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Research Report

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Nicola Revington
Master of Arts in Clinical Psychology
0008855N
Supervisor: Carol Long

Supervision and containment in community clinic contexts: A study of trainee clinical psychologists' experiences.

A research report submitted in partial fulfilment of the requirements for the degree of Master of Arts in Clinical Psychology in the Arts Faculty, University of the Witwatersrand, Johannesburg.

Abstract

This study conceptualises the workings of supervision within a South African community clinic setting, focusing specifically on trainees' experiences of work and supervision in such contexts. Training and working in community contexts has become increasingly important in the field of clinical psychology in South Africa. Multiple and varied challenges face trainees learning and working in these contexts. The experience may evoke overwhelming emotional responses for trainees. Supervision can play an important role in offering support and providing a reflective space for trainees, thus helping to render their experiences manageable and meaningful. A qualitative research design was used in this study to explore the experiences of trainee psychologists learning and working at a community clinic in Johannesburg as a component of their clinical psychology Masters training. Six past clinical psychology trainees from the University of the Witwatersrand were interviewed in order to gain understanding of their experiences of work and supervision from their own perspectives. What emerged from analysis of the interview material was a rich description of the community clinic and the challenges trainees are faced with in working there. The impact of being a new therapist within the environment was an area commonly discussed in interviews. Most significantly, the importance of supervision within the context was highlighted, with interviewees focusing on the need for containment and a space to think. Bearing these ideas in mind, the study draws on psychodynamic theory, particularly that of Wilfred R. Bion, to help conceptualise the workings of supervision in such a context. The study illustrates that considerable and meaningful work and learning can be done in less than ideal circumstances.

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Declaration

I declare that this research report is my own, unaided work. It is being submitted for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

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Nicola Revington

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Date

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Chapter 1: Introduction

Supervision has long been viewed as a critical component of clinical training within medical, psychological and counseling fields. Within the psychological realm, supervision has its roots with Freud and the beginnings of psychoanalytic theory (Bernard & Goodyear, 2004). Many different models of supervision have evolved since. There are debates in the literature as to the primary function of supervision but the importance of it is not questioned. Supervision is crucial for trainees, providing support and a "reflective space in which they can make sense of their experiences" (Gibson, Sandenburgh & Swartz, 2001, p. 34), particularly in difficult contexts and when working with difficult presenting problems.

Worldwide migration patterns and cultural diversity in contemporary society have impacted on the work that psychologists and counselors are called on to do (Batten, 1990 cited in Lago & Thompson, 1997). Trainee psychologists in South Africa are increasingly being called upon to work within community clinics, despite the fact that many of the difficulties and anxieties faced in community contexts would challenge even very experienced psychologists (Kottler & Swartz, 2004). In the past few decades much literature has focused on the complex and challenging issues inherent when a client and therapist are of different racial and cultural origins (Lago & Thompson, 1997). Eagle, Haynes and Long (2007, p. 133) assert that working within South African community clinic settings "invokes a very particular experience," one which goes beyond doing multicultural therapy. These authors use the term "the unfamiliar" to describe this visceral working experience and the unique challenges it presents. Multicultural difference, the intensity of the presenting problems faced, difficult social circumstances and working in an unfamiliar setting all contribute to the challenge of working with "the unfamiliar" and the particular anxieties that this evokes (Eagle, et al., 2007). Supervision becomes all the more necessary within community clinic contexts where both personal and context-related anxieties are evoked (Eagle et al., 2007). Such intense anxieties threaten to overwhelm therapists unless they are able to think about and understand these anxieties. There has been minimal study of supervision and its functioning within community clinic contexts.

Aims

This exploratory, descriptive study aims to produce a better understanding of the workings of supervision within a South African community clinic context, specifically focusing on how the supervision is experienced by clinical psychology trainees. A secondary aim of the study is exploring the experience of doing psychotherapy in this context, and how the experience of therapy relates to supervision. The study aims to produce an in-depth, rich description and appreciation of the context, the challenges faced there, and the experience of supervision, specifically from the supervisees' point of view. Investigating what trainees find particularly challenging within community clinic contexts, and how they experience these challenges, is of particular interest. Following from this, the study endeavors to examine how trainees manage these challenges with the help of supervision, focusing on how they used and experienced supervision. General similarities and differences in the trainees' experiences of the process of supervision within these contexts, and how these experiences affect their work and development as therapists, are also of interest.

In doing the analysis of the interview material it was noted that all of the interviewees spoke of the 'containing' function of supervision. It became evident that psychodynamic theory, and particularly Bion's (1962) theory of containment and thinking, could be useful in conceptualising the process of supervision in community contexts. Another aim of the study was thus to think about how theory could explain some of the process of supervision within a community context. By conceptualising the process in this way, the study aims to contribute usefully to the supervision literature.

Rationale

Supervision plays a central role in the training of many health professionals, including clinical psychologists, and an initial consideration for the current study arose from the general agreement in the literature that supervision is internationally an under-researched area, especially in psychology (e.g. Kilminster & Jolly, 2000). Similarly there is a lack of South African research and literature around supervision of psychologists. There appear to be a number of unpublished theses (e.g. Waks, 2001, Hitge, 2005) and a few articles (e.g. Kleintjies & Swartz, 1996). From this perspective, it seems that any

further information and increased understanding pertaining to supervision, as is the aim of this study, would contribute to the current dearth of literature.

Kilminster and Jolly (2000) mention the need for more investigation in the area of trainee experiences of supervision. Much of the research within the field of supervision is written from the supervisors' point of view using their own clinical experience as a base to discuss supervisees' experiences. There is a general paucity of research from the supervisee's perspective (Gower, 1989). By interviewing trainees directly this study offers an understanding of supervisee experiences of supervision, and hopes to contribute to closing some of these gaps.

A second area of interest for this study is the impact of context on supervision, particularly in South Africa where psychologists encounter varied and unique contexts. A number of authors (Stewart, 2004; Berman, 2000) suggest that the process of supervision is impacted upon by the context and setting within which it takes place. For example Stewart (2004, p. 354) cites the pattern that is often seen in primary care settings, where the supervision of counsellors often mirrors the "frenetic pace" of the work done in these environments. Berman (2000, p. 282) points out that "the supervisory relationship is often coloured by its institutional context and by its atmosphere and by the transferential feelings both supervisor and candidate develop towards their institute." The experiences of the clinicians in different contexts will thus impact on these clinicians' work and supervision.

Eagle, Haynes and Long (2007, p. 133) point out that increasing globalization has meant that contemporary psychotherapists are practicing in many different contexts and "working with culturally diverse client populations." Being able to work with what these authors call the "unfamiliar" is becoming ever more essential in psychotherapy practice worldwide. The significance of this is particularly evident in South Africa where, due to *apartheid*, the majority of the population has had limited access to mental health care resources. This has now changed, and practitioners are now called on to train and work in a variety of contexts.

The focus of many clinical psychology training programmes in South Africa has shifted to include a community based component (Gibson et al., 2001). Ahmed and Pillay (2004), however, emphasise that community work is still an underdeveloped area of clinical psychology training and practice in South Africa. They feel that a "fundamental challenge" in clinical training in South Africa is to "shift the balance in favour of community work" (Ahmed & Pillay, 2004, p. 648). This sentiment is echoed by other authors (e.g. Gibson et al. 2001; Pillay, 2003).

Gibson et al. (2001, p. 35) assert that it is important that careful attention is paid to trainees' experiences of community training lest the experience turns them "firmly … against it." A better understanding of what students need from the supervisory process in these contexts will enable those involved in clinical training programmes to ensure that the supervisory process and training programmes offer the most valuable experience, learning and support possible. It is hoped that findings of the study will provide broad recommendations for the supervision process generally, and for the supervision process specifically in 'unfamiliar' contexts.

Despite the potential ethical dilemmas (Eagle et al., 2007) in exposing trainees to unfamiliar contexts, community work is of vital importance in South Africa. As it seems that the future of psychology training in South Africa will be placing greater and greater emphasis on the community aspect of clinical psychology training, regardless of the definition of community work, the findings of the current study may prove to be particularly valuable for the future of clinical psychology training in this country. The more satisfying and positive the experience of doing this work is for trainees, the greater the benefit to both community and therapist.

A last consideration for this study was the recent introduction of community service for clinical psychologists in South Africa. In an attempt to address the need to extend mental health care services to the broader population (Ahmed & Pillay, 2004) the twelve month community service programme was introduced in January 2003 as a prerequisite for practicing clinical psychology in South Africa (HPCSA, not dated). As community service takes place in community settings similar to that of this study, some insight may be offered into the kinds of challenges and experiences that community

service may pose for psychologists. While there is no mandatory supervision requirement for the community service year, it is still hoped that this study may contribute, albeit indirectly, to the literature around this service year. As community service is relatively new there is currently very little literature around it and this study addresses some of the challenges of undertaking therapeutic work in community contexts.

The Context of "Alex" and Community work at the University of the Witwatersrand

This study is situated within the particular context of Alex community clinic, where trainees work and learn during their clinical psychology Masters training at the University of the Witwatersrand. This context will be further clarified later in this report, but a brief description is necessary in order to contextualise the research question.

There are a number of debates around the definition of community psychology and what it entails (Pillay, 2003). While some see community work as using a traditional psychotherapy model in a community setting, others understand community work as dealing with much broader social issues than traditional psychology practice. Some definitions focus on prevention rather than cure, and far-reaching social change is often seen as a responsibility of those conducting psychological community work (Pillay, 2003). Ahmed and Pillay (2004) see broader community intervention as central to community work and some university training in South Africa tends more towards this definition of community work in the training of their Clinical Psychologists (e.g. The University of Cape Town, Gibson et al., 2001). The University of the Witwatersrand training programme, on the other hand, conducts training in community settings but uses a more traditional individual psychotherapy and assessment model as a base from which to work, thus providing traditional psychological services in disadvantaged areas to communities who would otherwise not be able to afford such services. This study will be following the University of the Witwatersrand's current understanding of community work in the training of clinical psychologists.

The community work component of the clinical training programme at The University of the Witwatersrand involves using an individual psychotherapy model in a community

setting, rather than a systemic approach. During the first year of training Clinical psychology Masters students see clients through the University's Emthonjeni Community Centre as well as at two community placements, the Alexandra Health and University Clinic (referred to as "Alex") in the Alexandra township and the 'Trauma Clinic' in Braamfontein, close to the university.

Work at Alex and the Trauma Clinic is done one afternoon a week for the nine months of training, with students spending half of their time at each placement. This study focuses on the work done at Alex Clinic. Alex Clinic is a community clinic which provides numerous free health services to the people of Alexandra township (Eagle et al., 2007). Clients often wait a long time to be seen and up to four different clients may be seen by each therapist within a two hour period. Clients are seen in curtained cubicles within the main clinic. There is no screening process and trainees deal with a wide variety of clients with many different problems. Multiple losses, HIV/AIDS, violence, abuse and poverty are common. Added to this trainees need to address issues of language, cultural difference and an unfamiliar setting. Supervision in this context takes place in a group of approximately six trainees with two supervisors. Supervision groups meet for an hour before clients are seen and for two hours afterwards. Approximately ten minutes into therapy sessions trainees are encouraged to leave the room briefly in order to present cases to supervisors to discuss diagnosis and planning. Reports about each client are written by trainees and handed in and reviewed by supervisors every week.

In preparation, trainees are provided with basic theory and skills training specifically focusing on issues commonly seen in community work. Trainees are required to research and write short papers on topics such as bereavement, HIV/AIDS and cultural differences. These papers include theoretical understandings as well as possible interventions, and form a source of information for the group. Trainees are given the opportunity to voice their own feelings about community work and are encouraged to talk about their fears and anxieties. Prior to beginning work at the community placements, trainees are taken on tours of the clinics. In the case of Alex Clinic a tour of the surrounding township and potential referral clinics and resources is also done.

Structure of report

The above description serves to contextualise the study and following this the report proceeds to the literature review, Chapter 2. Chapter 2 describes, in more detail, Clinical psychology training programmes, focusing on training in South Africa. It discusses the community work components of these programmes, highlighting the challenges trainees face in these contexts. The importance of supervision within these contexts is discussed. A number of different models of supervision are presented. The review concludes with a review of psychodynamic supervision, focusing on the ideas of Bion. The importance of 'containment' in supervision is an idea which emerged directly from the interview material and is central to this study. The method adopted in this study is presented in Chapter 3. Interpretative thematic content analysis was conducted on interview material in order to elicit broad themes and the qualitative approach that was utilised is discussed. The ethical considerations of the study are also detailed in this chapter.

The report then presents the results of the study. Three central themes emerged from analysis of the interview material, namely the challenges faced by trainees in Alex, the significance of being a new therapist within the environment, and the experience of supervision as a containing space in an unfamiliar context. Chapter 4 presents the trainees' experiences of working in Alex and elaborates on the conditions under which trainees work. The many challenges faced in such a setting are explored using extracts from the interview material. Following from this, Chapter 5 focuses on the trainees' experiences of supervision with this context. The study shows that containment in supervision is of primary importance in contexts such as Alex. A number of participants mentioned the impact that working and learning in Alex had on their future work and professional development, and this is explored through their words.

Chapter 6 considers the findings of the study in relation to the theoretical material. It illustrates the ways in which the current study has added to the literature on supervision, specifically within unfamiliar contexts. The implications of the study for practice and further research are detailed. Finally the limitations of the current research are identified and elaborated on.

Chapter 2: Literature Review

It is generally agreed in the literature that the process of supervision is "perhaps the most important mechanism for enabling the acquisition of competencies" (Stoltenberg, 2005). Langs (1994, p. 6) calls supervision "the backbone of a trainee's development" and, as Holloway and Neufeldt (1995, p. 212) point out, supervision is "deeply embedded in our beliefs about what constitutes training in psychotherapy." Supervision is recognised by professional regulatory bodies both in South Africa and internationally as a requirement for psychotherapy training (Feltham, 2000; Holloway & Neufeldt, 1995; HPCSA, form 160, not dated). The following review will detail the training of clinical psychologists in South Africa and describe the different contexts in which clinical psychology Masters students are trained at the University of the Witwatersrand. The concept of community work and what this means will be considered. Supervision within a community context will also be discussed. The review will go on to describe what is meant by supervision within the psychological realm, the different models of supervision which have been proposed, and what these models entail for both supervisor and supervisee. Lastly, containment and thinking in supervision will be explored from the perspective of Bion's theory.

Clinical Psychology Training programmes

Training to be a psychologist is recognised internationally as a long, arduous and often difficult task (Stoltenberg & Delworth, 1987 cited in Hawkins & Shohet, 1989) with a number of reports of the stressful and emotional nature of the training (e.g. Cushway, 1992; Kottler & Swartz, 2004). Kottler and Swartz (2004, p. 55) describe the process of becoming a clinical psychologist as a "rite of passage," comparing it to an initiation process, in which there are "shifts in status and identity." During this time not only are new skills developed, but identity is transformed in often fundamental ways. The concurrent identity roles of "student," "trainee" and "clinician working directly with clients" (Kotler & Swartz, 2004, p. 60) have to be held through the process of personal growth. These authors describe the first year of training as one filled with anxieties, uncertainty and a sense of fragmentation.

Training programmes generally include a number of different methods of teaching and training such as coursework, examinations and the completion of research work (Silvera, Laeng & Dahl, 2003), as well as a large practical, clinical component. The various training components are structured to produce professionals with unique clinical identities and ways of working based on an understanding and flexible knowledge of various psychological models and practices (Huey & Britton, 2002).

The current training of clinical psychologists in South Africa covers a number of core competencies aimed at producing "clinical psychologists with a basic knowledge of diagnostic and assessment skills, together with a range of possible psychological interventions informed by a variety of theoretical frameworks" (Kottler & Swartz, 2004). Core competencies include assessment, formulation, psychopathology, psychotherapy, therapeutic management and the use of psychometric instruments (Ahmed & Pillay, 2004). Clinical psychology training at Masters level includes a research component, coursework, and supervised practical experience done both during the first academic year and more intensively during the internship of the second year of training (Kottler & Swartz, 2002; Unisa, 2006). Training courses in clinical psychology at South African universities lead to registration with the Professional Board for Psychology (Health Professions Council of South Africa- HPCSA) as a clinical psychologist. The graduate clinical psychologist must, however, complete the year-long community service component, introduced in 2003, before being allowed to practice. This community year arose from the need to transform the historical position of psychology in South Africa, and the evident need for broader intervention.

As previously mentioned, supervision is a requirement of most training programmes and is thus compulsory for trainees. The Health Professions Council of South Africa's (HPCSA) guidelines recommend that 10-20% of the training of clinical psychologists at intern level should be concerned with "personal moulding and tuition by a mentor, [and] participation in discussions" (Ahmed & Pillay, 2004, p. 640). The guidelines recommend that, during the internship, supervisors are available for at least one hour on a weekly basis, or two hours every second week (HPCSA, form 160, not dated). Thus supervision plays an important role in the training of clinical psychologists in South Africa, following international trends (Feltham, 2000). As the ultimate aim of supervision

is the protection of clients, the importance placed on supervision is in line with the increased focus on responsibility and accountability within psychology in South Africa.

Community work

Psychology in South Africa has a history that is deeply political in nature (de la Rey & Ipser, 2004), and the relevance of psychology has been debated in this country for a long time. With the abolishment of apartheid a more racially integrated psychological profession was seen to emerge, with the Psychological Society of South Africa being formed in 1994. The formation of the society was accompanied by changes in the curricula of Psychology Departments across South Africa (de la Rey & Ipser, 2004). Kottler and Swartz (2004) highlight the considerable progress that has been made in developing clinical psychology training programmes that are specifically suited to the South African context, noting that "a thorough appreciation of the particular challenges facing South African practitioners" (Kottler & Swartz, 2004, p. 57) is increasingly a focus of this training. de la Rey and Ipser (2004, p. 545) point out that, currently in South Africa, "almost all professional psychology training programmes in clinical and counselling psychology have a community component" which is seen as a huge development from previous programmes during the apartheid years. Ahmed and Pillay (2004), however, still question the extent to which the recognised competencies, and the training programmes developed around them, prepare trainee psychologists to work in the current South African context. They suggest that there is a lack of focus on short-term and systemic therapeutic modalities, as well as a continuing deficiency in preventative, community based psychological interventions.

Many debates exist around the definition of community psychology and what exactly community work involves. Pillay (2003) mentions that community psychology entails understanding people within their communities and socio-cultural worlds, while also striving to improve the human condition and broad psychological well-being of communities. Community psychology is generally seen to involve community interventions of a more systemic nature which happen at a broad level, and are aimed at prevention rather than cure (Pillay, 2003). Ahmed and Pillay (2004), however, point out that much community work done in clinical psychology training programmes in South Africa still focuses on "individual, curative work, rather than on preventive,

systemic interventions" (Ahmed & Pillay, 2004, p. 641). As already detailed, the clinical training programme at The University of the Witwatersrand uses this more individual approach to community work.

Challenges for trainees working in the community

Training to be a clinical psychologist involves a number of challenging tasks including development of a professional identity, integration of skills and knowledge, self-examination and involvement with the pain and hardships of clients (Kottler & Swartz, 2004; Eagle et al., 2007). Working and learning in a community context such as Alex presents many additional challenges and unique stresses for trainee psychologists. Given the long and costly nature of training to be a clinical psychologist, trainees, regardless of race, are typically from middle class, urban backgrounds (Eagle et al. 2007). Many have had little or no interaction with community contexts such as Alex, and even those who are from such backgrounds find the work difficult. Working in these contexts means that trainees have to adapt to drastically under-resourced communities where even basic resources such as electricity, running water and availability of primary health care are scant (Kottler & Swartz, 2004). Faced with these deprived contexts trainees may struggle psychologically themselves, and intense emotional responses and feelings of helplessness are common. Stewart (2004, p. 355) speaks about the "fragmentation that occurs in the face of overwhelming need" and this sums up what other authors discuss (e.g. Eagle, 2005; Gibson et al., 2001).

Cultural and linguistic differences, poverty, deprivation, violence and trauma, as well as seemingly insurmountable and unmanageable problems, are just some aspects of this work that may challenge students (Eagle, 2005; Gibson, et al., 2001). Trainees are "faced with a range of less familiar and sometimes daunting demands" (Gibson et al., 2001, p. 30) and theoretical confusion is common. At the beginning of training students are presented with "a number of widely different, and sometimes conflicting and contradictory, models of clinical work" (Kottler & Swartz, 2004, p. 59), and there is often a difference between practice in the community and more conventional forms of clinical practice which trainees may be familiar with (Gibson et al., 2001). Many trainees find it difficult to integrate psychological, including psychodynamic, understandings with the

reality of the shorter-term interventions that they find themselves implementing (Eagle et al., 2007).

