, they investigate (Kang & Evans, 2020). Quantitative research relies on the collection of quantitative data (i.e., numerical data) whereas qualitative research relies on the collection of qualitative non-numerical data such as words. Another distinction between the two approaches is that the quantitative research approaches focus on testing the hypotheses and the theory, whereas qualitative research follows the exploratory scientific method (Antwi & Hamza, 2015). Qualitative research is useful when there is limited knowledge about a topic or phenomenon and when the researcher wants to discover or learn more.

The current study was qualitative in nature since the researcher wanted to explore the experiences of SRCs during practicum. Creswell (2014) explains that the goal of using a qualitative research process is to understand social and human problems from more than

one perspective. A study by Iyamuremye and Brysiewicz (2012) aimed at exploring the mental health workers' experiences of Secondary Traumatic Stress (STS) when working with mental health clients in Kigalli, Rwanda, using a qualitative approach. A total of 30 participants were interviewed. Results indicated that mental health workers in Rwanda could experience immediate and long-term STS responses which might affect them emotionally and physically. Another qualitative study by Jaladin (2013) was carried out to identify barriers and challenges in the practice of multicultural counselling in Malaysia. Results revealed that the challenges encountered by counsellors during multicultural counselling in Malaysia were, the clients' presenting issues, and specific contexts issues. Fisher (2017) also used the qualitative approach to study about the status, professional identity, and training realities of RCs. The researcher used a qualitative research approach, based on the nature of the research question being studied. The reason for using this approach was because the topic of research was explorative and aimed at looking into the experiences of students during their practicum. This approach further helped to understand the meanings that the participants had constructed and how they made sense of their world and their experiences (Merriam, 2009).

### 4.3 Research design

The aim of the research design is to identify the kind of evidence that is needed to answer the research questions adequately. Mason (2002) stated that qualitative researchers are likely to impose their personal beliefs and interests on all stages of the research process, which often leads to the researcher's voice dominating the voice of the participant. With this statement in mind, the researcher employed a phenomenological research design because it assisted in understanding the lived experiences of the SRCs. Phenomenology is a qualitative method that is concerned with peoples' perceptions of the world" (Langdridge, 2007). The phenomenological design focuses on the individual experiences of people. It usually involves long, in-depth interviews with participants. According to Shamsaei et al. (2015), phenomenological research aims to examine the meaning of life through the interpretation of the individual's lived experience. Phenomenological research is concerned with capturing the totality of the human experience and understanding the meaning that social behavior has for the individual. Furthermore,

Cohen et al. (2007) maintained that phenomenological research studies individual experience, and additionally, behaviour is determined by the phenomena of experience.

A phenomenological research study by Bennett (2012) explored the experiences of mental illness stigma from eight psychologists who endured stigma experiences as patients themselves. Findings revealed the participants' stigma experiences to be, in part, like those of laypersons. Peters (2010) used a phenomenological research design to study the experiences of Professionals in Helping Professions (PHPs) with learning disabilities. Her study explored the extent, to which PHPs with learning disabilities can were able to outline the support, services, and assistance that they required to successfully engage in the range of activities for their daily living. The key findings from the study were that PHPs with learning disabilities are creative, strong- willed and persevering despite the challenges that they face. Barrow (2017) conducted a phenomenological study of the lived experiences of parents of young children with autism that are receiving special education service; the phenomenological approach was useful in Barrow's (2017) study, with participants expressing that they felt it gave them a 'voice'.

A phenomenological research design was therefore useful in studying the lived experiences of mental health workers, in this instance, SRCs Furthermore, the researcher chose a phenomenological design because of its effectiveness in bringing to the fore the experiences and perceptions of individuals from their own perspectives, and challenging assumptions.

### 4.4 Location of the study

The former SRCs who participated in the study received their academic training at the University of Venda, in Limpopo province, Vhembe district Municipality. Eleven of the participants also received their practicum training in hospitals within the Vhembe district, except for one who was placed at a hospital in the Waterberg District Municipality under the Mogalakwena local Municipality, Limpopo province. The study was conducted at Vhembe District Municipality which is located in the northern part of the Limpopo Province. The Vhembe District Municipality falls under a Category C municipality (referring to a municipality that has municipal executive and legislative authority in an

area that includes more than one municipality) as determined in terms of Section 4 of the Act. Vhembe District Municipality was established in the year 2000 in terms of Local Government Municipal Structures Act No. 117 of 1998. The Vhembe District Municipality is comprised of four local municipalities: Musina, Thulamela, Makhado, and Collins Chabane (Municipalities of South Africa, 2018).

Figure 4.1: Map of Vhembe District


(www.municipalities.co.za)

Health services in the Vhembe Municipality are delivered by: one Regional Hospital; six District Hospitals; one Specialised Psychiatric Hospital; eight Community Health Centres; 112 clinics; and 22 mobiles (Limpopo, Vhembe District profile, 2011). The health facilities are run by the province. There are six District/ Community hospitals, namely, Donald Fraser; Elim; Malamulele; Siloam; Louis Trichardt; and Hayani. Tshilidzini is the only referral (regional) hospital.

The SRCs are placed in regional, district and specialised hospitals. The regional hospital is characterised by having between 200 and 800 beds. It provides health services in the fields of internal medicine; pediatrics; obstetrics; gynecology; general surgery; and areas of specialities limited to provincial boundaries. The district hospitals are categorised into small, medium, and large district hospitals. A small district hospital has a minimum of 50 and a maximum of 150 beds; medium size district hospitals have more than 150 beds

and no more than 300 beds; and large district hospitals have a minimum of 300 beds and a maximum of 600 beds. District hospitals must serve a defined population within a health district and support primary health care. Specialised hospitals provide specialised health services like psychiatric services; tuberculosis services; infectious diseases; and rehabilitation services; and have a maximum of 600 beds (National Health Act, 61, 2012).

**Table 4.1 Hospitals found in the Vhembe District**

| **Name of Hospital** | **Category** | **Municipality** |
|---|---|---|
| Donald Fraser Hospital | Large District hospital | Thulamela local Municipality |
| Elim Hospital | Large District hospital | Makhado local Municipality |
| Tshilidzini Hospital | Regional hospital | Thulamela local Municipality |
| Malamulele Hospital | Specialised hospital | Collins Chabane local Municipality |
| Hayani Hospital | District hospital | Thulamela local Municipality |
| Louis Trichardt Hospital | District hospital | Makhado local Municipality |
| Siloam Hospital | District hospital | Thulamela local Municipality |
| Musina Hospital | District hospital | Thulamela local Municipality |

## 4.5 Population of the study

The population comprises the individuals in the research location who possess specific characteristics and is the totality of persons and or events with which the research problem is concerned (De Vos et al., 2011). Population refers to the people living in or populating a particular place, and furthermore it refers to the totality of objects or individuals under consideration for a study (Krieger, 2012). Asiamah, Mensah and Oteng-Abayie (2017) made distinctions between the general population (which is the largest group of potential participants of a qualitative study and contains participants whose inclusion in the study violates the research goals); the target population (which refers to the part of the general population left after its refinement, consisting of groups of individuals or participants with the specific attributes of interest and relevance to the study); and the accessible population (referring to individuals who are suitable to participate in the study but are unwilling to participate or will be unavailable at the time of data collection).

The researcher understood the general population in this study to be all students who had registered for the psychology degree within the faculty of Health sciences at the University of Venda. The target population consisted of former BPsych SRCs who had completed their practicum in the years 2018 and 2019. The accessible population were those former SRCs who were eligible to participate in the study but were willing to participate due to various reasons such as not feeling comfortable about talking about their experiences during practicum.

## 4.6 Sampling and sample size

Sampling is defined as “the process of selecting a sample from a population” (Rahman et al., 2022). A sample is a subset of the total population of interest for the study (Omair, 2014). According to Taherdoost (2016), it is doubtful that researcher would be able to collect data from all individuals of interest to answer the research questions. It is for this reason that sampling must be carried out. Another reason for sampling is that it is impossible in most cases to reach the entire population due to time and cost (Maree,

2016). The reason for sampling is to acquire that a small set of observations that can give an idea of what can be expected in the total population of the intended study.

Purposive sampling, also called judgmental sampling, was used in this study. It refers to the researcher's deliberate choice of participants due to the qualities the participants possess (Etikan et al., 2016). Purposive sampling improves the rigour of the study and trustworthiness of the data and results by matching the sample to the aims and objective of the research (Campbell et Al., 2020). It allows the researcher to decide what needs to be known and to choose participants who are willing to provide data by virtue of their experience or knowledge. The advantage of using purposive sampling was that the personal judgment of the researcher was used to purposefully select the former SRCs that were able to provide relevant experiences to help answer the research questions.

Purposive sampling was used to select former SRCs who had completed their practicum in the years 2018 and 2019 which was approximately two years prior to data collection, with the reason that they would still remember their full experiences of practicum. In the year 2018, the BPsych former SRCs were 20 in number, and in 2019 there were 10. Purposive sampling was chosen because it enabled the researcher to satisfy participants' specific needs in a project, as the principle of participant selection was the researcher's judgment (Robson, 2011). Researchers who use purposive sampling rely on their experience and/or previous research findings to obtain units of analysis that may be regarded as being representative of the relevant population (Welman et al., 2005). The sample size was 12 former SRCs who had completed practicum in hospitals in the Vhembe District Municipality.

### 4.7 Inclusion and exclusion criteria

Inclusion criteria

Inclusion criterias are key features of the target population that the researcher uses to answer their research question (Hulley et al., 2007). Examples of inclusion criteria may include demographic, clinical, and geographic characteristics of individuals (Patino & Ferreira, 2018). Former SRCs who had registered for the BPsych degree at the University

of Venda who were placed for practicum within the department of health (DOH) in Limpopo province, Vhembe district were included in the study. The researcher gave preference to former SRCs who did their practicum at DOH since they got more exposure to clients, hence, they had more experiences to share. The participants that were included in the study were those who had completed their practicum as SRCs in the years 2018 and 2019.The researcher preferred the 2018 and 2019 former SRCs as they could still recall their experiences as compared to RCs who did their practicum a long time ago prior to the study.

Exclusion criteria

Patino and Ferreira (2018) define exclusion criteria as "features of the potential study participants who meet the inclusion criteria but have additional characteristics that could interfere with the success of the study or increase their risk for an unfavorable outcome." Exclusion criteria prevent a person from being included in the study and are not the opposite of inclusion criteria (Gray et al., 2017). Examples of exclusion criteria can be such as not being able to read or speak a particular language, gender, and comorbidities (Connelly, 2020).

The study excluded all RCs and SRCs who had completed their practicum for a period of more than two years before the study was undertaken. The researcher excluded them because of the long time that had elapsed since they experienced a practicum setting and they may not have been able to fully recall and give rich data about it.

## 4.8 Entry negotiation

The researcher informed the eligible participants (SRCs) about the study when they came to campus to submit their practicum portfolios of evidence. Arrangements and appointments were made about when they would be able to come to the researcher for their interviews. In addition, the 2018 group of former SRCs were informed about the study when they came to the university to submit application forms for writing the HPCSA

board examination. Those who agreed to participate indicated dates when they would be able to come for the interviews.

### 4.9 Research instrument

An interview guide was developed and used to collect data. An interview guide is simply a list of topics that the researcher plans on covering in an interview with questions that should be answered under each topic (Menzies et al., 2016). The researcher opted to use semi-structured interviews for the study, which consists of a guided dialogue between researcher and participant, and is supplemented by follow-up questions, probes, and comments (DeJonckheere & Vaughn, 2019). Semi-structured interviews differ from unstructured interviews that take a narrative and free-flowing approach (Knott et al., 2022), and structured interviews that consist of questions that are exactly the same, and posed in the same order, for each interviewee (Croix et al., 2018). The advantage of using an interview guide during the semi- structured interviews was that it allowed the researcher to probe and come with follow up questions where there was a need.

The researcher used a semi-structured interview guide (see Appendix E), which provided predetermined closed- and open-ended questions to be asked during the interview (Adams, 2015). The researcher used the interview guide for the purpose of making sure that all the questions that were relevant to the study were asked. Kallio et al. (2016) also indicated that developing a semi-structured interview guide contributes to ensuring the trustworthiness of the semi-structured interview.

The semi structured interview guide allowed the order or structure of the questions to be adjusted, depending on how the interview was flowing. The interview guide comprised of two sections: namely, Section A, which had five questions that elicited the sociodemographic information of the SRCs, and Section B which comprised seven open-ended questions related to their experiences during practicum. The research instrument comprised open-ended questions, in order to get the participants to give detailed information related to the study without being limited (O'Leary, 2004).

The research instrument assisted the researcher to obtain the required data from the SRCs. Section B questions were open-ended, thus encouraging the SRCs to talk more about their experiences. They talked freely and openly about the different aspects related to their practicum experiences. The researcher was able to follow up on some of the responses given with the purpose of obtaining more information to answer the research questions.

### 4.10 Pre-testing

The researcher conducted pre-testing prior to the actual study. Pre-testing was done to check the clarity of the questions (Robson, 2011). Testing the interview guide made it possible for the researcher to make informed changes and adjustments to the interview questions (Chenail, 2011). Pre-testing the interview guide was important for this study, as it also helped the researcher to identify loopholes in the instrument and to adjust the instrument accordingly. Pre-testing the interview guide offered the researcher an opportunity to correct the mistakes in the instrument and clarify the questions that might have been difficult for participants to understand.

The interview guide was pre-tested using two former University of Venda former SRCs who had completed their six-month practicum training in the public hospitals in the year 2017. The participants who were interviewed for the purpose of pre-testing the instrument were not included in the actual study. The participants were contacted telephonically to inform them about the study and to set up appointments. They came to the researcher's office on the agreed dates. Semi-structured interviews were conducted with each participant. Pre-testing the interview guide assisted the researcher to make an amendment to Question number 6 in Section B of the interview guide. The original question was "Did you receive counselling after seeing clients?". The former SRCs that were asked to respond to the questions were not clear if they were required to talk about the counselling that they were offered by supervisors from the university or supervisors at the placement site. The question was then rephrased as follows, "Did your clinical supervisors at the placement site offer you counselling after seeing clients?". This change

was made to indicate to participants that they should talk about the counselling that they received from supervisors at the placement site.

### 4.11 Data collection

Data was collected using a semi-structured interview guide. Interviews are defined as a systematic way of talking and listening to people and are commonly used for gathering qualitative data (Croix et al., 2018). According to McMillan and Schumacher (2010), in-depth interviews are useful in phenomenological studies, to collect qualitative data. As indicated in the section above, the interview guide that was used consisted of predetermined questions that allowed the researcher to probe and seek and clarification of answers (Maree, 2007). The advantage of using a semi-structured interview method was that it was successful in enabling reciprocity between the interviewer and the participants, allowing the researcher to come up with follow up questions based on participants' responses (Galletta, 2012). Semi-structured interviews permit interviews to be focused while still giving the researcher the freedom to explore pertinent ideas that may come up during the interview (Adeoye-Olatunde & Olenik, 2021), The researcher was able to ask additional unplanned questions emerging from what the participants have said. Data was collected in a manner that allowed prompting and encouraged the participants to reflect on and clarify their responses, based on what they had experienced during practicum.

Rouillard et al. (2016) used semi-structured interviews to understand RCs' perceptions about their providing mental health-care services in South Africa. The use of semi-structured interviews was useful in their study, and the RCs indicated that they perceived their role as important. The RCs also shared their negative perceptions of the changing scope of their role in South Africa coupled with lack of acknowledgement from other mental healthcare practitioners, and ignorance from the public regarding the work of RCs.

Another study that benefited from the use of semi-structured interviews is that of Millon and Halewood (2015) which was about the effects of countertransference in the therapeutic relationship. Millon and Halewood (2015) wanted to explore the therapists' experiences with the processing of countertransference. They conducted semi-structured

interviews with five psychotherapists who practised mindfulness meditation as a way of dealing with the countertransference. The results indicated that those psychotherapists who exercised mindfulness meditation had deeper therapeutic relationships.

The semi-structured interview sessions with the former SRCs lasted between 30 and 40 minutes per participant. The researcher scheduled data collection dates that suited the participants. Data from the former SRCs who did their practicum in 2018 and 2019 was collected in January 2020. Following the suggestions of Greef (2005), to avoid 'stage fright' which can result from the use of a tape recorder, permission to be recorded was obtained from the participants; in addition, open ended questions were used.

Two of the former SRCs from the 2019 group needed assurance from the researcher that participating in the study would not affect their practicum marks. The researcher had to explain further the purpose of the study, and it was only after this that they signed the consent form. The former SRCs did not have any problem with the researcher recording the interview. Furthermore, the researcher was able to get them to talk freely about their experiences without fear of being judged. The former SRCs provided rich data about their experiences during practicum.

### 4.12 Data analysis

Qualitative data analysis is done with qualitative methods to reveal new aspects hidden in the data (Schoonenboom, 2023). Qualitative data analysis brings meaning to a data set such as images, observations, and unstructured, semi-structured, or structured interviews (Lester et al, 2020). After using the correct methods to collect accurate and reliable data, the researcher then has to do data analysis in order to extract useful information buried in the data for further interpretation (Ibrahim, 2015).

Data was analysed using Interpretative phenomenological analysis (IPA), which focuses on participants' meaning making and a detailed exploration of lived experience (Smith et al, 2009). IPA uses in-depth reflective inquiry to uncover what lived experiences mean; furthermore, interpretation of an individual's meaning-making is considered from the researcher's perspective (Peat et al., 2019).

The aim of using IPA was to explore in detail how former SRCs made sense of their personal and social world and to uncover the meanings that particular experiences, events, and states held for the participants (Smith & Osborn, 2007). IPA also emphasises that the research exercise is a dynamic process with an active role for the researcher in that process. A two-stage interpretation process, or a double hermeneutic, is involved, the participants are trying to make sense of their world whereas the researcher is trying to make sense of the participants trying to make sense of their world. The researcher using IPA tries to understand what it is like, from the point of view of the participants, to take their side. At the same time, the researcher self-reflects by asking critical questions about the texts from participants.

IPA has proven to be useful in making sense of the collected data. A study about the experiences of being an 'expert' during patient and public involvement within Child and Adolescent Mental Health Services was carried out by Idrees and Hartley (2020). Their research approach was also qualitative, and they used semi- structured interviews to gather data from six participants. The results suggest that patient and public involvement is a complex process that may be driven by positive/negative expectations; furthermore, they discovered that people value learning about others and recognising different perspectives while reaching shared goals in improving services. Another study that applied IPA is that of Ebbini and Lamont (2021) who were interested in exploring gay men's meaning making around sexuality whilst on pre-exposure prophylaxis (PREP). Data was gathered from eight participants using semi-structured interviews, and then IPA was applied. These two studies indicated the usefulness of IPA in bringing meaning to the different phenomenon being studied. The 'pros and cons' of using IPA are discussed in the next paragraphs.

The advantages of using IPA, as indicated by Smith and Osborn (2015), are that it produces an account of lived experience on its own terms, rather than on the ones prescribed by pre-existing theoretical preconceptions. IPA is useful in examining ambiguous, complex, and emotionally-laden topics, because it enables the participant to recount full account as possible of their experience. IPA pays attention to the lived experiences of participants in the everyday world. It offers the chance to obtain authentic,

and in-depth accounts of a phenomena as experienced by individuals or groups of people (Denscombe, 2010). Furthermore, IPA is suited for small-scale research because it is reliant on in-depth interviews which can be undertaken in specific locations, such as hospitals, businesses, and schools.

Smith and Osborn (2015) further indicated that using IPA requires a high level of skill on the part of the interviewer. The researcher using IPA must possess a strong empathic engagement and must be ready to probe further into interesting and important aspects. According to Leach (2014), however, critics claim that IPA is subjective and lacks scientific rigour because the approach delivers subjective accounts of people's lived experiences, and there are no objective measures of reliability or representativeness.

The following stages of IPA, as indicated by Pietkiewicz and Smith (2012), were followed to analyse the data collected from student registered counsellors.

**Stage 1: Multiple reading and making notes**

This stage required the researcher to read the transcripts a few times until the researcher understood the data. However, it is recommended that the researcher listens to the audio recorded data, provided that it is available. This helps the researcher to immerse fully into the data, remembering the atmosphere of the interview, as well as the locale or the background in which it was conducted. Moreover, the researcher is able to compile notes about their observations and reflections on the interview. The notes usually incorporate the content; the use of language, which includes the use of symbols, pauses and repetitions; and lastly, initial interpretive comments. Listening to the audio-recoded data helped the researcher to capture all that was said by the participants during data collection and to produce rich data. Lastly, Pietkiewicz and Smith (2012) indicated that it is important to highlight the participant's distinguishing or idiosyncratic and emotional responses. During this first stage of IPA, the researcher took time to listen to the interview recordings and to read through the data transcripts with the aim of understanding the experiences of SRCs during practicum. The researcher had noted down the emotional response of participants during the interviews. This process also enabled the researcher

to make notes about what was observed during the interviews, such as the emotional responses that were given when certain questions were asked.

**Stage 2: Transforming notes into emerging themes**

Rather than focusing only on the transcripts, the researcher focussed more on the notes which were made during the initial analytic stage. The reason for this was to convert notes into evolving or emerging themes. The researcher at this stage read the transcripts and field notes for the second time to produce various themes that were emerging from different participants. The themes that were identified during this stage were about challenges experienced during practicum; experiences of the SRCs; effects of counselling trauma clients; support received during practicum; and ways in which SRCs could be assisted to cope with challenges encountered during practicum.

**Stage 3: Seeking relationship and clustering themes**

This stage included looking for connections between the themes that were emerging, then grouping them together according to conceptual similarities. The clusters were given descriptive labels. Moreover, the themes which did not fit well with the emerging structure or due to weak evidential base had to be discarded. Moreover, the final list may have included multiple superordinate themes and subthemes. During the third stage of IPA the researcher was able to cluster and categorise the themes that were linked or related, to make sure that the next stage of writing up would be done in a logical manner.

**Stage 4: Writing up an IPA study**

The final stage in IPA leads to writing a narrative account of the study. It includes taking the final list of themes and writing them up one by one. As indicated by Pietkiewicz and Smith (2012), during this stage the researcher is expected to use the interview extracts and analytic comments to describe the themes. After describing the themes, the researcher proceeded to engage in writing up a narrative of the study findings. The narrative by the researcher comprised of a discussion about the themes and comments on the meaning of the findings. The results of the study that came after the researcher

conducted these stages of IPA will be presented and elaborated in detail in the next chapter, which is Chapter 5.

### 4.13 Trustworthiness

Trustworthiness is a criterion for assessing and evaluating the quality of a study in qualitative research (Polit & Beck, 2014). It refers to “the degree of confidence in data, interpretation, and methods used to ensure the quality of a study” (Polit & Beck, 2014). Trustworthiness is “a degree of confidence qualitative researchers have in their data, assessed using the criteria of credibility, transferability, dependability, and confirmability” (Salvador, 2016).

According to Anney (2014), trustworthiness should address the questions about how the researcher can establish confidence in his/her findings; that they are presented genuinely; how the applicability of the findings of the inquiry in other settings or with other respondents can be determined; how to ensure that findings would be repeated consistently with the similar participants in the same context; how to confirm there was no bias from the researcher; and that findings come solely from participants. Maree (2016) indicated that it is important to have procedures for assessing trustworthiness because it is the ‘acid test’ of data analysis, findings, and conclusions.

