Trainers' and Students' Experiences of a Postgraduate Diploma in Psychotherapy for Non-Specialist Professionals in South Africa

Tracy Plant

The University of Cape Town

Psychology Department

Supervisor: Associate Professor Debbie Kaminer

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Abstract

Research suggests that task shifting in mental health can be successfully implemented in low-income and middle-income countries. Therefore, it is valuable to evaluate training programmes for non-specialist professionals to gain insight into the most appropriate way to train them so that they can provide mental health services. This research explored trainers' and students' experiences of a postgraduate diploma in psychotherapy for non-specialist professionals in South Africa. A focus group with the trainers of the course yielded themes relating to creating a course for non-specialist professionals, neglect of basic mental health skills in non-specialist degrees and barriers to accessibility of the course. The interviews with the students produced themes relating to the key factors of the learning process, application of knowledge, intrapersonal journeys and recommendations. The findings suggest that although the postgraduate diploma was beneficial for the students, the broader value of this postgraduate diploma as a training method in the context of task shifting in South Africa is limited due to challenges that relate to feasibility and accessibility.

Keywords: task shifting; training programme; non-specialist professional

Trainers' and Students' Experiences of a Postgraduate Diploma in Psychotherapy for Non-Specialist Professionals in South Africa

Common mental disorders (CMDs) such as depression, anxiety and posttraumatic stress disorders, are considered to be a large contributing factor to the global burden of disease (Bradshaw, Norman, & Schneider, 2007; Patel, Chowdhary, Rahman, & Verdeli, 2011). An epidemiological study conducted by the South African Stress and Health Study (SASH) indicated that 16.5% of South Africans suffered from a CMD which included depression, anxiety or substance abuse disorder (Williams et al., 2008). CMDs can decrease an individual's quality of life, working ability and social functioning and have a broader negative impact on families and communities (Mendenhall et al., 2014). Although there are empirically supported treatments which are considered as effective interventions to treat CMDs, these interventions are not easily accessible in low to middle income countries (LMICs; Mendenhall et al., 2014; Patel et al., 2011; Singla et al., 2017).

There is a large gap between the need for and availability of mental health services in LMICs, this is known as the treatment gap (Bruwer et al., 2011; Mendenhall et al., 2014; Patel et al., 2011; Singla et al., 2017). Alem and colleagues (2009) highlight that the lowest income countries, such as Ethiopia, have a treatment gap of 90%. In South Africa, 75% of people who live with mental disorders do not receive the treatment that they need (Williams et al., 2008). Mendenhall and colleagues (2014) state that there is a shortage of approximately 1.18 million mental health specialists in LMICs. The urgency to increase and improve access to mental health services in LMICs has found momentum through these realities.

The treatment gap has provided policy impetus to improve access to mental health care services in South Africa (Kakuma et al., 2011; Schierenbeck, Johansson, Anderson, & van Rooyen, 2013). The National Mental Health Policy Framework and Strategic Plan places emphasis on the need to expand the mental health workforce and it identifies task shifting as a catalytic strategy to ensure accessible, equitable and comprehensive mental health care (South African Department of Health, 2013). Task shifting involves a rational redistribution of mental health services from specialist mental health professionals that receive the highest level of training and specialisation in mental health (such as psychiatrists, psychologists, mental health social workers and psychiatric nurses) to non-specialist professionals (Kakuma et al., 2011; Kirkmayer & Pedersen, 2014; Mendenhall et al., 2014; Patel et al., 2011; Swartz, Kilian, Twesigye, Attah, & Chiliza, 2014). A non-specialist professional is defined as anyone who provides mental health care but has not had professional clinical training in a field closely related to mental health (van Ginneken et al., 2013). Non-specialist professionals in

task shifting may include, but are not limited to, primary care doctors, nurses, social workers, auxiliary health staff and community health volunteers (Singla et al., 2017). Mental health professionals play an important role in task shifting through training or supervising non-specialist professionals to expand mental health services which will make these services more accessible to communities (van Ginneken et al., 2013). Integrating mental health care into primary health care through training non-specialist professionals is particularly important in LMICs as most individuals who have CMDs will enter into the health sector at primary health care level (Singla et al., 2017).