Eagle et al. (2007, p. 133) argue that there are many "context-related anxieties" which students experience in community settings, including anxieties around the lack of structure inherent in this work, and the anxieties provoked by the "unfamiliar". They theorise that there are three main sources of anxiety which come into play in working in unfamiliar contexts. These are 1) anxiety related to fear of persecution or annihilation; 2) anxiety related to narcissistic injury; and 3) anxiety related to the toxicity of the unfamiliar.

The first of these anxieties relates to fears for safety and the sense of vulnerability that trainees experience in the community. The realistic threat of violence is often compounded by a fantasised threat which is induced in trainees by the unfamiliar context (Gibson et al., 2001). Eagle et al. (2007) relate these fears to primitive persecutory anxiety as theorised by Melanie Klein. Klein (1948) postulates that from infancy we all have an unconscious fear of annihilation of life. This fear "is never eliminated and enters as a perpetual factor into all anxiety-situations" (Klein, 1948, p. 29). The experience of the primitive annihilation anxiety causes the external world to appear hostile (Klein, 1948). The persecutory fears arising in anxiety situations lead to "infantile feelings of helplessness and persecution" (Eagle et al., 2007, p. 141) and primitive defences such as splitting, denial, projection and idealisation may be used (Klein, 1946). Trainees may thus over-emphasise the threat to their safety in the environment. They may split, for instance, between community work and more formal clinical work, denigrating the former and idealising the latter (Gibson et al., 2001).

Anxiety related to narcissistic injury refers to "fear of failure or of potentially shaming experiences" (Eagle et al., 2007, p. 142). It is common for trainee therapists to doubt their competence and this is exacerbated by working within an unfamiliar environment. Trainees commonly experience a sense of impotence and guilt when faced with the poverty and deprivation of these communities (Gibson et al., 2001), particularly as psychology is held as a privileged profession (Eagle et al., 2007). The political and racial history of South Africa "further complicates many students' responses to their

clients and also plays an important part in affecting the students' feelings about their work" (Gibson et al., 2001, p. 30). Overcoming these types of anxieties, however, often leads to feelings of mastery and satisfaction (Eagle et al., 2007).

Lastly the anxiety related to the toxicity of the unfamiliar concerns the nature of the cases that trainees are required to work with in the community. These cases are often traumatic and "taxing in an extraordinary way" (Eagle, 2005, p. 205). Trainees are confronted with experiences that they may feel they do not have the internal resources to cope with. With this comes a potential "loss of innocence" (Eagle et al., 2007, p. 143) and a fear of contamination by the environment. The authors suggest that elements of the experience may seem so alien and unfamiliar to trainees that they fear psychological harm.

Many of the cases that trainees are exposed to "would challenge even very experienced clinicians" (Kottler & Swartz, 2004, p. 70). Eagle et al. (2007, p. 145) note the importance of the ongoing debates around "the nature of learning that takes place in becoming a psychotherapist and particularly about the politics of exposing trainee therapists to unfamiliar clients and contexts in the course of their training." There are potential ethical dilemmas around the type of work that trainees are required to do. However, given the need for these services to be offered to wider populations it is important that ways of dealing with the challenging nature of the work are thought about (Eagle et al., 2007).

Supervision in a community context

Within a context that evokes such specific and powerful anxieties, supervision plays an important role in supporting trainees and helping them to make sense of their experiences (Gibson et al., 2001). Supervision in community contexts is, out of necessity, very focused, with a short space of time within which to discuss each client. As such the supervision space can end up mirroring the "frenetic" pace of the work, making it difficult for therapists to "engage in a reflective process" (Stewart, 2004, p. 355). Community work often involves more administrative issues or 'case management' issues (Gibson et al., 2001) such as referral to other medical professionals or to social welfare organizations. As trainees are generally inexperienced in these areas and are

not familiar with many of these processes, much supervision time may be taken up in discussing these administrative issues. Unfortunately this may leave the emotional aspects and process of cases, and of working in a community setting, unexplored in supervision. Due to the specific nature of community work these aspects of supervision are essential, and it remains the role of the supervisor to ensure that the emotional significance of experiences in the community context is not overlooked (Gibson et al., 2001). The supervisor also needs to ensure that the material brought to supervision is analysed in sufficient depth, given the large number of clients and the "fragmentation" that trainees may experience (Stewart, 2004, p. 355).

The importance of a reflective space in which to think about and contain emotions cannot be underestimated in helping trainees to deal with their experiences in community contexts (Gibson et al., 2001). Indeed, it is the contention of some authors (e.g. Eagle et al., 2007) that the way in which trainee experiences are handled by supervisors may have an ongoing impact on trainee development and ultimately on whether trainees remain prepared to work in community contexts once they are qualified. Given the need in South Africa for more work to be done in the community, supervision could play an important role in promoting this work.

In addition to a specifically reflective space, supervisees may also require debriefing due to the traumatic nature of many of the cases seen in community contexts (Eagle, 2005). Eagle (2005, p. 204) describes debriefing in the context of supervision as entailing "not only an examination of the client's account and the course of the psychotherapy, but also the impact that working with the client and their trauma has had on the therapist." The supervision needs of trainees working in this type of community context thus seem to be quite specific and may differ from the needs of trainees in more structured university contexts. Eagle (2005, p. 206) emphasises the importance of the containment function of supervision in such contexts. She notes that "learning… cannot take place in the face of excessive anxiety." It must be noted that supervisors often have their own transference and anxieties about working within community contexts (Berman, 2000; Gibson et al., 2001) and the experiences of both students and supervisors in this type of environment impact on the supervision process (Gibson et al., 2001; Eagle, 2005). Supervisors are required to contain their own

anxieties while assisting trainees in supervision, and it is thus important that they too, have support of their own (Eagle, 2005; Gibson et al., 2001). Both Eagle (2005) and Gibson et al. (2001) suggest a multi-tiered approach to support, where supervisors have access to their own debriefing and containment from colleagues. Co-supervision can enrich the supervision process while offering a form of support and containment (Eagle, 2005).

Supervision

Very broadly supervision means to "oversee the execution of a task… [or] the actions or work of a person" (Allen, 1990, p. 1225). Within the health care realm, and specifically in the area of clinical psychology, however, there are many specific definitions of supervision (Bezuidenhout, 2003). The UK Department of Health (1998 cited in Bezuidenhout, 2003, p. 14) defines clinical supervision as "a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations." Having done a broad, interdisciplinary review of supervision literature, Kilminster and Jolly (2000, p. 829) suggest the following definition of supervision: "the provision of monitoring, guidance and feedback, on matters of personal, professional and educational development in the context of … care of patients." The quality of the work done by the supervisee, as well as their conduct, is assured by the supervisor who is responsible for this work (Leddick & Bernard, 1980; Stewart, 2002).

More specifically within psychotherapy training, supervision is seen as a "process in which students are helped to learn skills and integrate their knowledge… as well as develop an independent professional identity" (Waks, 2001, p. 30). Wosket (2000, p. 201), also referring to supervision within the psychotherapeutic profession, defines it as "a structured and formal collaborative arrangement whereby a counsellor or psychotherapist reflects regularly on their clinical work with someone who is an experienced practitioner and supervisor."

The majority of the definitions of supervision thus highlight the importance of support, learning and development of the supervisee, conveying some understanding of the purposes, functions and aims of supervision.

Wosket (2000) suggests three key functions of supervision: to support, develop and monitor the supervisee. Other authors reiterate similar function. Kilminster and Jolly (2000), for example, refer to a) the normative or administrative function, b) the formative or educational function and c) the restorative or supportive function of supervision. Maximizing the supervisee's effectiveness with clients (Feltham, 2000) and the protection of these clients can be seen as major purposes of supervision (Holloway & Neufeldt, 1995; Kilminster & Jolly, 2000). Ivey (2007, p. 46) points out that "the patient's personal development, as well as the professional development of the therapist, is a background supervisory objective."

Other functions and aims of supervision include the promotion of competence, knowledge, skills development and autonomy, thus enhancing the quality of therapeutic work (Wosket, 2000), the encouragement of self-awareness and confidence (Waks, 2001), and the replenishment of the emotional energy of the supervisee and protecting from burnout and stress (Wosket, 2000).

There is some debate in the literature as to the didactic, educational function of supervision as opposed to its supportive and reflective functions. A number of authors (e.g. Hackney & Nye, 1973 cited in Leddick & Bernard, 1980) suggest that supervision's main function should be a didactic one, with some going so far as to call for the development of standardised manuals for the delivery of supervision (Holloway & Neufeldt, 1995). Pointing out that teaching is different from supervision, Stewart (2002, p. 67) states that "supervisors have a teaching role." Hawkins and Shohet (1989) however, caution against the danger of supervision being too didactic as they feel that supervisees need to be responsible for their own learning. Langs (1994), for example, suggests that any teaching that is done in supervision should "unfold from the case material" (Langs, 1994, p.128); while Mollon (1989) proposes that supervision should simply provide a space to think rather than teaching techniques and problem solving. Other sources, such as the British Association for Counselling and Psychotherapy

(BAC) agree that supervision is “not primarily concerned with training” (Dryden & Thorne, 1991, p. 175).

The literature also suggests that there is a difference between client-focused supervision and administrative or managerial supervision. In “hectic therapeutic settings” (Freitas, 2002, p. 363) where caseloads are high and time is limited, administrative supervision is often dominant. This is likely to be particularly pertinent in South Africa where the community settings in which training clinical psychologists work are often over-crowded and under resourced (Ahmed & Pillay, 2005), and supervision time may thus be very limited.

Viewing supervision more psychodynamically, Frawley-O’Dea and Sarnat, (2001, p. 219) suggest that supervision is about voices, specifically about “therapists finding and refining their voices through the co-created conversations they have with their patients and supervisors.” Through supervision the supervisee develops her own unique voice, but one which is influenced by the internalisation of clinical and supervisory experiences (Frawley-O’Dea & Sarnat, 2001).

Roles within supervision

Most models of supervision generally centre around what Stewart (2002, p. 66) calls the ‘supervisory triangle,’ that is the triad of supervisor, supervisee and client. Hawkins and Shohet (1989) term this the ‘supervision matrix.’ Within the supervisory triangle the relationships can be complex as at any one time there are only two parties interacting, with the third being “physically absent…[but] present by implication” (Stewart, 2002, p. 66). Despite the many different theories, methods and models underpinning supervision, there seems to be a general consensus that what is of primary importance in supervision is the relationship between supervisor and supervisee (Kilminster & Jolly, 2000; Langs, 1994; Leddick & Bernard, 1980; Wosket, 2000), and hence the supervisor holds an important and powerful position within the triad. Given the supervisor’s position compared to the supervisee’s anxiety and lack of experience, the relationship may start out as a dependent one. It is common for supervisees to idealise their supervisors, especially initially, but this generally lessens as the supervisee develops (Kottler & Swartz, 2004).

Role of the supervisor

According to the HPCSA guidelines (Form 160, undated) a supervising psychologist must have been registered with the HPCSA for at least 3 years, have proven competencies in the field and must be registered in the same professional category as the supervisee. The supervisor must thus be trained, qualified, and competent in their field. The supervisor has the ethical responsibility of ensuring the welfare of the client is protected and is legally responsible for the supervisee's work (Wosket, 2000). The supervisor is also required to evaluate or assess the supervisee's therapeutic competence (Edwards, 1997). It is, therefore, important for the supervisor to challenge unethical, unwise or incompetent practices (Hawkins & Shohet, 1989).

Besides the official position the supervisor holds, the role may also include management, support, guidance, training, assessing and the facilitation of learning (Hawkins & Shohet, 1989; Stewart, 2002; Wosket, 2000). There seems to be agreement across schools of thought in counselling and psychotherapy about what constitutes good and bad supervision practices (Kilminster & Jolly, 2000). Effective supervisors are seen to have similar qualities to effective psychotherapists, including empathy, understanding, unconditional positive regard, warmth (Hawkins & Shohet, 1989), respect and genuineness (Wosket, 2000). Supervisors also should offer support, flexibility, instruction, knowledge and interest in supervision (Kilminster & Jolly, 2000). Wosket (2000), however, warns that the supervisor must not 'take over' the supervision process.

The supervisor needs to balance the "functions of containment (holding), processing, structuring and the development of a questioning attitude and observing ego within the supervisee" (Driver, 2002, p. 84). Hawkins and Shohet (1989) further explaining the containment function of supervisors, suggest that the supervisor should act as a container for the supervisee, holding the therapeutic relationship and providing a safe space where emotional disturbance can be felt, reflected on and learnt from. Similarly Stewart (2002, p. 82) discusses the supervisor as a container, enabling the supervisee to "think and cope with anxiety." He asserts that much learning is gained from the patient, and that the supervisor's containment allows this learning to happen.

Role of the supervisee

The supervisee is also seen to have responsibilities within the supervisory relationship. Kilminster and Jolly (2000) feel that it is important for the supervisee to have some control and input into the supervisory process. Hawkins and Shohet (1989) suggest that it is the responsibility of the supervisee to ensure that they make this input and Moore (1991) indicates that the supervisee should think carefully about how to use their time most constructively and should share issues freely within the supervisory relationship. At the same time the supervisee needs to identify and share the type of response they feel is helpful. Kilminster and Jolly (2000) suggest that the supervision relationship should begin with discussion about the structure of supervision and that the supervisor and supervisee should decide who is responsible for raising specific topics within supervision.

Supervision requires supervisees to engage in a certain amount of self-examination (Eagle, 2005) and being open to feedback and discriminating which feedback is useful, is an important part of the supervisee's role (Hawkins & Shohet, 1989). Being open to feedback requires supervisees to "explicitly acknowledge their relative ignorance about some general or specific aspect of their profession" (Ivey, 2007, p. 46). This may cause great discomfort for supervisees and learning to tolerate this discomfort is important for the supervision process (Ivey, 2007).

What trainees bring to supervision

As Kottler and Swartz (2004) point out, supervisees are expected to discuss practical and theoretical problems and questions with their supervisors as well as the struggles they encounter with their own feelings that emerge in therapeutic practice. They also suggest that the supervisor-supervisee relationship changes through the course of the first year of training. One of the supervisor's main roles is to encourage the autonomy of supervisee (Wosket, 2000). As the trainee psychologist gains more autonomy and confidence he or she becomes less dependent and idealises the supervisor less, and thus "supervisors are called on less to check every interaction with clients and are engaged in broader issues of theory and ethics, and debate about appropriate intervention" (Kottler & Swartz, 2000, p. 63).

Wosket (2000) suggests that the issues that are brought to supervision can be wide-ranging, extending beyond the mere content and process of the psychotherapy session. She notes that what is brought to supervision will alter according to what issues are important to the trainee at any one time. At the same time however, she highlights the importance of keeping issues clearly related to client work. Questions brought to supervision may focus on, among other things, the content of a therapy session, the process of the session or the therapeutic relationship. Issues discussed in supervision may thus include boundary problems, the structuring of sessions, strong transference feelings, cultural issues, feelings of stress or anxiety, loss of motivation or commitment, personal issues that impact on work or dealing with a sense of achievement or success in therapeutic work (Wosket, 2000).

Group Supervision

Supervision often takes place in groups, generally out of necessity. Group supervision can, however, offer "a rich and diverse container in which to explore, understand and develop clinical work and enable the development of the supervisees" (Driver, 2002, p. 95). Groups facilitate vicarious learning and can help trainees to feel less isolated and alone in their experience and responses (Driver, 2002). It also enables a higher level of thinking about the patient than is possible with just one supervisee and the supervisor (Mollon, 1997).

Group supervision has implications for both supervisees and supervisors and there are a number of difficulties which may serve to disturb learning and development. The group is impacted on by the personalities and pathologies of all members including the supervisor (Driver, 2002). High levels of anxiety and primitive unconscious conflicts affect the group (Bion, 1961) and thus each group will have its own dynamics, transference and projections. Anxiety, envy and rivalry all commonly play out in groups and the exposing nature of supervision is intensified in a group setting (Driver, 2002). Rivalry or competitiveness in groups has a negative effect on supervision in that it can stop "thinking that is aimed at understanding the patient" (Mollon, 1997, p. 33). This suggests that any process which disrupts thinking in supervision is unhelpful.

Supervisors need to be able to contain and process the group dynamics while also focusing on the interaction between supervisee (therapist) and client (Driver, 2002).

Problems encountered in supervision

Kernberg (2000) (cited in Waks 2001) identifies a number of problems that may occur in supervision. These include the "infantilisation of students, scientific isolation and ignorance, irresponsibility about students' educational experience, authoritarianism and arbitrariness and the denial of external social reality and its effects on education" (Kernberg, 2000 cited in Waks, 2001, p. 32). All of these problems seem to have the potential to hinder thinking and learning in supervision. Supervisors who lack empathy and support, or who are intolerant and disrespectful, are also seen to be problematic (Kilminster & Jolly, 2000). The inherent power dynamic within the supervisory relationship is commonly viewed as a potential problem in supervision (Kilminster & Jolly, 2000; Kottler & Swartz, 2004; Moore, 1991). The supervisor's 'gate-keeping' function most often involves an assessment or evaluation of the trainees competence and this re-enforces the power inequality (Edwards, 1997, p. 15). Linked to issues of power are the problems that occur with sexist or racial discrimination within the supervision context (Christian, Mokutu, & Rankoe, 2002, Edwards, 1997).

In addition to these common problems supervision in South Africa faces very specific difficulties. Because of this country's political history black trainee clinical psychologists in South Africa find themselves in a traditionally 'white' profession (Christian et al., 2002) which presents many complex issues (Kleintjies & Swartz, 1996). This may affect supervision as racial issues and dynamics may play out in the supervisory relationship. As the majority of supervisors in this country are still white (Christian et al., 2002) the "supervisory relationship mimics power relationships in the broader society" (Stevens, 2001, p.52) making the power dynamics of the relationship particularly complicated. While supervision potentially provides a place for supervisees to openly discuss the racial issues inherent in their work (Kleintjies & Swartz, 1996), the racial difficulties often experienced in the supervisory relationship itself may prevent these important discussions. There appear to be many issues which impact on what is able to be spoken in supervision.

Problems with research in the field of supervision

While supervision in clinical psychology training is extremely valuable (Worthen & McNeill, 1996) with many authors going as far as to say it is critical in a psychotherapist's development (e.g. Langs, 1994), some authors (e.g. Kilminster & Jolly, 2000), highlight the fact that the outcomes of supervision are very difficult to research. There is thus little empirical evidence supporting the widely held notion of the importance and usefulness of supervision (Feltham, 2000). Goodyear and Bernard (1998, p. 6) point out that despite the long history of supervision it "remains relatively new as a specific domain of inquiry."

As far back as the early 1980s Leddick and Bernard (1980, p. 186) asserted that the problem with supervision literature, particularly in the counselling literature, "is more a lack of clarity than of attention" (p. 186) and this view is still held by some authors today (e.g. Green & Dye, 2003). As previously discussed there is interest in the research of supervision practices and this interest does seem to be growing (Freitas, 2002). There are, however, many criticisms levelled at past and current research in the area.

The most frequent of these criticisms is that the quality of the research in the area of supervision is questionable due to the methods used in research (Gonsalvez, Oades & Freestone, 2002; Green & Dye, 2003). Most studies in this area are not methodologically robust (Kilminster & Jolly, 2000) and have problematic conceptual underpinnings (Green & Dye, 2003). The impact of supervision on clients is specifically a complicated area to research as many variables can interfere with results (Freitas, 2002; Holloway & Neufeldt, 1995). The quality and efficacy of supervision is often determined through subjective perceptions (Green & Dye, 2003; Holloway & Neufeldt, 1995). Gower (1989) suggests that supervision's similarity to psychotherapy makes it particularly difficult to research as an independent area.

Much of the past and current supervision research focuses on the supervisor's point of view (Gower, 1989) or on client outcomes (Holloway & Neufeldt, 1995), and there certainly seems to be a lack of research done on supervision from the supervisee's perspective. Various recent reviews (e.g. Holloway & Neufeldt, 1995; Kilminster & Jolly, 2000) of the supervision literature suggest that there are a number of specific areas of

supervision that are lacking in research attention. These include the quality of supervision and its content (Kilminster & Jolly, 2000), supervision efficacy (Gonsalvez, Oades & Freestone, 2002; Holloway & Neufeldt, 1995) and “what approaches to supervision help… students the most” (Goodyear & Bernard, 1998, p. 6). Holloway and Neufeldt (1995, p. 212) call for researchers to devise “clear methods of training for supervisors…[and] standardised manuals for delivery.” There seem to be contradictory calls for more attention to individuality *and* for more attention to standardisation.