The trustworthiness of qualitative study, generally, is often questioned by positivists because their concepts of validity and reliability cannot be addressed (Shenton, 2004). Since this study was qualitative in nature, it took into serious consideration the issue of credibility, transferability, dependability, and conformability as these guarantee the quality of the research. For data to be trustworthy it must meet these criteria. The present researcher was thorough, careful, and honest in carrying out the research to ensure trustworthiness. In addition, the researcher ensured trustworthiness by clarifying the notion of objectivity as it is manifested in qualitative research. The basic issue of trustworthiness is to check whether the findings of a study will be worth paying attention to (Anney, 2014). The study therefore ensured trustworthiness by complying with all the four criteria as discussed below:

Credibility

Macnee and McCabe (2008) defined credibility as the confidence that can be placed in the truthfulness of the research findings. Credibility concerns the researcher establishing confidence in his/her findings and ensuring the findings presented are genuine. Furthermore, credibility (truth value) has to do with assuring readers that the conclusions made from the study stem from the data. Member checking is at the heart of credibility (Onwuegbuzie & Leech, 2007). Member checking is also referred to as participant or respondent validation, and is a technique used to explore the credibility of results. Returning results to participants is done to check for accuracy and resonance with their experiences. Member checking is often mentioned as one of a list of validation techniques (Birt et al., 2016). The researcher did member checking by allowing participants to comment on the research findings and interpretations.

The advantages of member checking were that it gave the researcher an opportunity to understand and assess what the participants intended to do through their actions; it gave former SRCs the opportunity to correct errors made by the researcher and to challenge wrong interpretations; it provided the opportunity for adding information which may be stimulated; it afforded the opportunity to assess the adequacy of results; as well as to confirm particular aspects of the data (Angen, 2000).

The other step that the researcher took to ensure credibility was to record the semi-structured interviews that were conducted. The interview proceedings were captured using a voice recorder and the researcher also took field notes during the semi-structured interviews in order to ensure credibility of the study (Babbie & Mouton, 2009). In addition, to ensure credibility of the study, the results of the study were shared with former SRCs who did not participate in the study because they did not meet the inclusion criteria. The purpose of this exercise was to establish whether the results about practicum experiences were realistic.

Dependability

Dependability refers to “the stability of findings over time” (Bitsch, 2005). It addresses the stability of the data over time and over the conditions of the study (Connelly, 2016).

Dependability of the study addresses the consistency concern; researchers must ask themselves how one can check if the findings will be repeated consistently with the same participants in the same context. Researchers believe dependability has to do with the degree to which the readers can be convinced that the findings did occur as the researcher says they did. Dependability was accomplished firstly by avoiding researcher bias in the research steps that were used. The researcher aimed to ensure that the results of the study were based on inquiry and not due to the researcher's bias and that if the study was to be repeated, in the same context, with the same methods and with the same participants, the same results would be obtained (Shenton, 2004). The researcher also considered the dependability of the study by using member checking wherein the themes were discussed with the participants to ensure that they were accurate and dependable.

Secondly, an audit trail was done, wherein there was an examination of the inquiry process and product to validate the data, whereby the researcher accounted for all the research decisions and activities to show how the data were collected, recorded, and analysed (Bowen, 2009). The researcher kept the following documents safe in order to assist the auditor to conduct a thorough audit trial: raw data (recorded interviews); interview and observation notes; documents and records collected from the field; and other relevant documents. The researcher asked the UNIVEN faculty of health research office to help with the audit trail. After the audit trail, some corrections were recommended (see Appendix F). The researcher made the recommended changes.

Transferability

Tobin and Begley (2004) state that transferability refers to the degree to which the results of the research can be transferred to other contexts with other respondents. Transferability concerns ensuring the applicability of the findings of the inquiry in other settings or with other respondents. The researcher aimed to ensure that generalisations could be made from the data and context of the research to the wider population and settings. Transferability of the study was achieved by providing a thick description of the methodology, including sampling, the participants, and the context, which would make it easier for future researchers to replicate the study within similar condition in other settings (Babbie & Mouton, 2009). The researcher provided clear and detailed information about

the experiences of former SRCs who were caring for trauma clients at public hospitals to ensure transferability (Creswell, 2013). Providing a thick description enables judgments about how well the research context fits other contexts.

Confirmability

Confirmability establishes that the data and interpretations of the study findings are not figments of the researcher's imagination but are honestly derived from the data (Tobin & Begley, 2004). The reader of the research report should be able to examine the data and be able to confirm the results/interpretations. The researcher achieved confirmability firstly by having an audit trail. Bowen (2009) stipulates that an audit trail also ensures confirmability of the study because it offers visible evidence—from process and product—that the researcher did not simply find what he or she set out to find. Secondly, confirmability of the study was addressed by providing notes on decisions made during the research process, as well as the researcher's reflective thoughts (Korstjens & Moser, 2018). The researcher kept a reflexive journal that comprised all the events that happened in the field as well as personal reflections in relation to the study. The journal enabled the researcher to reflect on, interpret and plan during the process of data collection and analysis.

### 4.14 Ethical considerations

The researcher was aware that it is imperative to obtain ethical clearance from the ethics committee when people or animals are involved in the study. The study adhered to the University of Venda's institutional and external ethical considerations.

#### Institutional ethics

The proposal for this study observed the following institutional ethical codes: firstly, the proposal was presented in the Department of Psychology. Secondly, it was presented before the then School of Health Sciences' (currently named the Faculty of Health Sciences) Higher Degrees Committee for quality assurance. Thirdly, it was submitted to

the University's higher degrees committee (UHDC) for approval. Finally, the proposal was submitted to the University of Venda's Ethics Committee for ethical clearance.

**External ethical observations**

External ethical codes were taken into consideration, to ensure that the rights of participants were not violated. The researcher observed the ethical codes of informed consent; avoidance of harm or deception of participants; and respect for privacy, anonymity, and confidentiality.

Informed consent

Nijhawan et al. (2013) defines informed consent as the process wherein the researcher informs participants about all aspects of the study which are important to know before making the decision to participate; moreover, it is a legal requirement when human participants are involved. Participants must voluntarily confirm their willingness to participate in a study after having been informed of all aspects concerning the study and which are relevant to the decision of participating (Manti & Licari, 2018). Mandal and Parija (2014) stated that every participant puts their health and life at risk for the sake of science therefore they must be respected, and the researcher must make sure that information entailed in the consent form is true, covers all relevant aspects and does not hide any facts from the participants.

Informed consent was obtained from the former SRCs before collecting data using semi-structured face-to-face interviews. Participants who sign consent forms must have complete understanding of what is stated on the form; however, language barriers or inadequate translation may lead to misunderstanding which can lead to withdrawal of participants from the study (Nijhawan et al., 2013). SRCs who participated in the study were fluent in English, and the researcher gave them a full description of the study and gave clarity were there was a need. It was crucial to inform participants about the study, so that they understood what it entailed, their role and times of participation and how all these will affect them. The researcher informed the participants about the procedures to

be followed during the study and the possible advantages and disadvantages that participants might have been exposed to should they agree to take part in the study. Participants were provided with the necessary information about the study before they were asked to sign the consent form; namely, its aim, purpose, and their rights. Participants were given an information sheet explaining the purpose of the study. Furthermore, the researcher made sure that the participants understood the purpose of the study and their role in the study by making an elaboration of what was written in the consent letter (see Appendix C).

Information about the procedures that were to be followed during the study was explained with the aim of getting informed consent from potential participants. Participants were alerted that they could withdraw from the study at any time during the process if they wished to do so. The researcher took the responsibility of letting the participants know that they could have time to consider participating in the study (Robson, 2011). Lastly, the researcher ensured that the participants fully understood the research and what was expected from them before they signed the consent form (see Appendix D).

Avoidance of harm

During the present study the researcher protected the participants from any form of physical discomfort or emotional harm. According to Gray (2009), harm can occur in various ways, ranging from physical to mental and emotional harm. The researcher could harm the participants in a physical and/or emotional manner. Researchers have an ethical obligation to protect the participants from any form of physical discomfort that may emerge from the study. The study avoided any situation or setting in which participants could be made to feel anxious, stressed, embarrassed or lose self-esteem. The researcher treated all the participants with respect to avoid hurting their feelings in any way. After the interview, the researcher provided debriefing for two of the participants who became emotional while talking about their experiences at the practicum.

No deception of participants

Deception of participants refers to deliberate misinformation provided by the researcher about some essential component of the study's procedure (Boynton, Portnoy & Johnson, 2015). The researcher provided the participants with honest information regarding the nature of the study and their roles thereof. The researcher made it clear to the students and the psychologist that their participation was important for the study and that they would not be paid or compensated in any way because of participating in the study. According to Gray (2009), deceiving the participants could mean representing one's research as something which it is not, and so the researcher ensured that the participants were not lied to. All the facts that had to do with the study were presented to the participants honestly. Deception may also involve withholding information or offering incorrect information to participants with the aim of ensuring that they participate in the study. The researcher remained truthful at all times to the participants throughout the study.

Violation of privacy, anonymity, and confidentiality

The researcher ensured that the privacy of participants was respected. Privacy is understood by the researcher as that which is not intended for others to observe or analyse. It is for this reason, that the researcher is responsible for safeguarding the privacy and identities of the participants who participated in the study. Confidentiality was maintained by making sure that only the researcher and possibly a few members of the research staff were aware of the identity of the participants. The study was conducted in a manner that took into consideration the issue of anonymity by making sure that no one, including the researcher, would be able to identify the participants afterwards (Strydom & Delport, 2005). The researcher is obliged to take into consideration the wellbeing of the participants by not causing embarrassment and any kind of discomfort. The researcher treated the identity of the participants with confidentiality, to such an extent that it would not be possible for other people to make a connection between the participants and the data that was gathered from them.

## Phase 2: Guideline Development and Validation

### 4.15 Research approach

Phase 1 of the research methodology outlined the steps that were taken to identify the research population, data collection and analysis. After analysis of the data obtained in Phase 1 of the study, recommendations were made. The researcher decided to use a qualitative approach for Phase two of the study in order to explore the views of the participants in relation to the recommendations. A qualitative research method was relevant in exploring how participants felt about the recommendations made from the study in relation to their experiences of training as SRCs. Discussed below is how the participants for guideline development and guideline validation were identified.

### 4.16 Population

The population for guideline development comprised all the professionals in Limpopo province who were responsible for training SRCs. The guideline development group (GDG) and participants for guideline validation were drawn from psychologists who are involved in training SRCs at the University of Venda and at all the clinical placement sites.

### 4.17 Sampling

The participants were purposefully selected due to their involvement in the training of SRCs and their training institution or practicum placement. The researcher purposefully selected the GDG based on their involvement and experience of training SRCs. The researcher was interested in those who had at least five years' experience of training SRCs. One clinical psychologist (co-ordinator at student counselling unit University of Limpopo); two former BPsych co-ordinators at Univen; one RC (functional supervisor); one employee wellness practitioner; and one current BPsych programme co-ordinator at the university of Venda; were selected for the purpose of developing guidelines. For the

purpose of guideline validation, the provincial BPsych co-ordinator and two clinical supervisors at clinical placements were consulted.

### 4.18 Entry negotiation

Recruiting and negotiating participants for guideline development and validation was not too challenging due to two factors. Firstly, the researcher recruited the Guideline Development Group (GDG) that consisted of the BPsych coordinator and functional supervisors responsible for training SRCs at the University of Venda where she works. Secondly, recruiting participants for guideline validation was easy because the researcher had contacts of the hospitals and people she worked with while still coordinating the BPsych programme. The GDG and Guideline validation group were called and sent emails asking for their participation in the process of developing the guideline; and they showed interest and excitement to take part in the study.

### 4.19 Developing guidelines

The researcher worked with the GDG to develop the guidelines for assisting students during practicum. The recommendations identified from Phase 1 after data analysis and discussion were sent to the GDG so that they could assist in the process of developing effective guidelines to be used by SRCs and supervisors during practicum. The following steps of developing guidelines as proposed by Jaeschke et al. (2009) were adopted. These steps are detailed in Chapter 8 (guideline development).

1. Determining the purpose, scope, and intended audience.
2. Selecting the panel of guideline authors.
3. Specifying the main focused questions that the recommendations will answer.
4. Deciding on the relative importance of outcomes.
5. Finding and summarising the evidence supporting each recommendation, answering critical questions, and developing recommendations which will require retrieval and summary of all available evidence.

6. Determining the quality of available evidence.
7. Evaluating the balance of desirable and undesirable consequences of a particular course of action.
8. Formulating a recommendation to emphasise strengths of the treatment program.
9. Considering subsequent guideline implementation and evaluation.

## 4.20 Validation of the guidelines

### 4.20.1 Guideline Validation Instrument

The Appraisal of Guidelines Research and Evaluation Global Rating Scale (AGREE GRS) was used as an instrument to evaluate the proposed guidelines. According to Lohr and Field (1992) the AGREE instrument provides a framework for assessing the quality of clinical practice guidelines. It consists of four core items namely, 1. Process of development; 2. Presentation style; 3. Completeness of reporting; and 4. Clinical validity. The AGREE GRS requires a minimum of two appraisers to increase the reliability of the assessment. In this study, three participants were used to validate the guidelines.

### 4.20.2 Guideline validation process

The developed guidelines were sent to the provincial BPsych coordinator and two clinical supervisors at clinical placements, together with the AGREE instrument for them to check if the guidelines were valid to be used by them and SRCs during practicum. The AGREE offered the participants the opportunity to indicate areas that needed to be improved and to state if the guidelines were valid to be used for the purpose of supporting SRCs during practicum.

## 4.21 Conclusion

All the former SRCs who agreed to participate in the study gave detailed experiences of their practicum. The semi-structured interviews that were conducted elicited rich data about the participants' challenges and possible ways to deal with them. Phase two of the methodology was based on steps taken in relation to guideline development. Steps and results of Phase two are further discussed in detail in Chapter 8.

# CHAPTER 5
# PRESENTATION OF STUDY FINDINGS

## 5.1 Introduction

The overall aim of this study was to develop guidelines to support student registered counsellors during their practicum training. The previous chapter gave a detailed description of the research methodology that was used to obtain data from SRCs. The study was guided by these seven objectives:

1. To describe the profile of clients counselled by SRCs.
2. To explain activities and roles played by SRCs during counselling.
3. To determine the effects of counselling trauma clients on SRCs.
4. To explain mechanisms for identifying SRCs affected during practicum.
5. To identify coping strategies used by students to deal with challenges encountered during practicum.
6. To explore the kind of support received by SRCs during practicum.
7. To develop guidelines for supporting students who experience challenges while caring for clients during practicum.

This chapter gives a presentation of findings based on all six objectives of the study. Objective number seven which is about developing guidelines to support SRCs is addressed in Chapter 8. The interview guide that was used to collect data comprised questions that were designed to address all the objectives of the study. The SRCs were asked different questions related to experiences and challenges that they encountered during practicum. SRCs gave answers to all the questions, thus providing the required data to address all the objectives mentioned in the paragraph above.

The presentation that follows below is of the procedure used for data collection, and the demographical data which shows the number of SRCs who participated in the study, their age, gender, ethnicity, education level, and race. Furthermore, this chapter describes the

data that was obtained. The data presented in this chapter is a true reflection of the interviews that were conducted. The data is presented in main themes and subthemes that emerged from the discussions with SRCs.

## 5.2 Procedure

An in-depth, face-to-face, semi-structured interview was conducted with each former SRC. The interviews ranged from 30 minutes to an hour depending on the amount of information provided. All the former SRCs did not have a problem with the researcher using a voice recorder during the interviews. Most of the interviews were conducted in the researcher's office on different days when participants came to submit their portfolio of evidence from the practicum. There was one former SRC who could not come to the office because of family responsibilities, so she was interviewed at her home on the agreed date. The collected data was transcribed and analysed using IPA. The paragraph below comprises a discussion of the demographic information of the former SRCs that participated in the study.

## 5.3 Demographic information

The table below shows the number of participants, their age, gender ethnicity, educational level, and race. Only one of the 12 RCs are Asian, all the other participants are Black. Most SRCs in this study are of the Venda ethnicity because the University of Venda is based in the Vhembe district where Venda people are in the majority compared with other ethnic groups such as Swati, Tsonga, and Indians that come from other provinces in and out of South Africa. All genders were fairly represented as there were seven females and five Males. All the former SRCs in this study were under the age of thirty.

| | 1.Age | 2.Gender | 3.Ethnicity | 4. Educational level | 5. Race |
|---|---|---|---|---|---|
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Participant1 | 23 | Female | Swati | BPsych graduate | Black |
| Participant 2 | 27 | Female | Swati | BPsych graduate | Black |
| Participant 3 | 22 | Male | Venda | BPsych graduate | Black |
| Participant 4 | 27 | Female | Venda | BPsych graduate | Black |
| Participant 5 | 21 | Female | Indo-Aryan | BPsych graduate | Indian |
| Participant 6 | 24 | Male | Tsonga | BPsych graduate | Black |
| Participant 7 | 26 | Male | Venda | BPsych graduate | Black |
| Participant 8 | 23 | Male | Venda | BPsych graduate | Black |
| Participant 9 | 24 | Male | Venda | BPsych graduate | Black |
| Participant 10 | 23 | Female | Venda | Masters' student in Counselling | Black |
| Participant 11 | 24 | Female | Tsonga | BPsych graduate | Black |
| Participant 12 | 22 | Female | Pedi | BPsych graduate | Black |

5.4 Emerged themes and sub themes

| **Main Themes** | **Sub- themes** |
|---|---|
| 1. The kinds of clients offered counselling by participants. | • Para suicide<br>• Sexual assault |
| 2. Preparation to offer counselling | • Theoretical Knowledge<br>• Observation |
| 3. Challenges experienced during practicum training. | • Adjustment<br>• Language barrier<br>• Office space<br>• Workload |

| | |
|---|---|
| 4. Experiences of counselling trauma clients. | • Countertransference |
| 5. The effects of counselling trauma clients. | • Emotional<br>• Anxiety<br>• Growth |
| 6. Support received during practicum training. | • Debriefing<br>• Limited supervision |
| 7. Ways to assist students who experience challenges while on practicum training. | • Preparation<br>• Workshops<br>• Continued support |

The participants were asked seven sets of questions related to their experiences during practicum training; the data collected was analysed using IPA; and the researcher followed the four steps as outlined by Smith (2012). Their responses and interpretations are discussed below.

### 5.4.1. The kinds of clients offered counselling by SRCs

Participants indicated that they offered psychological counselling to a variety of clients both male and female from all age groups. Clients who seek psychological counselling come from different families, educational and work backgrounds. Some are referred by school or work whereas others are referred by the hospital or institution in which the RCs are doing their practicum. The clients are reported to have presented with several psychological problems ranging from being victims of sexual assault; para suicides (which

is an apparent attempt at suicide); medical conditions; marital and relationship problems; motor vehicle accidents; grief; bereavement; substance abuse; domestic violence; personality disorders; miscarriages and post-natal challenges; trauma; psychometric testing; HIV; and academic challenges. The two cases that were common amongst all SRCs were those of para suicide and sexual assault.

**Para suicide**

Most clients that were seen by SRCs were referred for counselling because they had tried to commit suicide. This indicates that there is a high prevalence of para suicide and therefore a serious intervention must be considered. Para suicide clients and those with suicide ideation are reported to have been prevalent amongst other clients that SRCs offered counselling to during practicum. This is evident from the statements below:

> *"So, I had suicide ideation, relational problems, attempts, psychosomatic, substance use and pregnancies clients. Yah those were the top cases that I saw. There were times I also had clients with symptoms of psychosomatic, some were using substances during pregnancy, some were using it as a coping mechanism, some for the first time which brought them psychotic features, yes and then… yah that is basically what I saw."* (Participant:4)

> *"Okay I saw multiple aspects, like I saw patients that were para suicide, or para suicide attempt I saw patients whom I referred for depression as well as bipolar…umm also there was a patient that I referred because I was suspecting personality disorder specifically borderline, but it was a personality disorder. I also saw patients who are going through bereavement and miscarriages and inter uterus foetal death, and these are all types of bereavement and miscarriages disorders, also trauma patients, I saw very few sexual assault cases which on the contrary were few as I was expecting a lot. mostly it was para suicides."* (Participant:5)

**Sexual assault**

The second prevalent case presented by clients was that of sexual assault. All participants also indicated offering counselling to quite an alarming number of clients who experienced some form of sexual assault:

> "*Okay, the cases that I saw mostly were sexual assault clients, para suicides and other medical conditions. They had a policy that whenever a patient is diagnosed with HIV or sugar diabetes, if it's newly diagnosed, they send them to us. I saw marital problems, relationship problems and trauma in general like motor vehicle accident and so forth."* (Paticipant:1)

> *"Most of the clients that I have seen they have experienced like rape, I think I had like…uhm, I saw 24 clients and out of the 24 I would say roughly maybe 16 were mostly girls but I also had boys who have been sexually assaulted so these were the most themes that were appearing in the counselling room. Addiction and uhm academic challenges as well and depression, yah". (*Participant :2)

> *"Normally there were youth, age from 16 to 24 they were the most vulnerable and for most of them the presenting problem was suicide attempt, some it was due to psychosocial stressors at home, and the second thing was medical related problems in some case some were admitted due to stroke perhaps so they were referred for psychological intervention, and in some cases more especially with those of suicide during the session you may find that they were likely to present with attention seeking disorder symptoms because the reason or the motive behind suicide attempt is sort of at home they were denying them to do certain things or denying them to buy them clothes, deny to give them cell phones and also the parenting style in which the parents used could also lead to some committing suicide or attempting*." (Participant :7)

There is a rising number of suicide cases reported in South Africa, even public figures such as celebrities are taking their lives. It is not surprising that the former SRCs reported seeing many para suicide clients. This is an indication that SRCs will continue to be exposed to parasuicide clients. It will therefore be helpful to more offer workshops about suicide to SRCs so that they are better equipped to face this case that is prevalent during practicum.

### 5.4.2. Preparation to offer counselling

When asked about how prepared and ready the SRCs were to offer counselling to clients during practicum, only two out of 12 indicated that they felt that they were not thoroughly prepared by the training institution as they did not get enough exposure to actual clients while still in class. The rest indicated that they were properly prepared, having theoretical knowledge from the university and observing clinical supervisors with a client helped them to cope with the practicum.