A barrier to the adoption of task shifting approaches in South Africa is the lack of adequate training and support programmes to enhance the mental health workforce (Bruwer et al., 2011; Petersen, Lund, & Stein, 2011; Schierenbeck et al., 2013). This is problematic because adequate training and supervision are paramount to the success of task shifting in LMICs (Murray et al., 2011; Saraceno & Dua, 2009). Hence, in addition to policy and legislative frameworks, plans to ensure the training of human resources to carry out task shifting should also be in place. This needs to be addressed with urgency as the shortfall of human resources for mental health in LMICs is likely to grow unless proactive steps are taken (Cooper, 2007; Kakuma et al., 2011).

As task shifting relies on the training of non-specialist professionals, training programmes need to be evaluated to ensure the development of a workforce with appropriate skills to strengthen the human resources for mental health (Kakuma et al., 2011). The evaluation of training for non-specialist mental health professionals in South Africa is important from a cultural perspective. Most training programmes have a basis in psychoanalysis and/or cognitive behavioural therapy evidence based practices (EBPs), and the relevance of these training models for LMICs needs to be evaluated. The assumption that standardised treatments can be readily applied across countries with different social and cultural contexts has been critiqued (American Psychological Association, 2006; Chambless & Ollendick, 2001; Kazdin, 2016; Kirkmayer & Pedersen, 2014). The information that is gathered through understanding the application of certain modalities in certain contexts can help training programmes be designed in a way that is contextually and culturally appropriate (Bartoli, Keisha, Bentley-Edwards, Michale, & Ervin, 2015).

Psychotherapy training courses are built on the premise that through training, individuals are able to learn skills and abilities to provide psychological care. Evaluating the teaching methods that are most effective in imparting these skills and abilities could lead to more targeted training (O’Donovan & Dyck, 2001). Singla and colleagues (2017) conducted

a systematic review of 25 studies reporting on the delivery of psychological treatment by non-specialist professionals in LMICs; of these, 18 articles described training methods. The majority of the programmes used mixed methods (77.8%) which combined theoretical knowledge with the practical application thereof, whereas the others only used didactic methods such as classroom teaching. Binder (1993) proposed that without procedural application of knowledge in training programmes, declarative knowledge about the theoretical concepts will remain 'inert' because application of theory allows for better understanding. Evaluation of training programmes could lead to the development of implementation guidelines for training non-specialist professionals, which is a vital aspect of building mental health programs in LMICs (Murray et al., 2011).

However, insufficient attention has been devoted to understanding and evaluating mental health training programmes and outcomes for non-specialist professionals in LMICs (Murray et al., 2011). Research that relates to non-specialist professionals in LMICs largely focuses on the outcomes of interventions rather than going into detail about training processes (Bolton et al., 2003; Mendenhall et al., 2014; Patel et al., 2011). Devoting more empirical attention to the investigation of mental health training for non-specialist professionals could improve the training domain through enhancing knowledge regarding content, optimal teaching strategies and the effectiveness of training on non-specialist professionals' skills and the implementation of such skills (McGillivray, Gurtman, Boganin, & Sheen, 2015).

Despite efforts to decrease the treatment gap in South Africa and policy impetus that has followed, implementation of task shifting mental health care to those who are not highly specialised mental health practitioners remains inadequate. Although much research has highlighted the benefits of task shifting of mental health care in LMICs, research about the evaluation of training programmes which could lead to guidelines for training non-specialist professionals is limited (Murray et al., 2011). This research aimed to address this gap in literature through using qualitative research to explore trainers' and students' experiences of a post-graduate diploma (PGDIP) in Psychotherapy for non-specialist professionals in South Africa, the PGDIP in Psychotherapy offered by the Department of Psychiatry and Mental Health at the University of Cape Town.

Method

Research Design

Qualitative research aims to explore how people experience the world, understand the world and what meanings they associate to particular events (De Vos, Strydom, Fouche, & Delport, 2011; Willig, 2013). Therefore, a qualitative framework was suitable for this research because it allowed the participants to describe their own experiences in their own words to capture the multiple meanings that the participants attribute to their experiences of the PGDIP in Psychotherapy.