Despite the many problems with supervision research, it has over the years given rise to a number of helpful models of supervision (Leddick & Bernard, 1980), many of which incorporate what are seen to be ‘good supervisory practices’.

Approaches and Models - Current trends in supervision

The current models of and approaches to supervision have a long history and much of their content can be seen to have developed from very early views of supervision (Ekstein & Wallerstein, 1958; Edwards, 1997). A number of different models exist such as Hawkins and Shohet’s (1989) ‘process model’, Gonsalvez et al.’s (2002) objectives approach to supervision, various psychodynamic models and, perhaps most common, the developmental model of supervision. Edwards (1997, p. 16) argues that “the many and varied styles of supervision” models can be divided into two main models, namely didactic and experiential models. Didactic models focus on the teaching of technique and theory and the "mode of learning is primarily rational, concerned with conscious thought processes" (Edwards, 1997, p.16). Experiential models emphasise the "trainee's feelings and unconscious emotional responses" (Edwards, 1997, p.16), and learning is more subjective.

The particular model adopted by the supervisor will generally affect the content and style of supervision (Kilminster & Jolly, 2000). Edwards (1997) notes that inflexibility in supervision is not helpful. He advises that the process of supervision, and what is most useful for the supervisee, should always be considered over the promotion of a particular supervision model. Green and Dye (2003) also promote caution when using supervision models as they feel that “most are constructed on shaky empirical

foundations" (Green & Dye, 2003, p. 108). Developmental and psychodynamic models will be discussed here as these are the most relevant to the current research.

Developmental Models

Probably the most dominant model of supervision internationally in terms of theory and research is the developmental model (Gonsalvez et al., 2002). First introduced by Hogan in 1964 (Waks, 2001), developmental models of supervision were made popular in America, with many subsequent models developing (Hawkins & Shohet, 1991; Gonsalvez et al., 2002; Stoltenberg & Delworth, 1987 cited in Hawkins & Shohet, 1989). There seems to be some support for the efficacy of these supervision models in comparison to other models (Stoltenberg, 2005) but many authors have criticised the lack of sound research in this area (e.g. Goodyear & Bernard, 1998; Gonsalvez et al., 2002, Kilminster & Jolly, 2000). None the less these models seem to provide a comprehensive and broad framework of supervision, and tend to be consistent with clinical practice (Gonsalvez et al., 2002).

Developmental models of supervision are based on the understanding that trainees go through a sequence of developmental stages in supervision comparable to the stages of human development or the stages of a medieval craft guild apprenticeship (Hawkins & Shohet, 1989). At each stage trainees "struggle with various developmental issues and concerns" (Watkins, 1995, cited in Gonsalvez et al., 2002, p. 69) and these models therefore suggest that the supervision needs of the trainee are dependant on their experience (Kilminster & Jolly, 2000) and on their developmental level. The developmental level of the trainee will thus determine what constitutes 'good supervision' (Worthen & McNeill, 1996) and supervisors should "have a range of styles and approaches which are modified as the counsellor gains in experience and enters different definable developmental stages" (Hawkins & Shohet, 1991, p. 106).

Hawkins and Shohet (1989) suggest that that within a developmental model of supervision the centre of focus and concern shifts as the trainee moves through the different levels or stages of development. In the first stage the predominant concerns are self-centred, followed by more client-centred concerns in the second stage. The third stage includes concerns about the process, while the fourth stage integrates all

previous stages with a “process-in-context” focus. There seems to be an increased need for structure, support and more direct and specific instruction and guidance in the early stages of training (Hollloway & Neufeldt, 1995, Kilminster & Jolly, 2000; Wosket, 2000). In a study examining what supervisees find effective in supervision, Gower (1989) found the insecurity and dependence that supervisees feel at the beginning of training requires more structure and containment in supervision. This can be provided through emotional reassurance, as well as through straightforward and consistent didactic input from supervisors. Staying with the same supervisor throughout training may help the developmental process as the supervisor is then able to provide feedback and encouragement arising from their own experience and knowledge of the trainee’s work as it develops over time (Wosket, 2000).

It can be argued that the questions asked by supervisees in supervision may follow their development and the prominent concerns of each stage. Thus early on in supervision questions may be more centred around personal issues and client issues, while later on questions asked in supervision may broaden to include the process of therapy and ultimately the whole context of the therapeutic relationship. Supervisees appear to develop a greater reflective capacity through the experience of being helped to think by the supervisor. The developmental model also suggests that with time trainees are able to move beyond their personal anxieties and emotional reactions. The supervisor may assist the trainee to process these feelings.

Integrated Developmental Model

More recently Stoltenberg, McNeill and Delworth (1998, cited in Stoltenberg, 2005) proposed an Integrated Developmental Model (IDM) of supervision. More detailed than previous developmental models, this model provides a framework detailing how supervisees change over time. It also describes how “various supervision environments (broadly) and supervision interventions (specifically) can enhance and detract from the development of professional competencies” (Stoltenberg, 2005, p. 858). Developed from supervision literature and clinical experience, the IDM is based on the idea that trainees’ “changes in self and other awareness, motivation, and autonomy tended to occur systematically as supervisees gained proficiency” (Stoltenberg, 2005, p. 859). Supervisees are thus seen to move from an anxious, self-focused level through a client-

focused level, to finally arrive at a level where they are able to focus on the client while being aware of their own feelings, thoughts and behaviour. It is here that they are able to use their growing knowledge and experience to reflect on the process of therapy.

Limitations of developmental models

As mentioned previously the empirical basis of developmental models has been questioned by a number of authors and some feel that there has been "less than adequate translation from theory to actual supervision practice" (Gonsalvez et al., 2002, p. 69). While the models may provide an accessible framework within which to work, Hawkins and Shohet (1989) caution against using the models too rigidly. They advise that the needs and development of the individual supervisee must always be considered in the supervision process. The American context in which developmental models arose should also be taken into account when applying these models elsewhere (Hawkins & Shohet, 1989). This is an important consideration within the South African context.

Psychodynamic Supervision Models

Speaking the language of psychodynamic theorists like Klein, Bion, Winnicott and Searles, psychodynamic models of supervision tend to consider the internal dynamics and object relations of the patient, the therapist and, more recently, the supervisor. Berman (2000, p. 273) describes psychodynamic supervision as "the crossroads of a matrix of object relations of three persons, of a complex network of transference/counter-transference patterns."

Frawley O'Dea and Sarnat (2001) divide psychodynamic models of supervision into 3 primary models. Firstly, they discuss the Patient-Centred or Classical model where the main focus of supervision is the "patient's mind and correct technique" (Frawley O'Dea & Sarnat, 2001, p. 29). In this model the supervisor is seen as an "uninvolved, objective expert" (Frawley O'Dea & Sarnat, 2001, p. 29) who holds a purely didactic function.

The second group of models are the Therapist-Centred models. This group includes ego-psychological, self-psychological and object relations models, and these focus on the supervisee's resistances, self-states and anxieties respectively. Generally in these

models the supervisor is also seen as an objective expert. With the object relations model however, the supervisor also acts as a “receptacle for induced feeling states” (Frawley O’Dea & Sarnat, 2001, p. 29).

The last model that Frawley O’Dea and Sarnat (2001) discuss is the Supervisory-Matrix-Centered or Relational model. Here the supervisor is viewed as “an embedded participant in a mutually influencing supervisory process” (Frawley O’Dea & Sarnat, 2001, p. 41). This is similar to Berman’s (2000, p. 273) ideas of supervision as a “matrix of object relations of three persons.” The focus is on all relational events within the matrix, those between client and supervisee, and supervisee and supervisor. The supervisor plays an “actively influential role in co-constructing the relational events that take place in both dyads” (Berman, 2000, p. 62).

Parallel Process

Searles’ (1955, 1962) ideas around ‘parallel process’ have been influential in many psychodynamic models of supervision and are evident in the relational model discussed above. Parallel process refers to “the means by which the supervisory dyad enacts one or more dynamics also alive in the treatment dyad” (Frawley O’Dea & Sarnat, 2001, p. 41). Thus the supervision space comes to mirror, in some ways, the therapy space, and behaviours and interactions in therapy may be repeated in supervision (Whitman & Jacobs, 1998). In this "reflective process" (Ganzer & Ornstein, 1999, p. 232) the supervisor uses an awareness of her own reactions to the supervisee in order to assist the supervisee in working through issues with the client (Ganzer & Ornstein, 1999).

In psychodynamic supervision transference and counter-transference issues are considered in a similar way as in psychodynamic therapy (Berman, 2000). Some models of psychodynamic supervision (e.g. The ‘Sheffield’ model, discussed in Shipton, 1997) do not make a distinction between therapy and supervision, and supervisors play the dual roles of therapist and supervisor. Much of the literature, however, suggests that despite the inherent ambiguity between the roles, this should be avoided and supervisors should be aware of the risk of assuming the role of therapist rather than of supervisor (Eagle, 2005; Kottler & Swartz, 2004). Having noted the distinction, discussing the similarities between supervision and therapy is also of relevance. Apart

from its didactic function, supervision, like therapy, becomes a supportive space (Kilminster & Jolly, 2000) and a place to think (Mollon, 1989). Both therapy and supervision offer containment and processing, and both are concerned with the development of a questioning attitude and an observing ego (Driver, 2002). The development of a questioning attitude implies that the supervisee has fostered an ability to think for herself, while an observing ego suggests the ability to contain oneself.

Containment and Thinking in therapy and supervision

The relationship between therapist and client can in many ways be likened to the relationship between mother and infant (Mendelsohn, 2007). Winnicott's (1960) concept of the 'holding' mother and Bion's (1962) concept of the 'containing' mother are two models which have been used to describe the therapist's role (Banks, 2002). The therapist can be seen to provide a containing function similar to that of a mother, and through this containment and holding, the patient (infant) comes to internalise aspects of the therapy and the relationship. A similar process can be said to occur in supervision (Eagle et al., 2007).

Bion's theory (e.g. 1962) is useful in describing the containment function of supervision in greater depth. The theory also offers insight into how containment can enable thinking, learning and ongoing development. This containing function of supervision is of particular importance in community contexts, given the specific quality of the work done in these contexts. The containment of anxieties and emotions evoked in these contexts is crucial in enabling trainees to both learn and offer adequate therapy to clients, and supervisors thus have the potential to transform supervisees' experiences (Kottler & Swartz, 2004).

Bion (1962) sees an infant's experience as initially made up of a "confusion of impulses and sensations" (Waddell, 1998, p. 30). "The infant personality by itself is unable to make use of the sense-data" (Bion, 1962, p. 116). This "sense-data" needs to be converted in some way in order for it to be meaningful to the infant, and so that the infant is not overwhelmed. The process of producing understanding, or "alpha-elements", from raw experience he terms "alpha function" (Bion, 1962, p. 115). Alpha function is "the unknown process involved in taking raw sense data and generating out

of it mental contents which have meaning, and can be used for thinking" (Hinshelwood, 1989, p. 218). If this process does not take place the infant is left with unprocessed raw experiences, 'beta-elements,' which do not make sense to him. The infant is unable to think about or represent these experiences and is only able to evacuate them through projective identification or acting out (Eagle, et al., 2007).

The mother's capacity to take in and contain the infant's confusion and terror plays a key role in helping the infant to make sense of raw data and tolerate anxiety. The mother takes in the baby's projections of anxiety and pain and lends shape and form to them. She removes the terror from these projections and gives them back to the infant in a manageable, recognisable state (Waddell, 1998). In order for the mother to provide this 'containing' function for the infant, she herself must be in a state of "calm receptiveness" (Hinshelwood, 1989, p. 420). She must be able to contain the infant's distress while not becoming overwhelmed by her own anxiety (Waddell, 1998). Bion (1962) uses the term "reverie" to describe her capacity to do this.

When the mother is able to provide alpha function and a sense of reverie, the infant introjects an understanding mother and begins to develop "his own capacity for reflection on his own state of mind." (Hinshelwood, 1989, p.420). The ability to learn from experience allows growth and development to occur (Waddell, 1998). Thoughts and a framework for organizing these thoughts are thus created, and it is through the development of these two things that 'thinking' can take place (Bion, 1959). 'Thinking' for Bion is the "emotional experience of trying to know oneself or someone else" (O'Shaughnessy, 1981, p. 178), and thus the developing mental function is central in the development of personality structure.

Just as maternal reverie is central in the development of an infant, so too is supervisory reverie central in the growth and development of trainees. Reverie assists the infant to become familiar with and understand different parts of the self and relationships with others (Waddell, 1998). Supervisory reverie is crucial for trainees to develop and understand their therapist selves. Self-knowledge leads to a greater self-trust and a sense of competency and mastery.

It is the task of the supervisors to “facilitate the transformation of trainees’ raw emotional experiences into emotional experiences that can be borne, thought about and learnt from” (Eagle et al., 2007, p. 137). It is thus important that supervisors are aware of the specific anxieties present in contexts such as Alex in order to understand the projections present in such contexts. It then falls on the supervisor to accept and think about these anxieties and projections in order to “put them into words, and then offer them to students in a form which they are able to receive and then integrate” (Eagle et al., 2007, p. 137).

This chapter has given a brief description of clinical psychology training programmes, focusing on community work, in order to contextualise the current study. Literature around different understandings of supervision, and the challenges inherent in the supervision process was then presented. Different models of supervision were assessed. A more in depth exploration of psychodynamic understandings of the supervision process followed.

Chapter 3: Methods

Research Design

The objective of this study was to gain a deeper understanding of the workings of supervision within a community context, using clinical psychology trainees' experiences of their work and supervision at Alex clinic. The study aimed to produce a more in-depth, rich description and appreciation of the topic than a quantitative study would be able to give, and hence a qualitative approach was utilised. Parker (1994, p. 2) defines qualitative research as "the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made." The researcher is thus key to producing an "illuminative representation" of the meaning of a particular issue (Parker, 1994, p. 3).

Qualitative research is particularly useful in studying phenomena about which little is known (Elliot, 1999) and is thus often "more exploratory than confirmatory; more descriptive than explanatory; more interpretive than positivist" (Rennie, Watson & Monteiro, 2002, p. 179). In this type of research, rather than predetermined ideas and structure, many of the concepts unfold from the data itself and thus preexisting theory is less important than in quantitative research (Elliot, 1999). In a similar way, much of the research design emerges as the "inquiry proceeds" (Guba & Lincoln, 1983, p.325). The research is an "exploration, elaboration and systematization" (Parker, 1994, p. 3) of the phenomena of interest, in this case trainee experiences, and the aim is to produce a meaningful account of these experiences and perceptions. Qualitative research focuses on individual experience, attempting to produce context specific "in-depth descriptions and understanding" (Babbie & Mouton, 1998, p.270), as opposed to aiming to generalise to a wider population.

Given the dearth of literature focusing on supervision specifically in South African contexts, this was an appropriate research design for this study. I was interested in discovering the issues relating to supervision in Alex and had only a broad idea of these prior to collecting data. I also expected issues and ideas to emerge from the data and hence did not have a precise predetermined research design.

Research Participants

Participants were selected using a non-probability sampling method, specifically purposive sampling. Babbie and Mouton (1998, p. 166) describe purposive sampling as selecting the sample based on the researcher's "own knowledge of the population, its elements, and the nature of [the] research aims." This form of sampling was most appropriate for this study as the population is limited and the aim of the research was to gain an understanding of individual experiences of working and being supervised in Alex.

As a clinical psychology Masters student myself I was able to use my knowledge of this population in order to select subjects according to specific criteria. The first criterion was that participants needed to have completed but recently experienced the therapy and supervision processes at Alex Clinic. Past clinical psychology Masters students at the University of the Witwatersrand were thus contacted. The second criterion was that the subjects' experience of Alex needed to be recent but they also needed to have had time following this to gain further experience outside this context. One cohort of students from a previous year of study was chosen. These people were either completing community service or working. A list of contact details for these students was obtained and they were contacted via telephone with information of the study, and then invited to participate.

Of the twelve potential participants on the list, the first eight past students were contacted, with two being unavailable for interviews at that time. A total of six past students were interviewed. Interviews were stopped at this point as transcripts were evaluated and it was felt that data saturation had occurred and no new material was emerging from the interviews. Kelly (2006, p. 289) refers to this as "sampling to redundancy." As the nature of this research study is exploratory it was felt that these six interviews provided sufficient material in order to identify and describe pertinent issues within the field of study (Kelly, 2006).

Typically, today's psychology students represent a relatively mixed demographic. In the past, however, the demographic was more specific, being mainly white, female and middle class. This has changed somewhat in recent years. However, the majority of

students tend to still be middle class with less of the poorer sector evident, particularly at Masters level. There is also an excess of female students.

The cohort of students from which the six participants originate comprised a mix of races with a relatively equal representation. The gender difference was skewed, with 9 of twelve students being female. For this reason, and in order to protect confidentiality, the terms ‘she’ and ‘her’ will be used for all interviewees regardless of gender. Almost all students were from middle class backgrounds. None of the participants had had experience with Alex prior to working there during their Masters year.

Given the narrowly defined population from which the participants were selected, transcripts of interviews have not been included in this study as it was felt that this would compromise confidentiality. Generic, western female names (Kerry, Olivia, Lucy, Amy, Sarah and Jill) were chosen as pseudonyms for further confidentiality and so as not to betray identity through cultural classification.

Interview procedure

Examination of case notes

During the first year of training in Masters in Clinical Psychology at the University of the Witwatersrand, psychology students are required to write case notes after each client session. These notes document the content of the session as well as what happened between client and therapist. A ‘points for supervision’ section containing questions the students may have for their supervisors is also included in the notes. The university psychology department holds case notes written by training clinical psychologists of previous years, and the first step in the research process was a brief examination of these notes.

Focusing on the points for supervision section, I reviewed the case notes from two previous cohorts of students. I jotted down broad themes from the questions asked and noted which themes recurred. This provided a broad idea of the types of issues students raised in supervision. From this I was able to see that much of what students asked was linked to working in Alex specifically. I could group issues broadly into

categories, for example questions focused on referrals, or questions related to diagnoses. I then used these categories to inform the interview schedule.

Drawing up the interview schedule

I chose a semi-structured interview format, allowing for flexibility (Kerlinger, 1986) while obtaining a relatively deep understanding of individual trainee therapists' experiences of working in Alex. An interview schedule was drawn up to ensure that similar topics were covered in each interview.

The initial interview schedule was developed from the objectives of the study, and open-ended questions were informed by my examination of the case notes as well as my own reading around the topic. Questions were open-ended to "offer the respondents an opportunity to expand on their answers, to express feelings, motives or behaviours quite spontaneously" (Rosenthal & Rosnow, 1991, p. 179).

It was important to gain a better understanding of trainees' experiences of working in Alex as well as the usefulness of supervision within this context. Questions were thus developed with the aim of fleshing out these experiences. The schedule included questions focused on participants' experience of doing therapy and receiving supervision in Alex. It also included questions about their perceptions of the impact that the context had on their experiences, as well as their fears and anxieties. Questions around what they found particularly helpful and unhelpful in supervision were also covered and participants were asked about what issues they raised in supervision. I was interested in obtaining specific examples from participants and these were requested in relation to some of the questions.

I conducted a pilot interview with a colleague from another year of study to test the relevance, sequencing and wording of questions (Rosenthal & Rosnow, 1991). This was also done to ensure that the questions would elicit useful information of appropriate depth. Minor adjustments were made to the initial interview schedule for the final version (appendix A).

Interviews

Interviews were set up at venues convenient to each participant and thus took place either at the university or the participant's place of work or home. On meeting each participant I provided an Information Letter (appendix B) detailing the purpose of the research and what the interview would entail. Participants were informed that they could decline to answer questions and could withdraw from the research at any time without any negative consequences. Participants signed informed consent forms (appendix C) and recording consent forms (appendix D). All interviews were recorded electronically. Interview duration varied between one and one-and-a-half hours. Interview questions followed the interview schedule with further elaboration being asked for where necessary. Towards the end of the interviews, participants were asked for further comments or thoughts.