There was also one participant who indicated that she was not ready to offer counselling to clients because of losing a parent prior to the commencement of her practicum training. However, after undergoing counselling she managed to attend to clients:

*"During the first week of the practicum I was not emotionally stable after I lost a parent but through that we managed to work around by attending psychological counselling by the clinical psychologist at the university and I was also receiving support from my supervisor and counselling related to grief since I was still grieving myself but I also managed to see a few patients, but in all the cases it was suicide attempt patients, there was one that had convulsion symptoms and the other one was psychosocial stressors, so yah. So, I would say that I was prepared after the first few weeks."* (Participant:4)

**Theoretical Knowledge**

The student registered counsellors below indicated that they received proper training from the training institution, which is the university, and they outlined the importance of the theoretical knowledge that they received in class and the importance of the modules that equipped them with various counselling techniques:

*"Yes the background knowledge that we were given, I think it was very good especially ethics as well as the counselling techniques that we learned from the university were very handy because that's how we learned how to establish rapport and stuff, so when I went to the clinical setting it was actually like applying the knowledge that I have learned so its seeing the practice from theory so I think it was effective."* (Participant :5)

*"Yeah I think I was in terms of theory I was well prepared, I had enough information you know, to use, enough theory to materialise into practical service in a manner ..um the only thing I can say I wasn't prepared with is that I was still tired ,still coming from class with a lot of pressure, so coming straight from class with a lot of assignments and exams and so on straight to practicum going to spend the whole day for six months from half past seven to half past four it was a lot tiresome. With everything I was not prepared but I was prepared theoretically and so on yah."* (Participant :6)

*" I think theoretically I feel that I was well prepared but obviously a person will experience just like other people I experienced anxiety like how am I going to do this but I think theoretically based on what I was taught during my degree I was well prepared it's just that once the practicum started and we started seeing clients we realised that it's not so easy to transfer theoretical knowledge to practical life situations that was just the challenge because it feels like no matter how much information you have it will never be the same when you see a client because in the text book you will read that if you see a client who comes with this symptoms this is*

*what you do but when you get to a counselling session with a client it's not just like that…this is a person who have a background history there are different attitudes to us counsellors, the way we do things and so on, so yah it was just quite challenging although I felt I was prepared theoretically, just the practicum side of it was challenging for me."* (Participant:10)

**Observation**

The other aspect that came out from the interviews was the importance of observing clinical supervisors when they are offering counselling, as a way of preparation to see clients. The SRCs talked about how it caused them anxiety to have to see a client and not being aware of what they will present with when they came to the session. It is indicated in the statements below that having a day or a few weeks to observe a session gave them the confidence to perform the duty of counselling, and it reduced anxiety of having to offer counselling to a client for the first time:

> *" Yes I think what helped me to be well prepared was the fact that I had a period of three weeks for observation so that helped me know actually what counselling is like and the techniques that different counsellors use like I did not have exposure to only one counsellor, we were four in the department and I used to have experiences from everybody so I used to observe all of them, I tried to adapt their styles and see until I find a technique of my own style so I think it was very helpful for me, I did gain the confidence to be able to be with clients*."(Participant:5)

> *"I honestly feel that I was well prepared academically by the University before going to my practicum. The second thing that helped is when supervisors allowed us to observe the first session when they are with a client.*" (Participant: 3)

It is clear from the quotations above that both the University and the clinical supervisors at the placement sites played a huge role in preparing the students to offer psychological counselling to clients. However, some of the SRCs in the statements below indicated they experienced anxiety due to the fact that they were going to see an actual client in front of them for the first time. It is therefore important that the onsite supervisors observe and help students with these anxious feelings and those that feel incompetent, so that they will cope with the demands of practicum training:

> *"I would say that I was well prepared or ready, I was nervous and anxious and everything but then I was prepared, well prepared. My supervisors, both my supervisors provided me with the necessary help for me to be able to provide counselling to the client."* (Participant:1)

> *"Mmmm I might say yes in some cases but in other circumstances no, because you will never know what the patient when he or she comes to counselling what they are going to present about because they won't say I have PTSD for example, they will just present with symptoms of PTSD which some according to DSM, some they are similar with ASD but if you were well prepared with the scope of practice and took the training during level four, some cases for sure you will be prepared."* (Participant: 7)

It seems that even though the SRC are prepared theoretically during the academic training, they still felt anxious about offering counselling to actual clients during practicum. Most of them reported that observing the supervisor with a client helped them to understand how they should conduct the counselling sessions. This raises a concern about the amount of exposure that the SRC must have before they start with practicum. The academic training institutions should perhaps find ways of exposing SRCs to actual counselling sessions with real clients before they commence with the practicum.

### 5.4.3. Challenges experienced during practicum training

When they were asked about the challenges they experienced during practicum, the SRCs expressed several challenges that ranged from adjustment to a new environment; getting used to a work environment; shortage of office space; secondary trauma; countertransference; not managing workload; to feeling incompetent. The challenges brought forward by most SRCs were adjustment issues; language barriers; lack of office space; and workload.

**Adjustment**

One of the challenges that seemed to affect almost all the participants was adjusting to a new environment. The SRCs had to get used to new people not only at their place of residence but also at their workplace, as indicated in the statements below:

> *"Adjustment …I was struggling to adjust because I felt so all alone and then uhm the workload was too much."* (Participant: 2)

> *"Adjustment to a new environment and work, loneliness because I know nobody at the new place. The major challenge for me was the workload because I had to see clients then write reports on the other hand plan for community outreaches and be busy with my research project. So basically, striking a balance between practicum work and research is a major challenge. I also struggled a lot with my research work." (*Participant :12)

The participant below also experienced secondary trauma due to the fact that it was a first-time experience to counsel a real client and the participant felt pity for the client:

> *"The first challenge was secondary trauma because it was my first-time experience during the counselling session. I remember there was a case about sugar diabetes that woman was presenting...the MSE of the patient was*

*sadness..., tearful so it was… I don't know countertransference like, I was feeling pity for the patient yah and so the other challenge was that eeeh the case presentation… during the oral exam it was challenging because it was our first experience presenting on the podium for people who know who have been on the field for quite some while and as for me it was for the first time. We are given a case where we must read and talk about the treatment plan, how we are going to help the patient, we presented in detail. the challenge were only case presentation and countertransference, no challenge with colleagues*." (Participant: 7)

**Language barrier**

The other major challenge that was outlined by participants was the language barrier. They indicated their frustrations of being placed for practicum at a new province or an area where the language which is spoken there is different from their own. This challenged the participants because not all clients could speak English. Some of the language barrier concerns are seen in the statements below:

*"The top it would be language barrier, because I am Swati speaking, I was placed in Tsonga mixed with Pedi environment so language was a barrier and the fact that it was a rural hospital not all of the patients I was seeing were able to talk and relate in English so that was the first challenge that I encountered, and then secondly it was my body structure when they would find me in the office , they will be like I'm not going to share my problems you, you are a child* (laughs), *so it would be difficult for me to ensure and reassure them that I know what I am doing and everything, and yah the environment in terms of the residence, it was very depressing because I was placed in a residential area full of elderly people, so it would be difficult to socialise with them given the fact that you relate to them as they are your mother, so the environment turned to be a bit depressing especially after a long day at work coming back to the room."* (Participant :1)

"*Because I was placed in Mokopane Voortrekker hospital…um I, and I'm actually from Venda, language was a bit of a barrier but it wasn't that difficult because when I had patients who could speak in English to a point that counselling would be effective it wasn't as bad, and later on I developed a skill of understanding Sepedi as well, so I could get work done…it was manageable. It was difficult at first because I couldn't understand a single thing but then it gets better with time*. (Participant: 5)

**Office Space**

Another worrying matter that was raised was that of a shortage of office space as indicated below. Having to wait for another colleague to finish with their client so that the same office could be used, was reported as problematic, as it limited SRCs from getting enough exposure to clients:

*"And then another challenge was the issue of space, it was a bigger challenge because we had to share one office sometimes you may find there is a lot of clients who are sitting outside and then we must wait for another one to finish his or her session before going in, so yah that was one, the other challenges so yah I think that's all. Mm yah sometimes you may find that eh I was seeing a substance use client who was busy showing symptoms and then I had to refer the client but I had this issue where the client said that he will not allow me to, he will not go to another person for counselling, so I told him my scope of practice but he refused and said he is not going anywhere else he want to be counselled by me."* (Participant: 3)

*"We also had challenges of consulting rooms because there were only two offices and so we had to give space to each other, yes."* (Participant: 4)

**Workload**

The other matter that cannot be overlooked from what the SRCs reported was workload and being unable to strike a balance between the demands from the practicum and the University. The other negative aspect reported related to workload was that SRCs were frequently sent to malls to buy certain items for supervisors instead of obtaining the much-needed experience in the office

> *"The workload was too much so I had to learn how to balance and manage my time well because I was always tired and stuff yah, and pretty much we had a lot of projects, so I had to juggle in between writing reports and seeing clients and having community engagements and all of those things so it was a bit too much….*
> *Also, I couldn't finish my project in time because of the workload I couldn't balance the two, the practicum work and the research."* (Participant: 2)

> "*The major challenge for me was the workload because I had to see clients then write reports, on the other had plan for community outreaches and be busy with my research project. So, striking a balance between practicum work and research is a major challenge. I also struggled a lot with my research work."* (Participant :12)

> *"Challenge…I would say as a male person or as a guy usually when we go to this practicum sites, these supervisors we are appointed to or I should say those who choose us, they also choose guys so that they can appoint certain tasks and responsibilities that they think are guy related. I will be honest, I will tell you the truth, I am tired of going to the mall, buying lunch for people being sent around sometimes disproportionally so when it is not necessary at all. You will find such happening. I can say I am tired of sometimes being sent around to banks, sometimes I was unable to see clients as much as I should, so that is some of the problem I faced maybe because I am a male person*."
> (Participant :6)

Putting into practice what the SRCs had learned in class also proved to be challenging to most as indicated below. In class students learned about different counselling techniques and how to apply them, they did role plays with each other but when they saw actual clients for the first time in front of them, they experienced anxiety due to not knowing what the client would present with and whether they would be able to assist the client properly:

> *"I think one most common challenge which is with everyone I believe is with the demand, having to take theory and make it practical, there is a challenge over there because its no longer role plays it's no longer cases written in paper, but now you are seeing real clients, real people with real matters. There are issues such as countertransference involved there whereby you will find yourself getting affected by a person's problem because it's somehow related to you, you know? Yah one can find themselves being affected by such then I can say that a number of times I experienced countertransference though I was able to deal with it but that one of the problems I did face as well and then umm one other challenge."* (Participant :6)

SRCs also reported another negative aspect that was experienced during practicum. It is indicated in the statements below the frustration caused by how practicum supervisors would disagree or have different perspectives on how SRCs were supposed to conduct certain tasks during their training:

> *"The challenges that I faced umm for me the main thing is that I always felt like I was not…I feel like I was struggling to help clients, I felt like I didn't know what I was doing and I don't think I was getting thorough supervision, there was a lot of confusion from the supervisors because there are several psychologists and they were supervising several students as well. During case presentations the ones which are not given marks and everything, ummm… a student will present in front of everyone, they will present the case and everything and all this people*

*will say different things about the scope of practice, most of them were not sure of what we were supposed to do and what we were not supposed to do and it sort of confused us as interns even more because we asked ourselves what are we supposed to do and not to do for instances where I will see a client and I will see a client and then I go to my supervisor and say this is what happened in my session, and they will say I know you heard the other supervisor saying you are not supposed to do this but I am telling you to do this, so for me that was the challenge, feeling like I was not making any progress and not knowing what exactly I was doing."* (Participant: 10)

Lastly, there was a challenge with the physique for some SRCs. It was reported that having a smaller body structure (looking younger than their age) made some clients uncomfortable to discuss some of their problems, as they felt that the young SRCs would not be able to assist them:

*"Secondly, it was my body structure when they would find me in the office, they will be like I'm not going to share my problems you, you are a child* (laughs), *so it would be difficult for me to ensure and reassure them that I know what I am doing and everything." (*Participant 1)

The counselling practicum comes with a number of challenges of which some can be addressed while others such as having a small body structure will be difficult to change. The major challenge identified by the study is related to coping in a new working and living environment (adjustment issues), coping with the traumatic content presented by clients and office space. SRCs should be assisted to deal with these challenges to ensure that their practicum if fruitful.

### 5.4.4 Experiences of counselling trauma clients.

During practicum, SRCs deal with a variety of clients including those who had experienced a variety of trauma related issues. The researcher wanted to establish the experiences of participants while dealing with traumatic content.

Former SRCs reported that they had experienced countertransference coupled with fear, because of working with trauma content that the clients presented during the session. Most former SRCs mentioned countertransference. However, there were also a few participants who indicated that they did not have any challenges while working with traumatic content.

**Countertransference**

The former student registered counsellors below reported that counselling trauma clients affected them. They reported that they experienced anxiety and fear due to the countertransference that took place during the sessions with the clients. Most SRCs reported having experienced countertransference as seen in the statements below:

> *"With trauma, umm it affected me , it got to me especially because like there was this other case it was similar you would experience countertransference so it would be difficult for you to*…( pauses), *I have never been involved in a car accident before, so when you relate to the patient trying to make the patient know it's a bit difficult because some will say you have never been in the situation, so with trauma it was a bit challenging."* (Participant:1)

> *"Yes, I think so, there were times when I was scared to go to my room alone where I stayed. I would be thinking about the trauma that my client told me about and I would be thinking what if the same thing happens to me since I am staying alone. I had to seek professional help, so I sought counselling."* (Participant :2)

*"In some cases I was affected because I remember I saw this patient, it was a female patient who was involved in motor vehicle accident, on the scene she was with her mother- in-law, her husband, and her younger sister…unfortunately the mother-in-law passed away and the patient sustained severe head injuries, her husband was referred to Polokwane because he was in critical condition and her younger sister sustained pelvic bone injury, so during the first session she was crying nonstop , I ended up not knowing what to do, so I was affected by that, I ended up asking for time off at work fortunately I was having good with the supervisor, she allowed me to have a bit of time to rest because it was my first time experiencing such…I saw the patient in the morning, I think she was my first client then after the session I asked my supervisor if I can go home to rest then she agreed so I went home for the afternoon. The next day when I came to work, she firstly talked to me to find out how I am doing and feeling."* (Participant:7)

*"Yes I was affected because trauma clients seemed to be the most difficult to deal with because of the traumatising content that they will be sharing during counselling. So, yah there is no way a person can say they were not somehow affected because of the nature of trauma work."* (Participant:10)

*"Yes, I was especially with an individual that I experienced in a form of sexual harassment or domestic violence. That for me affected me because it's just difficult for any women to hear that you know something horrible such as rape or sexual abuse has happened to another woman, so I think that for me was hard and it just made me start being anxious about everything that I do, following all of that."* (Participant:11)

While most of the SRCs above indicated several challenges that they came across while working with trauma clients, there were a few who reported that they were fine and experienced no problems related to working with trauma clients as seen in the statements below:

*"I would not say that I was affected because I was well prepared at school that we might come across challenges and then we must not allow things like personal impairment...we must not allow ourselves to be affected by those things that our clients are experiencing, so I don't think I was affected negatively."* (Participant:3)

"*Most of them had a positive effect or impact on me because it made me realise that there is a lot of situations that traumatise people, so different people are traumatised by different situations, so it made me have a different outlook on how people see things and how they view things rather than only on what I have experienced as traumatic, so that has made me learn and understand a lot of people and different people at the same time."* (Participant:4)

*"Umhhh not really but I think debriefing is helpful so because I had received constant debriefing over my cases I think I was good. Had it not been for debriefing I think it is easy for one to be traumatised depending on the cases we see and the heaviness of the case. With us my supervisor told me from the onset that whenever a case is too overwhelming or a session becomes too overwhelming make sure you see anybody from our department immediately after, so it was always done, there was no specific time but whenever I felt I need to speak there will always be room for me."* (Participant:5)

*"Not at all. Everything was okay."* (Participant :6)

*"Not really, the only depressing thing for me was that the environment I was working in, I had colleagues who are older than me and I could not relate to them, that's all*." **(**Participant :9)

Few former SRCs reported that the were not affected by trauma work during practicum, however it was evident while they talked about their challenges that their practicum

experience was in more than one way affected. It is crucial to identify SRCs that are affected by trauma work during practicum and offer them counselling to avoid problems such as countertransference that was revealed by this study to be affecting most SRCs.

### 5.4.5. The effects of counseling trauma clients

The previous question required SRCs to talk about their experience with counselling trauma clients. This one required them to elaborate on how the experience of counselling trauma clients affected them. The participants mentioned a number of ways in which they were affected by counselling trauma clients. They indicated that they were affected emotionally; the countertransference that was experienced caused some of them to feel scared to be alone; others felt they were not doing enough to help their clients. Some indicated that their experiences during practicum had positive effects.

> "…it *affected me, it got to me when I saw a case that was similar, I experienced countertransference, some of the clients will tell you that you won't understand them because you have never been in a similar situation and did not experience what they went through."* (Participant: 1)

> *"As I have indicated I would experience secondary trauma and have fear of being alone".* (Participant: 2)

**Emotions**

The emotional effects of counseling trauma clients are reported in the statements below, they indicate that participants were overwhelmed by the trauma content presented by their clients.

> *"I might say I was emotionally affected eeh seeing that patient crying in front of me non-stop even what she was presenting, that thing provoked my emotions in such a way that during the session… I don't know how I may put it (Ndo vha ndi khou tou di fara) in such a way that eh I ...my ... I wanted to cry by then but*

*because it's during the session if the client is crying I don't have to cry , who is going to comfort someone ..so I ended behaving myself not to cry in such a manner that even when I went home I was thinking about what she was saying trying to imagine the incident and how it occurred as she said it was an unexpected accident that happened as she was changing the lane and then boom another car hit hers on the side of where the mother-in-law was sitting that's why she passed away. She was also putting the blame on herself to say what if she was driving recklessly."* (Participant:7)

*"I was really affected I won't lie…dealing with trauma cases is a big challenge because most cases are scary and painful at the same time, so as a human being yourself it affects you. Most of the time after a trauma case I would be feeling down and rethinking what the client just told me inside the office and imagine if it happened to someone I knew and loved or even if it happened to me, it's not good hey."* (Participant:9)

*"I would say I was affected by the fact that I didn't know what I was doing, so I didn't feel like I was helping clients to actually overcome a certain issue that they presented during a session."* (Participant: 10)

*"Yes I was, especially with individuals who had experienced any form of sexual assault or domestic violence umm…that for me really affected me because it's just difficult for any woman to hear that something horrible such as rape or sexual abuse has happened to another woman so I think that for me was really hard and it just made me start being you know… anxious about anything that I would do following all of that".* (Participant: 11)

*"I would say I was affected because I felt like carrying the client's troubles on my own shoulders more especially because I also saw a lot of rape client and am a woman, so I took their experiences personal as if they were mine."* (Participant:12)

The quotations above clearly demonstrate the effects of counselling trauma clients. Surprisingly, not all SRCs reported that counselling trauma clients affected them negatively.

**Growth**

The statements below indicate that working with traumatic content affected SRCs in a rather positive way since they learned how different people react to different traumatic events. They saw this experience as an opportunity to grow professionally, meaning they will be able to deal with trauma clients in the future:

> "*As I was seeing clients, I only thought that maybe the problems that were out there are those that I am aware of so I didn't know that people can experience those problems to an extent that it's more severe than what I know, so I was able to see and I learned new perspectives about how others are experiencing their problems. I can say that there is growth in me".* (Participant: 3)

> *"I was affected, I think it was my opportunity to grow, yes I do realise that people do face problems in life but it's not as normal as I used to think it was, people can be affected in a huge way by things we consider to be little, by things we deem so small then they get affected by such, so it taught me not to undermine people's problems, not to undermine people who are in pain, people who are crying, people who are bothered by various problems of life uhm.one other thing is that it was an opportunity for me to grow in terms of my profession and then again I gained a lot of experience in counselling and use of assessment tests and so on. So, yah I was affected positively." (Participant: 6)*

There was only one participant who explained that he was affected both positively and negatively. This indicates that during practicum there is a possibility for students to be affected either negatively or positively by their experiences:

*"Okay, during the time I can say that I was positively and negatively affected, first during the counselling sessions I realised that there are lot of gaps between academics and the population itself meaning that when you are counselling you need to have a scale of saying this person is suffering from trauma and then you need to classify that trauma whether its ASD, PTSD or its just adjustment, so given that the academic content provides a certain guideline. It does not meet the criteria, I mean the people were suffering from trauma, but they did not meet the criteria or what they were experiencing is not in the criteria so the only challenge that I had or the only thing that affected me was that the books are not explaining what African people are facing, it is rather in a Western way. I was positively affected to say as a person I need to do something maybe to align academics with the population."* (Participant: 8)

The effects of working trauma clients were not all negative, while others reported their emotions were affected negatively some indicated that the experiences offered them a positive opportunity to grow. At the end of the practicum the SRCs are expected to work independently, it is a good outcome if their practicum offers them an opportunity to grow emotionally.

### 5.4.6. Support received during practicum training

Practicum training comes with challenges and demands. SRCs were asked about the kind of support that they received from their supervisors during training. Their responses differed, as some indicated that they had received support while others reported that they had none.

The participants below indicated that they had received the needed support from their supervisors in form of debriefing, supervision, referral for counselling, and discussion about challenges they encountered during a session.

**Debriefing**

Debriefing, among other forms of support reported by SRCs, was the most prevalent, and as seen in the quotations below, most indicated the importance of having some debriefing especially after seeing a challenging case:

> *"Yes, yes they did, with every trauma case, they debriefed me and assured me to say don't take every problem and make it your own, don't personalise the patient's problems but then so that you will be able to go through the day and see another patient.*
> *So, we had this internal joke, if you were traumatised, they would give that trauma a name and every day we would joke about until you say that this is just a joke, so they normalise the situation for me."* (Participant: 1)

> *"I can't necessarily say counselling, but they would ask us after each month the experience in which we experienced during the counselling of a patients, what challenges we came across, what we did not understand and so forth. They also gave us the platform that if we are seeing a patient and there was something that we were not understanding in terms of probably the symptoms and duration we could ask for clarity, so that we should not at least offer counselling on something that is not relevant for the patient."* (Participant: 4)

> *"Yes, there were times when we were offered counselling sessions or debriefing and there were times where we also went somewhere just to clear our minds and for supervisors to like say to us what we are going through is normal and as practitioners especially psychologists we may also be exposed to challenges.*
> *No, we went out we went to the Elias resort for a day, we sat down we talked about our challenges that we faced in that particular time and what they can potentially do to us."* (Participant: 8)

*" We would have supervision on our cases so for every case that I saw in a week, so towards the week we will have supervision and if some days we have gaps like with no clients we would update ourselves with the cases, so I did have …I don't know if I can call it counselling but it was more of a supervision wherein we would share ideas like how I handled the situation, what I could do better and where was the pitfall, so those are the things we discussed. We can call that debriefing I guess because we were discussing the case". (Participant: 5)*

**Limited supervision**

While most SRCs in the statements above indicated that they did receive support from their onsite supervisors, there were others who indicated that they did not receive any support. The participants below reported not receiving enough support from their clinical supervisors during practicum:

*"No…sometimes, but well just sit around and talk about what we are facing, and she would just comfort based on what happened during the sessions and told us not to overwhelm ourselves."* (Participant: 3)

*"Okay at first, we would* (scratches head) *we have been communicating with other students and some were meeting very regularly but, in my case, we didn't really have that regular meeting. In writing it was there that we should meet every Thursday, but such was never done. I don't know the reason why, but we didn't meet with the supervisors, we were just together in the office working. Only when we are facing challenges and we have curiosities then and there we would consult but we have never had this supervision sessions."* (Participant: 6)

*"That never happened, just as I explained with the challenge that I faced I was never offered any sort of counselling. Whenever I saw a client, I would go to the supervisor and explain the case she would ask what you plan to do and so on, do this do that. There was never any form of debriefing it was supervision only,*

*that was the only thing that happened there is no counselling at all."* (Participant: 10)

*"Not really… I would only go and make consultation if I was experiencing challenges for example, I was struggling to come up with a treatment plan after I saw a client or any other difficulty that I encountered in a session."* (Participant:12)

There is a group of former SRCs that indicated the received continuous supervision during practicum, and those that reported they did not receive any form of supervision from their supervisors. Former SRCs who received supervision were able to cope better with the challenges such as not knowing how to deal with certain clients and countertransference whereas those who did not receive proper supervision expressed frustrations with practicum work. The importance of supporting the SRCs through supervision, counselling, debriefing e.t.c can never be overemphasized because it plays a role on how the SRC learn during practicum.

### 5.4.7 Ways to assist students who experience challenges while on practicum training.

SRCs were asked to talk about different ways that they felt would make practicum training better. They were asked to talk about the kind of support that they would require and to suggest ways of improving practicum. Preparation, workshops and continued support were the most mentioned by SRCs.