Prior to conducting the interviews I familiarised myself with Kelly's (2006) recommendations for interviewing. This included helpful suggestions on conducting interviews as well as common errors with interviews. I was thus aware of the way I was asking questions and my own and the participants' body language. I also tried to remain aware of my own thoughts and feelings throughout the interviews in order to avoid reacting to participants' answers in ways that may have been influential. I wrote brief notes during and after each interview, recording the process of the interview as well as my own ideas, feelings, thoughts and experiences during the interview.

Recordings of interviews were transcribed word-for-word by myself, and further notes were made during this process. I found transcribing the interviews time consuming but a helpful first step in familiarising myself with the data. In the words of Gale and Newfield (1992, as cited in McLeod, 2001, p. 96) transcribing the interviews was "part of the discovery process itself."

Position of the researcher

Researcher reflexivity (Parker, 1994) plays an important role in awareness of potential bias and objective versus subjective views in qualitative research. As Parker (1994, p. 13) explains, "qualitative research does not make claims to be 'objective', but it does

offer a different way of working through the relationship between objectivity and subjectivity." The researcher's subjective experience and involvement in the qualitative research process is thus significant and it is important to "show how one used one's subjective capacity" (Terre Blanche, Kelly & Durrheim, 2006, p. 277) in the process. A qualitative researcher uses his or her personal insight, feelings, and perspective to assist in understanding the topic of study, while remaining aware of his or her own values or assumptions (Neuman, 1994).

As a Clinical Psychology Masters student myself, and having had my own experience of working in Alex, it was important that I was mindful of my own subjectivity throughout the research process. I also needed to consider my position as a white, middle-class female who had no experience of Alex prior to working there during Masters. My position did allow me a unique perspective from which to hear the stories in the research, but it was important to evaluate how my values and assumptions may have affected my research process. During the interviews, for example, I was aware that at times I had pre-conceived ideas about what interviewees would say. Many times I noticed this during the interviews but transcribing, reading and re-reading the interviews enabled me to highlight instances of my own assumptions and analyse the ways in which interviewees responded to these. It was also important to note each interviewee's differing interaction with my position as interviewer *and* colleague. I found that keeping notes of my own thoughts was helpful in reflecting on my own experience of the research process. The notes were used in formulating the analysis of the interview material.

Data analysis

Interpretative Thematic content analysis

Interpretive thematic content analysis was conducted on the interview material to determine broad themes as well as patterns, trends, commonalities and differences in the trainees' experiences of working in Alex. The study was primarily an inductive process and interpretations were inferred from the data. While some general issues of interest around the topic of work and supervision in Alex had become evident in reviewing the theoretical literature and case notes, the specific categories and themes to be explored were not predetermined (Ezzy, 2002). Thematic analysis differs from

strict content analysis in that “categories into which themes will be sorted are not decided prior to coding the data” (Ezzy, 2002, p. 88). Rather the researcher sifts through data in a relatively systematic manner (Babbie & Mouton, 2005) and categories are induced from the data allowing unanticipated ideas and issues to surface. Themes and ideas are further developed through the researcher’s interpretations.

Terre Blanche Durrheim and Kelly, (2006) discuss qualitative research as a process rather than as a set of distinct procedures. They suggest that the analysis of data in qualitative research begins during interviews. These authors discuss five steps in interpretive data analysis, namely familiarization and immersion; inducing the themes; coding; elaboration, and interpretation and checking. They emphasise the fact that qualitative research does not proceed in a linear fashion but is, rather, cyclical. Data is returned to over and over again, the ‘steps’ are revisited and questions reformulated throughout the research process. A process of ‘trial and error’ is common in this type of research (Wimmer & Dominick, 1983).

Process of analysis

In this study the process of analysis did indeed begin during interviews. I began noting, during each interview, the themes that the participant seemed to focus on. The process of ‘familiarisation’ and ‘immersion’ began during the transcribing of interviews. Patterns, trends, commonalities and differences in the participants’ experiences of working in Alex were noted, and potential themes, based around the research aims, began to emerge naturally (Terre Blanche, Durrheim et al., 2006). I began highlighting interesting extracts in each interview. This inductive process produced, from the outset, themes around the unfamiliarity of the context, containment in supervision and ideas around being a new therapist.

Once interviews were transcribed I read each transcript, jotting down notes, observations and queries on the printed transcripts. I then made summaries of each interview. My supervisor and I met to discuss each interview. These meetings were an important part of the analysis. It was useful to consider a different reading of the interviews, and having another person’s input helped to clarify themes and verify my own interpretations. “Credibility checks” (Elliott, Fischer & Rennie, 1999, p. 222), or

validating the interpretation through consultation with others, play an important role in legitimising qualitative research.

The focus at this stage in the process was to form a coherent structure within the themes. All interviews and summaries were read a number of times until I felt a deep understanding of the material had been gained. Relevant extracts were highlighted and coded by theme. This means different sections of the data were marked as relevant or as instances of the emerging themes (Wimmer & Dominick, 1983). The emerging themes and questions were reformulated and refined during these readings, as well as during the meetings with my supervisor. The theme of 'supervision as containing', for example, was an idea that came directly from the interview material and occurred throughout all interviews. Once categories were clarified I returned to each interview to look for further instances of the themes.

I adopted an open-coding process (Terre Blanche, Durrheim et al., 2006), whereby new ways of coding were developed if I found the original codes did not accommodate the data. Coding was fluid and was also reformulated and refined as the process progressed. Themes were explored more closely through a process of elaboration and re-coding in order to ensure that a deep understanding of the data was established, and that all new insights into the data had been explored (Terre Blanche et al., 2006). Themes were integrated where necessary. I used these themes along with my reflections on the data to write up my interpretations of the material. Extracts from the data have been integrated into the analysis chapters. In these extracts "(.)" indicates a pause, and "…" indicates that some words have been left out.

The results and analysis are presented together as is common in qualitative research. Two chapters are used to present the findings. The first focuses on themes linked to the uniqueness and unfamiliarity of Alex, and the challenges that trainees experienced there. The contradictions evident in the experience of Alex are explored. The difficulty of being a new therapist in such a context was a common theme throughout interviews, and is thus elaborated on. The second results chapter focuses specifically on supervision in Alex and the interaction between the context and trainees' experience of

supervision. The idea of supervision as containing emerged in all interviews and this idea is used to explore secondary themes related to supervision.

Principles of good practice in Qualitative Research

In *quantitative* research issues of validity and reliability are of great importance for the quality of the research. In *qualitative* research, these issues are approached from a "trustworthiness" point of view. Stiles (1993, as cited in Elliott et al., 1999) equates reliability in quantitative research to trustworthiness of observations and data in qualitative research. He also equates standards of validity to trustworthiness of interpretations or conclusions made from the data.

Based on Stiles' ideas and a number of other sources, Elliott et al. (1999) developed seven guidelines pertinent to qualitative research in order to:

- Contribute to the process of legitimising qualitative research;
- Ensure more appropriate and valid scientific reviews of qualitative manuscripts, theses, and dissertations;
- Encourage better quality control in qualitative research through better self and other monitoring, and
- Encourage further developments in approach and method.

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Under the heading of each guideline I have noted the ways in which this research attempts to follow these guidelines.

1.**Owning one's perspective** - I have remained aware throughout the research and writing up process of my own position as a Clinical Psychology Masters student who has experienced working at Alex Clinic. It has been important to note how this may have affected my observations and reactions in interviews, as well as my reading and interpretations of the data.

2.**Situating the sample** - Basic descriptive data has been provided about the research participants in the study. This is to ensure that readers may assess the relevance of research findings to possible situations and populations. Of importance in this study was situating Alex and the supervision at Alex clinic. As each participant's specific life

circumstances are not of particular relevance to the research a more general approach to describing the sample has been taken than perhaps in other qualitative studies.

3.**Grounding in examples** - Many examples from the data are used in the results section in order to illustrate the process of analysis and the interpretations that have been made. This provides readers with an opportunity to produce their own ideas and interpretations in relation to the data, and to assess the author's understanding of the data.

4.**Providing credibility checks** - Throughout the process of analysis and writing up the original data has been re-read and continually referred back to in order to ensure credibility. Discussion with my supervisor throughout the process has helped to validate my interpretation and to make me aware of any inconsistencies in interpretation and understanding. Interpretation was also validated with one of the supervisors from Alex who felt that the research provided a credible interpretation of the data. Patton (1980, p. 339) states that "the ultimate tests of the credibility of an evaluation report is the response of decision makers and information users to that report," thus validation by the supervisor provides a positive appraisal of credibility. Comparing data to my original notes taken from the case notes has also been helpful in assessing the 'trustworthiness' of data and interpretations.

5.**Coherence** - This guideline states that understanding should be presented in a coherent and integrated way while preserving nuances in the data. Much time was taken in developing the structure of the presentation of results in this study. This planning was done to ensure coherence and consolidation of findings. Many full quotes, including seemingly peripheral comments by interviewees, have been used throughout the presentation of results in order to preserve nuances.

6.**Accomplishing general vs. specific research tasks** - The focus of the study is on understanding trainee clinical psychologists' experiences of work and supervision in Alex specifically. A more general understanding would have required a larger sample. The limitations in extending the findings to other contexts and individuals have been mentioned, however the specific insights gained will no doubt be useful more generally.

7.**Resonating with readers** - In writing the research report I have strived to stimulate resonance in readers. An expanded understanding of the context of Alex has been given, followed by a portrayal of trainee therapists' experiences of working there. The aim is to expand the reader's knowledge and understanding of the experience of

working and having supervision at Alex clinic and all that this entails for trainee therapists.

Ethical considerations

This study complied with the University of the Witwatersrand's standards of ethics for research, and ethics approval was granted by the University's Human Research Ethics Committee (Non-Medical). Issues of informed consent, voluntary participation, confidentiality and consideration of potential risks and benefits for participants were of ethical importance. These issues were monitored throughout the research process.

I contacted participants by telephone and gave information about the research. I informed participants that participation in the research was voluntary. Participants were later given an Information Letter detailing the purpose of the research and what interviews would entail. Participants were informed that they could decline to answer questions and could withdraw from the research at any time without any negative consequences. They were also made aware that there would be no direct benefits or risks related to the research. It was felt that there were no direct risks related to the research as participants are not a vulnerable population and questions in the interview schedule were not intrusive or personally exposing for them. Should any difficult issues have arisen, participants, given their positions as psychologists, all had access to support in the form of their own personal therapists and the training staff at the university.

Prior to being interviewed participants were required to sign informed consent forms and recording consent forms. As there was a strong possibility that participants would discuss clients that they had seen at the clinic I requested, prior to the start of the interview, that pseudonyms be used to ensure the anonymity of these clients, and that participants disguise client material.

Interviews were done face-to-face and thus anonymity could not be guaranteed. Confidentiality of participants was however ensured through the use of pseudonyms, the exclusion of identifying details in extracts and the non-disclosure of the gender of participants. Further, as the Clinical Psychology Masters students form a small

population, only sections of the transcripts are used in the write up of the research to minimise the likelihood of recognition. Full transcripts of the interviews are thus not included in the appendices.

As participants were students at the same university as I, and as my supervisor may have evaluated these students previously in other contexts, my supervisor was not made aware of who was interviewed. Only I had access to the audio interviews. All identifying information was removed during transcribing and prior to the supervisor having access to the material. This ensures confidentiality and that the supervisor's evaluation of the student in the academic context is not affected in any way. This was not a direct risk since the supervisor was not directly evaluating any participant in an academic context. However, since the supervisor had previously been a lecturer to participants, it was important to preserve confidentiality in all material the supervisor read. The names of the supervisors in Alex have also been removed from transcripts and have been replaced with the letters 'H' and 'H.' All material is to be destroyed once the research report is handed in and marked.

Chapter 4: Results Part 1 - The Context of Alex

As described in chapter 3, analysis of the interviews was somewhat informed by theory and was influenced by the examination of the supervision notes. However, the study was predominantly inductive and the core themes and ideas to be discussed emerged primarily from the interviews themselves as analysis progressed. A number of striking commonalities and differences were evident. The study focuses on experiences of the context of Alex, and experiences of supervision within this context, and particularly how these experiences relate to each other. From the interview material obtained, three central themes emerged, namely the trainees' experiences of Alexandra (Alex) as unfamiliar and different; their struggles as new therapists, particularly working within a strange context; and their experience of supervision as a space within which to 'think' about these experiences and difficulties, and have them contained. This chapter addresses the first two themes.

Trainees describe facing a number of different struggles at Alex Clinic. Firstly, given that trainees are in their first year of Masters training and many are seeing "real patients" for the first time, there is an intense discovery process taking place. Trainees related the feeling of being new therapists and the process of trying to find a space for themselves as therapists. This task was made all the more challenging given the context within which they were trying to do this. The context has its own unique challenges and difficulties. It seems to be the interaction between these challenges, being a new therapist and working in a community context, which make the need for supervision all the more intense. As supervision is also a new space for trainees, however, this too has its own complications, within which trainees are attempting to find a way of working. What emerged from the interviews was a process, in many ways unique to the context, of development as a therapist over time, and the digestion, and sometimes non-digestion, of the elements of the context through the process of supervision.

The analysis will follow the trainees on their "journey" from encountering the unique context of Alex for the first time, through the struggles and challenges that are presented to them as new therapists, all the while being aware of the role that

supervision plays in making this process manageable. The contradictions in this process are also discussed; i.e. the particular anxieties, frustrations and struggles that are evoked both in the therapy space and in the supervision space; the content that remains unspoken and unprocessed; and lastly, the lasting effect that the experiences have on the new therapists' professional identities and future work. This chapter will focus specifically on contextualizing the trainees' experiences by presenting their descriptions of Alex and the clinic.

Experiences of Alex

In order to fully appreciate the relationship between trainees' experience of the context of Alex and their experience of supervision within the context, it is necessary to first understand how the interviewees experience Alex and what their responses to the context are. Relating experiences of working in Alex in the interviews seemed to stir up relatively intense emotions for many of the participants. More than one participant became emotional during the discussions. What emerged from the data was a rich and descriptive sense of Alex township, the context of Alex Clinic within this, and the therapy space embedded within both of these.

Amy broadly contextualises Alex within South Africa: "*Alex was, the context was so unique just because of um its place in South African society*." She touches on how distinct Alex feels as a setting as opposed, perhaps, to other places with which she is more familiar. The uniqueness of Alex gives it a very 'real' feel, as described by Lucy:

> *I think again the context specifically being very real and raw and poor frankly, um (.) made it taint everything in the experience with a sense of grittiness and realness.*

The words '*raw*' and '*grittiness*' suggest aspects of a basic environment which is not softened in any way.

Alex is introduced to the trainees prior to their arrival at the clinic to work. Trainees relate how the context is presented in such a way that some of their preconceived anxieties are contained:

> *They [the supervisors] explained to us that people do feel a bit tense driving into a township, but it's quite a safe place.* (Lucy)

Again the supervisors made it, were very reassuring about Alex. There were no, we weren't ever told anything bad was going to happen or to be fearful of anything. It was presented as sort of a good clinic to go to and this is what our experience is going to be. That sort of set the foundations for what I expected. (Sarah)

By setting up the context of Alex in particular ways the supervisors provide a sense of containment. They assist the trainees to think about the context before it is realised.

The context is first experienced without full engagement in the form of a tour of Alex township and the clinic, organised by the supervisors. Jill remembers:

We went for some kind of a tour or whatever in the hospital, seeing the different places and seeing the poverty, just that first encounter, the people and the lack of resources.

It is evident that simply entering the context of Alex and being faced with the social circumstances of people living there is striking for this trainee, a reaction shared by many of her colleagues.

Despite the preparation and 'pre-containment,' entering Alex evokes difficult feelings and anxieties for many of the trainees. Going into Alex township tends to be a new experience for many trainees and common to all of the interviews was a sense of Alex being a 'different,' 'unfamiliar' space.

It's a township and I had never been to a South African township as such, um that was a fear. (Amy)

I think it was difficult going into Alex, just you know being in that environment. (Sarah)

The context evokes fear because it is new and unknown. This is in spite of physical proximity to the trainees' known worlds.

Alex is a township close to the more affluent suburbs of Johannesburg, where many of the trainees live. Yet, they see their own worlds as very removed from the context of the township.

> *I think what struck me ... is that it's pretty close to where I live. I mean this is my area, I've lived in this area my whole life and all of a sudden I was exposed to, um a reality of my home town, which, I guess I had been quite sheltered from and that I hadn't really been that aware of before.* (Olivia)

The proximity of the township to her home intensifies the feeling of the 'unknown.' It is an unexpected, unfamiliar space which she has not previously been a part of.

A sense of being separate is similarly mentioned by Amy who uses the term "*outsider*" to describe her experience:

> *What's aroused by going into Alex … What was aroused for me … Kind of feeling like an outsider going in and not knowing what was happening in Alex, not that it's a different universe, but kind of not feeling a part of the community and not knowing what to expect*.

Despite her assertion that Alex is not a 'different universe' her disclaimer suggests that it does *feel* like a different universe to her.

The unfamiliarity of the context breeds anxiety for trainees and the consciousness of the unknown prompts fears for safety. "*Just a fear for my own safety. A fear for my car, my material safety,*" Amy says. Lucy debates her values in relation to her personal safety:

> *I've always been a strong activist and humanitarian and all of that, and challenged racism and all of that, but I think we all realistically, driving into Alex where you know that crime is even higher than anywhere else, so you know there is that kind of maybe anxiety, is it safe? Are we going to be safe going into Alex?*

Trying to downplay her fear, it seems important for her that she holds onto her identity as a non-racist "*activist and humanitarian*." The deep anxieties are, however, evident in her escalation of her own questioning and these anxieties seem to need containment. There is a sense that the anxiety is a primary one related to safety, life and death. The anxiety stirred up by being in Alex is of a primitive, and hence often terrifying, nature.

Struggling with personal values and identity seems to be common for trainees working in Alex. In terms of identity, trainees seemed to be acutely aware of being 'different' within the context. This sense of identity difference produces its own anxieties, specifically related to identifying with and understanding the people within Alex: "*How am I going to identify with these people. Our experiences are so different, I come from such a different world*" (Sarah). Like Amy, Sarah uses the idea of "different worlds" to describe how she feels in Alex. She is acutely aware of how different her own life experience differs from that of a person in Alex.

For some trainees the idea of difference is linked to cultural and racial distinction:

> *I think also a racial fear, not necessarily (.) For myself I think I stand out, my fear would have been that I was standing out like a sore thumb and being white in a mostly black area, um and wondering what that meant inside for other people, insecurities, I mean not necessarily fears but insecurities around um (.) Whether I knew enough about um (.) Um, also the cultural differences, that whether I knew how to respect an elder, that I, or that I knew the subtle differences in how to treat people whether that's in the sense that I wanted a client to feel comfortable or I didn't want to be seen as an ignorant white person.* (Amy)

Amy transfers her personal, racial fear to a fear of being ignorant. She questions her own knowledge and ability to fit into the context.

In spite of the many contextual anxieties most of the trainees held a positive view of being within the context where their clients live:

> *I think actually being based in the township is quite nice, working within the community clinic gives you more of a sense of where people are at in the real world than just like at varsity or living in the kinds of places we live in. Generally most trainees come from relatively middle class kind of backgrounds.* (Lucy)

Being based in Alex gives a more real sense of the clients' lives and, to some degree, bridges the gap between trainee knowledge and the unfamiliarity of Alex.

> *My experience, it was a wonderful experience, um it really expanded my world view although I had theoretically thought about a lot of it and I'd, I mean a lot of the context, the context of Alex and the suffering and struggle, the type of things that happen in Alex, you know about it, or I knew about it on the theoretical plane but actually to be in it, but to be in it, to become a part of it, to share in a lot of the things that people were struggling with, that was, it was very special (.) Or it was, it was intense because a lot of the time, I think in the beginning I felt quite helpless around it.* (Amy)

The real experience of being in Alex prompts a growth in cultural knowledge for Amy, something she seems to value. From these quotes it is evident that the intensity of the environment is in one sense 'special' and 'wonderful' but in contrast to this is the feeling of helplessness that it arouses.

Ambiguities of being helpful and helpless pervade the interview material. On the one hand an urge to "do something," to give as much as possible, is prompted by the striking deprivation, poverty and need evident in Alex township. On the other hand there seems to be a feeling of helplessness and inadequacy. Lucy tells of wanting to provide: "*I think a very strong sense of needing to be able to provide something (.) help.*" Amy echoes this idea when remembering a specific case:

> *There was … a young girl who had been abused and my, and I think my initial response was no, you know wish you could get her out of the situation or you could change her life for her and it's not like that, you can't do that and it felt initially quite helpless to just be there and um, sit with it with her, rather than to be active and do something about it.*

There is a clear contradiction between her urge to "do something" and her helplessness at not being able to do anything.

Much of the helplessness plays out in a different way to the anxiety for one's own safety. The feeling of helplessness creates an anxiety around the usefulness of therapy within a context where basic needs are not met. Trainees start to question the

profession of psychology and the context prompts the fear that the work the trainees are expected to do will be of no use. Three interviewees voice this in similar ways:

> *It kind of made me think about, well what kind of good can I do here if people don't have food to eat and are living in such terrible conditions*. (Sarah)

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> *Sometimes you know one wonders what talking will do when a person doesn't have food, doesn't have proper shelter, that kind of thing, their basic, basic needs are not met. Um (.) So then it makes one anxious, what am I actually going to be doing? Am I actually going to make some kind of difference or will these people just come ask me for money and then I'll have to say no, because that is what we do, don't give them money*. (Jill)

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> *Feeling consciously incompetent, the high levels of anxiety from a personal perspective, um, the difficulty in how you really help people whose financial, material um you know, place in the world is dire and you can't actually do much about that and does it really help having someone sitting and talking to you when they are going back to this abusive husband or terrible life conditions with nothing, no money, you know that kind of thing?* (Lucy)

All three of these extracts show an acute awareness of the living conditions in Alex and what this potentially means for the therapy space and the trainees' work here. Concerns about social circumstances are converted into anxieties about personal and professional competence.

The feelings of helplessness and inadequacy play alongside the anxieties around being a new therapist and trying to establish one's way of working, such that one feels useful and competent. Without a predefined professional identity the struggle for competence in an environment defined by such need, is intensified. This doubt, questioning and anxiety does, however, find some sense of containment in supervision where encouragement about the usefulness of therapy is given:

We are coming with this thing that this is how it should be and this context just isn't good enough, but you'll find the people who come there, do feel that it is good enough and they take something away from it. So for supervisors, and I know H, she has been there for a long time, she's able to encourage it in that way, you know it does work, it does help. With experience with the clients you do see that. (Jill)

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Jill also points to her own realisation, over time and with experience, that therapy helps despite the need and the lack of resources. She goes on to relate a case:

There was someone I saw there, a bereavement case, and (.) Ja (.) she was (.) very poor and would sometimes come to the sessions, having had nothing to eat and she wasn't asking for something to eat and she never asked for money, she just wanted someone there to go with her through the process of mourning, the loss of her son, and for me that was quite powerful because someone else would think, you know why am I even going to talk if I haven't had anything to eat, but to her in someway it just, it wasn't, it was more important to come.

Jill is surprised by her client's commitment to therapy, but at the same time there is a sense of admiration for the woman.

Amy and Sarah speak of a similar reassurance of the usefulness of therapy, and more specifically psychology, within the space of Alex:

The more you are busy and the more you see what you are doing, what it does to be, to be a psychologist, um, the more comfortable I got with being in that space and feeling that that space was valid. (Amy)

←

I think because it was the first part, sort of the first part of my year. I think it really provided me with a sense of my own competence really and also just working with the people and noticing the difference that you're making at the clinic. (Sarah)

As new therapists the trainees need proof of the usefulness of their work. Only with experience are they able to feel useful and competent within the context.

Alex Clinic

Within the context of Alex township the actual Clinic is experienced in different ways by trainees. For some it seems to provide some containment and a sense of safety, for example:

> *I knew that the community centre (.) the community centre itself felt like quite a safe space to be in. I think we all sort of felt that, because um (.) and it helped to dispel a lot of those misconceptions maybe.* (Lucy)

For others, however, the clinic was not particularly separated from the rest of Alex and there is more of a sense of being immersed in the culture, the context and the difficulties of the township:

> *I felt quite, at times, vulnerable. A woman and white and different and um (.) Also 'cause you're not really, at Alex, you're not really, almost locked away in a kind of a hospital or building that you can call your own or that you know how to um, how to stay safe or how to, you know it's all very out there and open and um, anything can happen and you just need to deal with it.* (Amy)

The trainees' accounts suggest that there are specific anxieties that are stirred up by being in this environment and the sense of vulnerability that seems to go with it. The anxieties are linked to a fear of harm or annihilation, and being "*out there and open*" makes this fear more apparent.

Another aspect of the environment that impacts on trainee experiences is the fact that Alex Clinic is a primary healthcare clinic and as such the space is a particularly medical one. Sharing space with medical staff presented its own difficulties for trainees. Cubicles are shared with doctors and nurses, and the volumes of patients, both medical and psychological, mean that cubicles are in high demand. Trainees cannot be certain that they have a space to see their clients. Setting up a space for therapy or "*conquering a cubicle*" (Amy) becomes the trainee therapist's first task in therapy. Trainees describe having to fight for cubicles, "*Sometimes not finding one and then,*

you know cubicle, and then going to find another cubicle" (Kerry). One of the challenges is being assertive within the medical environment. What makes this more difficult is their uncertainty of their position within this environment. Finding a space for psychology within a medical framework presents practical as well as internal struggles for trainees as discussed by Amy:

> *There was not a space for psychology as such and you were part of either the female sexual, gynaecological ward or you were part of the medical ward, I believe it was the other one, and it was about being assertive with doctors or registrars that walked in and said 'well we need this cubicle', giving me the sense that I didn't have a right to the cubicle because I was just a psychologist, um so in that sense also not a space for psychology, it's, um in the medical world it felt like it wasn't being valued ... For me at that time, um I felt particularly disregarded as a, ja as a psychologist*.

Again this seems to play into trainees' anxieties relating to the use of psychology and their own sense of helplessness and incompetence.

Once "conquered," cubicles are not ideal for doing confidential, uninterrupted therapy. Descriptions of the cubicles paint a picture of a tiny space, open to the noisy ward and separated by only a "*tattered kind of curtain*" (Kerry). Interruptions by doctors, nurses and other patients are frequent. Olivia describes this:

> *Initially I found it a bit intimidating working in the small booths and um, I found the lack of privacy almost an intrusion as well. The holes in the wall and knowing that people can kind of hear you and the nurses or doctors would be peeking their head in. I guess these kinds of uncontrollable intrusions that were part of the location um (.) I initially found quite difficult to deal with*.

The word 'intrusion' suggests a discomfort and lack of safety. The uncertainty of the experience is described similarly by Kerry:

> *I think in the placement you feel quite um (.) it's pretty scary, I think. Um, you know the cubicles, where the cubicles are … you know that you get interrupted a lot, and dealing with those interruptions and how to, how to deal with that stuff.* (Kerry)

Learning to deal with interruptions becomes a part of the overall learning process.

The experience of working in small cubicles is initially intimidating and “scary.” The lack of resources is a further challenge for trainees:

> *You know are going to see a child and you are working in a hospital um, or whatever, or even at Wits and then you organise the room, play therapy you have toys. You have resources, now if you go into Alex, there is no such, I mean you'll have paper and crayons*. (Jill)

←Mentioned in this way, paper and crayons are not sufficient. The lack of resources challenges Jill's previous experience of, in this instance, play therapy.
←

Being part of the medical ward also means that psychology trainees are mistaken for medical doctors, in a literal way, by the patients. Kerry remembers an instance of this:

> *The clinic culture as well, you know that you share cubicles in a men's check up section or whatever. Um you know I had quite a, a very interesting experience, that I had some guy drop pants, his pants ... I couldn't read the referral (.) ja he thought I was the doctor*.

Although spoken of humorously the shock of the experience in evident in Kerry's description. Jill, who had a similar experience, speaks about having to deal with “*those kind of weird experiences*.” The setting presents trainees unique challenges and all of these factors play together to create an even more unfamiliar experience. Olivia describes how this impacted on her:

> *I found it quite shocking at times, especially initially. I think after a couple of weeks I got some tolerance to it, but um (.)*

←
There is a certain shock associated with working in Alex and the clinic is a place that needs to be “*adapted to*,” it is not somewhere where trainees immediately feel comfortable and at ease:

> *Adapting to such a different environment where, um the therapy space wasn't so separate and removed and private and um, I think that was quite a step for (.) I mean I understand the necessity for it, um, but I think it was quite challenging for me to deal with … getting used to, working in a much smaller room, um, with less resources , with less*

privacy (.) um ja so I think partly it was adapting to that new environment and which was very different to any personal counseling I had done in the past, and the room, if I was using a room, the room was mine and the rooms were relatively big and we had a comfortable chair and we weren't, there was no chance of it getting interrupted, um so, so, I don't know it was quite a, quite a change to begin to work in a venue that was so different to anything I had experienced in the past, and I think, I think I, over time I did acclimatize to it and it became quite normal and I became quite used to it. I would try and find the same booth if possible. (Olivia)

←There is a strong contrast between what Olivia is used to and what she needs to adapt to in Alex. Finding some familiarity, such as the same booth, makes adapting more manageable. Speaking more broadly, Jill comments on what specifically trainees have to adapt to:

One has to adapt to the circumstances. The poverty the people are faced with, the lack of resources. Sometimes there would be disorder.

←

The sense of "disorder" relates to more than just the physical adjustments trainees have to make in working in the cubicles. There is lack of structure within the clinic which is linked to the setting, the circumstances and the lack of resources. This "disorder" is echoed by Lucy who experiences the atmosphere as chaotic:

You were really put out there and there was a lot, often it felt like it was a chaotic environment and you had to be assertive and sort of confront people.

←Being assertive and confronting people is not something Lucy seems used to or comfortable with, and the phrase "*put out there*" suggests a sense of vulnerability.

←

An unreliable space creates a greater sense of instability and insecurity and, in some cases this seems to affect the work that the trainees are doing. Olivia describes how she found it difficult to do therapy in a space where she did not feel secure:

Maybe it was more difficult for some of the clients to open up in that space, or for me as well, maybe I … more than in a space that I felt was more secure … I think in a situation where there's a more secure

environment, a more stable office, and stable frame and set periods of time, I think perhaps it would be possible to allow people to open up a bit more, I don't know. Perhaps it would be a little bit easier for me to deal with … I think it would entail less adapting.

Olivia transfers some of her own discomfort with the lack of stability to her clients, assuming they, too, find this difficult. She realizes, through speaking, that the difficulty is more to do with her own need to adapt.

The certainty of the psychological frame is removed and trainees cannot rely on having a set, stable physical space in which to do therapy.

It was quite funny 'cause we were being taught the frame so intensely and the first thing that happens is that you go to Alex clinic and the frame is so tenuous because you are in these little cubicles with curtains that people just open even if you've stuck signs up saying … do not disturb and we would tell everybody and the medical students would just come barging in, or people would come barging in because they needed something from the room and that kind of thing. (Lucy)

Lucy highlights the contrast between theoretical knowledge and clinical practice, the difficulties inherent in adjusting theory to context. Trainees are having to create the theoretical frame and contained space without the reality of this space physically, and regardless of what is going on around them. This is made all the more difficult given their relative inexperience.

I think what is unhelpful is that the context is so (.) transient and so loose and so, but you have, but one has to create it. (Amy)

Creating this space is something that trainees describe as developing over time, but which, conversely needs to happen quickly in order for therapy to take place within the setting. Lucy explains the challenge:

That was quite difficult because you are trying to learn something and then already learn to be flexible with it. But I think as you develop as a therapist the frame becomes more around you and the patient regardless of the context and you learn to kind of take interruptions far more easily and the frame stays intact more even when somebody

is knocking on the door and barging in … so that was quite an interesting thing to be experiencing in quite a practical way.

Lucy suggests that the difficulties linked to the context are contained in some way and thus interruptions and intrusions become more manageable with experience.

Working with patients at the clinic

Doing therapy within the context of Alex clinic holds its own unique complications and difficulties, many of which an experienced therapist might find challenging and intimidating. The physical challenges discussed above play an important role, but the types of patients seen further complicate the situation. The task of the trainees is made more challenging by the fact that they are, as Amy relates, "*beginning (.) [the] journey in terms of learning to be a psychologist*." Many are seeing "real patients" for the first time and there is an intense discovery process taking place:

> *I felt that we had to learn all at once not simply just doing therapy but also how do you make yourself, how do you give yourself a space and how do you give psychology a space, the therapy space in a context where initially it felt like we were much of an afterthought and maybe that was my learning as well that I felt that psychology was a bit of an afterthought.* (Amy)

For Amy the intense learning experience evokes personal anxieties about the profession of psychology, evident in her idea of feeling like an "*afterthought.*" She hints at personal realisations which result from dealing with the anxieties present in working in the context.

The number of patients to be seen is particularly anxiety provoking for many trainees. Sarah found this particularly difficult:

> *I think the sheer volume of the patients that we saw, I think that was really difficult. Ja, sort of, I can remember going in, thinking I don't know how I am going to manage to see all these patients and hold all their stuff … I'd never seen so many people before, so … That was new and difficult, I think, to, keeping track*.

She questions her own competence and ability to deal with "*all these patients*."

The number of patients and shortage of time leads to a situation where there is not time to think about clients. Jill relates her experience of this:

> ←*This is your patient, maybe coming only for two session, this is the issues, how can you help them and then ... and then there are other people so you know the ball just keeps rolling. You don't just sit and really, really think … being in that context*.

A sense of urgency is evident in this extract, mirroring Jill's difficulty around the lack of time for reflection.

A further difficulty is that patients at the clinic are not screened for therapy and therapists can end up seeing patients with any type of problem. Olivia speaks about this challenge:

> *I think it felt a lot more challenging, just because of the sheer amount of possibilities that were open to anyone who came in. I mean it could be any person with any psychiatric problem and the psychiatric problem could be of many different degrees of um, of difficulty*.

Kerry relates the fear that seeing any type of case provokes, but the possibility of seeing "anything" also presented her with some interesting and unusual experiences:

> *You know again if someone requests therapy they kind of get therapy. So there's no kind of screening, so you could get almost anything. And sometimes you might see very inappropriate stuff, um (.) but I suppose that, you just learn, I mean you learn what is useful or not. But that was, I mean that is something you do sort of fear a bit. I mean I got interesting things*.

←

The types of problems that patients present with seem to have an intensity and urgency to them, linked in some way to the setting. Trauma, multiple bereavement and violent abuse are common. Olivia describes "*the intensity of some of the problems" as "quite shocking initially*." Amy found the stories "*powerful and touching*." Being in the community intensifies the experience of these problems and their immediacy. Lucy shares an example:

In relation to the issues that came up because it was based in the community specifically, you know, and in the environment very specifically, um 'cause when people were talking about being mugged or something it was like two blocks away. Just over there (.) Trauma Clinic people were coming all the way to Braamfontein and they were being hijacked out there somewhere, you know or coming from you know other countries and that kind of thing. Whereas in Alex by virtue of the proximity of the clinic to the people's actual residence, gave you a much stronger sense of location in what the experiences were more immediately.

Lucy is unfamiliar with the immediacy of that the context presents. The "*poor community*" creates "*immediate issues, very dire issues often*" (Lucy) which need to be heard and dealt with urgently:

I would say that sense of urgency, that sense of people really need help, they really need support, they really need a space to be heard, to be felt with, and (.) there was much more of that urgency than I experienced in my other supervisory contexts. (Lucy)

←

The variety of cases and types of problems are scary and unfamiliar on the one hand, and yet exciting and stimulating on the other. There is a sense that there is a great deal of unfamiliarity for the trainees which makes therapy more challenging. Trainees often experience patients as "*lower functioning*" (Sarah) than people that they are perhaps more used to seeing, and the idea of what therapy entails and what its use is, does not seem to be widely understood within the population of Alex. Trainees relate stories of having to explain the process of therapy and how it may be helpful.

The difference in language between most trainee therapists and their patients is difficult for many of the trainees to adjust to. Therapy often has to be done in simple language or with a translator. Olivia remembers working with "*a translator who doesn't translate what you are saying*." It follows that therapy, based on speaking and listening, is rendered more difficult.

The language difference is also related to the difference in culture and class between the trainees and the patients, and the stereotyping that results from these differences. Olivia continues:

> *… and I don't know, maybe dealing with some conceived ideas or stereotypes as well, um for me, as well as for the clients*.

She explains the ways in which this difference was challenging:

> *I think it would have been easier for me to work with people that I guess I was more accustomed to um, but it's having to challenge myself in terms of the limitations of my own um, knowledge as a clinician as well as culturally. It was quite a large challenge for me as well, I think the combination of those things was quite, quite anxiety provoking for me*.

The challenging nature of the work evokes a specific type of anxiety for her, one that taps into very personal issues and limitations. The degree of self-reflection needed for the work prompts deep personal anxieties which may be difficult to think about.

The nature of the setting also means that clients are "*mostly inconsistent*" (Amy). Sarah alludes to the frustration and sense of helplessness this creates for the therapist:

> *It was difficult to maintain coming to therapy because of financial reasons and, but I don't think we could ever come to sort of a, there was nothing that could really be done about that except referring them to social work*.

Amy uses the word "*fragile*" to describe the therapy situation, and hints at her own sense of incompetence in this:

> *It was more fragile. There was less room to make mistakes and learn from them. You'd make a mistake and … the client would just not come back*.

Again the experience feels very personal, perhaps more so than in other settings. Thus the trainee therapists' feelings of helplessness and incompetence are exacerbated by the inconsistency of the patients. Kerry discusses her personal doubts openly:

> *People not pitching is a big thing as well. There's anxiety around, you know, is this, can you provide for the person and really do good*

therapy and maybe you are going to mess up. And then there is also um, will this person come back, and there are a couple of fears around that. The one is sheez I'm not really that good, the person hasn't come back. Another one is you know, supervisors, one of the things they mentioned is can you hold a client, so if they don't come back that doesn't reflect well. Is it something about me?

Kerry illustrates how the anxiety related to people not returning for therapy also finds its way into an anxiety about being evaluated in supervision. There is an awareness that a client's inconsistency in therapy may reflect something about the therapist. The inconsistency, like the other challenges in doing therapy at Alex, is something that impacts on the way trainee therapists work with their clients.

Therapy is in many ways moulded around the multiple challenges that trainee therapists are faced with in the therapy situation at Alex clinic. Despite the intensity of the cases that present, therapy is described as often being "*quite superficial*" (Amy). Trainees describe interventions as generally more concrete and practical as a result of the context:

It doesn't mean the therapy was any less useful. It was just a different kind of use, and sometimes more pragmatic maybe … a recurring theme that kept coming up was that socio-economic problems were such an important factor in so many of the cases … and um, I think for that reason as well the therapy was less intense as well because those needs were more apparent and had a great demand and I guess, like Maslow's hierarchy of needs, you can't focus on in-depth psychological introspection if you don't have basics. (Olivia)

This extract gives the idea that therapy at Alex clinic is focused on basic survival.

And I think in Alex its kind of quite different than in other places. Just thinking about it now, because um (.) it's a very, the surroundings are very unstructured and you know the person's environment is very unstructured, so you just want to give them structure or hold them in some kind of way, and I hope this isn't getting too complicated but I don't even think, you know even though you are not aware of, completely of what holding means or whatever you do have that

feeling that that's what you want to provide and do for that person (.)and um ja you become very invested. (Kerry)

The focus of therapy for Kerry is on holding and providing a structure for clients. Primary needs are again most prominent in the therapy situation.

Similarly, Amy felt "*most of the time it [therapy] was about containment and hoping that someone would come back*." She goes on to describe a particular case of a child she saw:

… giving someone attention and thinking with someone and wondering about stuff with someone was already, for most of the people that I saw, was already very valuable that they had a place where they could sit down and talk and even this child, um that there was a possibility to do something together and do it with care and um, to play a bit also to create together was very unusual for her in her context, in her daily life, where she went to school, and came home, and had one pair of socks, and had to you know clean them everyday, and if she didn't, she got a hiding for it and um, it's, it's not a context where she could do a lot of playing or where playing was a part of reality in, um at home. So it was, that was a very big thing for her to be able to do something like that.

←

Flexibility and creativity are spoken of as concepts which are invaluable, or even essential in the context, given the lack of structure:

It wasn't like TMI or another child facility that had been structured in that there were rules about how you work and there are processes that you go through, that wasn't there so you do that every time, for each individual it's a creative process and you're very much a part of that in that context. So it's the context that it's not, you're not plodding, you're not fitting into something that already exists but you are the one who, in your group that that group is creating what's there. (Amy)

Again Amy focuses on the differences between what she is used to and the work in Alex. While a lack of structure may be difficult, there is also something exciting about being a part of a creative process.