#### Preparation

The statements below emphasise the importance of preparation of SRCs about what to expect while on practicum. It seemed like they struggled, especially with the first client, as they were not confident enough to carry out the session.

*"I suggest there should be well prepared in advance about the workload that is required from them, there should be more awareness about that, then number two there should be like before they could even start counselling others they should seek counselling themselves and the number three learn how to balance uhm their social life and work ...yah…*
*Yah, reports can't we just like type monthly reports and okay the schedule and monthly report because typing weekly is a lot."* (Participant:2)

*"Okay maybe if you can just like make students aware of what to expect, what kind of challenges that are there so that might be able to get the idea and that they may be able to prepare themselves so they can overcome those challenges, so awareness of what they will face."* (Participant: 3)

*"I think one of the most important things is to …I feel like not just myself but when I was observing other interns we were struggling with how to help clients we didn't know what to do even after six month period I didn't know how to help a client, I didn't really know how to counsel a client, I knew the counselling skills here and there but really helping a client move past something I didn't know and I also heard my fellow interns saying the same thing and when I am looking at the practicum site, the main problem was not getting thorough supervision and that is where a lot of challenges come from. So, yah the confusion of not knowing what you are doing if you are making any progress of some sort."* (Participant: 10)

*"I think the first one would be offering more in-depth classes on how to, and how students could actually counsel patients instead of having just to you know sitting in class and doing role plays and then be expected to learn everything in that one hour class , I think that is the most fundamental thing , and I think the other thing that could be done would be to basically just like encourage students to understand that whatever they are feeling during that time is okay to be feeling that way because they are human and you are prone and vulnerable to feel that*

*way especially when someone is telling you all of that and that whenever you are feeling that way it is okay for you to go to your supervisor and explain to them what you are feeling, then I think the other thing that can also be done is basically teaching student beforehand what can be done to actually write down all the information that needs to go down and that needs to go in in the clients file because when I got there I realised that is not the same it was presented to as at school and how it was at practicum."* (Participant: 11)

**Workshops**

Workshops were suggested by some of the SRCs who indicated that there should be more than one workshop to prepare them before they go on practicum. They also indicated the need to have more workshops during practicum where they get to talk about their challenges.

*"When you are in the office you are like a vessel, everyone just comes and pours something on you, so it would be nice I think it can be improved in terms of finding more trauma counsellors and more uhm… let me just put it like more workshops where you can go debrief and talk about your experiences as students who are in hospital or counselling section and a share experience and find out what other students are experiencing in order for you to know like if this one managed to cope with this maybe I can also try to utilise that"* (Participant: 1)

*"I think the workshops, because I remember we only had the one workshop the time we were leaving for practicals and only the role plays in classes because some of the role plays were not serious it was not the actual point, then the first time when you see the client you don't know how to conduct the session or some they don't have supervisors on their sites. I remember I heard some of the students who were placed at higher education, there was no on site supervisor they were only supervised by the lecturers from the University, they don't have*

*that time wherein they will observe a session from the supervisor, how is the session conducted so they end up doing things that they know which they think is correct or true whereas it's not true because they haven't observed any session from their supervisor or how it should be conducted. The other way is to try and squeeze students in the department of health sort of hospitals and clinics wherein there will be supervisors because they are more likely to have more exposure and experience. In the higher education institutions, it might happen that they see two or three clients in a week and those ones will be having challenges on their studies so at health institutions they are more likely to see different types of cases and presenting problems."* (Participant:7)

*"I would suggest that probably after a month or two there be a workshop or sort of like a mini meeting where we all discuss with our supervisor, what challenges we came across so that at least you may find that we are all coming across with similar challenges but because me and my colleague we are coming across the same challenges and situation we can't able to assist each other because it's a challenge to both of us but if we can sit and talk about it and probably organise a workshop that can help."* (Participant: 4)

**Communication and support**

Support from the University and onsite supervisors was suggested as one of the ways that practicum experience can be improved. SRCs below indicated the importance of receiving support from their lecturers and the importance of communication between the University and the institution providing practicum.

*"I think my practicum experience was actually really nice because of the constant support I have been receiving from my supervisor, so I would recommend that its nice if everybody, every student has a supervisor like that who is supportive and motivating and encouraging because that keeps the student motivated and it keeps the students looking forward to the next day and as a University I think*

*also it would be nice if universities would constantly check on their students to say how is practicums? How are you guys keeping up? Just support is very good."* (Participant: 5)

*" Uhm this one will be difficult to deal with because of it's a bit external but I would say the supervisors that are appointed by the University as in our lecturers, they should have a close interaction and communication with students as they are supposed to come to the practicum and check what is going on and check how things are going, they should also give students the opportunity to open up and talk about issues they are facing so that they don't wait for six months to end then they deal with matters, some of which have potential to interfere with them functioning properly during internship so if certain issues are dealt with on time then it can do better. Students are affected by issues that need serious intervention because some will be having issues with their supervisors or receiving bad treatment because some supervisors have their own personal issues. If the University appointed supervisor is not communicating with the student, then the student suffers. It would do better if supervisors get a bit closer to the students it will be better."* (Participant:6)

*"For me what I would like to see is the involvement of the University, for me as a student who is coming from Thohoyandou to a different place I felt that obviously as a person I will be exposed to challenges, language, adjustment but I did not have any one from the University to support me or even care or even come check where I am staying or check how I am living, how are things going. I would like to add that, for practicums I think the University should… I'm saying this because I still feel that I am still impacted by this, I was one of the best students who was awarded a certificate for being the best learner but the University and the department of health they are not… I think they have a relationship, but the relationship is not well aligned there is a misalignment given the fact that I got 86 that side and 76 this side, that discrepancy between the institution and the department is not well. There should be a better*

*communication between the two and student, I think the University need to do a follow up to students to say did you understand that you need to do this and that this is the criteria for the University and there is also a criteria for the department of health and I think there is a greater need for transparency particularly between lecturers and whoever is in charge of the practicum with learners because there was a lot of misunderstanding between students and the institution itself."* (Participant: 8)

*"I feel like if that if there was supervision of some sort a lot of things would have been better and I think debriefing can help as I have already indicated I never received any form of debriefing, most of the times we were just stressed because of a lot of activities that we were doing to such a point where we did not want to see clients anymore not because we were tired but because we were not getting thorough supervision and that is were a lot of challenges come from so yah, the confusion, not knowing what you are doing, if you are making any progress of some sort yah I feel if there was thorough supervision, a lot of things would have been better and I think debriefing can help. Also, a workshop on teamwork to address the stress and tension within groups."* (Participant: 10)

The other aspect that was mentioned by most participants was about getting support and guidance from the supervisors at the practicum sites and from the supervisors (lecturers from the University).

*"The thing for me that I think must be improved is better communication between the students and our lecturers back at the University, for instance at least we must be allowed to go for research supervision once a month, the other thing is for onsite supervisors to offer us better support especially when we have our own personal crisis such as losing a relative, they should not be too strict on us."* (Participant:12)

The SRCs quoted below raised concerns about working with peers. They suggested that younger psychologists must be hired to train them because they can better relate to them better than supervisors who are older than them.

*" uhm what I feel needs to be done based on my experience I think it would be to in terms of the department, hiring or finding more younger people in the work environment so that it is easy for you to relate to your own peers if ever you feel stuck or anything else, and also what can be improved again would be the workload that is there. Hiring more trauma counsellor being there …it was a regional hospital it was over flooding everyday with clients, so you get overwhelmed with the workload so hiring more trauma counsellors in the hospital setting rather than just having one because we had one. In terms of regional hospitals, I would prefer that the hospital should at least absorb three or have three students there."* (Participant: 1)

*"Having other young people to work with will be helpful because I can relate to them as compared to those older than me. Secondly, there must be group discussions between the registered counsellors where they meet and talk about their experiences and best ways of coping and dealing with challenges they come across during practicum."* (Participant: 9)

The former SRCs outlined several ways to help them deal with challenges encountered during practicum. It is important for the training institutions to implement these suggestions that are made by the SRC since they are in a better position to know what will help them.

## 5.5 Conclusion

This chapter offered an insight into the experiences of former SRCs during their studies. Their experiences were both pleasant and unpleasant. Countertransference, anxiety, and fear were the most common challenges experienced especially after offering counselling

to trauma victims. Furthermore, there were concerns about being emotional and feeling overwhelmed with practicum and research work. It is reported that all the unpleasant experiences were dealt with by going for supervision with the onsite supervisors and going for counselling when necessary. Seeking supervision and debriefing after a challenging case were said to be helpful with coping during the practicum. Another positive aspect reported was that exposure to challenging cases resulted in learning and professional growth. Important recommendations were made, such as improving communication between the University supervisors and the practicum supervisors and allowing SRCs to go back to their universities at least once a month for research purposes. The data that is presented here is discussed in detail in the next chapter.

# CHAPTER 6

# DISCUSSION OF STUDY FINDINGS

## 6.1 Introduction

The previous chapter comprised a presentation of the study findings. The aim of this study was to explore the challenges experienced by SRCs during practicum and to develop guidelines to support them during practicum training. The SRCs were asked questions about the kind of clients they offered counselling during practicum; if they were prepared to offer counselling to trauma clients; the challenges they encountered; if they were affected by counselling trauma clients; how they were affected; and what kind of support they received during practicum. These questions helped the researcher in addressing the objectives of the study, which were to describe the profile of clients counselled by SRCs; explain activities and roles played by SRCs during counselling; determine the effects of counselling trauma clients on SRCs; explain the mechanisms for identifying SRCs affected during practicum; identify coping strategies used by students to deal with challenges encountered during practicum training; to explore the kind of support received by SRCs during practicum; and finally, to develop guidelines for supporting students who experience challenges while caring for clients during practicum.

This chapter comprises a discussion based on the findings that were presented in the previous chapter. Themes and sub themes emerged from the study after data analysis. The subheadings that are discussed in this chapter are as follows: the kinds of clients offered counselling by SRCs during practicum; preparation to offer counselling; challenges experienced during practicum training; experiences of counselling trauma clients; the effects of counselling trauma clients; support received during practicum; and ways to assist students who experience challenges while on practicum training.

## 6.2 Sociodemographic of participants

There were 12 SRCs that participated in the study. Five out of the 12 participants were male, indicating that there were more females. The University of Venda is in Venda, which

is occupied mainly by Tshivenda speaking people, which was evident in the ethnic group represented in the study. The dominant ethnic group in the study was Venda, with six participants, followed by Tsonga and Swati which each had two participants. One participant was Pedi, and another participant was Indian. One of the challenges reported in relation to ethnicity during practicum was that of language barriers, especially for those placed within a different ethnic group who spoke a different language. Some SRCs reported that they were placed at practicum sites in which a different language from theirs was spoken. This poses a problem for clients who are not fluent in English and may in turn affect the relationship between client and counsellor.

The establishment of a counselling relationship between a counsellor and client is crucial for effective counselling sessions. This is supported by a study done by Behn, Davanzo and Errazuriz (2018) that revealed that clients easily observe the demographic attributes of counsellors such as age, gender, and socioeconomic status. Additionally, clients will establish their trust in their counsellors based on these observable attributes. The SRCs have a responsibility to establish a healthy counselling relationship with their clients; they can achieve this by making their clients comfortable during the sessions, although they may be of different ethnicity, gender, and age. The age of SRCs may be an attribute that can contribute to the effectiveness of counselling. This is discussed below.

Some studies have indicated that the therapist's age and theoretical orientation does not directly relate to the effectiveness of counselling (Beutler et al., 2004; Duncan et al., 2010; Miller, Hubble & Duncan, 2007; Okiishi et al., 2006). The age group of SRCs in this study ranged from 21 to 27 years, indicating that they were all young. A few of them indicated that older clients were not completely comfortable with getting counselling from them because of their physique as they looked younger, however the findings indicate that the age of the SRCs did not affect the effectiveness of counselling. The key lies in establishing rapport and assuring the client of the capability of the counsellor regardless of their age. Some SRCs narrated their exposure to real trauma clients as an eye-opener about what is really happening in the real world, and that they were providing the services required by the client.

### 6.3 The kinds of clients offered counselling by participants

The previous theme offered a discussion about the sociodemographic data of the participants. This section focuses on the clients. The researcher wanted to establish profiles of the various clients that the SRCs offer counselling to during practicum. “Various South African (and international) contextual challenges, such as HIV/AIDS, poverty, divorce, and other psychosocial risks, generate a need for well-trained counsellors who have an impact regarding psychological support to communities” (Khanare, 2012). The SRCs indicated that they offered psychological counselling clients presenting with different issues, such as sexual assault; para suicides; medical conditions; marital and relationship problems; motor vehicle accidents; grief; bereavement; substance abuse; domestic violence; personality disorders; miscarriages; and many more. This indicates that SRCs, like all other mental health workers, were vulnerable to different challenges associated with providing care to mental health clients. These findings are in line with the findings of Elkonin and Sandison (2010) whose study revealed that RC trainees fulfilled several roles within the various organisations, and they gained experience in multidisciplinary teams. Their study also revealed that they worked with individuals and groups; furthermore, they offered services such as trauma debriefing; assistance with lifetime choices; academic challenges; career issues; HIV/AIDS counselling; self-esteem development; psychoeducation about study methods; and wellness (Elkonin & Sandison, 2010). The current study revealed that the two cases that seemed to be common amongst all SRCs were those of para suicide (those who had attempted suicide) and sexual assault.

The first case to be discussed is para-suicide. The study revealed that SRCs saw many para suicide clients during practicum. This is an indication that suicide was a common problem that needed urgent attention. These findings are supported by literature on suicide. The following studies done indicate that suicide rates are a cause of concern, not only in South Africa, but globally. Suicide has been declared a global health crisis by the World Health Organizsation predicting that ~1.53 million people will commit suicide annually by the year 2020 (Bertolote & Fleischmann, 2002). A decade later, a study by

Engelbrecht et al. (2017) revealed that the incidence of suicide has not changed and that only methods of committing suicide changed. Suicide is a major public health challenge; it is not surprising that while on practicum, SRCs came across many clients who had attempted to commit suicide. This also indicates that globally, there is a need for serious interventions in order to reduce suicide rates.

The second common case that the SRCs reported on was that of sexual assault. Sexual assault clients were reported to be prevalent in addition to para suicide. Sexual assault comes in many forms including: unwanted or non-consensual sexualised touching (e.g., fondling someone's private parts while dancing); attempted sexual penetration (e.g., oral, anal, or vaginal intercourse); or completed sexual penetration (i.e., rape) (Walsh et al., 2021). A study by Oinas et al. (2018) supports this finding as it indicated that "South Africa has one of the highest rates of sexual assault in the world, and while absolute numbers are unreliable because of under-reporting, adolescent girls and young women are particularly at risk". It is due to the high rates of sexual assaults in the country that SRCs were also exposed to a high number of clients who had experienced some form of sexual assault.

### 6.4 Preparation to offer counselling

The previous theme indicated the two common aspects that clients presented with during counselling. This theme comprises a discussion about whether SRCs were prepared for practicum. The results revealed that only two of the 12 participants indicated that they were not well prepared by the training institution, as they felt that they did not get enough exposure to actual clients while still in class. A study by Mehzabul and Nazia (2021) found similar results. The study which was about the perceptions of university students about internship programs before they were placed revealed that students had misunderstandings about the purpose of their education and employability, these misunderstandings contributed to their continued under-preparedness for the employment market. Under-preparedness of the students before practicum adds to their frustrations about what is expected from them, which may leave SRCs feeling that they are not doing enough to assist their clients.

The remaining ten SRCs indicated that the training received from the university was enough to prepare them for the practicum. The importance of getting enough preparation is outlined in other studies, such as that of mental health workers by Goodman (2015) which revealed that mental health counselors must be prepared to understand and address issues related to traumatic stress regardless of their practice setting or area of focus. The findings indicate that student were prepared theoretically. The SRCs seem to have theoretical knowledge about counselling and counselling techniques, however, a few struggled to put their theoretical knowledge into practice as indicated in the paragraph above.

In addition to theoretical preparation, SRCs also indicated their appreciation for the preparation that they received from the onsite supervisor through observation. They indicated that on site supervisors allowed them to observe at least one to two sessions with a client before they started to see clients on their own. This indicates that it is of paramount importance for SRCs to be offered an opportunity to first observe sessions before the start to offer counselling. This is supported by a study of Okolie et al. (2021) who explored university students' career curiosity and perceived supervisor support during work placement. The study discovered that students undergoing training required support from their supervisors to help improve their learning experience. Observing their supervisors assisted SRCs to deal with the anxiety and lack of confidence that they experienced during practicum due to the fact that they would have to offer counselling to real clients for the first time on their own.

### 6.5 Challenges experienced during practicum training

The previous theme was about whether SRCs were prepared to offer counselling during practicum. This section is about the challenges that they faced while undergoing training. The SRCs in this study did not talk much about financial challenges, however they indicated that they faced a number of other challenges. Shared challenges mentioned were adjusting to a new environment; getting used to a work environment; shortage of office space; secondary trauma; countertransference; language barriers; not managing

workload; having a small body structure; not enough support from the training institution; and feeling that they are not competent. This is supported by a study of Maidment (2006) which revealed that students on practicum experience challenges such as unsatisfactory supervision; problematic workplace practices; financial hardship; struggling to balance practicum and personal life; and workload.

The challenge that the researcher found to be striking was the anxiety that the SRCs experienced because they were not sure what they were expected to do during the first session. It was discussed in Section 6.3, that students felt the need to observe the supervisor with the client before they started to see clients on their own. They indicated that they felt that they were not competent enough to help a client. Even though SRCs indicated that they experienced anxiety due to the expectations during practicum, they were able to overcome this due to the support that they gained from their supervisors. Another striking challenge was that they felt that their supervisors from the University were not giving them enough support, and they felt that there should be more support visits to check on them to see if they have challenges. The issue of support visits is crucial, and one of the SRCs indicated that they spent more time being sent around on different chores such as going to the mall to pay bills for the supervisor and making tea instead of spending more time in the office and learning more skills related to counselling. These findings are supported by a similar study of students' experiences on internship which revealed that they experienced the workplace in all its variety, pressure, injustice, and ill-articulated demands (Gashaw, 2019). This calls for more support visits so that SRCs would not be exploited, and to afford them the opportunity to voice their worries and obstacles to effective learning during practicum.

Adjusting to a new residential area and a new work environment were also challenges that SRCs encountered. They have to leave their homes and accommodation at the University and stay at/near the practicum site where they are placed so they can go to the office on time. Most of them found this change to be challenging because they did not know anyone. Some also indicated that they did not feel safe enough in the rooms that they were allocated at the placement site, and this affected them because they were

afraid to go to the room by themselves. Adjustment was not limited to residential areas during practicum, some indicated that they struggled to adjust to the work environment, especially because they had to work with people who were older than they were. The problem of adjusting to the residential area and work environment can be addressed during functional supervision. In line with what Gashaw (2019) said about functional visits, the study indicated that functional visits from the supervisor is crucial, because, if not visited, the student misses the guidance of the educational institution that is needed to make the internship meaningful. The study was guided by the EST developed by Bronfenbrenner (1993) which states that an individual exists in different layers which influence how they function. Furthermore, the theory states how human development is influenced by different environmental systems. The first layer is the environment microsystem, it contains the relations between an individual and the immediate environment that surrounds them, such as the home and school. This theory relates to the findings discussed above, When SRCs go on practicum they have to adjust to a new work environment and a new residential place. They reported challenges of adjusting. Helping students adjust with the new workplace is crucial for their professional development during practicum.

In addition to adjustment challenges, the language barrier was mentioned as another problem that required attention. SRCs indicated that they experienced challenges when they were placed in an area where people spoke a different language from them. The problem was that they could not use English because some clients were not fluent in English. This can be addressed by making sure that all SRCs are placed within organisations or communities that speak the same language as them. The training institution and the practicum must place SRCs at practicum sites that will not give them challenges with language. This is supported by a study about the experience of internship students in relation to intercultural communication challenges and strategies in the hospitality industry, where it found similar results that language barriers negatively affect student learning during practicum, and furthermore it was suggested that academic programs should equip students with proficiency in foreign languages and cultures, thus equipping them for multilingual and multicultural working environments (Nomnian, 2020).

Language barriers should be properly addressed because they limit the learning of SRCs, and they will not obtain much-required experience if they avoid clients due to language barriers.

The next challenge to be discussed that was reported by SRCs is insufficient office space. Insufficient office space caused problems for some of the RCs as reported in the findings. A study by Jeske and Axtell (2013) that supports this finding, was about e-internships and they revealed that training students is costly and that many organisations have limited financial means or office space to provide space for interns. SRCs indicated that they were sharing an office with others, and as a result they saw fewer clients. They indicated their concern and felt that if they each had had their own office, they would have been able to offer counselling to more clients and in return learn more from the practicum. It is important that practicum sites that do not have enough office space avoid taking more than one SRC so that they get the required exposure during practicum.

The last challenge to be discussed that was reported by most SRCs in the study is that of workload which seemed to be overwhelming. SRCs have to offer counselling to various clients during practicum; plan for treatment; write reports for each client; plan and conduct community outreaches; and complete their research projects within the six month that is allocated for practicum. It was clear in the findings that all the activities that are expected from the SRCs during practicum were perceived as too much. This finding is supported by Kokkinos and Stavropoulos (2016) in their study about practicum- related stressors. It revealed that emotional exhaustion and personal accomplishment were predicted by practicum workload. Having a workload that is not managed leaves the SRCs feeling overwhelmed and puts them at risk of not completing their practicum on tine or experiencing other psychological problems such as burnout. It is crucial that SRCs are equipped with skills such as time management so that they can manage their workload.

### 6.6 Experiences of counselling trauma clients

This theme differs from the previous ones because it does not focus only on the negative experiences or challenges. The researcher wanted to gain insight into how the SRCs experienced their practicum. They were asked to share their experiences in relation to offering counselling to various clients during practicum. The participants indicated that they experienced psychological challenges especially when they offered counselling to trauma clients because of the trauma content that was presented during the session.

Most former SRCs reported countertransference, caused by attending to the trauma content presented by clients during the session. The same was echoed by Pedhu (2019) when he reiterated that countertransference is considered as a negative factor that may affect counseling relations. It is the therapist's reactions and feelings toward their client in therapeutic relationships, and the feelings might influence their attitude and behavior toward clients (Boyd-Franklin et al., 2013). These feelings must be recognised by the therapist to prevent the negative impact of countertransference (Noorani & Dyer, 2017). Trauma work can be challenging, as it may pose a danger to the mental health of the psychologist and may cause them not to be effective when doing their work.

Schwartz-Mette (2009) Indicated that psychologists' stress and impairment have a negative effect on their ability to work effectively with their clients. SRCs are not immune to this stress caused by trauma work and as a result may experience learning challenges during their practicum. Countertransference can interfere with the learning of SRCs during practicum if it is not recognised and addressed. This shows that there is a need to monitor whether SRCs experience countertransference or any negative elements due to offering counselling to trauma clients, and to find ways of dealing with these so that students can continue to learn as much as they can in the given six months of practicum.

However, there were also a few participants who indicated that they did not have any challenges while working with traumatic content. A study by Hunter and Maple (2014) supports this finding, as their study emphasised that managing the demands of trauma

counselling requires counsellors themselves to be aware of and manage their own limitations and fluctuations in wellbeing. This indicates that it is important that SRCs know their limitations and should always be aware as to whether they are coping or not so that they would know when to get help or take a break.

### 6.7 The effects of counselling trauma patients

When asked to share their experiences of how they were affected by counselling clients, especially the ones who presented with trauma, SRCs indicated mostly what was discussed in the previous section. They talked about countertransference, and how they felt emotional, especially with sexual assault cases. A study conducted by Bober and Regehr (2005) of 259 individuals providing mental health counselling services supports this finding. Their study revealed that those who offered counselling to more trauma clients reported higher levels of traumatic stress symptoms. It is difficult to provide counselling to trauma clients and not be affected. This theme is supported by the Constructivist Self-Development theory (CSDT) which also guided the study. The CSDT talks about the process of disruption to one's sense of safety, control, trust, and intimacy, because of continuous exposure to traumatic material over time during trauma work with clients (Sprang & Craig, 2015). The findings of this study are in line with this theory, since the SRCs reported that they experienced disruption (e.g., anxiety) due to counselling trauma clients. In addition, Pearlman (2013) suggested that trauma can disrupt a person's schema across five areas of fundamental psychological needs namely: safety; dependency/trust; power; esteem; and intimacy. The effects on the cognitive schemas that can come as a result of trauma work should be dealt with so that student counsellors can be effective.

The other important aspect that came out from this question was that due to the trauma content that was presented to students by the clients, they felt anxious that they will not be able to fully help their clients. A study by Kurtyilmaz (2015) of counsellor trainees' views on their forthcoming experiences in a practicum course, revealed that they experienced feelings of confusion, anxiety, excitement, curiosity, and fear. They

experienced fear and anxiety in terms of professional practice, and they were concerned about being professional and managing the process of counselling. Kurtyilmaz's (2015) study further explained that counsellors may experience evaluation anxiety which is a preoccupation with being good counselors. Therefore, the SRCs' evaluation anxiety must be addressed to avoid impairment during practicum. They must find ways of dealing with the anxiety and continue to learn and help their clients professionally.

In contrast, there were some former SRCs who indicated that they were positively affected by the experience of counselling various clients during the six months of practicum. They narrated their exposure to real trauma clients as an eye opener to what was really happening in the real world. They indicated that being exposed to different clients who presented various problems afforded them the opportunity to grow both personally and professionally. Literature indicates that there can be both negative and positive effects of offering counselling to trauma clients. Stamm (2002) supports this finding that compassion satisfaction is one of the protective mechanisms for practitioners who work with trauma clients. These are all positive changes that can occur in the process of coping with trauma work. Furthermore, a study by Hunter and Maple (2014) indicated that counsellors perceived trauma counselling work as having both challenges and rewards. The counsellors also indicated that the rewarding element of trauma counselling work was being able to aid others. The SRCs in this study also indicated that they felt that they were ready to see more clients and that they would be more effective in helping them, and they said that they were affected positively. "Mental health professionals working with trauma survivors often experience both psychological costs and benefits" (McKim & Adcock, 2014). The study uncovered that some SRCs were affected positively because they indicated that they grew personally and professionally due to experiences during practicum.

Personal growth

It is reported in the findings by some of the SRCs that working with traumatic content affected them personally in a positive way since they learned how different people react

to different traumatic events. The term 'compassion satisfaction' has been used to describe positive outcomes associated with stress and trauma for helpers (e.g., counsellors, crisis responders). SRCs reported that working with trauma clients gave them an opportunity to gain experience indicating that this was satisfying. This is in line with a definition by Stamm (2005) who referred to compassion satisfaction as the pleasure derived from effectively helping others through psychotherapeutic work.

Professional growth

Participants indicated that they were affected positively by getting exposure to trauma clients. They felt that they benefited as they were better equipped professionally to deal with trauma content presented by clients. They saw this experience as an opportunity to gain experience professionally, meaning they would be able to deal with trauma clients in the future. The study by Arnold et al. (2005) revealed results related to what the SRCs reported. Their study discovered that there is professional growth related to trauma work. Their study explored the impact of trauma work on 21 psychotherapists, focusing on memory systems and psychological growth; even though some negative consequences where discovered, all the clinicians described positive outcomes. This indicates that offering counselling to trauma clients is necessary for SRCs to grow professionally as they learn how to manage difficult cases.

### 6.8 Support received during practicum training

The researcher felt that it was of immense importance to establish the kind of support that the SRCs received during practicum. This was because of the experience that the researcher had had prior to the study, while doing support visits to SRCs during practicum, wherein they tended to have a number of complaints that need to be addressed. Some of the SRCs in this study indicated that they had received support from their onsite supervisors in the form of debriefing, after each session; supervision when needed; referral for counselling especially if they were affected and not coping after seeing a client; and discussion about challenges they encountered during a session.

The results indicated that support from supervisors was crucial during practicum. There is a lot of literature that supports this statement as discussed in this paragraph. These studies found related results. The study of Govaerts and Dochy (2014) revealed that support received from the supervisor is important for an employee to apply in practice the competences developed during a training programme. Receiving support from supervisors is of paramount importance for the learning experience of the SRC. Another study by Hunter and Maple (2014) revealed that all participant counsellors acknowledged the importance of receiving support in maintaining their ability to conduct trauma counselling work, and they mentioned clinical supervision, and peer support as means of support. The importance of support from the supervisor cannot be stressed enough. The kinds of support that were received by SRCs in this study are discussed below.

SRCs indicated that they received support from their supervisors in the form of supervision and debriefing. In addition to these functions of the supervisor mentioned, Chiabaru et al. (2010) indicated that the other responsibilities of the supervisor are development of trainees by providing the time for skill practice and aiding them in implementing their skill. Furthermore, Bailey et al. (2017) reported that the site supervisor is considered to be the source of content expertise during practicum. It is evident from the study that practicum supervisors play an important role of guiding SRCs about how to deal with challenges that accompany the practicum. During supervision, students get a chance to talk about the difficulties they encounter personally and professionally.

Debriefing sessions was mentioned as another form of support received from supervisors during practicum. Debriefing is useful in helping the SRCs understand their challenging experiences and how to deal with them to continue with the practicum. On the contrary to the findings a study done by Gunasingam et al. (2015) about the prevalence of burnout among postgraduate students indicated that debriefing session did not help in reducing burnout but was valuable in offering of emotional and social support. In this study debriefing sessions were useful in helping the SRCs to talk about their challenges, get assistance and cope with practicum. This is supported by Jacobs et al. (2020) who

conducted a study on facility-based counsellors delivering counselling services for chronic disease patients. The study discovered that weekly supervision and debriefing enhanced the confidence and counselling skills of counsellors.

Peer support was also mentioned as another means of coping during practicum. Sharing of experiences that were sometimes similar aided in normalising the challenges encountered during counselling. Peer support occurs when individuals make an inter-personal connection based on shared experiences of disadvantage and distress and come together to support and learn from each other (Gillard, 2019). A study by Gunasingam et al. (2015) found similar results about peer support. The study uncovered that informal debriefing with peers was seen as a useful way of managing stress and preventing burnout. Allowing the SRCs to share their experiences during practicum proved to be useful as it helped them to cope with the various challenges encountered at different placement sites. They reported that they talked to each other about matters regarding their training and possible ways to overcome them.

There was however another group of former SRCs who shared a different story from the discussion above. They reported that they never received any of the above support. “Lack of clinical supervision increases job stress, professional burden, and accumulation of duties, which may lead to psychological exhaustion and job dissatisfaction” (Morris & Bilich, 2017). It is concerning to hear SRCs saying that they had to deal with their own challenges or call others placed at different institutions for support. This sends a message to the university supervisor and the onsite supervisor that students must always be monitored and offered support. There are other studies confirming that counsellors wish to receive clinical supervision (Boulton, 2014; Kemer et al., 2018). Support is crucial because students will not be effective in doing their work if they are experiencing burnout or any factor that is distressing them. Maidment (2006) indicated that students experience stress because of unsatisfactory supervision arrangements. It is necessary that students receive support through counselling or debriefing so that they will not feel overwhelmed by the work expected from them during practicum.

### 6.9 Ways to assist students who experience challenges while on practicum training

SRCs emphasised the importance of preparation. They indicated that they must be made aware of expectations while on practicum. They further indicated that they struggled with the first client as they were not confident enough to carry out the session. The University conducts a practicum preparation workshop every year for final year students just before they leave for practicum. The basic topics that are presented in this preparatory workshop are: professionalism; ethics; psychological formulation; filing; counselling skills; how to complete different forms used during practicum; etc. The students are also given a chance to ask questions related to practicum training. This workshop has been conducted every year, but the findings indicate that students still feel underprepared when they get to the practicum site. The findings then suggest that the training institution together with the practicum site must do more in terms of preparing the students. It is evident that one preparatory workshop is not enough and that more workshops to help students with knowing exactly what is expected from them, and how to deal with anxiety, are needed.

The SRCs also mentioned that getting support and guidance from the supervisors at the practicum sites and from the supervisors (lecturers from the University) is important. Kourieos (2012) also highlighted the importance of supervision during practicum, by indicating that supervisors should put more effort into visiting and guiding students during practicum, and they should provide as much feedback as possible. The former SRCs felt that they should get continuous guidance and support from their supervisors so that they would know if they were 'on the right track', and this would also help them to deal with the anxiety that they experience after they give counselling to clients.

The former SRCs also raised concerns about working with peers. They suggested that younger psychologists must be hired to train them. This was because most SRCs felt that they could not relate to older supervisors. These finding complements work by Moore et al. (2020) who found that interns tended to look first to their peers and seniors for support after they experience distressing events. One of the participants even reported that they had to talk to fellow SRCs placed at other institutions if they experienced challenges

because they were not comfortable with the supervisor who was not their peer. The importance of peer support among SRCs was evident in this study.

Another crucial point that was suggested as a means of support during practicum, was that of workshops. The study of Freedman and Cucoş (2021) supports what the RCs reported about workshops. It is indicated in their study that internship workshops provide information about professional aspects. SRCs proposed that in addition to the one workshop that is done before they start with practicums there should also be workshops that are conducted during practicum where they get to talk about their challenges and ways to overcome these, because some of them confronted personal crises while on practicum. This suggests that SRCs must have multiple workshops and exposure before they start with practicum and more workshops about selfcare during practicum. One of the SRCs said the following statement:

*"I would suggest that probably after a month or two there be a workshop or sort of like a mini meeting where we all discuss with our supervisor, what challenges we came across so that at least you may find that we are all coming across with similar challenges"*.
Practicums last for a period of six months, and the statement above suggests that there should be at least three workshops in which students are also given a chance to share their experiences with each other.

Lastly, the SRCs suggested more support visits from the University supervisors as a way that practicum experience can be improved. They indicated that they sometimes experience challenges such as not getting along with the onsite supervisor or being asked to perform tasks that are not part of what they are supposed to learn. This finding is in line with what Al-Jaro, Asmawi and Abdul-Ghafour (2020) found in their study, that limited supervisory support affects the students' practices. Currently, the University supervisors go to the training institution twice in six months to offer support to the SRCs. The findings suggest that there is a need do more support visits so that the students would be able to talk about the challenges they have and get the support needed during training.

In addition to increased support visits from the University supervisors, the SRCs talked about communication between the University and the institution providing training. One of the participants shared their experience of getting high marks on the portfolio of evidence when it was marked at the practicum and but then getting lower marks when it was marked at the University. This calls for an improvement in the communication between the University and the practicum site in relation to the agreement about how the students' work will be assessed.

Another aspect was that there must be better communication between SRCs and their lecturers back at the University in relation to their research work. The students must complete their research projects while on practicum, and one of them indicated that they should be given times or dates at least once a month wherein they would go back to the University for research supervision and to work on their projects.

## 6.10 Conclusion

The findings from the study revealed interesting factors related to the practicum experiences of SRCs. The prevalent cases that they encountered during practicum were sexual assault and para suicide. Offering counselling to various clients, especially those who presented with trauma content, left the SRCs vulnerable to experiencing psychological problems such as countertransference and anxiety. These challenges have proven to affect learning during practicum. Support from supervisors in the form of supervision and debriefing have been identified as useful in helping the SRCs to cope with the demands of practicum. Other strategies suggested by the SRCs, and which are anticipated to bring changes to the way they are trained, included peer support; improved communication between the University and the practicum site; and more workshops.

# CHAPTER 7
# RECOMMENDATIONS OF THE STUDY

## 7.1 Introduction

The previous chapter contained a discussion about the experiences, challenges, and support that was received by the SRCs during practicum training. This chapter entails a discussion of suggested recommendations based on the findings of the study.

## 7.2 Recommendation for the training institution

The training institutions for BPsych must provide the students with at least three practicum preparation workshops before they are placed at different institutions. There needs to be more exposure of students to real life situations or actual clients in therapy sessions before they begin with the practicum. Students normally attend outreach programmes during the third year of study, in which they plan and prepare various mental health topics to be presented to the community or a selected audience. It is suggested that the training institution must consider exposing students to actual clients during the third year of study or earlier, as this will help them to deal with the anxiety of offering counselling to a client for the first-time during practicum.

## 7.3 Recommendation for the practicum training institution

The study yielded two recommendations for the practicum training sites. The SRCs indicated that they felt that learning will be better if there were younger psychologists or registered counsellors who were supervising them because they would relate better to them. The other problem that was indicated, was a lack of office space and sharing of the offices. It is therefore recommended that the practicum training institution must provide enough office space for the SRCs so that they can see as many clients as possible and

not miss learning because of the lack of office space. Lastly, the training institutions must allow, if possible, younger RCs or psychologists to supervise SRCs.

### 7.4 Recommendation for functional supervisors

The former SRCs reported that they felt as if the University lecturers (functional supervisors) were not offering them enough support during practicum. At the time of this study, due to covid-19, the functional supervisors were required to go for support visits at least twice in the six months that the SRC are trained. It is therefore recommended that functional supervisors must make more time to support SRCs by going for support visits at least once every month. Support visits also are necessary because SRCs can talk about their challenges and also address any assistance and clarity that might be required from the university. Functional supervision should be continuous and SRCs must be allowed to indicate and make appointments at any given time if they feel the need to get functional supervision.

### 7.5 Recommendation for on-site clinical supervisors

It is recommended that on site supervisors must conduct workshops at least once in two months. The proposed workshops will help the SRCs to share and discuss their anxieties and other challenges that they are facing during practicum. Supervision of SRCs in practicum should be ongoing, so that they can learn without any underlying problems that are not resolved. Supervisors are advised to make sure that the student get as much exposure to clients and learning in the six months duration that they are given, and they can ensure this by minimising sending them on daily chores that are personal and not related to practicum. One of the former SRCs indicated that he was always sent to the mall to pay bills for the supervisor and thus felt that he was missing the opportunity to gain experience with what he is supposed to be learning. It is recommended that onsite supervisors maximise student exposure to clients and learning and minimise engaging them in activities that are less beneficial to them.

### 7.6 Recommendation for SRCs

It is recommended for SRCs to act professionally during practicum and to use time management tools so that they can complete their practicum and research projects during the allocated time. SRCs must communicate their challenges during practicum to both on site supervisors and supervisors from the University. Furthermore, they must request counselling if they feel overwhelmed by the work or if they experience a personal crisis during practicum.

### 7.7 Recommendation for BPsych coordinators, the training institution and practicum placement site.

This recommendation addresses the concern that was raised by some of the former SRCs that there seems sometimes to be miscommunication between the training institution and the practicum placement site. The study recommends that there should be constant communication between the BPsych coordinators at the training institution and the placement site. Communication between the coordinators is necessary for discussing how to assist SRCs during practicum. Decisions such as when and how students will be assessed must be communicated between the coordinators and students.

### 7.8 Recommendation for the Health Professions Council of South Africa (HPCSA).

It is recommended that the policy makers within the HPCSA amend form 258 or develop a new policy that incorporates monitoring of supervision hours. Secondly to allocate a timeframe indicating when SRCs should complete their research projects. It also recommended that the curriculum should be adjusted so that SRCs are assisted to complete their research projects before they commence with their practicum.

## 7.9 Recommendation for future researchers

The present study was done for the purpose of developing guidelines to assist SRCs during practicum. Future research can be done to check and validate if the guidelines are working for the intended purpose.

## 7.10 Conclusion

A total of seven recommendations were made from the findings of this study. The major recommendations that the researcher is emphasising are for the academic training institution to provide opportunities for SRCs to get exposure to real clients/counselling session before they go to practicum, and to increase the number of practicum preparation workshops. Furthermore, there should be improvement on and continuous communication between the academic training institution and clinical placement site, and better support provided for SRCs from both the academic training institution and practicum site.

# CHAPTER *8*
# GUIDELINE DEVELOPMENT

Phase 2: Development of guidelines

## 8.1 Introduction

Practicum training forms part of any holistic curriculum; it also offers students the possibility of applying theoretical knowledge, skills, attitudes, and values into a real work environment (Pill & Pilli, 2013). Counselling practicum is done for the purpose of building and expanding basic counselling skills and integrating theoretical professional knowledge into practice. It is important to link theory with practice so that the professionals do not put the lives of people they serve at risk (Chaminuka & Kaputa, 2014). SRCs on practicum are exposed, likely for the first time, to intense professional expectations, while in the meantime they have course work, research responsibilities, and psychotherapy training. They learn to use, and also integrate the theoretical aspects of the profession. The professional requirements for RCs include diverse skills such as relationship, helping/counselling, case conceptualisation, diagnosis, strategies, and interventions (Cormier & Hackney, 2008).
The stress encountered by students during practicum must be monitored and addressed so that it may not lead to increased risk for impairment (Schwartz-Mette, 2009).

BPsych students at the University of Venda must complete a six-month counselling practicum during their final year in the second semester. During this practicum, students face a number of challenges that were discovered in this study. Guidelines are therefore based on the current results which indicated a number of challenges, that ranged from adjusting to an unfamiliar environment; getting used to a work environment; shortage of office space; secondary trauma; countertransference; not managing workload; having a small body structure; to feeling incompetent. Therefore, guidelines were developed to assist students who encounter challenges during practicum.

Phase 1 of the study explained how data was gathered from SRCs who had just completed their practicum. After data was gathered and analysed accordingly, the research findings/results assisted in guiding the researcher on areas that needed to be considered when developing the guidelines. The researcher applied globally accepted guidelines to develop effective guidelines for training SRCs. The developed guidelines were given to the psychologists who supervise students on practicum so that they could check the usefulness of the developed guidelines. The World Health Organisation (WHO) defines a guideline as any document, whatever its title, that contains recommendations about health interventions, whether they be clinical, public health or policy interventions (World Health Organisation, 2011).

**8.2 Guideline Development**

The following steps of developing guidelines as proposed by Jaeschke et al (2009) were adopted.

1. Determining the purpose, scope, and intended audience

The first step in developing guidelines is concerned with the researcher determining the purpose of the study and the target audience thereof. At this stage, the scope of the guideline was defined by the researcher. The researcher identified the purpose of developing the guidelines which was to assist SRCs deal with challenges they experienced during practicum.

2. Selecting the panel of guideline authors

Once the target population of and scope of guidelines is decided on, a guideline panel must be established. The task of the researcher was to choose people who would conduct the guideline development process. The guideline panel was chosen for guideline development.

3. Specifying the main focused questions that the recommendations will answer

During this step, the decision was made in relation to the priority accorded to specific clinical questions. An idea of which questions are important is evident from the start. Questions regarding the population of interest, other interventions, and outcomes of interest are usually refined at later stages. The researcher answered questions related to the Population, Intervention, Comparator and Outcomes (PICO).

4. Deciding on the relative importance of outcomes

It was of importance at this stage to consider all outcomes that are important to patients when making decisions to use or not to use a particular management option. At this stage, the panel decided on the relative importance of each outcome and decided on the ones that would be taken into consideration when developing the guidelines.

5. Finding and summarising the evidence supporting each recommendation

Answering critical questions and developing recommendations required retrieval and summary of all available evidence. All available evidence was summarised at this stage so that it could be used to support the given recommendations.

6. Determining the quality of available evidence

This step involved making judgements about the quality of evidence for each outcome of interest. The quality of evidence refers to the degree of confidence that an estimate of the effect of a given intervention is adequate to support a recommendation. The panel studied the summarised evidence for each of the outcomes in order to check whether quality work was done.

7. Evaluation of the balance of desirable and undesirable consequences of a particular course of action.

After the quality of evidence for each outcome is assessed separately, the guideline panel had to then determine the overall quality of evidence across all outcomes supporting a recommendation. The evidence profile needed to consider, whenever possible, both the positive and negative consequences of a particular course of action. At this point, the data development panel looked for both positive and negative outcomes for each recommendation.

8. Formulating a recommendation to emphasise strengths of the treatment program.

Once the guideline panel was familiar with the evidence (estimates of the effects for the interventions being considered), has judged its quality (the panel's confidence in the estimates) and has determined the final balance between desirable and undesirable consequences, it was appropriate for the panel to formulate the recommendation. The panel developed the recommendations based on the evidence that was gathered and judged for its quality.

9. Considering subsequent guideline implementation and evaluation.

If the guideline panel is confident, they formulate a strong recommendation. It is frequently easier to develop new guidelines than to ensure that they are used or to keep them up to date. The guideline panel must ensure that the guidelines are implemented and that target users know about them. At this stage, the researcher developed the new guidelines based on the recommendations from the panel.

### 8.3 Population, intervention, Comparator and Outcomes (PICO)

The WHO (2012) indicates that there must be PICO questions that are answered in the process of guideline development. PICO refers to elements that should be in a question governing a systematic search of the evidence which are: Population, Intervention, Comparator and Outcomes (PICO). The PICO questions were followed to guide the

process of guideline development. Secondly, the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) was taken into consideration. The PICO and GRADE plus the AGREE were used because they ensured a clinical based evidence approach. The researcher decided to apply the PICO tool for this study because it comprises elements that are required in a question that leads to a systematic search of the evidence. Figure 8.1 Framework for PICO and GRADE

## 8.4 Description of PICO and GRADE framework development

The WHO (2012) indicates that there must be PICO questions that are answered in the process of guideline development. PICO refers to the four elements that should be in a question governing a systematic search of the evidence (Population, Intervention, Comparator and Outcomes).

### 8.4.1 Population for the problem

There must be a population that is targeted by the action being recommended. The population must be described in relation to demographic factors such as age groups, sex, ethnicity, social identities, behavioural characteristics, etc. The setting of the population is also required. The process of guideline development for this study required the inclusion of all the psychologists (clinical psychologists and registered counsellors) who are currently training SRCs at all organisations in which students are placed (hospitals, NGOs, University counselling unit, TVET).

### 8.4.2 Intervention or exposure

The second PICO element requires guideline developers to think about what action is being considered. It gives an answer to which treatment, procedure, risk factor, lifestyle change, social activity, screening test, preventive measure, or approach is being evaluated. The aim of developing the guideline is to assist SRCs with various challenges encountered during practicum training. Lastly, under intervention, the guideline developer is supposed to indicate whether there are variations that should be considered such as dosage, frequency, delivery or administration, personnel and delivery channels, timing, and duration, etc. This study developed guidelines to assist with delivery/administration of training of SRCs. The guidelines offer direction on how frequently the workshops for SRCs should be done.

### 8.4.3 Comparisons or comparative intervention

The third element asks what the alternative choices of action are. This may refer to what is being done currently or another measure that may be considered in comparison. The

researcher searched for current guidelines that may be available for the same purpose of assisting SRCs during practicum. However, most guidelines address how mental health workers can take care and maintain good mental health whilst taking care of their clients

### 8.4.4 Outcomes

The last element of PICO answers the question of what the purpose of the recommendation is. The other important question is what would the guideline achieve? And if there would be any kind of harm caused by the guidelines. The guidelines are developed for the purpose of helping SRCs during practicum. The challenges encountered during practicum by most SRCs during training will be avoided and properly addressed if these guidelines are followed. The developed guidelines are not going to be harmful in any way but will be useful for supervisors who are training SRCs so that practicum runs smoothly.