Kerry speaks of needing to "*vary your tools, especially if you're working really short term and you're in a community where you could pretty much see anything*" (Kerry). "*Versatility*" becomes important, as does **"***being allowed to be creative in that small space in those circumstances*" (Jill).

Trainees explain that within the context "*you do what you can*" (Jill), "*you just have to go with it and do the best you can in that situation … And do the best that you can in that moment*" (Olivia). 'Doing what one can,' however, comes with a sense of responsibility, a "*burden*" which Kerry speaks about:

> *I think in the placement you feel quite umm (.) it's pretty scary, I think. Um, you know the cubicles, where the cubicles are, it's just those tattered kind of curtains and you see like a very variable kind of cases. No real screening process and um, you are quite uncertain about what to do and you have a very limited amount of time. So in terms of that you feel like shoo you know it's, there's a lot of responsibility … becoming aware that you are almost this person's only source of support is an incredibly big burden*.

Paradoxically the sense of responsibility seems to create, for trainee therapists, an increased investment in the therapy work that that they are doing. In contrast to the difficulties experienced, the therapy space within Alex is also described in positive ways. Kerry sums this up:

> *That hour is so precious and it does become that privileged space, it's almost sacred (.) but in the same way it's, it's hectic*.

The words "*precious,*" "*privileged*" and "*sacred*" are meaningful and hold strong positive connotations. As with many of the extracts depicting Alex the description is balanced by the tangible experience evident in the word "*hectic.*"

The ways in which Alex is experienced are in juxtaposition to each other and yet trainees are able to hold seemingly opposite sentiments about the context. The trainees find Alex different and foreign. The challenges they face are unfamiliar and yet have the potential to be exciting. Trainees are continually aware of how different Alex is to what they know, and a great deal of adaption and personal growth is required to work in the context. While some experience of the context remains raw and unprocessed, to a considerable extent experience is thought about and contained. Anxieties and challenges are rendered meaningful through a process of transformation or ‘digestion’ that happens. From various comments in the interviews, it would appear that supervision plays a prominent role in this process.

Chapter 5: Analysis Part 2- Experiences of Supervision

Trainees' descriptions of supervision offer insight into the process of supervision in Alex. The intricacies of the workings of supervision are indicated in the trainees' discussions of the intense challenges and contradictions inherent in receiving supervision in Alex. Despite the frustrations of supervision, it is evident that a process occurs in supervision that has the ability to contain and transform experience and anxieties. Trainees describe being given a safe space to feel and think in supervision, and it is this space that promotes development and growth.

Experiences of Supervision

Containment

What was most striking about the interviews as a group was the common description of supervision as "*containing*." Within the first page of all six transcripts, the word "*containing*" was used to describe the experience of supervision within Alex. For example:

> *So that, yeah, I think containing would be the word I would use immediately*. (Amy)

←

> *So I think for me, it was really useful, the whole way through was the containment that was provided, I know I'm saying that over and over*. (Sarah)

Within the context of Alex, containment becomes the most important aspect of supervision. Trainees feel they need "*a lot more containment, a lot more direction*" (Sarah) than in other settings, and supervision offers a sense of structure and boundaries, in contrast to the chaos and unfamiliarity of the setting. Olivia describes how structure is created within the supervision space:

> *It's like the structure, the way the supervision was set out, and it's a very definite structure. It was very clearly delineated, almost like a frame (.) and um, H particularly, and H as well, they were very clear on maintaining those boundaries on how the structure was run … Like*

after seeing your client you could not speak about two clients, you could only speak about one … so I mean there was a very definite structure that gave both the supervisors and us, the students, a very clear idea of what we could expect in the space.

Trainees know what to expect in the supervision space and this is containing for them.

Trainees learn a variety of psychodynamic theories within their first year, and many have received undergraduate degrees with a psychodynamic leaning. Similarly, supervisors have their own theoretical ideas and styles. What is distinct in the interview material, however, is the common use of the language of Bion's theory and Bionic concepts. There seems to be something about the processes that Bion describes between mother and infant that are useful in talking about the process of supervision, particularly within the context of Alex. The concepts of containment, reverie and alpha function all find a place in describing and talking through the experience of supervision in Alex.

Supervision as new space

For many of the trainees, particularly those working in Alex during their first six months, having supervision is a new experience. It is another space that they need to adapt to and some of them give accounts of trying to find ways of accessing the supervision space to its full potential. As Kerry acknowledges:

You are kind of also figuring out what supervision is about, especially if Alex was your first six months (.) umm (.) and how to use supervision. I mean, I wasn't even too sure about how to use supervision, you know like in the best kind of way.

The trainees' anxieties in Alex, together with a relative lack of understanding of the function of supervision, means that trainees often expect a lot from supervision. There is a sense that trainees want supervision to provide a structure for therapy. They also seem to expect supervision to make the unknown known, as suggested by Jill:

You know I presented this case but, I'm getting out of supervision but, I still don't know what the next step is going to be … In some ways one wants to prepare for the next session, know where to go and then

you're told just go with what the client brings, and you want to be prepared [laughs].

←

She expresses a desire for supervision to provide her with 'a plan.' She goes on to describe how with time she learns to trust in herself more and to work with what the patient presents in the session:

Now I understand what it means to just wait and see what the client brings, because when you go in with your own agenda, it just doesn't work. So at the time, I was still fresh, still trying to ... How can I help him, how can I explain, you know … So it's almost like you are being told um (.) Again, you'll know in the room, you can't know now. You can't know ahead of time. What you can do is talk about was has already happened in your sessions, not what is going to happen 'cause you don't know, but it makes much more sense now than it did then. (Jill)

The extract suggests a level of frustration at not being told exactly what to do. A part of being 'fresh' and becoming familiar with how to use supervision is learning how to deal with the frustration inherent in the process.

The impact of the context on supervision

In asking the trainees whether they felt that the context of Alex impacted on supervision there was a general feeling that there was a definite and strong link between the two. Olivia was emphatic about this idea:

Did the context impact on the supervision? (.) Without question. You see for me in my experience I can't, I know that Wits has been, you see it's hard for me to separate the two, the supervision from the context, because I know that Wits has been using Alex clinic and providing a service there for a number of years.

←Olivia's knowledge of the history of psychotherapy at Alex clinic impacts on her views of supervision. Something about the context creates a unique feel to the experience of therapy and supervision there, and dictates the meaning of supervision.

←

Amy links the need for containment in supervision specifically to the stories that are heard at Alex:

> *You are listening to stories that are very powerful and touching and um, and that you need other people to help you contain that at times um (.) So yes that would, that context, that a lot of stuff happens in Alex, I think because of the poverty and because of the crowdedness and that people are working really hard and ja all of that*.

←Amy insinuates that without containment from an outside source the stories and "*stuff*" that happens threatens to overwhelm her.

←

Of the six interviewees only one trainee, Kerry, felt that supervision in Alex was no different to other supervision she had experienced.

> *The way supervision is done isn't vastly different from anywhere else. I think what really makes it different is (.) different is the setting of the place, which doesn't really change the supervision but it changes what you bring to supervision*.

Despite her apparent insistence that supervision is not particularly different in Alex, the focus of her comment is on the ways in which it is different. She goes on to say:

> *I think you see a very specific types of client in Alex, a very specific type of population, where, I think Alex in some ways, my sense is that it has its own culture, you know um, so you like take that to supervision.* (Kerry)

Again, what seems to be highlighted is the distinctive nature of the context of Alex, and yet the distinctive nature of the supervision in Alex seems to follow directly from this context. The particular culture evokes particular responses for trainees, which would suggest the need for a particular type of containment in supervision.

Stated differently, Sarah used a similar argument to show how supervision in Alex *is* different to other supervision:

> *I think that it was different from any other kind of supervision that I've had, because I think it was difficult going into Alex, just you know being in that environment. I think that the supervision extended from what was happening in the therapy, but also in terms of being aware*

of community problems and developing sort of, um (.) like what kind of therapist you are in that kind of environment. So it was specific to that.

The difference and specificity of supervision in Alex is what the majority of trainees speak about in the interviews. Echoing Sarah, Lucy simply states, "*it was different to the kind of supervision we had in other contexts.*" Trying to explain further she says:

I suppose they work kind of dialectically into each other, the dynamic between them, because the nature of being in the community and doing community work influenced the kind of stuff that was coming out to be supervised. And then that in turn fed back into (.) is that making sense?

Lucy cannot isolate the exact process of supervision in the community. She suggests that what is of use is the fact that the context and the process work together to provide trainees with what is needed.

The intrinsic link between supervision and the context seems to be evident for most trainees. Sarah describes supervision as being "*matched to the context*." In many ways trainees see supervision as evolving from the context over time. Olivia describes her understanding of this process:

I feel that the supervision in turn had um, really evolved from being in that context and from having to supervise first year Masters psychology students … I think, maybe it's just a fantasy on my part, but I think a structure like that doesn't just happen over night. Um (.) I mean from a supervisors' perspective you kind of start doing something and you see what works and what doesn't and slowly you edit and you kind of change things to make it more functional. I don't know, maybe it's just fantasy on my part, but to me it felt like it had developed into quite a functional structure to um, facilitate providing a psychological service to the clients and also um, supervision so as to, for us the students as well.

This extract gives a sense of a well-developed and structured supervision space which is particular to Alex clinic and to the clinical Masters students. Describing the

relationship between the way supervision is structured and the experience of doing therapy in Alex, Olivia later uses the term "*symbiotic*," suggesting a live relationship that adapts and changes as necessary.

One thing that is striking about these extracts is that they make sense but they do not say exactly what the link is between the context and supervision. Perhaps a clue to understanding this vagueness can be found in the throw away remarks included in some of the extracts, for example "*is that making sense?*" and "*maybe it's just fantasy on my part*." This may indicate that the usefulness of supervision lies, at least partly, in its emotional experience rather than in identifiable 'factors'.

In evolving from the context supervision seems to parallel the therapy that happens within the context in many ways. The immediacy and urgency experienced by the trainee therapists in the therapy space plays out in the urgency they feel regarding supervision. This is described by Lucy and Jill:

> *You did feel much more immersed in it [the context] and, I think the supervision linked to it because we were having to respond in that way. Much more immediately, often to people's much more material circumstance.* (Lucy)

> *At Alex what would be different I guess is that some things were more urgent (.) Um so you need something* now. (Jill)

There is a strong need to be heard and supported and supervision needs to be immediate and available 'now' in order to meet the trainees' needs within Alex.

Wanting to protect the supervision space is a theme common to many of the interviews. Some trainees are aware of the fact that they may have idealised the supervisors at Alex during their time there, but also in speaking about the supervision having left Alex. For example:

> *I think I did respond to some of (.) my supervisors in quite an idealistic way, um (.) and even a year and a half afterwards, I do think that the job was done really well. So although a part of it may be me being idealistic, I also feel in my experience of different supervisors that the*

particular instance at Alex was handled really well. (Olivia)

The idealisation of supervision can be seen as a function of the 'neediness' that trainees report experiencing at Alex. The cases seen in Alex prompt a need for protection and a need for a particular type of nurturance and care. Kerry discusses this:

> *I think coming into Alex and having to do the kind of work we have to do, you know the clinical work and start counselling or doing therapy, I think you feel quite out of your depth. So for me what I felt to them is a bit needy maybe. Like you need reassurance, so their kind of, their guidance and their, some of their appraisal and what they have to say, becomes actually quite important, I mean they can be potentially very containing, um you need their support*.

The 'reverie' offered by supervisors incorporates an assortment of functions. They offer "*reassurance*," "*guidance*," "*support*" and "*appraisal*," all of which contribute to the containment that is felt by Kerry.

Exploring her neediness, Sarah focuses on the need for protection within the environment:

> *I think at Alex, I needed a lot more, as I said before, I needed a lot more containment, a lot more direction in terms of what to do with the patients ... I kind of, I felt at Alex, that I needed to be protected almost, that I needed a protective space. I think it was the newness of it*.

She relates her need for protection to both the context as well as the fact that she is a new therapist. Protection is another aspect of the supervisors' containing function.

Lucy is also aware of being a new therapist and the effect this has on her neediness. She finds containment in knowing the supervisors have experience within the context:

> *At times they were a real life line in a very, much more real way as a growing therapist and I think that urgency, realness, grittiness um (.) Definitely influenced my interactions with them and now how I look*

back on it (.) Um (.) 'Cause I don't think I would have managed as well if they hadn't been there and them particularly and the way they responded … Needing them more and needing them in the way that they were because they both had had experience being in Alex for a while … I think if a supervisor who hadn't had experience in working in that kind of context came to supervise us it would have been very different, you know you need to be a lot more aware of what Alex is about, working in Alex is about to be able to supervise in a way that is effective or helpful even let's say.

The "*urgency, realness, grittiness*" of Lucy's experience calls for a specific type of interaction in supervision. Her development as a new therapist is dependent on the experience and knowledge of the supervisors, and she needs them in a way a child might need a parent in exploring a new situation.

Amy rather overtly admits that she feels she would have been more critical of the supervisors had she not needed them as much as she did in Alex:

I think maybe I held onto them for dear life and in another context I might have been more critical towards them definitely, um but I needed, I felt I needed their support so much that I um, and again I feel when I talk about it now I idealise it, um, that it was hard for me to be critical about it. (Amy)

She admits not feeling "*particularly comfortable or a great affinity*" to the supervisors but goes on to describe how, in the context of Alex, this becomes less important:

I think in any other context, I think that would have already made me think well never mind, or you know, that kind put down my barriers, but, but in that context I had to get over that and appreciate it anyway and get used to their ways and their style and their kind of nurturance.

Again the focus is on the strong need for nurturance and containment above all else. Amy cannot specify what exactly she needs from the supervisors but she recognises that in the context supervision plays a crucial role in facilitating her work and development.

It seems that it is not possible to pinpoint exactly what prompts and feeds the process of transformation that happens in supervision. During the interviews trainees mention different aspects of supervision which they found particularly helpful, but there is no one particular factor which can explain the containment and transformation that happens. What is evident, however, is that what is obtained in supervision is invaluable in making therapy possible in Alex. The anxieties related to the context are contained in supervision and the fear of seeing patients is made manageable through supervision. In retrospect trainees seem acutely aware of this primary function of supervision. Amy states simply: "*Over the whole without the supervision that we got there I wouldn't have been able to cope*."

Lucy relates an example in describing a similar feeling:

> L: *The other particular example was this couple, again the flexibility story but again I think I was so scared to see them and then, with the help and input from the supervisors and actually seeing them, I really enjoyed them, and I really enjoyed the therapy together, it was probably, they were my favourite patients … I mean it was scary but once I started easing and relaxing in to it I actually enjoyed it a lot. I actually, I enjoy couple work a lot more than I thought I would*.
> N: *Ok and it sounds like supervision was really helpful for you in that (.)*
> L: *very helpful! Very, very helpful, 'cause I think I wouldn't have (.) I would have just stayed scared. I would have*.

She describes a process of transformation that happens. She does not remain scared but rather ends up enjoying the experience of therapy. Her view of couple therapy is changed into a positive view.

Trainees generally speak about supervision in very positive ways. The supervision space is described as "*an open space where people could speak and express themselves*" (Olivia) and "*a safe space and such a containing space*" (Sarah). For Olivia what was useful was "*just knowing that you are not alone and you do have the opportunity to ask for help*". Feeling "*supported*" and "*encouraged*" (Amy) by supervision is important for trainees but there is something more that is taken from supervision. Amy uses the metaphor of being fed in supervision:

> *That when I didn't know where I was going that I would get support and that, and I would use that, also because it was, I had no prior experience, I didn't come into Masters with any kind of experience so for me it was, anything I got from them I was, I was like a greedy child I would eat it all and I would use it all*.

The image of a "*greedy child*" eating it all, seems to imply an eagerness to learn and grow without discounting the vulnerability and inexperience of being a 'child.' This implies that supervision provides the thinking and holding function of a parent. Being a trainee therapist means that a specific type of nurturance is needed in supervision, particularly in Alex. Some of this nurturance is provided literally, and this sense of being 'fed' is represented in the snacks that form a part of afternoon supervision. A couple of trainees commented on this, for example:

> *The snacks helped as well, the snacks really helped. I think there's something nurturing about that*. (Olivia)

This nurturance is all the more important given the length of the afternoon at Alex, particularly the two hour supervision session following therapy. Lucy voices her experience of this:

> *I mean the length of time, it was actually hideously long … that was just tiring, I don't know how else they could do it differently, or if they would but it is very long and very draining, very, very draining, but then again that might be a function of being new therapists and seeing people for the first time is very draining cause you haven't learnt to keep up your own sort of barriers. You just take on everything*.

Trainees were able to leave therapy in order to have supervision during a therapy session and "*being able to pop in and out*" (Sarah) was something that many trainees report finding helpful. Olivia focuses on the practical aspect of this interaction:

> *We could leave during the session and ask for help if we needed it, which I found extremely useful because I don't think I had that much confidence in my diagnostic skills and I think, in the interventions that had to be done, that flexibility was really important in making an appropriate diagnosis and making an appropriate referral.*

She emphasises diagnosis, intervention and referrals, and describes the engagement during these supervision times as "*short and pragmatic and focused*."

Despite the usefulness of this space the difficulties associated with leaving therapy are also acknowledged. Olivia discusses feeling that in some ways it broke therapy:

> *As useful as I found it I also found it quite difficult. To kind of switch from giving therapy to kind of asking for advice to kind of going back, it was, it felt quite difficult to me to kind of move through the different tasks, to kind of disrupt the therapy*.

Integrating supervision and therapy for Olivia feels disruptive and requires effort, even if supervision is more practical and about "*asking for advice*." There is a evident frustration with the process.

In contrast to viewing this element of supervision as simply asking for advice, Amy felt that it was "*something you can run to when you're feeling desperate or scared*." What is important for her is the emotional availability of the supervisors and the emotional containment that takes place within the supervision space during therapy. Her need for emotional containment is also apparent in the longer, more formal supervision which takes place after therapy. She acknowledges:

> *I just presented a kind of muddled mess and hoped that someone else could help me with it.* (Amy)

Explaining further she says:

> *I think I generally took everything to supervision [laughs], at that point, also because it was the beginning of my training but um, for me everything was a question so it was, um, and it wasn't, I think at that point I couldn't even articulate the specific questions so it was about presenting a mess and saying that, help me make some sense of it often*.

The context influences what is spoken about, as does the fact that she is a new therapist. The experience is so overwhelming it is unable to be articulated, but supervision transforms the "*muddled mess*" into something manageable and meaningful. A process happens in supervision that makes sense of incomprehensible sensory experience.

Others speak about needing more supervision specific to the context. Kerry felt she needed to learn "*how to actually operate in that kind of setting*," while Jill was aware of drawing from the supervisors' experience in Alex in order to find the most useful way of working:

> *Like there are things you can do in the space and there are other things that you can't do, that kind of thing so in supervision you get other ideas because they've been there, they know what limitations there are, they know students have been there before maybe tried whatever, then they suggest it to you.* (Jill)

She later acknowledges that she needed to develop a trust in herself:

> *I think the main thing for me (.) was trusting myself more … As opposed to having all those doubts. You know that whatever, if I, at times when I did come up with my own ideas they were encouraged, you know before that (.) just trust yourself more and allow yourself to come up with more ideas and whatever and do what you are thinking of doing*.

Supervision encourages thinking and the creation of ideas, and this in turn feeds the 'doing' in therapy. The new trainee develops a knowledge about herself and trust in her abilities through the provision, in supervision, of a safe space to think and feel.

Supervision as thinking space

Amy expands on the concept of supervision as a thinking space:

> *The idea of what supervision is, as a place where you think about what you, what work you're doing and where you get support and also teaching about the work you are doing*.

As mentioned previously, doing therapy at Alex clinic does not provide many opportunities to 'think,' and thus the concept of supervision as a place to think becomes even more important than in other contexts. Supervision provides a space to think about what is only able to be felt in the therapy cubicle. This 'thinking' forms a vital part of the containment that is experienced in supervision. Furthermore, 'thinking' plays an important role in the process of digestion which appears to take place in supervision.

With a particular case in mind Jill describes how supervision helped her to think about her feelings:

> *But you know if it's a borderline person your focus shifts and you are like this person just irritates me so much and this is how I feel. So the supervision is more about controlling that, you know thinking about that, thinking that this is exactly how the person is outside, this is how she is making other people feel and this is why she is so isolated because people don't want her around them, you know*. (Jill)

It is evident in this extract that being able to think about the patient is integral in being able to sit with her in therapy. The development of trainee understanding and knowledge is dependent on the supervisors' abilities to provide a thinking function in supervision.