## 8.5 Study methodology or design

The study was qualitative in nature. The population comprised SRCs who had just completed their practicum. A phenomenological research design was used. Data was collected using a semi-structured interview guide. IPA was used to analyse the collected data. The guidelines where developed based on recommendations that were made after a study was conducted. The aim of the study was to develop guidelines that will assist to identify and offer support to students affected during practicum.

## 8.6 Evidence on balance between benefits and harms and certainty

The researcher took into consideration both institutional and external ethical issues. At the end of the study, based on the findings, the researcher was able to come up with guidelines that will be used to support student counsellors on practicum. The guidelines were developed not to cause any harm to the target users but to offer guidance on how to best offer support to RCs during practicum. This guideline will be reviewed externally before publication, and should further researchers wish to amend or update the

guidelines they should be able to do so by obtaining the current guidelines after publication.

### 8.7 Evidence on cost and cost effectiveness

The developed guidelines are clear and achievable by those who are supposed to use them. The guidelines are less costly and beneficial to the users. The guidelines will be made available and user friendly to all stakeholders. Copies of the guideline will be provided in a flyer to remind the supervisors of ways to support students during training.

### 8.8 Evidence on acceptability, feasibility, implementation, and other issues

The guideline development group (GDG) were drawn from psychologists who participate in training SRCs. The GDG comprised one clinical psychologist and one registered counsellor who also functions as a clinical supervisor, two functional supervisors, one employee wellness practitioner, one BPsych programme co-ordinator at the University of Venda, and one BPsych programme coordinator at the Department of Health, Limpopo province.

The guidelines were developed in a period of twelve months allowing the GDG to make amendments and to refine the recommendations. The GDG ensured that the recommendations are acceptable, feasible, and can be implemented. Suggestions and comments were attended to and amended in the guideline.

### 8.9 Evidence on views and preference

Comments that were made by others were taken into thoughtful consideration to ensure that the guidelines are relevant. The GDG was able to check the suitability of the guidelines to the target population.

### 8.10 Recommendations

The recommendations were formulated by the GDG. The strength of each guideline to be used by supervisors to support SRCs during practicum was assessed and the following recommendations made:

8.10.1 Students should get exposure to actual clients or a counselling setting during the second and or third year before they go for the actual practicum during their final year of study.

8.10.2 A minimum of three practicum preparation workshops should be conducted by the University to prepare students before they are placed at a different institution.

8.10.3 The practicum training institution must make sure that there is provision of enough office space for the SRCs so that they are able to get more exposure to clients and not have to wait for the other counsellor to finish.

8.10.4 Practicum training institutions should have both older and younger supervisors to work with SRCs as this will make them feel comfortable and free to consult supervisors who are young.

8.10.5 On site supervisors must conduct workshops at least once in two months. The proposed workshops will help the SRCs to share and discuss about their anxiety and other challenges that they are facing during practicum.

8.10.6 Provide continuous supervision and counselling for SRCs during practicum.

8.10.7 Ensure that SRCs receive maximum exposure to clients and training.

8.10.8 SRCs must utilise time management tools so that they can complete their research and practicum on time and seek counselling if they are not coping with the workload.

## 8.11 The guidelines development Process

### 8.11.1 Setting objectives

The main objectives of the study were to explore challenges experienced by students during practicum training; to determine the effects of counselling trauma clients on students; to explore the kind of support received by students during practicum training; to establish coping strategies used by students to deal with challenges encountered

during practicum training; and lastly, to develop guidelines for supporting students who experience challenges while caring for clients during practicum training.

8.11.2 Targeting the audience

Guidelines were developed to assist supervisors to be able to identify and support SRCs who encounter various challenges during practicum. The aim of the study was to develop guidelines that will assist to identify and offer support to students affected during practicum. The guidelines were developed not to cause any harm to the target users but to offer guidance on how to best train and offer support to SRCs during practicum.

8.11.3 Timelines

Guidelines were developed over a period of twelve (12) months to allow the guideline panel to critique the content and ascertain if the guidelines covered evidence on all the necessary questions. Below is the timeline used for the guidelines development:

**Table 8.1 Timeline framework for guidelines development**

| **Activity** | **Responsible Team** | **Target** |
|---|---|---|
| Guidelines Proposal | GDG | Jan-Feb 2020 |
| Submission of draft | GDG | March- Apr 2020 |
| Corrections and submission | GDG | May 2020 |
| Approval | GRC | June 2020 |
| Developing Guidelines | GDG | Jul- Aug 2020 |
| Evaluation | Functional and clinical supervisors | Jan 2021 |
| Dissemination | Researcher | May 2021 |

### 8.11.4 Existing guidance and resources

Existing literature that talks about the need and the importance of self-care for various mental health workers or psychologist is available. Mental health workers encounter a number of challenges that range from burnout, and secondary trauma, to counter-transference, however guidelines to support students during practicum are not available, hence the present guidelines were developed for that purpose.

### 8.11.5. The evidence based

The developed guidelines were a result of the evidence obtained from this study. The results that were obtained from the study aided in the development of the guidelines. Guidelines were developed based on recommendations that were made after a study with SRCs was carried out.

### 8.11.6. Who was involved?

The guideline development group (GDG) was involved, which consisted of psychologists who are involved in training SRCs. The GDG comprised one clinical psychologist and one registered counsellor who also functions as a clinical supervisor, two functional supervisors, one employee wellness practitioner, one BPsych programme co-ordinator at the University of Venda, and one BPsych programme coordinator at the Department of Health, Limpopo province. The Guideline Review Committee (GRC) was established to give expert knowledge and directives in the development of the guidelines.

### 8.11.7. Type of publication

The guidelines will be made available and accessible to all users. The guidelines will be printed into flyers and distributed to various organisations responsible for training SRCs once they are finilised.

### 8.11.8. Scope and purpose of the guidelines

Couper (2000) indicated that there is little research in South Africa on the supportive needs of workers or students training at organisations dealing with trauma cases. SRCs deal with a number of cases during their practicum which include trauma. Literature has proven over the years that trauma work does have a negative effect on the wellbeing of the mental health worker. SRCs are not exempt from the negative effects of trauma work. The main objective of the present guidelines is to assist and support students who experience challenges while offering counselling to various clients during practicum training. Supervisors of students on practicum will also know how to best assist the students because these guidelines are developed based on recommendations that were developed from the findings of a study that was conducted with former SRCs.

### 8.11.9. Stakeholder Involvement

The guidelines were developed based on the study that was conducted with former SRCs. The guidelines were developed by the researcher who is a RC, two supervisors, a registered psychometrist and a Doctor of Philosophy. The recommendations were also given for input from a clinical psychologist who is also a BPsych coordinator. Before the guidelines can be adopted four psychologists in the Vhembe district who supervise students will be asked to evaluate the usefulness of the recommendations. The target groups that will use these guidelines are firstly, the training institution, as they will have to provide exposure to clients before students are placed for practicum; secondly, all practicum functional and on site supervisors at different organisations (NGO's, TVET, Department of Health, University counselling units, Correctional services, Department of Education) will use the guideline to assist students during training.

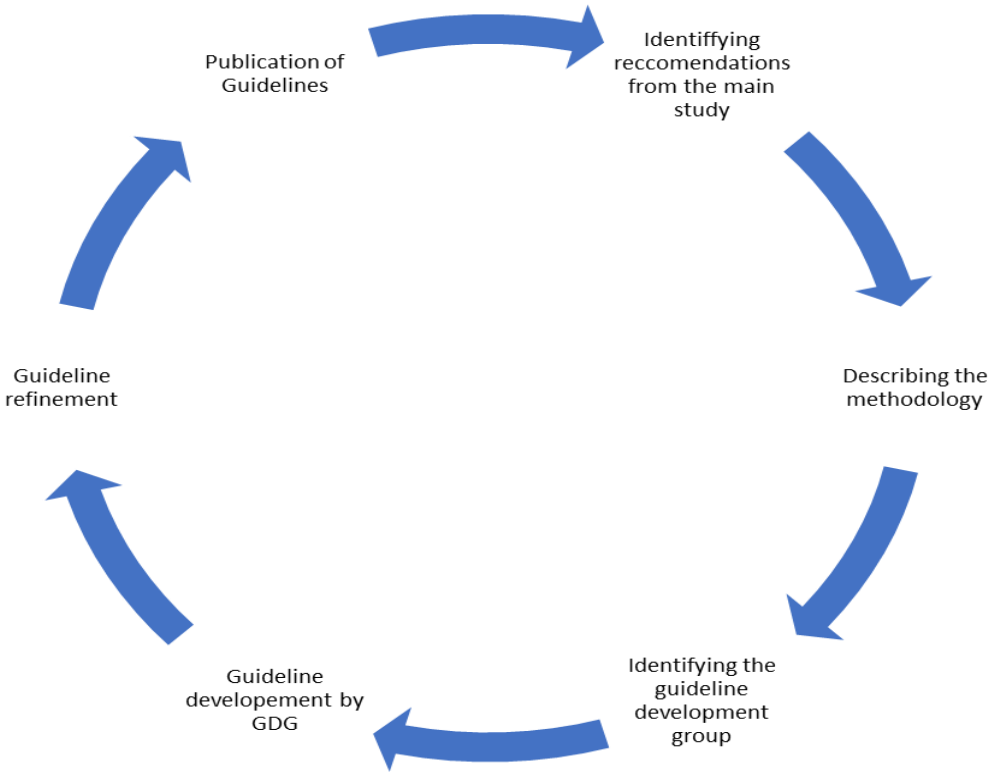
### 8.11.10. Rigour of Development

The guidelines were developed based on recommendations that were made after a study was carried out. The aim of the study was to develop guidelines that will assist to identify and offer support to students affected during practicum. The study was qualitative in nature. The population comprised former SRCs who had completed their practicum.

A phenomenological research design was used in which data was collected through a semi-structured interview guide. Interpretative phenomenological analysis was used to analyse the collected data. The researcher took into consideration both institutional and external ethical issues. At the end of the study, based on the findings, the researcher was able to develop guidelines that will be used to support student counsellors on practicum. The guidelines were developed not to cause any harm to the target users but to offer guidance on how to best train RCs. These guidelines will be reviewed externally before publication and should further researchers wish to amend or update them, they should be able to do so by obtaining the current guidelines after publication.

**Figure 8.2 Planning for guidelines**

Figure 8.2 illustrates the guidelines process



## 8.12 Scoping the guidelines

The developed scope for the guidelines was for SRCs. All SRCs from the University of Venda, Department of Psychology, regardless of gender, who are undergoing practicum in various organisations such as Department of Health, Department of Education, Department of Correctional services, NGOs in Limpopo Province formed part of the scope of guidelines.

The guidelines further excluded other students who are doing practicum but not in the psychology section. The guidelines to support SRCs were developed because the trauma work that they encounter during practicum could leave them vulnerable to experiencing a number of challenges, due to the fact that trauma work affects their mind and their performance and determines how much they will be able to learn during training.

The developed guidelines' scope of practice was applicable to the following target groups: Firstly, the training institution, as they will have to provide exposure to clients before students are placed for practicum; secondly, all practicum functional and on-site supervisors at different organisations (NGO's, TVET, Department of Health, University counselling units, Correctional services, Department of Education) will use the guideline to assist students during training.

The table below indicates the entire scoping process:

**Table 8.2:** Scope, purpose and stakeholders

| | |
|---|---|
| **Title of the guidelines:** | **GUIDELINES TO SUPPORT STUDENT REGISTERED COUNSELLORS DURING PRACTICUM TRAINING** |
| **Principal authors** | PhD Candidate: Ms Mphephu K.E<br>Supervisor: Prof Mulaudzi M.T<br>Co-Supervisor: Dr Takalani F. J |
| **Guideline development group (GDG)** | The GDG comprised:<br>One clinical psychologist (Co-ordinator at student counselling unit U.L).<br>Two former BPsych co-ordinators at Univen.<br>One Registered counsellor (Functional supervisor).<br>One employee wellness practitioner.<br>One Current BPsych programme co-ordinator at the university of Venda. |
| **Duration** | 12 months, from April 2020 to March 2021 |
| | The reason for the 12-month duration was to come up with evidence-based clinical guidelines and to afford the GDC an opportunity to refine the guidelines. |
| **Clinical problem** | Student registered counsellors are not exempt from the negative effects of trauma work. The present guidelines will assist to identify and support students who experience challenges while offering counselling to various clients during practicum training. |
| **Care providers** | Functional and clinical supervisors |
| **Consumers** | Student registered counsellors |

| | |
|---|---|
| **Review date** | Three (3) years or when there is new study with new recommendations |
| **Setting for guideline implementation** | All the organisations proving practicum training for student registered counsellors in the Limpopo province. |

## 8.13. Guidelines and recommendations

**Table 8.3:** Recommendation 1

| Provide Student registered counsellors with exposure to real clients in a counselling session before they start with practicum. | |
|---|---|
| **Guideline 1** | |
| **1.1** | Provide student registered counsellors with enough role plays and simulations of a counselling session in class. |
| **1.2** | Identify modules in which students will be taken to observe/ experience a counselling session with a real client. |
| **1.3** | Student registered counsellors should get exposure to a real counselling session during their second year of study. |
| **1.4** | Student registered counsellors should get exposure to a real counselling session during their third year of study. |

**Table 8.4:** Recommendation 2

| Provision of practicum preparation workshops. | |
|---|---|
| **Guideline 2** | |
| **2.1** | The training institution must conduct more than one practicum preparation |

| | |
|---|---|
| | workshop for student registered counsellors. |
| **2.2** | The first practicum preparation workshop to be conducted for student registered counsellors during the first quarter of their final year of study. |
| **2.3** | The second practicum preparation workshop to be conducted for student registered counsellors during the second quarter of their final year of study. |
| **2.4** | The third practicum preparation workshop to be conducted for student registered counsellors during the last week before they leave to go and resume practicum at different placement sites. |
| **2.5** | The BPsych coordinator at the university must ensure that the students are available to attend these workshops. |
| **2.6** | The practicum preparatory workshops must cover topics related to practicum such as, expectations, time management, professionalism, filing, counselling skills, case formulation and conceptualisation. |
| **2.7** | The practicum preparatory workshops must also teach student registered counsellors about the importance of self-care during practicum. They must be taught about burnout, secondary trauma and countertransference. |

**Table 8.5:** Recommendation 3

| **Provision of adequate office space for student registered counsellors.** | |
|---|---|
| **Guideline 3** | |
| **3.1** | Practicum training institutions are required to provide office space to student registered counsellors. |
| **3.2** | Practicum training sites to identify how many students they can accommodate in their offices before allowing them to be placed at their |

| | |
|---|---|
| | organisation. |
| **3.3** | Practicum training sites must avoid sharing of office space between student registered counsellors. |
| | |

**Table 8.6:** Recommendation 4

| **Availability of younger clinical supervisors at practicum site.** | |
|---|---|
| **Guideline 4** | |
| **4.1** | Placement sites to have a combination of both younger and older supervisors. |
| **4.2** | Availability of younger supervisors at placement sites to mentor the student registered counsellors. |

**Table 8.7:** Recommendation 5

| **Provide workshops during practicum training.** | |
|---|---|
| **Guideline 5** | |
| **5.1** | Clinical supervisors must identify areas in which students require help or need to be trained on during practicum. |
| **5.2** | Clinical supervisors must be available for student counsellors to attend workshops during practicum. |
| **5.3** | A minimum of two workshops should be provided during practicum. |

| | |
|---|---|
| **5.4** | Workshops during practicum should give student registered counsellors a chance to share their experiences and challenges. |

**Table 8.8:** Recommendation 6

| **Provide continuous supervision and counselling for student registered counsellors during practicum.** | |
|---|---|
| **Guideline 6** | |
| **6.1** | Clinical supervisors must provide supervision for students on a weekly basis. |
| **6.2** | Clinical supervisors must identify student registered counsellors who are in need of supervision and counselling. |
| **6.3** | Clinical supervisors must provide debriefing for student registered counsellors who need it. |
| **6.4** | Provide sufficient support and refer students for counselling if there is a need during training. |
| **6.5** | Student registered counsellors should be able to consult with supervisors at any time if they experience any challenges during practicum, whether it is related to their training or personal. |
| **6.6** | All concerns raised by student registered counsellors during clinical supervision and or counselling must be resolved soon so that their learning is not affected. |

**Table 8.9: Recommendation 7**

| Ensure that student registered counsellors receive maximum exposure to clients and training | |
|---|---|
| **Guideline 7** | |
| **7.1** | Clinical supervisors must make sure that student registered counsellors get an opportunity to first observe and then see as many clients as possible. |
| **7.2** | Afford student registered counsellors as much time as possible to see clients. |
| **7.3** | Student registered counsellors must not be engaged in other activities that will make them miss the opportunity to be with a client. |
| **7.4** | Student registered counsellors should not be put at a disadvantage if they refuse to do other activities for the clinical supervisor instead of attending to a session with a client, |

**Table 8.10: Recommendation 8**

| Offer enough functional supervision to student registered counsellors during practicum. | |
|---|---|
| **Guideline 8** | |
| **8.1** | Student registered counsellors must receive functional supervision at least |

| | |
|---|---|
| | once each month |
| **8.2** | Student registered counsellors must be given time to engage in functional supervision. |
| **8.3** | Student registered counsellors should be allowed to set an appointment with the functional supervisor at any given time during the practicum. |
| **8.4** | All concerns raised by student registered counsellors during functional supervision must be attended to immediately so that their learning is not affected. |

**Table 8.11: Recommendation 9**

| **Student registered counsellors must be given time to attend to both practicum work and research work** | |
|---|---|
| **Guideline 9** | |
| **9.1** | Student registered counsellors must be provided with time management skills for practicum. |
| **9.2** | Student registered counsellors should be given at least one day in a week to work on their research and on their portfolio of evidence |
| **9.3** | Student registered counsellors must be allowed to go to the University to consult with their research supervisors. |

**Table 8.12: Recommendation 10**

| Communication between BPsych coordinators at the training institution and at the practicum site. | |
|---|---|
| Guideline 10 | |
| **10.1** | BPsych coordinators must communicate regularly. |
| **10.2** | Co-ordinators must discuss all aspects related to student training such as supervision and how assessment of learning will be done. |
| **10.3** | BPsych coordinators must have a meeting schedule. |

## 8.14. Guideline Appraisal

The Appraisal of Guidelines for Research and Evaluation, Global Rating Scale (AGREE GRS) was used as an instrument to evaluate the proposed guidelines. According to Lohr and Field (1992) the purpose of the AGREE Instrument is to provide a framework for assessing the quality of clinical practice guidelines. These guidelines are developed statements used to assist practitioner and patient decisions about appropriate health care. Clinical practice guidelines make recommendations that influence what clinicians do.

The quality of clinical practice guidelines means that the potential biases of guideline development have been addressed adequately and that the recommendations are valid and feasible for practice. Ensuring the quality of guidelines involves considering the benefits, harms, and costs of the recommendation. The AGREE GRS is a shorter and refined version of the AGREE II that was developed in 2012. The AGREE GRS is based

on the AGREE II; it is a short item tool to evaluate the quality and reporting of practice guidelines. It includes the following items for assessment: overall quality of guideline development methods; and overall quality of guideline presentation. This instrument is used to assess the quality of reporting, and the quality of the recommendations that are made. The AGREE instrument measures the validity of the guideline (the likelihood of it achieving its intended outcome), and not the impact of the guideline on patient's outcome.

The AGREE GRS brings the following items of guideline development into consideration: the process of development; the presentation style; completeness of reporting; and the clinical validity of the guidelines. The assessment of guidelines involves checking the methods used for developing the guidelines; the content of the final recommendations; and the factors linked to their uptake. A minimum of two appraisers and preferably four are required to increase reliability of the assessment. The AGREE GRS instrument is in (Appendix H).

### 8.15. Conclusion

SRCs like any other mental health workers encounter a lot of challenges that come with working with various clients, especially trauma clients. SRCs are not safe from the challenges encountered by other mental health workers. They are at risk of developing conditions such as vicarious trauma which can affect their overall functioning.

Many studies have been conducted to understand the challenges that come with mental health work and how these challenges affect people differently. The current guidelines were formulated based on findings from a study conducted with RCs who shared their experiences of working with various clients during practicum. The formulated guidelines are meant to help SRCs to overcome challenges so that they can learn as much as they can without interference.

The guidelines propose that during the third and the final year of study, students should get at least three exposures to real clients in a counselling session, as this will help them to deal with the anxiety of offering counselling to a client for the first-time during practicum. Secondly, the training institution must conduct more than one practicum preparation

workshop. Currently, students get one workshop before they leave for practicums. This recommendation is applicable, as it suggest a minimum of three workshop as compared to the one that is only offered. The training institution must make sure that they make time for three practicum preparation workshops in the final year wherein full details about what is expected from students during practicum is shared with the students, as a way of preparing them for the coming six months that they will spend doing the practicum.

The third recommendation is that the practicum training institutions are required to create and offer more office space so that the SRCs will get to see more clients and learn more instead of sharing an office and getting less exposure as a result. This can be achieved if practicum institutions can organise more offices for SRCs or only take the number of students that can be accommodated in the available offices.

The fourth aspect that can be applied, is that younger clinical supervisors should be made available to SRCs during practicum, as they indicated in the study, that they will be freer to learn around younger supervisors as compared with older supervisors. This will only be applicable at placement sites that have younger supervisors to mentor the SRCs.

The fifth recommendation on the guideline is applicable, as it requires a minimum of three workshops during practicum wherein students get to share their experiences with supervisors and peers. These workshops during practicum can be achieved by setting a day aside once in two months to give SRCs time to attend.

The sixth guideline indicates that clinical supervisors must provide supervision and counselling for SRCs during practicum. This guideline was developed after the recommendation from the main study that indicated a need for SRCs to get continuous supervision. During supervision, SRCs can identify what they struggled with during a session with a client, and they can also be given a chance to reflect on their experiences and how they may be affected personally and professionally.

The seventh recommendation was to ensure that SRCs receive maximum exposure to clients and training. This guideline was developed due to the fact that SRCs in the main study indicated that they could have had more time to see clients if the clinical supervisors did not constantly keep sending them to do other chores that are not related to practicum.

SRCs should be given every opportunity that is available for learning content which is beneficial to their professional development. Clinical supervisors should avoid and limit sending these students to other places or to do chores at the expense of their learning.

The eighth recommendation and final guideline is achievable, as it requires the students to use time management skills so that they are able to balance and finish their practicum training and research on time. The practicum preparation workshops that they will receive at the training institution will also equip them with various time management tools that will help them to balance practicum and research work. The supervisors should allow the students to go for research supervision whenever possible as this will reduce the stress of striking a balance between practicum work and research work.

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Appendices

**Appendix: A :Consent letter**

This is a study about ‘Guidelines to support students during practicum training at a selected University in Limpopo Province, South Africa’’

The study aims to investigate the experiences of caring for clients at public hospitals during practicum training. The finding of the study will be used for the benefit of the people (clients) who will be receiving services from registered counselors in Limpopo province and other provinces. The findings will be used to understand the experiences of registered counselors while caring for trauma clients thus also identifying if there are challenges that they encounter during their practicum. This study will help the department of psychology in the University of Venda to see whether their Bachelor of Psychology Students are prepared enough for the practicum. The supervisors of students at hospitals will be able to the challenges experienced by student and to plan on how to address them when training other students in the future.

If you decide to participate in this study your participation will be kept confidential, and private. However, the finding of this study will be made available to the public to read. The findings of this study may also be made available to other stakeholders to enable them to make the recommended changes or adjustments that may be suggested due to the findings.

If you decide to participate on this study, your participation should be at your own free will. Thank you.

Mphephu K.E

Signature:_____

Appendix B: **Consent form**

I will require your approval by printing your name and signing in the space provided below:

I ……..... certify that the consent form has been read out to me and all questions I had, have been answered. I give my consent and agree to participate in this study about development of guidelines to support university of Venda's students during practicum: a case study of psychology professionals in Vhembe district municipality and I have been given a copy of this consent form and information sheet. I furthermore agree that this interview will be audio recorded for quality purposes.

Signature of Participant…….

Name of interviewer…….....

Signature of interviewer ……..

Date…….....

Appendix C: **Interview Guide**

Section 1: Socio-demographic information

1. Age

2. Gender

3. Ethnicity

3. Educational level

4. Occupation

5. Race

Section 2

1. What kind of clients did you offer counseling to during your practicum training?

2. Do you feel that you were well-prepared to offer counselling to trauma clients during practicum?

3. What are the challenges you experienced during practicum training?

4. Were you affected by counselling trauma clients during practicum training?

5. Explain how you were affected by counselling trauma clients during practicum.

6. Did your clinical supervisors at the placement site offer you counselling after seeing clients?'

7. What can be done to assist students who experience challenges while on practicum training?

## Appendix D: Data transcripts

Data transcript

### Section 1: Socio-demographic information

1. Age

P1: 23
P2: 27
P3: 22
P4: 27
P5: 21
P6: 24
P7: 26
P8: 23
P9: 24
P10: 23
P11: 24
P12: 22

### 2. Gender

P1: Female
P2: Female
P3: Male
P4: Female
P5: Female
P6: Male
P7: Male

P8: Male

P9: Male

P10: Female

P11: Female

P12: Female

**3. Ethnicity**

P1: Swati

P2: Swati

P3: Venda

P4: Venda

P5: Indian

P6: Tsonga

P7: Venda

P8: Venda

P9: Venda

P10: Venda

P11: Tsonga

P12: Pedi

**4. Educational level**

P1: BPsych graduate

P2: BPsych graduate

P3: BPsych graduate

P4: BPsych graduate

P5: BPsych graduate

P6: BPsych graduate

P7: BPsych graduate

P8: BPsych graduate

P9: BPsych graduate

P10: Masters student in Counselling

P11: BPsych graduate

P12: BPsych graduate

**5. Race**

P1: Black

P2: Black

P3: Black

P4: Black

P5: African

P6: Black

P7: Black

P8: Black

P9: Black

P10: Black

P11: Black

P12: Black

**SECTION 2: QUESTIONS RELATED TO EXPERIENCES DURING PRACTICUM**

**QUESTION:1. What kind of clients did you offer counselling to during your practicum training?**

**Participant 1**

'Okay, the cases that I saw mostly were sexual assault clients, para suicides and other medical conditions. They had a policy that whenever a patient is diagnosed with HIV or sugar diabetes, if its newly diagnosed, they send them to us. I saw marital problems, relationship problems and trauma in general like motor vehicle accident and so forth."

**Participant:2**

"Most of the clients that I have seen they have ha experience like rape I think I had like. Uhm, I saw 24 clients and out of the 24 I would say roughly maybe 16 were mostly girls

but I also had boys who have been sexually assaulted so these were the most themes that were appearing in the counselling room".

**Interviewer**: So, besides these rape cases did you have others?

**P2:"** Addiction and uhm academic challenges as well and depression, yah".

**Participant:3**

"I saw grief, depression, psychosocial, trauma, behavioural, relational and schizophrenia patients".

**Participant:4**

"so I had Suicide, Relational problems, attempts, psychosomatic, substance use and pregnancies clients. "Yah those were the top cases that I saw". There were times I also clients with symptoms of psychosomatic, somewhere using substances during pregnancy, somewhere using it as a coping mechanism, some for the first time which brought them psychotic features, yes and then yah that's basically what I saw."

**Participant:5**

"Okay I saw multiple aspects, like I saw patients that went para suicide, or para suicide attempt I saw patients whom I referred for depression as well as bipolar…umm also there was a patient that I referred because I was suspecting personality disorder specifically borderline, but it was a personality disorder. I also saw patients who are going through bereavement and miscarriages and inter uterus foetal death, and these are all types of bereavement and miscarriages disorders, also trauma patients, I saw very few sexual assault cases which on the contrary were few as I was expecting a lot. mostly it was para suicides."

**Participant:6**

"Okay clients who were consulting, I was actually seeing every client that has come to consult at the psychology section in the hospital where we were placed. These people were consulting with various kinds of cases, some grief, bereavement, somewhere

psychological disorders that we would identify and make necessary referrals and so on but it was various cases. But most common cases were of depression and grief from neonatal grief and so on, there was a lot of grief and depression cases."

**Participant:7**

"Normally there were youth, age from 16 to 24 they were the most vulnerable and most of them the presenting problem was suicide, some it was due to psychosocial stressors at home, and the second thing was medical related problems in some case some were admitted due to stroke perhaps so they were referred for psychological intervention. them

**Interviewer**: Do you want to add or is that all?

**P7:** 'And in some cases more especially with those of suicide during the session you may find that they were likely to present with attention seeking disorder symptoms because the reason or the motive behind suicide attempt is sort of at home they were denying them to do certain things or denying them to buy them clothes, deny to give them cell phones and also the parenting style in which the parents used could also lead to some committing suicide or attempting."

**Participant:8**

" I saw different clients depending on the issue at hand, for instance , I saw older patient ranging from the age of 65 to 75 and I also the case of a seven year old with my supervisor wherein they were referred for psychometric testing and then I also saw youth ranging from ages 18 to 35 and adults ranging from 35 to 60.

**Participant:9**

"I saw a variety of patients that included para suicides, trauma clients because of the high rates of violence in our country .and then there was a large number of rape cases that I had to attend to. In terms of ages, I saw the young and old even though the old did not want to talk to a young person".

**Participant:10**

"So I was placed at a university in a student counselling centre and mostly for me the clients were just students, yah it was fellow students who were studying there and in addition we also conducted tests and psychometric assessment and also went to schools and conducted tests there and did psychoeducation, yah it was basically counselling for students but we did other activities besides counselling."

**Participant:11**

" I offered counselling to trauma patients and these are patients that have experienced any type of domestic violence, sexual assault and patients who were nearly diagnosed with HIV or patients who had the virus as well as patients who tried to commit suicide as well as patients who had experienced the death of a loved one and had a very huge difficulty accepting that their loved one is no longer there with them."

**Participant:12**

"I saw a lot of rape cases as compared to other clients' that were about academic challenges and depression ,referred for grief and psychotic characteristics, and domestic violence cases where mostly women were abused by their spouses."

**2.Do you feel that you were well-prepared to offer counselling to trauma clients during practicum?**

**Participant1**

'I would say that I was well prepared or ready, I was nervous and anxious and everything but then I was prepared well prepared. My supervisors, both my supervisors provided me with the necessary help for me to be able to provide counselling to the client.

**Interviewer:** So, you are saying your supervisors played a huge role?

**P1:** "Yes, they did play a huge role.

**Participant 2**

“In terms of preparation. not well but I didn’t struggle a lot and as well the help from my supervisors was tremendous because she was always there, so I didn’t have a lot of challenges.”

**Participant:3**

I honestly feel that I was well prepared academically by the University before going to my practicum. The second thing that helped is when supervisors all of us to observe the first session when they are with a client.

**Participant: 4**

“During the first week of the practicum I was not emotionally stable after I lost a parent but through that we managed to work around by attending psychological counselling by the clinical psychologist at the university and I was also receiving support from my supervisor and counselling related to grief since I was still grieving myself but I also managed to see a few patients, but in all the cases it was suicide attempt patients, there was one that had convulsion symptoms and the other one was psychosocial stressors, so yah.” So I would say that I was prepared after the first few weeks.”

**Interviewer:** You talked more about preparation from the practicum site can you talk about preparation from the University:

**P4:** “yes looking at all the theory work that we did and the practical examples that we were given here on campus it was an emotional preparation as well, so we were well prepared before going to practicums.”

**Participant:5**

“ yes I think what helped me to be well prepared was the fact that I had a period of three weeks for observation so that helped me know actually what counselling is like and the techniques that different counsellors use like I did not have exposure to only one counsellor, we were four in the department and I used to have experiences from everybody so I used to observe all of them, I tried to adapt their styles and see until I

find a technique of my own style so I think it was very helpful for me, I did gain the confidence to be able to be with clients.

**Interviewer:** So besides the support from the onsite supervisor do you feel that the university prepared you enough?

**P5**: Yes the background knowledge that we were given ,I think it was very good especially ethics as well as the counselling techniques that we learned from the university were very handy because that's how we learned how to establish rapport and stuff ,so when I went to the clinical setting it was actually like applying the knowledge that I have learned so its seeing the practice from theory so I think it was effective.

**Participant:6**

"Yeah I think I was in terms of theory I was well prepared, I had enough information you know to use ,enough theory to materialise into practical service in a manner ..um the only thing I can say I wasn't prepared with is that I was still tired ,still coming from class with a lot of pressure, so coming straight from class with a lot of assignments and exams and so on straight to practicum going to spend the whole day for six months from half past seven to half past four it was a lot tiresome. With everything I was not prepared but I was prepared theoretically and so on yah".

**Participant: 7**

"Mmmm I might say yes in some cases but in other circumstances no, because you will never know what the patient when he or she comes to counselling what they are going to present about because they wont say I have PTSD for example, they will just present with symptoms of PTSD which some according to DSM ,some they are similar with ASD but if you were well prepared with the scope of practice and took the training during level four, some cases for sure you will be prepared."

**Participant:8**

"Depending on the practicum, we talking about the institution or the supervisor?

**Interviewer:** You can talk about both.

**P8:** "Okay I felt like the institution prepared me well, they offered enough training with the sufficient knowledge and I would also say materials that covered what was expected of me at the time and when I went to the practicum area I was offered more than enough , I can say that I had a great supervisor who took me through training we went for training through the department of health . we also went for training in the hospital and my supervisor was there in the first session as to guide me here and there so I felt that I was prepared more than what I could ask for."

**Participant: 9**

"I think it's safe to say I was well prepared for the practicum , we were taught about the theories and all that, plus we did role plays ,however it is not the same when you have an actual real client seated in front of you. At the end of the day, one is able to adjust and gather the confidence to see clients alone."

**Participant:10**

" I think theoretically I feel that I was well prepared but obviously a person will experience just like other people I experienced anxiety like how am I going to do this but I think theoretically based on what I was taught during my degree I was well prepared it's just that once the practicum started and we started seeing clients we realised that it's not so easy to transfer theoretical knowledge to practical life situations that was just the challenge because it feels like no matter how much information you have it will never be the same when you see a client because in the text book you will read that if you see a client who comes with this symptoms this is what you do but when you get to a counselling session with a client it's not just like that…this is a person who have a background history there are different attitudes to as counsellors ,the way we do things and so on ,so yah it was just quiet challenging although I felt I was prepared theoretically, just the practicum side of it was challenging for me."

**Participant:11**

" No I don't think I was fully prepared because we were only offered with one class that actually taught us how to counsel a patient and I think that when I went to practicum and I had to interview my first client it was extremely difficult for me to counsel them because um the way in which we were taught at school and the way that our onsite supervisors did it was completely different ,so I dint know which approach I had to follow so I think in that sense and I wasn't that well prepared."

**Participant: 12**

"I personally feel that I was not well prepared or ready to see clients however after getting support from the supervisors everything became less stressful."

**QUESTION:3. What are the challenges you experienced during practicum training?**

**Participant:1**

"The top it would be language barrier, because I am Swati speaking, I was placed in Tsonga mixed with Pedi environment so language will be a barrier and the fact that it was a rural hospital not all of the patients I was seeing were able to talk and relate in English so that was the first challenge that I encountered and then secondly it was my body structure when they would find me in the office , they will be like I'm not going to share my problems you, you are a child ( she laughs), so it would be difficult for me to ensure and reassure them that I know what I am doing and everything, and yah the environment in terms of the res ,it was very depressing because I was placed in a residential area full of elderly people ,so it would be difficult to socialise with them given the fact that you relate to them as they are your mother , so the environment turned to be a bit depressing especially after a long day at work coming back to the room."

**Participant: 2**

"Adjustment …I was struggling to adjust because I felt so all alone and then uhmm the work load was too much so I had to learn how to balance and manage my time well

because I was always tired and stuff yah, and pretty much we had a lot of projects so I had to juggle in between writing reports and seeing clients and having community engagements and all of those things so it was a bit too much."

**Interviewer:** Are these the only challenges you experienced?

**P2:** 'Also I couldn't finish my project in time because of the workload I couldn't balance the two, the practicum work and the research."

**Participant:3**

' okay some the challenges was that we had to go for outreach intervention but was transport issues and we couldn't go for going out to conduct the outreach. And then another challenge was the issue of space was a bigger challenge because we had to share one office sometimes you may find there is a lot of clients who are sitting outside and then we have to wait for another one to finish hiss or her session before going Inayah so yah that was 1 the other challenges soo yah I think that's all."

Interviewer: so you mentioned challenges in the office ,did you experience any challenges with seeing clients?

"Mm yah sometimes you may find that eh I was seeing a substance use client who was busy showing symptoms and then I had to refer the client but I had this issue were the client said that he will not allow me to, he will not go to another person for counselling, so I told him my scope of practice but he refused and said he is not going anywhere else he want to be counselled by me."

**Participant:4**

" Okay the first thing that was a challenge when I started offering psychological services was that we all tried to have like a definition of being perfect but you can never be perfect, and everyone has their own way ,so you think that saying something makes you feel incompetent to do something because of the way in which the person is going to respond so you feel as if the question you asked ifs irrelevant to what the patient is coming across. So you feel that you are not competent enough, looking at the observations that we have been doing with our supervisors before we saw patients, it was like you feel as though you are not doing what is expected f you, some challenges were that you actually

come across patients who do not want to ventilate ,some have an attitude towards you because they saw me as a small girl simply because I have a small body and I'm short so the actually thought that they can't be ventilating and talking about their problems with someone this young. There was an incident when a patient came and when we had to assist she said no ,whatever problem that she is coming across is too much for young people to handle, so it sometimes makes you feel that probably you are not competent enough.so it also becomes a challenge when you come across such things…yes".

**Interviewer**: So these are all the challenges

**P4:** We also had challenges of consulting rooms because there were only two offices and so we had to give space to each other, yes".

**Participant:5**

"Because I was placed in Mokopane Voortrekker hospital…um I ,and I'm actually from Venda, language was a bit of a barrier but it wasn't that difficult because when I had patients who could speak in English to a point that counselling would be effective it wasn't as bad , and later on I developed a skill of understanding Sepedi as well, so I c could get work done…it was manageable. It was difficult at first because I couldn't understand a single thing but then it gets better with time.

**Interviewer:** So besides language barriers are there other challenges?

**P5:** Yes I did have adjustment issues.

**Partcipant:6**

"I think one most common challenge which is with everyone I believe is with the demand, having to take theory and make it practical, there is a challenge over there because it's no longer role plays its no longer cases written in paper ,but now you are seeing real clients, real people with real matters. There are issues such as countertransference's involved there whereby you will find yourself getting affected by a person's problem because its somehow related to you, you know?. Yah one can find themselves being affected by such then I can say that a number of times I experienced countertransference though I was able to deal with it but that one of the problems I did face as well and then umm one other challenge I would say as a male person or as a guy usually when we go to this practicum sites, these supervisors we are appointed to or I should say those who

choose us, they also choose guys so that they can appoint certain tasks and responsibilities that they think are guy related. I will be honest ,I will tell you the truth, I am tired of going to the mall, buying lunch for people being sent around sometimes disproportionally so when its not necessary at all. You will find such happening .I can say I am tired of sometimes being sent around to banks, sometimes I was unable to see clients as much as I should, so that's some of the problem I faced maybe because I am a male person.

**Participant: 7**

"The first challenge was secondary trauma because it was my first-time experience during the counselling session. I remember there was a case about sugar diabetes that woman was presenting...the MSE of the patient was sadness.., tearful so it was… I don't know countertransference like, I was feeling pity for the patient yah and so the other challenge was that eeh the case presentation… during the oral exam it was challenging because it was our first experience presenting on the podium for people who know who have been on the field for quite some while and as for me it was for the first time. We are given a case where we have to read and talk about the treatment plan, how are going to help the patient, we presented in detail. the challenge were only case presentation and countertransference, no challenge with colleagues."

**Participant:8**

"For me the most difficult challenge that I faced was one…uhm I had a problem of language, I'm Venda and I was working in Botlokwa were they speak Sepedi so it was a bit difficult for me to adjust at first given that the people there are speaking a different language so I needed to learn that particular language and familiarise myself with it so that when I go to sessions sometimes I was having a communication problem or not understanding what the client was trying to say because of the language barrier but as time goes on as I said my supervisor was busy not only teaching me how to counsel but they were also teaching me the language."

"The other issue that I felt I experience was in the part of the University ,I felt that while they took us there to learn and to gain experience they forgot to also show us support

and supervision that we may have needed from people that we are familiar with or that we can share problems that we are facing from the practicum site."

**Participant: 9**

"For me honestly speaking the major thing was the language challenges. I t is not nice to be in front a client and not being confident that you will do enough for them as you can hear them completely, so yes of all the things I was coping well but language was my problem"

**Interviewer:** How did you deal with the language barrier?

**P9**: I had to find a person to teach me this language and in the meantime, try and avoid those who cannot speak English.

**Participant:10**

" The challenges that I faced umm for me the main thing is that I always felt like I was not…I feel like I was struggling to help clients, I felt like I didn't know what I was doing and I don't think I was getting thorough supervision, there was a lot of confusion from the supervisors because there are several psychologist and they were supervising several students as well. During case presentations the ones which are not given marks and everything, ummm… a student will present in front of everyone ,they will present the case and everything and all this people will say different things about the scope of practice, most of them were not sure of what we were supposed to do and what we were not supposed to do and it sort of confused us as interns even more because we asked ourself what are we supposed to do and not to do for instances were I will see a client and I will see a client and then i go to my supervisor and say this is what happened in my session, and they will say I know you heard the other supervisor saying you are not supposed to do this but I am telling you to do this, so for me that was the challenge, feeling like I was not making any progress and not knowing what exactly I was doing.

One of the outstanding challenges that I faced when I was offering counselling was when I saw a client who presented with symptoms related to schizophrenia ,we were not told that we were not supposed to see clients who presented with such symptoms if we see them we must automatically refer and all of that, I saw the client for like an hour or so then she was just behaving in a strange way and all that and made me really afraid of seeing clients again and I didn't receive any debriefing whatsoever…everything just continued as if it was normal they didn't ask me how I was affected by it she was just angry that I saw the client at that time even though I didn't know I was not supposed to see the client. So for long time I was afraid to see clients and I had already told myself that in the future I don't want to work with such people because I don't know how to handle them ,,like that could have been handled in a better way like debriefing."

**Participant: 11**

"The first challenge would be the language barrier because I speak Tsonga and I was doing my practicum at Elim hospital and most of the people that stayed there spoke Venda, so that for me was extremely difficult because my Venda is not that great. That was my first challenge, my second challenge was trying to counsel the patient while having to write everything down in their file , it was just extremely difficult to multitask between those two because you wanted to give all your undivided attention to the patient and but you still have to write everything down in their files so that was part of the challenges that I experienced."

**Participant: 12**

"Adjustment to a new environment and work, loneliness because I know nobody at the new place". The major challenge for me was the workload because I had to see clients then write reports on the other had plan for community outreaches and be busy with my research project. So basically, striking a balance between practicum work and research is a major challenge." I also struggled a lot with my research work.

**QUESTION 4. Were you affected by counselling trauma clients during practicum training?**

**Participant:1**

" With trauma, umm it affected me , it got to me especially because like there was this other case it was similar you would experience counter transference so it would be difficult for you to…( she pauses), I have never been involved in a car accident before, so when you relate to the patient trying to make the patient know it's a bit difficult because some will say you have never been in the situation ,so with trauma it was a bit challenging."

**Participant:2**

"Yes I think so, there were times when I was scared to go to my room alone were I stay. I would be thinking about the trauma that my client told me about and I would be thinking what if the same thing happens to me since I'm staying alone. I had to seek professional help, so I sought counselling.

**Participant:3**

"I would not say that I was affected because I was well prepared at school that we might come across challenges and then we must not allow things like personal impairment ..we must not allow ourselves to be affected by those things that our client are experiencing, so I don't think I was affected negatively.".

**Participant:4**

" Most of them ha d a positive effect or impact on me because it made me realise that there is a lot of situations that traumatise people .so different people are traumatised by different situations, so it made me have a different outlook on how people see things and how they view things rather than only on what I have experienced as traumatic ,so that has made me learn and understand a lot of people and different people at the same time.

**Participant: 5**

"Umhhh not really but I think debriefing is helpful so because I had received constant debriefing over my cases I think I was good. Had it not been for debriefing I think it is easy for one to be traumatised depending on the cases we see and the heaviness of the case.

**Interviewer**: To follow up on that how often did you have debriefing?

**P5:** With us my supervisor told me from the onset that whenever a case is too overwhelming or a session becomes too overwhelming make sure you see anybody from our department immediately after, so it was always done that was there was no specific time but whenever I felt I need to speak there will always be room for me.

**Participant:6**

"Not at all. Everything was okay."

**Participant:7**

"In some cases I was affected because I remember I saw this patient, it was a female patient who was involved in motor vehicle accident, on the scene she was with her mother in law ,her husband and her younger sister…unfortunately the mother in law passed away and the patient sustained severe head injuries, her husband was referred to Polokwane because he was in critical condition and her younger sister sustained pelvic bone injury, so during the first session she was crying nonstop ,I ended up not knowing what to do, so I was affected by that I ended up asking for time off at work fortunately I was having good with the supervisor, she allowed me to have a bit of time to rest because it was my first time experiencing such.

**Interviewer**: To follow up on that, how long were you given time off?

**P7:** I saw the patient in the morning ,I think she was my first client then after the session I asked my supervisor if I can go home to rest then she agreed so I went home for the afternoon. The next day when I came to work she firstly talked to me to find out how I am doing and feeling.

**Participant:8**

"No."

**Participant:9**

Not really, the only depressing thing for me was that the environment I was working in had colleagues who are older than me and I could not relate to them, that's all.

**Participant:10**

“ Yes I was affected because trauma clients seemed to be the most difficult to deal with because of the traumatising content that they will be sharing during counselling. So yah there is no way a person can say they were not somehow affected because of the nature of trauma work.”

**Participant: 11**

“Yes I was especially with an individual that I experienced in a form of sexual harassment or domestic violence. That for me really affected me because it’s just difficult for any women to hear that you know something horrible such as rape or sexual abuse has happened to another women so I think that for me was really hard and it just made me start being anxious about everything that I do ,following all of that.”

**Participant: 12**

“ The only problem I had at the accommodation was when the university finance department was delaying to pay the landlords and they will be reminding us about their money as if we are crooks. The other is misuse of power by supervisor such as making tea and being sent to buy things whereas one is there to learn it was not good because you cannot say no with the fear that you will fail.”

**QUESTION:5. Explain how you were affected by counselling trauma clients during practicum.**

**Participant:1**

‘affected me, it got to me when I saw a case that was similar I experienced Countertransference, .some of the clients will tell you that you won’t understand them because you have never been in a similar situation and did not experience what they went through .”