Another example from Sarah shows how being able to think in supervision is also helpful in containing personal anxieties:

> *Just thinking about things in different ways, providing me with a different perspective, so me thinking "Oh, I'm a terrible therapist and that's why she is not coming back and I'm being completely unhelpful" and being stuck in that; and then the supervisor kind of thinking about it in a different way, sort of whether it's practical things like we know she doesn't have any money and or maybe she couldn't get here, or that the stuff was really (.) 'cause I think it was a bereavement, or the stuff was really difficult for her to deal with so she maybe needs a longer time to process it and then come back. So just sort of, being helped to think of different ways of understanding that behaviour*.

It appears that being a new therapist, particularly in Alex where many patients do not return, prompts personal anxieties to come to the fore. Without the space to think about these anxieties they may become overwhelming, as Sarah notes in her idea of "*being stuck in that*". This is where supervision is helpful. As Sarah explains, the supervisors hear and accept the anxieties, think about them and offer comprehensible thoughts and explanations. This process allows anxieties to be explored and renders the experience more manageable. Meaning and understanding can thus be gained from the experience.

Balancing thinking and feeling

Linking the experience of supervision to that of an infant with a mother, Amy later extends the description of supervision as a thinking space:

> *It helped me think about it, rather than feel it, or and feel it, so um, ja, almost like a containing, a mother who could help me through the symbols and make them legible for me, understandable*.

She usefully points out that it is not just the 'thinking' but also the 'feeling' that is important in the containment and digestion process. This implies that the supervision space acts as a container for both thoughts and feelings.

This idea is shared by Lucy who suggests that having a space to feel is as important as having a space to think:

> *… so reassuring on occasion, but generally I think with the supervisors allowing you the space to voice and feel the uncertainty and anxiety without always reassuring, 'cause I mean that's not always helpful but, and just like opening the space to feel it and be ok with feeling it and then containing it … so both giving us the space to start having our own ideas and thinking about it and then also giving us directions which then we could learn from, modeling a bit for us*.

It is important for her that emotions are felt, and only then contained through thinking. Olivia states this more explicitly:

> *They also struck quite a nice level of allowing people to expose their emotions in a relatively comfortably way. So quite intense emotions could be expressed but it wouldn't get overwhelming or focus too much on a particular person*.

There seems to be a fear in this extract that emotions would become overwhelming and the balancing of this is what is useful. The word 'expose' suggests an element of discomfort in sharing emotions and a possible ambivalence to do so.

What is censored in supervision and remains unprocessed

Despite the amount of containment and processing that takes place in supervision, a number of things seem to remain unspoken and thus unprocessed for trainees. The line between what is spoken in supervision and what is not spoken seems to be ambiguous

and some anxiety must be contained by the trainees themselves or remain unprocessed. For example:

> *Some of the fears and anxieties were never brought up in supervision. You know like, like um traveling to Alex*. (Kerry)

Kerry does not feel she is able to share certain fears but does not give specific reasons for this. Clues are given in other interviewees' comments which suggest possible reasons for not discussing certain things in supervision. Evaluation by supervisors and an awareness of the lack of time in supervision were mentioned as restricting factors in what was spoken in supervision.

The awareness of being evaluated in supervision can impact on what is spoken and can feel unhelpful:

> *Always at the back of your head you know that you are getting a mark for something I think that is unhelpful but it is, I mean that is unhelpful anywhere*. (Amy)

Always holding evaluation in mind means that some feelings are censored and not spoken about due to the fear of judgment. Kerry feels that evaluation "*contaminates*" supervision and "*how transparent you can make that process*." She continues, saying:

> *(.) it's something that wasn't really spoken about by students, and also the thing about you know about losing clients and how you might be perceived in that sort of way by your supervisor. It's not something that is (.) it's not a spoken kind of a thing. Which I think now is a bit of a pity. I think that's something that students should make real themselves. That kind of evaluatory sort of stuff, especially because Alex is a place where you do, where it's difficult to hold … The evaluation thing is never spoken about and it's interesting that it's never spoken about, because I think it makes, it definitely changes supervision*.

She suggests that trainees miss out on a possible area of development within supervision because certain things cannot be spoken about.

Despite the length of supervision a major frustration articulated by interviewees is that there is not *enough* time in supervision. Trainees speak about a shortage of time in the therapy space and this is mirrored in the supervision space.

I don't know if I found anything particularly unhelpful, um, maybe that it was, um (.) that the group was quite big, sometimes it meant that there wasn't much time to speak about everything. (Amy)

You know there would be two cases I would want to speak about but you couldn't speak about them both um and um (.) sometimes, something would strike more of a nerve emotionally and you could only explore it in relation to the time you had present, and there was flexibility but it was, I guess it was still limiting in that way. Because I mean it's a group of people and everyone needs to get their, their turn. (Olivia)

Olivia gives the sense that amount of time offered is not always sufficient to contain the intensity of the emotions she felt. Being unable to process her emotions fully limits her appreciation of the experience. The same sense of deeper detail being left unprocessed is echoed by Kerry:

I mean there was only a certain amount of time like you could have for your individual clients, so um in order to really, really get to the detail of things, I don't think there was that much time to do that. (Kerry)

Not being able to "*get to the detail of things*" seems frustrating for Kerry. She later says:

'Cause you are like learning and you want to speak about all three, and you want to know if you are doing ok and you're just kind of learning and you feel like you just want to talk and talk and talk, and sometimes you get to the point where there's not enough time and you realise there are other guys that have to talk as well and you talk into their time. Or you have that happen to you, I remember that as well. You know someone talks into your time and you've got very little time and you feel a bit agitated and resentful.

The desperate need "*to talk and talk and talk*" is linked ways to her being a new therapist and learning. She is honest about the emotions which the shortage of time stirs up in trainees, and these types of emotions are mentioned by others.

Sarah, for example speaks of her "*frustration*" and "*getting bored*" listening to others' stories:

Even though I did find the group really helpful, sometimes I would get a bit frustrated with listening to other people's stories … Especially when I had

> *lots of patients and I'm thinking, actually I needed more time ... I can remember getting bored … I think that was sort of the disadvantage of having a group, is that there had to be time, even though it was flexible there has to be time for everyone. So when I was feeling particularly, I can't think of a specific example, but if I did feel like I needed more time and there just there wasn't, then that built over to the frustration of having to listen to other people, when I'm trying to process everything I had just experienced*.

The frustration builds from the intensity of trying to process her own experiences as well as everyone else's. The nature of working in Alex makes it impossible for the supervision space to contain *all* experiences. Trainees leave with raw and unprocessed experiences which are unable to be spoken.

It is not just unspoken experience which remains unprocessed, some material seems to remain raw despite being spoken about in supervision. Sarah gives the example of a client who came intermittently throughout the six months but did not arrive for the last session. She discussed this in supervision but was still left with a sense of the unprocessed:

> *The one that I have been speaking about does [stand out], and I think when I had finished at Alex I thought about her often … I think it's because she missed the last session so we didn't finish off. So it always felt like something hadn't been processed and sort of an unfinished process, and that was really difficult, and I can remember speaking about that in sort of one of the last supervisions about how difficult that was to not know … It was helpful to speak about it, but I'm still left with kind of ambivalent feelings about ending*.

It can be argued that being left with unprocessed experience is a function of supervision generally and is not distinct to supervision in Alex. However, the personal anxieties that are evoked in Alex amplify the intensity of the experience, thus making it more difficult to process challenging encounters. Sarah seems to struggle to make sense of her "*unfinished process*" and she is left with raw feelings which make her ambivalent about ending.

Experiencing the group as helpful

The supervision group becomes a vital part of the supervision process in Alex. In many ways it is viewed as helpful and supportive, but it can also be frustrating and limiting. As with many elements of their experiences at Alex interviewees speak about their experience of the group in fairly ambivalent way.

What is helpful about the group is the opportunity to learn from, and identify with colleagues who are having similar experiences:

> *So it wasn't just because of the two supervisors that were there but also because the group was there and the group was going through the same, not the same experience but we were doing the same things and because of that that felt supportive … It felt like we could relate to each other, um and um (.) Also nice to hear similar feelings and similar experiences from other people, yeah it felt like we were all learning and we were all finding it at times wonderful and at times difficult (.)* (Amy)

The group is a form of support for Amy and stops her from feeling alone in her experience. She speaks about the containment in being able to "*come back to a group*" from an "*unorganised*" context.

In a similar way Lucy finds a source of identification in the group:

> *To be able to talk about it in the group kind of helped, because sometimes I think you found that you know, you thought it was you on your own really struggling and sometimes when you heard what other people were going through it helped to have that kind of group experience. To be able to bounce off each other and realise that other people were going through similar things and to learn what, say if you didn't see a psychotic patient but one of your colleagues did it helped you to learn what that was like for them you know. So you could learn through, vicariously through the other people which I think was helpful*.

The supervision group is also about learning from her colleagues' experiences. This is echoed by a number of other trainees, for example Sarah says:

> *Just learning from the others about how they dealt with it, that was helpful. I really found the group context helpful*.

Trainee therapists find listening to others' experiences in the group helpful, but many of them also comment on the usefulness of being encouraged to speak about and offer ideas about each others' cases. Olivia discusses how supervision is a space to listen but also a space to express oneself:

> *Every person that was sitting there had a chance to speak their mind if they had something important to say, and ja, I found that incredibly useful in terms of listening to observations that my fellow students made or that my supervisors made that I had no idea of, hadn't noticed (.) And also being able to express myself and um get an opportunity to offer things that I thought may be useful to other people, and to um, come up with original ideas that I thought made sense and see how people responded to them*.

There is a sense of testing the new identity of being a therapist with "*original ideas*," and perhaps a sense of evaluating oneself through other people's feedback.

Olivia later acknowledges the difficulty of speaking in a group but describes a sense of trust that develops within the group:

> *I think although it wasn't always easy for everyone to speak, everyone in our group contributed and I think there was quite a lot of trust between us as students … and I think as the level of trust grew in the group there was more of a space for people to express themselves (.) and I found that incredibly useful*.

Sarah appears to hold a shared viewed to Olivia:

> *I think it was just useful because we were all encouraged to comment on everybody else's experiences. So it was nice to get the feedback from others about what you were doing. As well as hearing their experiences and how that was supervised, so almost, I don't know if it was a comparison, but it was helpful to see what other peoples experiences were and what kind of comments they were getting. That kind of gave an indication of where I was at*.

Having an "*indication*" of where she is at is important to her, but her passing comment of "*I don't know if it was a comparison*," seems to suggest an anxiety about being

compared. It is useful to know 'where she's at,' but there may also be an aspect of 'a comparison' that is difficult for her.

Amy is less ambiguous than Sarah regarding experience of feeling compared:

> *There were times when I also felt compared to the other students in the group, or, and maybe that's why some of the things that I was insecure about I wouldn't mention, I wouldn't, that I still felt that I had to hold my own, um, I couldn't be completely, entirely vulnerable all the time myself, but yeah I think that's more a personal thing than the type of supervision*.

Despite the trust that develops within the group there is also a sense of vulnerability that goes with sharing in a group. For Amy the fear of being judged by others in the group restricts her from talking about all of her insecurities and even in the interview she dismisses this as a "*personal thing*." There is a common sense in these interviews, however, that, as useful as the group is, it is also difficult to be vulnerable in that group context. Lucy, for example, speaks about the courage it takes to be honest and how she found the group somewhat inhibiting:

> *Then in terms of my own anxieties, I think I (.) it takes a lot of courage to be honest about how anxious you are, I remember with our group … there was this thing that we were supposed to know what we are doing and none of us is supposed to have any fears ... to not show any, you know pathology, anxiety or depression or any of those things … So I would say it was hard to be always entirely, harder to be honest in the group, than with the supervisors actually. So as helpful as the group was to bounce things off of and share things with, in retrospect, now that I'm thinking about it more, I think it was what, for me personally, inhibited me a bit more, because the rest of my group always seemed to be really sussed and nobody showed emotion and everybody was really fine and, I was the crier! I was the crier in our group*.

In speaking about the group she realises the dichotomy in her experience of it. On the one hand the group is helpful, but on the other it is intimidating and frustrating. The group constrains her in how much she shares and how honest she is about her own anxieties and insecurities. She feels the group is "*sussed*" and together, while she is

"*the crier*," and in a similar way to Amy's experience, the group hinders, to some degree, the processing of her experiences.

Development and Transformation through Supervision

Despite the difficult working conditions and the anxieties that trainees speak of in the interviews, the overall experience of working in Alex seems to be beneficial. The trainees are developing on many different levels and this gives a richness to the experience. Amy mentions this:

> *So there were a lot of parallel things that I think were happening at once, and I think, yeah, that made my experience quite amazing*.

Sarah also speaks positively about her experience:

> *It was a very rewarding experience, like when I look back on it was one of my favourite parts of the whole M1 year. I think it leaves something with you*.

She gives the sense that she, herself, has been changed in some way by her experience. She goes on to say:

> *So ja (.) I think I learnt a lot about myself in the process. What kind of therapist I wanted to be and what kind of therapist I didn't want to be, and just dealing with a whole variety of problems*.

In addition to her professional development, she has gained knowledge about herself through her experience. Many trainees recall the experience as a time of intense learning and growth. What is evident from these extracts and others is that this growth is related to more than just professional development. There is also a sense of personal growth and transformation that seems to happen in many cases.

Internalising supervision space

With the progression of therapy and supervision, trainees speak about a process of incorporating the supervision space, and all that this entails, into their identities as new therapists and "learning to trust that developing therapeutic instinct" (Lucy). Lucy explains the internalisation in a useful way:

> *It's interesting cause I think I felt, I started realising that I had a little H and H in my head and that helped me when I was sitting in the room*

'cause I knew I wasn't alone. 'Cause I think I always felt, you know when you are starting out you feel like 'I'm this idiot, I don't know anything, how can I help these people' and you knew that there were these other two people who had experience and who supported you, and even if you were sitting in that room making a mistake they were still there to kind of help you and support you and that was quite, um, very containing, very, very containing … I think that sums it up for me most amazingly and most fundamentally (.) I'll try not to cry here (.) deep breath (.) is the extent to which you internalise them as objects, ja (.) and how containing that is in itself and therefore therapeutic because that is what so much psychodynamic therapy is about, internalising the consistent stable object in the room and I guess if your supervisors are able to do that with you in the same way that if you take Winnicott, like the father has to do that for the mother so she can do it for the child, in a way the supervisors.

In talking about her experience, Lucy realises the profoundness of her experience and she struggles to contain the emotion that is stirred up. She, like others, uses infant-parent relationships to speak about supervision and its containing function.

Olivia speaks more broadly and describes internalising the voice of the supervision group as a whole:

I remember thinking at the end of 6 months, if I've internalised some of the way that, um, problems were dealt with in that space, then I've internalised a very useful voice, and it wasn't the voice of any particular person, it was a cumulative voice of all the different people that were there.

The experience of doing therapy and receiving supervision in Alex seems to impact greatly on trainees development as new therapists, and the internalisation of the supervision space is an important part of this process. Many trainees report that their experience in Alex prepares them for the work they do later on during internship and community service.

Future work

At the time that the interviews were conducted the interviewees had completed their internships and many had started community service. Many interviewees mentioned the link between their work in Alex and their future work within the communities with the emphasis on the preparation that working in Alex provided for them in their future work.

> *I didn't realise at the time how much I was learning, but I think it was only long after I left, that I was able to recognise how huge it had been. I think at the time it was really difficult to sort of track that … but it was definitely a long time afterwards. Probably only in my internship, where I was in the same kind of situation, seeing lots of patients and being in clinics and things that I recognised what the experience at Alex had meant in terms of what I'd learnt.* (Sarah)

There is something about the work in Alex which makes it difficult for Sarah to note her progress as it happens. The impact of the work, however, is evident to her once she is working elsewhere.

Comparing her community post to her work in Alex, Lucy describes her later work as "*similar kind of community work dealing with similar kinds of issues*." She maintains that doing therapy and having supervision in Alex "*held me in amazingly good stead*" and "*really laid the ground work*" for future work. She describes seeing patients at her community service post:

> *I saw my first lot of patients last week and I wasn't anxious at all and I felt competent enough, good enough mother, good enough therapist, you know*.

Through her experience of supervision she has developed her own containing and thinking functions which enable her to manage her anxieties and experiences.

Amy discusses a very similar experience:

> *If I think back to having been placed in community clinics last year I think having done Alex and having had supervision around that allowed me to feel confident about going to those clinics on my own, knowing that I kind of understood the context a bit better and I had tasted it before, um and knowing that in supervision I had spoken*

about many things and I kind of knew my own abilities and capabilities and my own downfalls as well, so I knew where I would, what I would struggle with in general terms I think that that developed as well. So in a way being able to think about the context um, helped me gain confidence in being able to do that more.

Both Lucy and Amy mention supervision as an important part of their experience. They seem to suggest that without the supervision, the experience may have been a very different one and that they may not have gained as much confidence without it.

Future development and Personal Transformation or not, in some cases

Working in Alex seems to provide a real sense of what it is to be a psychologist within South Africa.

I felt that I learnt a tremendous amount about working as a psychologist, but even more so, working as a psychologist in South Africa. I guess the realities of kind of psychological problems that present and the factors that complicate them, often being socio-economic, but also cultural that I hadn't been that familiar with despite being a South African. (Olivia)

Olivia describes becoming familiar with the unfamiliar. She explains how working in Alex inspired her to learn more about other cultures and frameworks:

Once I became more accustomed to it, I really felt I wanted to know more about cultures and ways of seeing things in Alex and in the people that were coming to therapy. It was fascinating for me to begin to get an inkling of the way people see things and of the many different ideas that inform people's behaviour and people's problems.

Working in Alex prompts more than just professional development, it encourages a growth in knowledge and a personal transformation. Despite elements of the unprocessed that trainees may be left with, they gain something profound from working in Alex and this seems to stay with them:

I think it left a lasting impact on me. A respect, I felt humble as well and that I still have a tremendous amount of learning to learn. (Olivia)

In closing the interview with Jill I asked if she had any last thoughts about Alex. She replied:

> *Well maybe just that, um (.) after seeing the needs there, um (.) I wanted to actually go back at some point even if it's just once a week, if it's possible, I don't know how (.)*

The raw experience of working in Alex has been contained and transformed in a such way that enables Jill to envisage returning to the context for future work. There is a suggestion of a personal meaning and gratification that is gained from working with such need.

From the trainees descriptions of supervision it is evident that the workings of supervision in Alex are not easily explained. Supervision is at the same time frustrating and helpful, and yet trainees are adamant that without it they would not manage the experience of working in Alex. Containment seems to be a key aspect in explaining the usefulness of supervision, however this process is complex and perhaps not fully understood by trainees or supervisors. What is apparent is that a transformation takes place in supervision which allows trainees to manage and make sense of their experiences.

Chapter 6: Discussion

By interviewing past psychology Masters trainees this research has sought to explore and gain a better understanding of supervision within community contexts, focusing specifically on trainee therapists' experiences of working and receiving supervision at Alex Clinic. It aimed to identify key aspects of the experiences of trainee therapists, highlighting some of the complexities and intricacies involved. As little research has been done on supervision from the supervisees' perspective, particularly in South Africa, the study aimed to offer new insights from this point of view.

The discussion endeavours to consolidate the analysis of the interview material, and to discuss possible implications, both for practice and for future research. The limitations of the study are also noted. What was evident in the interviews was that working in a community clinic was a new and different experience for interviewees. A number of personal and context-related anxieties are evoked in such a context (Eagle et al., 2007), and these were discussed by trainees. They all mentioned finding the work challenging in some way, and many noted that the challenges were made all the more difficult given their positions as new, training therapists. Without exception, however, all interviewees mentioned the positive impression they were left with having worked in Alex. It is argued that supervision, and what it provides for trainees, plays an important function in rendering the challenging work satisfying and meaningful. Concepts of containment have been useful in conceptualising the process of digestion and transformation that appears to take place in supervision.

Putting the research in context

For all of the interviewees, entering Alex was a new experience. Analysis of interviews revealed that trainees' initially found Alex quite intimidating and scary. They described finding the context "shocking" and needed to adjust to it. The intensity of the setting was suggested in the interviewees' use of words like "raw" and "gritty," and many participants discussed a fear for their personal safety going to Alex. Gibson et al. (2001) point out that in South Africa, trainees' work in community contexts holds realistic threats to their safety, but that many trainees also "bring with them a set of fantasy

fears related to entering the township areas, which *apartheid* presented as being off limits" (Gibson, et al., p. 30). Fears about personal safety seem to tap into early anxieties around persecution and annihilation (Eagle et al., 2007, Klein, 1948). Eagle et al. (2007) explain that concerns about physical safety often become a metaphor for fears for psychological safety.