**Participant:2**

“As I have indicated I would experience secondary trauma and have fear of being alone”.

**Participant:3**

"As I was seeing clients I only thought that maybe the problems that where out there were those that I am aware of so I dint know that people can experience those problems to an extent that a its more severe than what I know so I was able to see and I learned new perspectives about how others are experiencing their problems. I can say that there is growth in me".

**Participant:4**

" Okay to add some were a negative effect because after the process of grieving I had to see clients who required grief counselling so it would sometimes bring back the whole experience that you experienced which you felt it was negative, while at some point it can be positive because while you are helping another person its making you understand more on how you should be healing yourself rather than having to tell another person on how to understand what they are going through while you cant even understand what you are going through.

**Participant: 5**

I can say that…ummm I don't know….(pauses).i think when clients would give in-depth details it does get overwhelming but grounding techniques often help, coming back to reality em ,assuring the client the worst is over and seeing a positive change always helps.

**Participant:6**

"I was affected, I think it was my opportunity to grow, yes I do realise that people do face problems in life but its not as normal as I used to think it was ,people can be affected in a huge way by things we consider to be little by things we deem so small then they get affected by such ,so it taught me not to undermine people's problems, not to undermine people who are in pain, people who are crying, people who are bothered by various problems of life uhm.one other thing is that it was an opportunity for me to grow in terms of my profession and then again I gained a lot of experience in counselling and use of assessment tests and so on. So yah I was affected positively.

**Participant :7**

"I might say I was emotionally affected eeh seeing that patient crying in front of me non stop even what she was presenting, that thing provoked my emotions in such a way that during the session… I don't know how I may put it ( Ndo vha ndi khou tou di fara) in such a way that eh I ..my .. I wanted to cry by then but because it's during the session if the client is crying I don't have to cry , who is going to comfort someone ..so I ended behaving myself not to cry in such a manner that even when I went home I was thinking about what she was saying trying to imagine the incident and how it occurred as she said it was an unexpected accident that happened as she was changing the line and then boom another car hit hers on the side of where the mother in law was sitting that's why she passed away. She was also putting the blame on herself to say what if she was driving recklessly."

**Participant:8**

"Okay ,during the time I can say that I was positively and negatively affected ,first of all during the counselling sessions I realised that there are lot of gaps between academics and the population itself meaning that when you are counselling you need to have a scale of saying this person is suffering from trauma and then you need to classify that trauma whether its ASD ,PTSD or its just adjustment, so given that the academic content provides a certain guideline.

It does not meet the criteria, I mean the people were suffering from trauma but they did not meet the criteria or what they were experiencing is not in the criteria so the only challenge that I had or the only thing that affected me was that the books are not really explaining what African people in particular are facing, it is rather in a western way. I was positively affected to say as a person I need to do something maybe to align academics with the population."

**Participant:9**

"I was really affected I wont lie…dealing with trauma cases is a big challenge because most cases are scary and painful at the same time ,so as a human being yourself it affects

you. Most of the time after a trauma case I would be feeling down and rethinking what the client just told me inside the office and imagine if it happened to someone I knew and loved or even if it happened to me, its not good hey."

**Participant:10**

"I would say I was affected by the fact that I didn't know what I was doing , so I didn't feel like I was not helping clients to actually overcome a certain issue that they presented during a session."

**Participant:11**

" Yes I was especially with individuals who had experienced any form of sexual assault or domestic violence umm..that for me really affected me because its just difficult for any woman to hear that something horrible such as rape or sexual abuse has happened to another woman so I think that for me was really hard and it just made me start being you know… anxious about anything that I would do following all of that".

**Participant:12**

"I would say I was affected because I felt like carrying the clients troubles on my own shoulders more especially because I also saw a lot of rape client and am a women ,so I took their experiences personal as if they were mine besides that I was sympathising I would not say I was affected."

**QUESTION:6. Did your supervisors at the training placement offer you counselling after seeing clients?**

**Participant: 1**

'Yes , yes they did ,with every trauma case, they debrief me and assure me to say don't take every problems and make them your own, don't personalise the patients problems but then so that you will be able to go through the day and see another patient."

**Interviewer**: So explain how this was helpful to you.

**P1:** "So we had this internal joke, if you were traumatised ,they would give that trauma a name and every day we would joke about until you say that this is just a joke, so they normalise the situation for me."

**Participant:2**

“Yes they did refer me to another psychologist for counselling after I indicated that I am experiencing secondary trauma”.

**Participant:3**

“Offer counselling?”

**Interviewer**: YES

**P3**: NO…sometimes, but well just sit around and talk about what we are facing and she would just comfort based on what happened during the sessions and told us not to overwhelm ourselves.

**Participant: 4**

“I can’t necessarily say counselling, but they would ask us after each month the experience in which we experienced during the counselling of a patients, what challenges we came across, what we did not understand and so forth. They also gave us the platform that if we are seeing a patient and there was something that we were not understanding in terms of probably the, symptoms and duration we could ask for clarity, so that we should not at least offer counselling on something that is not relevant for the patient.

**Participant: 5**

“ We would have supervision on our cases so for every case that I saw in a week, so towards the week we will have supervision and if some days we have gaps like with no clients we would update ourselves with the cases, so i did have ..i don’t know if I can call it counselling but it was more of a supervision wherein we would share ideas like how I handled the situation ,what I could do better and where was the pitfall, so those are the things we discussed. We can call that debriefing I guess because we were discussing the case”.

**Participant: 6**

“Never at all.”

**Interviewer:** Can you tell me then what happened after you saw clients.

**P6**: okay at first, we would (scratches head) we have been communicating with other students and some were meeting very regularly but in my case we didn't really have that regular meeting.in writing it was there that we should meet every Thursday but such was never done. I don't know the reason why but we didn't meet with the supervisors, we were just together in the office working. only when we are facing challenges and we have curiosities then and there we would consult but we have never had this supervision sessions.

**Participant: 7**

"Yah normally she did…on the second day as I have indicated that during the time that I came back at work ehhm she asked me, it was not normally a full session but she was just asking questions like how are you feeling ,any challenges/ and I just told her that no im fine and im trying to deal with my own issues."

**Participant:8**

"Yes there were times when we were offered counselling sessions or debriefing and the where times were we also went somewhere just to clear our minds and also for supervisors to like say to us what we are going through is normal and as practitioners especially psychologist we may also be exposed to challenges."

**Interviewer**: when you say you went out do you mean within the hospital premises

**P8:** "No we went out we went to the Elias resort for a day ,we sat down we talked about our challenges that we faced in that particular time and what they ca potentially do to us."

**Participant:9**

'I was offered counselling after every trauma case that I treated. This exercise was helpful as we will talk about the trauma."

**Participant:10**

“That never happened ,just as I explained with the challenge that I faced I was never offered any sort of counselling. whenever I saw a client I would go to the supervisor and explain the case she would ask what do you plan to do and so on, do this do that. There was never any form of debriefing is was supervision only, that was the only thing that haopped thee is no counselling at all.

**Participant:11**

“No , I don’t remember them doing that , yah I don’t remember them doing that.”

**Participant:12**

“Not really.. I would only go and make consultation if I was experiencing challenges for example I was struggling to come up with a treatment plan after I saw a client or any other difficulty that I encountered in a session’.

**QUESTION:7. What can be done to assist students who experience challenges while on practicum training?**

**Participant:1**

“ uhmm what I feel needs to be done based on my experience I think it would be to in terms of the department, hiring or finding more younger people in the work environment so that it is easy for you to relate to your own peers if ever you feel stuck or anything else, and also what can be improved again would be the workload that is there. Hiring more trauma counsellor being there …it was a regional hospital it was over flooding everyday with clients, so you get overwhelmed with the workload so hiring more trauma counsellors in the hospital setting rather than just having one because we had one. When you are in the office you are like a vessel, everyone just comes and pours something on you, so it would be nice I think it can be improved in terms of finding more trauma counsellors and more umhh… let me just put it like more workshops were you can go debrief and talk about your experiences as students who are in hospital or counselling section and a share experiences and find out what other students are

experiencing in order for you to know like if this one managed to cope with this maybe I can also try to utilise that"

**Interviewer:** so when you say hire more trauma counsellors you are referring to the ones working at hospitals or you mean we need to place more students there?".

**P1**: "In terms of regional hospitals I would prefer that the hospital should at least absorb three or have three students there."

**Participant: 2**

"I suggest there should be well prepared in advance about the workload that is required from them ,there should be more awareness about that, then number two there should be like before they could even start counselling others they should seek counselling themselves and the number three learn how to balance uhmm their social life and work ..yah…"

**Interviewer:** Anything you would want to add?

**P2:"** Yah, reports can't we just like type monthly reports and okay the schedule and monthly report because typing weekly is a lot.

**Participant:3**

"Okay maybe if you can just like make students aware of what to expect, what kind of challenges that are there so that might be able to get the idea and that they may be able to prepare themselves so they can overcome those challenges, so awareness of what they will face."

**Participant:4**

"I would suggest that probably after a month or two there be a workshop or sort of like a mini meeting where we all discuss with our supervisor ,what challenges we came across so that at least you may find that we are all coming across with similar challenges but because me and my colleague we are coming across the same challenges and situation we can't able to assist each other because it's a challenge to both of us but if we can sit and talk about it and probably organise a workshop that can help."

**Participant: 5**

"I think my practicum experience was actually really nice because of the constant support I have been receiving from my supervisor, so I would recommend that its nice if everybody, every student has a supervisor like that who is supportive and motivating and encouraging because that keeps the student motivated and it keeps the students looking forward to the next day and as a University I think also it would be nice if Universities would constantly check on their students to say how is practicums?, how are you guys keeping up?, just support is very good."

**Participant:6**

" Uhmm this one will be difficult to deal with because of it's a bit external but I would say the supervisors that are appointed by the University as in our lecturers, they should have a this close interaction and communication with students as they are supposed to come to the practicum and check what is going on and check how things are going, they should also give students the opportunity to open up and talk about issues they are facing so that they don't wait for six months to end then they deal with matters ,some of which have potential to interfere with them functioning properly during internship so if certain issues are dealt with on time then it can do better. Students are affected by issues that need serious intervention because some will be having issues with their supervisors or receiving bad treatment because some supervisors have their own personal issues. If the university appointed supervisor is not communicating with the student, then the student suffers. It would do better if supervisors get a bit closer to the students it will be better."

**Participant:7**

" I think the workshops ,because I remember we only had the one workshop the time we were leaving for practical's and also the role plays in classes because some of the role plays were not serious it was not the actual point, then the first time when you see the client you don't know how to conduct the session or some they don't have supervisors on their sites. I remember I heard some of the students who were placed at higher education

,there was no on site supervisor they were only supervised by the lecturers from the University, they don't have that time wherein they will observe a session from the supervisor, how is the session conducted so they end up doing things that they know which they think is correct or true whereas it's not true because they haven't observed any session from their supervisor or how it should be conducted. The other way is to try and squeeze students in the department of health sort of hospitals and clinics wherein they will be supervisors because they are more likely to have more exposure and experience. In the higher education institutions, it might happen that they see two or three clients in a week and those ones will be having challenges on their studies so at health institutions they are more likely to see different types of cases and presenting problems."

**Participant:8**

"For me what I would like to see is the involvement of the University, for me as a student who is coming from Thohoyandou to a different place I felt that obviously as a person I will be exposed to challenges, language , adjustment but I did not have any one from the university to support me or even care or even come check where I am staying or check how I am living ,how are things going . These kinds of things expose other learners to move challenges given that some people do not have any support at all and they are far far away from home, so I felt that the University needs to be more involved so that they show they are more caring and empathetic to their students.

**Interviewer:** Is there anything you would like to add?

**P:8** "I would like to add that , for practicums I think the University should I'm saying this because I still feel that I am still impacted by this, I was one of the best students who was awarded a certificate for being the best learner but the University and the department of health they are not… I think they have a relationship, but the relationship is not well aligned there is a misalignment given the fact that I got 86 that side and 76 this side, that discrepancy between the institution and the department is not well. There should be a better communication between the two and student, I think the university need to do a follow up to students to say did you understand that you need to do this and that this is the criteria for the university and there is also a criteria for the department of health and I think there is a greater need for transparency particularly between lecturers and who

who ever is in charge of the practicum with learners because there was a lot of misunderstanding between students and the institution itself."

**Participant: 9**

"Having other young people to work with will be helpful because I can relate to them as compared to those older than me."

Secondly there must be group discussions between the registered counsellors where they meet and talk about their experiences and best ways of coping and dealing with challenges they come across during practicum."

**Participant: 10**

"I think one of the most important things is to ..i feel like not just myself but when I was observing other interns we were struggling with how to help clients we didn't know what to do even after six month period I didn't know how to help a client ,I didn't really know how to counsel a client, I knew the counselling skills here and there but really helping a client move past something I didn't know and I also heard my fellow interns saying the same thing and when I am looking at the practicum site, the main problem was not getting thorough supervision and that is where a lot of challenges come from. So, yah the confusion of not knowing what you are doing if you are making any progress of some some sort. I feel like if that if there was supervision of some sort a lot of things would have been better and I think debriefing can help as I have already indicated I never received any form of debriefing, most of the times we were just stressed because of a lot of activities that we were doing to such a point were we did not want to see clients anymore not because we were tired but because we were not getting thorough supervision and that is were a lot of challenges come from so yah, the confusion, not knowing what you are doing, if you are making any progress of some sort yah I feel if there was thorough supervision, a lot of things would have been better and I think debriefing can help. We were never asked how we are doing or anything like that. I just feel like if the supervisors themselves, not just supervisors but maybe if there were workshops for self-care for psychology professionals , that would have helped a lot because we were working just everyday Monday to Friday and we had research ,over the weekend you are still trying

to complete the forms that needed to be completed, so it was work work, work even though we didn't know what we were doing but we were just working and.. even with the ethical dilemmas there wasn't much supervision ,if we had extra supervision a lot of ethical dilemmas we would have been able to solve them on our own. I would just hear a lot of interns complaining that my supervisor is angry at me because I did this and this but if the supervision was thorough that would not have happened because we got there in July we were just doing some orientation ,then in August we started seeing clients after seeing clients we were supervised for a month only after that they would say you can see the client and decide what you want to do with the client whereas we don't know what we are doing.Also a workshop on teamwork to address the stress and tension within groups."

**Participant: 11**

I think the first one would be offering more indepth classes on how to ,and how students could actually counsel patients instead of having just to you know sitting in class and doing role plays and then be be expected to learn everything in that one hour class , I think that is the most fundermental thing , and I think the other thing that could be done would be to basically just like encourage students to understand that whatever they are feeling durind that time is okay to be feeling that way because they are human and you are prone and vulnerable to feel that way especially when someone is telling you all of that and that whenever you are feeling that way it is okay for you to go to your supervisor and explain to them what you are feeling ,then I think the other thing that can also be done is basically teaching student beforehand what can be done to actually write down all the information that needs to go down and that needs to go in in the clients file because when I got there I reslised that is not the same it was presented to as at school and how it was at practicum."

**Participant: 12**

"The thing for me that I think must be improved is better communicatin between the us students and our lecturers back at the university, for instance at least we must be allowed to go for research supervision once a month,the other thing is for onsite supervisors to

offer us better support especially when we have our own personal crisis such as loosing a relative they should not be too strict on us.”

***Appendix E: Ethical clearance***

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
**Mrs KE Mphephu**

**Student No:**
**11530508**

PROJECT TITLE: **Guidelines to support students during practicum at a selected University in Limpopo Province, South Africa.**

PROJECT NO: **SHS/19/PH/22/2410**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

| NAME | INSTITUTION & DEPARTMENT | ROLE |
|---|---|---|
| Prof MT Mulaudzi | University of Venda | Promoter |
| Dr FJ Takalani | University of Venda | Co - Promoter |
| Mrs KE Mphephu | University of Venda | Investigator – Student |

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: October 2019
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2019 -10- 29
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
*"A quality driven financially sustainable, rural-based Comprehensive University"*

## Appendix F Audit letter

Topic:

GUIDELINES TO SUPPORT STUDENTS DURING PRACTICUM TRAINING AT A UNIVERSITY IN LIMPOPO PROVINCE, SOUTH AFRICA

Dear Mrs K. E Mphephu

Receive feedback on the work that you requested me to check. You requested me to assist with an audit trail / checking your data transcripts and the audio recording and to see if the transcripts are a true reflection of what the participants described during the interview. I have taken time to listen to the interview audio recording and I have read the transcripts and the notes you have written during the interviews.

I have checked your work and came to conclude that the data transcripts are a true reflection of what the participants narrated during the interview. I did not pick up any bias information that was added by the researcher to the data. You were accurate in the process of data transcription however I picked u with participant number six you omitted the response to question number 7. I therefore advise that you listen to the audio recording and rectify that omission. I hope that I was helpful in ensuring dependability of your study.

Kind Regards

Chueng M.

_____ Date: 23/12/2021

University of Venda

Faculty of Health Sciences

Research Office

076 393 7514

## Appendix G: The AGREE GRS INSTRUMENT

**APPRAISAL OF GUIDELINES FOR RESEARCH & EVALUATION**
**Global Rating Scale**

**AGREE GRS**


AGREE

November 2017

SUGGESTED CITATION:
Brouwers MC, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G, Fervers B, Graham I, Grimshaw J, Hanna SE. The global rating scale complements the AGREE II in advancing the quality of practice guidelines. J Clin Epidemiol 2012;65(5):526-34; doi: 10.1016/j.jclinepi.2011.10.008

FUNDING:
The development of the AGREE II Instrument was funded by a grant from the Canadian Institutes of Health Research

CIHR IRSC

For more information about the AGREE GRS, please contact the AGREE project office at agree@mcmaster.ca or visit the AGREE website at www.agreetrust.org

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Ms. J Makarski, McMaster University, Hamilton, Ontario, Canada
Dr. L. Zitzelsberger, Quebec, Canada

# AGREE GLOBAL RATING SCALE INSTRUCTIONS

## I. Background

Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances (1), including health promotion, screening, diagnosis, and treatment. The 23-item AGREE II tool has become an international standard to direct the development, reporting and quality appraisal of guideline (2,3); however, user feedback indicates that there is need for a shorter appraisal tool as an alternative to the AGREE II when resources are sparse and application of a comprehensive tool is not feasible. A shorter tool was tested and published in 2012 as the Global Rating Scale (GRS) (4). Reliability testing indicates that the AGREEE GRS was able to predict important outcome measures related to guideline adoption despite its lower sensitivity in detecting differences in guideline quality when compared to AGREE II (4). We continue to recommend the AGREE II as the primary tool to assess the methodological quality of clinical practice guidelines.

## II. Preparing to Use the AGREE Global Rating Scale

### i) Accompanying Guideline Documents

Before applying the AGREE GRS, users should first carefully read the guideline document and any relevant supporting documents published elsewhere.

### ii) Number of Appraisers

We recommend that each guideline be assessed by a minimum of two appraisers to increase the reliability of the assessment.

## III. AGREE Global Rating Scale Items

### i) Items and considerations

The tool consists of four core items:

1. Process of development,
2. Presentation style,
3. Completeness of reporting
4. Clinical validity.

To guide the appraisal, a list of considerations is provided for each item.

### ii) Rating Scale

The four AGREE GRS items are rated on the following 7-point scale:

| Lowest Quality | | | | | | Highest Quality |
|---|---|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** | **6** | **7** |

Score of 1 *(Lowest Quality)*. A score of 1 should be given when there is no information that is relevant to the AGREE GRS item, if the concept is very poorly presented in the guideline, or if the authors explicitly state that the criteria were not met.

Score of 7 *(Highest Quality)*. A score of 7 should be given if the quality of reporting and presentation is exceptional and if the considerations have been fully met.

Scores between 2 and 6. A score between 2 and 6 is assigned when the reporting of the AGREE GRS item does not meet the full considerations. A score is assigned depending on the completeness and quality of reporting and presentation.

It is important to note that item ratings require a level of judgment. The considerations are provided to guide, not to replace, these judgments. Thus, none of the AGREE GRS items provide explicit expectations for each of the 7 points on the scale.

## IV. Overall Assessment

Upon completing the four items, AGREE GRS users are asked to provide three overall assessments of the guideline. The overall quality assessment requires the user to make a judgment as to the quality of the guideline (1=lowest quality, 7=highest quality), taking into account the criteria used in the assessment of the four core items. Users are also asked whether they would recommend the guideline for use in practice and whether they would make use of a guideline of that quality in their own professional decisions (1=strongly disagree, 7=strongly agree).

## References

1. Woolf SH, Grol R, Hutchinson A, Eccles M, Grimshaw J. Clinical guidelines: potential benefits, limitations, and harms of clinical guidelines. BMJ. 1999;318(7182):527-30.
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3. Makarski J, Brouwers MC. The AGREE Enterprise: a decade of advancing clinical practice guidelines. Implement Sci. 2014 Aug 15;9(1):103.
4. Brouwers MC, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G, Fervers B, Graham ID, Grimshaw J, Hanna SE, Littlejohns P, Makarski J, Zitzelsberg L, for the AGREE Next Steps Consortium. The Global Rating Scale complements the AGREE II in advancing the quality of practice guidelines. J Clin Epidemiol 2012;65:526-34.

# AGREE GLOBAL RATING SCALE

**PROCESS OF DEVELOPMENT**

**1. Rate the overall quality of the guideline development methods.**

Consider:

- Were the appropriate stakeholders involved in the development of the guideline?
- Was the evidentiary base developed systematically?
- Were recommendations consistent with the literature?

| Lowest Quality | | | | | | Highest Quality |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | ● | 6 | 7 |

*Comments*

**PRESENTATION STYLE**

**2. Rate the overall quality of the guideline presentation.**

Consider:

- Was the guideline well organized?
- Were the recommendations easy to find?

| Lowest Quality | | | | | | Highest Quality |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

*Comments*

**COMPLETENESS OF REPORTING**

**3. Rate the completeness of reporting.**

Consider:

- Was the guideline development process transparent and reproducible?
- How complete was the information to inform decision-making?

| Lowest Quality | | | | | | Highest Quality |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

*Comments*

**CLINICAL VALIDITY**

**4. Rate the overall quality of the guideline recommendations.**

Consider:

- Are the recommendations clinically sound?
- Are the recommendations appropriate for the intended patients?

| Lowest Quality | | | | | | Highest Quality |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

*Comments*

## OVERALL ASSESSMENT

**1. Rate the overall quality of this guideline.**

| Lowest Quality | | | | | | Highest Quality |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**2. I would recommend this guideline for use in practice.**

| Strongly Disagree | | | | | | Strongly Agree |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**3. I would make use of a guideline of this quality in my professional decisions.**

| Strongly Disagree | | | | | | Strongly Agree |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

*Comments*

Appendix H: Editorial letter

**Delia Layton (PhD)**
**Language editing, proofreading, curriculum development**

Associate member: Professional Editors Guild (PEG) #LAY002
Associate member: South African Freelancers' Association (SAFREA) #SAF03765

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8 March 2023

**To whom it may concern**

This letter serves to confirm that I have edited and proofread the thesis entitled: *Guideline to support students during practicum training at a university in Limpopo Province, South Africa* by Mphephu Khathutshelo Edith.

My involvement was restricted to language usage and spelling, completeness, consistency, and referencing style.

All changes were indicated by Track Changes (MS Word) for the author to verify. As the editor I am not responsible for any changes not implemented, any plagiarism or unverified facts. The final document remains the responsibility of the author.

Yours faithfully

Dr Delia Layton