Working with the "unfamiliar" - Challenges at Alex

Relating their experiences of being in Alex, interviewees described a sense of difference and the feeling of being "outsider[s]." Using terms such as "a different world," they describe Alex as being foreign and unknown. This 'strangeness' intensifies feelings of helplessness and inadequacy. Eagle et al. (2007, p. 133) argue that working within such a community context entails "interfacing with the 'unfamiliar'." They highlight the challenges for trainees of working and learning in this type of context and note that the experience is challenging, even for experienced therapists. The analysis of the interviews supports this view, and clearly illustrates that working within a community context such as Alex is indeed a challenging experience for trainees. Interviewees spoke of the realness and intensity of the work and a number of unique challenges, many of which echoed those discussed in the literature.

Working in a context of poverty and deprivation

Difficult social circumstances compound the demanding nature of working within a community clinic (Eagle et al., 2007; Gibson et al., 2001). Interviewees highlighted the evident poverty and deprivation as a major challenge in their work at Alex. Many anxieties played out through feelings of increased helplessness and inadequacy. Ambiguities of helplessness and helpfulness are evident throughout the interviews. The need and deprivation in Alex inspired trainees to provide help, yet at the same time they found the intensity of the setting, and the number of clients to be seen, overwhelming. They described often feeling helpless and unable to offer anything of value. There is a certain "fragmentation that occurs in the face of overwhelming need" (Stewart, 2004, p. 355), and working in such environments can provoke "feelings of impotence and guilt," especially for inexperienced therapists (Gibson et al., 2001, p. 30). Interviewees spoke of feelings of inadequacy and of questioning the use of psychology in such

circumstances. Sarah, for example, remembers wondering, “What kind of good can I do here if people don’t have food to eat and are living in such terrible conditions.”

Variety and intensity of cases

Not only did interviewees discuss the number of clients but also the range. Interviewees were unaccustomed to the variety and intensity of cases that they saw in Alex. They mentioned finding this difficult, particularly without prior experience. The inconsistent attendance of clients made working with difficult cases more complicated. Eagle et al. (2007) note the powerful emotional impact that intense presenting problems have on therapists. They suggest that this contributes to the “visceral experience” (Eagle et al., 2007, p. 133) of working in a community clinic. Intense emotional reactions make processing the experiences all the more difficult for trainees. Without being helped to think about these cases and their own emotional responses, trainees may become overwhelmed.

Language and cultural differences

Trainees reported that working with difficult cases was intensified by language and cultural differences. Language differences meant translators had to be used, or therapy was done using very simple language. This suggests an obvious shortcoming in a practice based on speaking, listening and understanding. There was a self-consciousness and anxiety evident in many of the interviewees’ comments regarding cultural difference. Many of them mentioned being concerned about being ignorant, and they were worried that they would offend people at Alex through their lack of cultural knowledge. This difficulty is mentioned by a number of authors (e.g. Eagle et al., 2007; Gibson et al., 2001). Gibson et al. (2001) note that while linguistic and cultural differences may be evident in other settings, these differences are generally cushioned by the conventions of more traditional settings. The uniqueness of being “immersed” in the context was something interviewees described in the interviews.

Balancing theory and practice

Interviewees were given theoretical input prior to their work in Alex but many of them mentioned the difficulty of integrating their theoretical knowledge with practice. They found that the context and the nature of the cases were not conducive to working

according to traditional psychological models. Much of their experience was about learning to be flexible and developing unique ways of working within the given context. Lucy mentioned the challenge, as an inexperienced therapist, of working with a "tenuous" psychological frame while being taught the importance of the frame in other components of the course. She noted the difficulty in having to "learn something and then already learn to be flexible with it." The differences between community work and conventional forms of clinical practice, and the resulting theoretical confusion, is discussed by Gibson et al. (2001).

A process of transformation

Alex clinic presents less than ideal circumstances for doing therapy, and what is evident from both the literature and the interviews is that working and learning in a community setting such as Alex is demanding and has unique challenges. The emotional impact of working and learning in a community setting such as Alex is significant. The emotional experience and anxieties of trainees have the potential to disrupt therapy and impede learning (Eagle et al., 2007; Gibson et al., 2001). Yet, throughout the interviews descriptions of the challenges and difficulties were offset by comments about the positive and rewarding nature of working in Alex. Trainees spoke about seeing the impact of their work and the sense of mastery that accompanied this. The initial overwhelming experience and anxiety is transformed into a meaningful and satisfying encounter. What makes this transformation possible was explored in the interviews, and what interviewees highlighted was the significant role that supervision plays in making the experience manageable and, more importantly, meaningful. Without supervision Amy "wouldn't have been able to cope," and Lucy "would have just stayed scared."

Supervision experiences

Interviewees reported feeling more "needy" in Alex, and idealising the supervisors. In many of the interviews there was a theme of needing to protect the supervision space and not be critical of it, even long after the actual experience. The persecutory fears and particular anxieties that are stirred up by working in Alex often lead to reliance on more primitive defences such as splitting and projection (Eagle et al., 2007, Klein, 1946). In the interviews supervisors are generally seen as all good in the scary and

‘bad’ context of Alex. Supervision can potentially play an important role in preventing splitting in such contexts (Gibson et al., 2001).

Interviewees suggested that supervision was critical in preventing them from becoming overwhelmed by their experiences and by the emotions that were evoked by being immersed in the context. Stewart (2004, p. 369) stresses the need for supervision within primary care settings, noting that it allows therapists to better manage the demands in these settings by providing a “secure base.” Olivia contrasted the structure that supervision provides with the chaos of the clinic. She found this containing. It was mentioned that the administrative function of supervision played an important role in Alex, given the socio-economic problems.

There was a general sense that supervision corresponded in many ways to the context of Alex and met the specific anxieties and needs of the trainees. The idea of supervision coming to parallel the context in some way was evident in the participants’ descriptions of the “urgency” and “immediacy” of supervision, with some like Lucy explicitly discussing this link. This relates to the idea discussed by Stewart (2004, p. 355) that supervision in primary care settings is very focused, often mirroring the “frenetic” pace of the work and impeding the therapists’ ability to “engage in a reflective process.” It was clear in the interviews that being able to think in supervision was crucial as there was no time outside of that space to reflect.

Although discussed by almost all interviewees, the link between the context and supervision is never clearly defined. Interviewees gave a more general sense of supervision being useful and could not identify particularly useful ‘factors’. The overall emotional experience and containment seem to be what made supervision indispensible.

Containment in supervision

All of the interviewees highlighted the words “containing” and “containment” in speaking about supervision at Alex clinic. It was noted that this containment was needed a great deal more in the unfamiliar context of Alex than in other settings. The context seemed

to produce feelings of rawness and a sense of 'the unprocessed' which needed containment.

What was made clear through the language used by interviewees was that the metaphors of mother and infant, particularly the ideas of Bion, were especially useful in describing the process of supervision, specifically in the unfamiliar context of Alex. Trainees need their experiences to be processed in much the same way as Bion (1962) speaks about a mother processing experience for her baby. It is the "supervisory reverie" (Eagle et al., 2007, p. 133) that makes digestion of the elements of the unfamiliar experience possible. Interviewees mentioned that the supervisors helped ameliorate many of their fears, suggesting that supervision ensures psychological safety by processing both general anxieties and "fantasy fears" (Gibson et al., 2001, p. 30).

The alpha function of the supervisors ensures that for many trainees the experience is rendered meaningful. Non-sensical, raw beta elements are transformed into meaningful and understood alpha elements. Trainees are able to learn from their experiences and thus "experience is transformed into growth" (Waddell, 1998, p. 41). Due to this transformation the experience of Alex can be integrated as a positive and satisfying one, even inspiring some trainees such as Jill to want to return to Alex for future work.

Thinking and feeling in supervision

It is through containment *and* the provision of a space to reflect and think, that feelings and experiences are digested in supervision (Stewart, 2004). Interviewees made it clear in their discussions that supervision was helpful in containing feeling but that it also played an important role in providing a space to think. Again Bion's (1962) theory is helpful in understanding this. "Thinking" for Bion is "an emotional experience of trying to know oneself or someone else" (O'Shaughnessy, 1981, p. 179). He uses the symbol K (Bion, 1962) to represent this type of thinking and links it closely to containment (O'Shaughnessy, 1981). The mother's capacity to contain confusion and anxiety, and to think about it (i.e. to K), renders the experience tolerable for the infant. The infant can then re-introject the "known and tolerated experience" (O'Shaughnessy, 1981, p. 179). This process gradually forms the infant's framework for organising thoughts.

The thinking function that the mother holds in relation to the baby may similarly be held by the supervisors. Through allowing trainees to express feelings, they have the potential to think about and process these feelings and experiences. Experiences can then be given back to trainees in a manageable form to be re-integrated. A baby who has the experience of a “thinking breast” (Waddell, 1998, p. 33) often enough will introject a thinking function for himself. This thinking function forms the core of a “reality ego” (O’Shaughnessy, 1981, p. 179) which can has the capacity to be “conscious and unconscious of the self” (Bion, 1962, p. 116). Experience can then be thought about, dreamt about and translated into action (Bion, 1962). The supervisors’ capacity to contain and think allows development of a thinking function in the trainees. Stewart (2004) notes that supervisees need to be able to rely on the supervisor’s functioning mind in order to introject this function for themselves. This is described vividly by Lucy who speaks of eventually realising she had “a little H and H in my head.”

The introjection of the thinking function plays an important role in the trainees’ development. With an infant the developing mental function is central in the development of personality structure. For trainees, this function forms the core of their developing professional identity. As the infant gains the sense that he has an “inner strength of his own and is not wholly and anxiously dependent on external help” (Waddell, 1998, p.33-34), so too does a trainee develop a sense of confidence and assurance in her work. Supervisory reverie is central in trainees’ getting to know and understand their therapist selves. Through supervision many anxieties and fears can be overcome allowing a sense of mastery and fulfillment to develop. Trainees spoke about gaining confidence through the reassurance of the supervisors and through seeing the impact of their work. Development also enables supervisor and supervisee, and indeed the whole supervision group, to think together. There were instances where interviewees spoke about the joint discussion and reflection that began to happen in supervision.

The supervisors

The process of transformation is dependent on the “quality of interaction between container and contained” (Waddell, 1998, p. 41). The mother needs to contain her own

anxieties while transforming the infant's anxieties. Similarly it is important that the supervisors do not become overwhelmed by their own anxieties and that they are able to contain the trainees' anxieties. The work is demanding for supervisors (Stewart, 2004) and Gibson et al. (2001) note the importance of support for supervision staff within these contexts. Many interviewees mention how helpful it was having two supervisors who supported each other. It could be further theorised that the previous experience of the supervisors within the context of Alex, a factor which was also mentioned by a number of interviewees, may enable them to not be overwhelmed by their own feelings and anxieties around being within the context of Alex.

According to Stewart (2004, p. 354) the primary task of supervision in challenging settings is to help therapist "understand and manage the complexities of the setting… in order that the clinical work can be thought about and understood." Supervisors need to allow a space to think and talk about clinical work, but they also need to be aware of the more unconscious anxieties and difficulties. It is important that these unconscious aspects are addressed in supervision so that they aren't acted out, without being thought about and processed (Eagle et al., 2007; Stewart, 2004).

What is not transformed

Despite the digestion and meaning making that was spoken about in interviews, there is a certain amount that remained unprocessed and untransformed for interviewees. It is possible that this is the reason that speaking about Alex stirs up a lot of emotion for people, something which was evident in many of the interviews. Because of the intensity of the setting and the rapid development that took place within the time at Alex, it seems there was not enough time or enough resources to contain and digest everything. Interviewees described demanding circumstances, and supervision, like the therapy was not ideal. Interviewees mentioned some anxieties that remained unspoken, such as fears related to safety. Issues such as lack of time and being a part of the group further hindered the transformation process, and trainees left Alex still holding undigested, raw experiences.

Future development- personal and professional

What was striking about the interviews is the transformation that *does* take place, from the initial fear and apprehension through to the positive appraisal of the experience of working in Alex. There is in the interviews a noticeable lack of persistent anxiety and fear about the experience. The analysis suggested that not only does professional development take place, but that a personal transformation is also prompted by the experience. What was gained through the experience was an increased ability to tolerate the unprocessed and the frustration that forms a part of sitting with raw experience.

The fact that all of the interviewees spoke positively of their overall experiences of Alex suggests that supervision, despite its frustrations, is 'good enough', and the processing that does happen is sufficient to enable trainees to assimilate their experiences. There is a sense that personal meaning and gratification is gained from working within such a context. Olivia mentioned how the experience gave her a good idea of what it means to be a psychologist in South Africa and inspired further cultural learning for her. In many cases the raw experience of working in Alex is contained and transformed in such way that trainees are able to envisage returning to the context for future work. By making the unfamiliar more familiar the supervision process has made learning, and the consideration of future work in such contexts, more possible.

Limitations of the current research

There are some limitations to this study that are important to review. The small sample of interviewees that was used in the research could be regarded as a limitation of the study. However, generalisability is not an aim of qualitative research and this study aimed to offer insights and understanding rather than broad conclusions. This limitation is thus not significant to the research. It could be argued that the subjective nature of the accounts used, focusing solely on trainees' experiences, is limiting to the research. It is these accounts, however, that provide the rich and descriptive material used in the analysis.

The fact that I, as the researcher, have experienced work and supervision at Alex Clinic could be argued as a limitation to the study. This personal experience, however, gave me a unique understanding of the sample and allowed me, as researcher, to explore the participants' experiences in a potentially more insightful way. What is important in qualitative research is an awareness of one's own position as researcher and reflexivity around this position. Considering my own experience and position has been an important component of the research process.

Conclusions - implications for practice and future research

There are important ongoing debates about "the nature of learning that takes place in becoming a psychotherapist and particularly about the politics of exposing trainee therapists to unfamiliar clients and contexts in the course of their training" (Eagle et al., 2007, p.146). Through the use of anecdotal material this research has offered a viewpoint on this process. By interviewing trainees directly, this study has provided insight into experiences of work and supervision in a community context. There is a paucity of studies from the supervisees' point of view and this study has offered a unique understanding of this viewpoint.

Despite the potential ethical dilemmas in exposing trainees to unfamiliar contexts (Eagle et al, 2007), community work is of vital importance in South Africa and will continue to be an important part of psychology training in this country. Gibson et al. (2001, p. 29) assert that the emotional experience of trainees can have "considerable and direct impact on their clinical learning." It is thus important that every attempt is made to ensure that this emotional experience is a favourable one. The more satisfying and positive the experience of working in the community is for trainees, the more benefit there is to both community and therapist. A favourable experience of working in the community is important in ensuring that therapists continue to provide services in community contexts.

The study has drawn attention to the many challenges faced by both supervisors and trainees working in seemingly deficient conditions in unfamiliar contexts. More importantly, it has shown how difficult experiences and anxieties, both conscious and unconscious, can be transformed into meaningful work. It is hoped that the information

gleaned from this research may be of use for trainee therapists and supervisors alike. For trainees it may offer a preparation for unfamiliar contexts, and, possibly, a source of identification and reassurance. For supervisors perhaps it may offer some insight into the important role they play in the containment and transformation of trainees' experiences, particularly in unfamiliar contexts. The study has highlighted the importance for supervisors to be aware of the unconscious aspects and the difficult feelings that such contexts evoke. It is hoped that some of the understandings may trigger further thoughts on how best to contain trainees in these types of contexts.

With increasing globalization and migration taking place globally, working with the unfamiliar is of increasing relevance not only in South Africa but throughout the world (Eagle et al., 2007). Further research on making the experience of working in unfamiliar contexts as manageable as possible is becoming more and more important to those who work under such conditions. This study has begun to explore the implications of working in unfamiliar contexts, particularly for supervision and supervision styles. In considering trainees' personal experiences and understandings of supervision, it has addressed a gap in the literature in this area. Through the use of psychodynamic theory, the study offers deeper insight and understanding into the complex, and not always understood, workings of the supervision process in an unfamiliar community context. Overall the study illustrates that considerable work and learning can be done in less than ideal circumstances.

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Appendix A: Interview Schedule

Interview schedule:

Supervision

What was your experience of supervision at the Alex Clinic?

Do you feel the context affected / impacted on your supervision? How?

What was your experience of doing therapy at the Alex clinic?

Do you feel the context affected the therapy?

What types of fears or anxieties do you feel you experienced in Alex as a specific context i.e. different to Emthonjeni centre for example?

How were these dealt with in supervision?

In terms of supervision what did you find helpful/useful at Alex Clinic? Can you give examples? Specific clients?

When did you feel you learnt a lot at Alex Clinic?

In terms of supervision what did you find unhelpful at Alex Clinic? Can you give examples?

What issues did you raise during supervision at the Alex Clinic?

Do you feel the context impacted on what you asked or what you took to supervision?

Did the supervision in the context of Alex impact on you? How?

Did the supervision in the Alex context impact on your work with your clients? How?

At Alex Clinic do you feel what you took to supervision was more general (eg technical, practical such as referrals); more client specific? Or more personal (counter-transference issues for example)?

Do you feel the context of Alex impacted on your feelings towards your supervisors?

In what ways do you feel your experience at the Emthonjeni centre differed from that at Alex?

Do you feel your supervision needs differed between at the two contexts?

Appendix B: Information Letter

School of Human and Community

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Development

Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559
Email: 018lucy@muse.wits.ac.za

My name is Nicola Revington, and as I mentioned on the telephone I am conducting research for the purposes of obtaining a Masters degree at the University of the Witwatersrand. My area of focus is the experiences of the process of supervision of clinical psychology masters students, and I am particularly interested in exploring the experiences of this process in the different contexts in which the students train, namely the university's Emthonjeni Clinic and the Alex community clinic. The research aims to understand students' experiences of supervision in these different contexts and to establish what the supervisory needs of students are in these different contexts. We would like to invite you to participate in this study.

Participation in this research will entail being interviewed by myself, at a time and place that is convenient for you. The interview will last for approximately one to one-and-a-half hours. With your permission this interview will be recorded in order to ensure accuracy. Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. Participation in the research will not impact in any way on your academic evaluation and marks. All of your responses will be kept confidential, and no information that could identify you would be included in the research report. The interview recordings will not be heard by any person in this organisation at any time, and will only be processed by myself. My supervisor will only have access to the interview material once the interviews are transcribed and all identifying information has been removed. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point.

If you choose to participate in the study please contact me either telephonically or by sms at 082 560 4368 or via e-mail at revingtonn@students.wits.ac.za.

Your participation in this study would be greatly appreciated. This research will contribute both to a larger body of knowledge on the supervision of psychology students, as well as to the universities understanding of what is useful within the supervision process.

Kind Regards,

Nicola Revington
Clinical Psychology Masters Student
082 560 4368
revingtonn@hse.pg.wits.ac.za

Appendix C: Consent form

Consent Form

I _____ consent to being interviewed by Nicola Revington for her study on the Supervision Experiences of Clinical psychology masters students in different contexts.

I understand that:

-Participation in this interview is voluntary.

-There are no direct benefits or risks by my participation in the study.

-Participation in the study will not impact on my academic evaluation and marks in any way.

-That I may refuse to answer any questions I would prefer not to.

-I may withdraw from the interview at any time.

-No information that may identify me will be included in the research report, and my responses will remain confidential.

-The supervisor of the current research project, who is also a member of the clinical training team, will only have access to anonymised transcripts of the interviews and so will not be able to identify individual students' responses.

-If, during the study, I raise issues of inadequate or unsatisfactory supervisory experiences it remains my responsibility to take up my dissatisfaction through the appropriate channels should I feel this is necessary. It will not be the researcher's responsibility or right to raise these issues in any other context.

Signed _____

Date _____

Appendix D: Recording consent form

Consent Form (Recording)

I _____ consent to my interview with Nicola Revington for her study on the Supervision Experiences of Clinical psychology masters students in different contexts being tape-recorded.
I understand that:

-The tapes will not be heard by any person in this organisation at any time, and will only be processed by the researcher.

-No identifying information will be used in the transcripts and these will only be seen by the researcher and her supervisor.

-All tape recordings will be destroyed after the research is complete and marked.

-No identifying information will be used in the research report.

Signed _____
Date _____