The theoretical framework of this study is located within the interpretive phenomenological analysis (IPA) approach. The aim of IPA is to understand how participants make sense of their own experiences of their world (Smith, Jarmen, & Osborn, 1999). IPA allowed the researcher to gain an in-depth understanding of the participants' experiences of the PGDIP in Psychotherapy and the meaning that they attributed to their experiences. IPA allowed for the individuals' experiences of the course to be illuminated, rather than generating an objective statement of the course itself (Smith, 2004).

Setting

The original target group of the PGDIP in Psychotherapy was clinical psychology interns. However, the target group then changed from specialists to non-specialist professionals because clinical psychology interns could not complete their work and study for the diploma at the same time. There was also a call from other mental health professionals in the field to expand the course in order to effect task-shifting in South Africa. This research is focused on the trainers' and students' experiences of the PGDIP in Psychotherapy after this shift had taken place. The inception group intake was over two years (2012-2013). The course was offered over one year for new students enrolling from 2014. This research project is focused on trainers' experiences of teaching the PGDIP in Psychotherapy to non-specialist professionals and non-specialist professionals' experiences of participating in the PGDIP in Psychotherapy between 2014 - 2016.

Participants

In line with the qualitative nature of this study, purposive, non-probability sampling was used. Purposive sampling allowed for the inclusion of participants who had characteristics that served the purpose of the study best (Cozby, 2009; De Vos et al., 2011). These predetermined criteria included students who had completed the PGDIP in Psychotherapy and staff who were involved in teaching the PGDIP in Psychotherapy.

Eleven students have completed the PGDIP in Psychotherapy between 2014 – 2016. All eleven students were invited to participate in this study. However, only seven students, were available to be interviewed for this research. The sample included one nurse, one social worker, one counsellor and four general practitioners. In terms of gender, there were five females and two males who participated in this study. The racial demographics were five White students and two Coloured students. The language used by the non-specialist professionals at their respective work places included English and Afrikaans. Six clinical psychologists who were trainers in the PGDIP in Psychotherapy participated in the focus group.

Data Collection

The data collection process needed to be open ended and flexible enough to allow participant generated meanings and experiences to be heard (Willig, 2013). To promote this interactive process of data collection, face-to-face semi structured interviews were conducted with the past students (see Appendix A for interview schedule). The questions acted as triggers which encouraged the participants to talk whilst also directing the interview to obtain certain data to answer the research question (Willig, 2013).

Once the interviews with the students were completed, a focus group with the trainers involved in the PGDIP in Psychotherapy was then conducted. The reason for using a focus group with the trainers was because they work together as a group in the PGDIP in Psychotherapy, thus a focus group allowed for reflections on the course and exchanging ideas as a team. This highlighted common experiences and allowed for a rich discussion about the research question (Willig, 2013). The researcher participated through probing interesting and important issues that arose through the use of open ended questions and the use of follow-up prompts (see Appendix B for focus group schedule).

Procedure

Access to the participants was gained through the course convenor of the PGDIP in Psychotherapy. The students were interviewed over a period of three weeks. Six interviews took place at the participants' respective places of employment and one interview took place at a participant's house. All interviews were recorded using a recording device. Rapport was developed through establishing a non-threatening and comfortable environment for the interviewees so that they could share their personal experiences of the PGDIP in Psychotherapy (Di Cicco-Bloom & Crabtree, 2006). Rapport was also enhanced through active listening (Willig, 2013). The students were asked questions about their reasons for doing the course, their experiences of the course, their experiences of applying what they

have learned and recommendations for the PGDIP in Psychotherapy. After the interviews with the students were conducted, they were transcribed and analysed using thematic analysis.

The focus group with the trainers was conducted and recorded at Valkenberg Hospital. During the focus group, questions about the development of the course and the trainers' experiences of implementing the course were explored. Once the focus group was completed, it was transcribed and analysed using thematic analysis.

Data Analysis

Thematic analysis allowed for the identification and reporting of themes that emerged from the interviews and the focus group. IPA guided the thematic analysis because participants' experiences were given primacy. Furthermore, the themes were identified through an inductive way to ensure that the themes related to the data themselves rather than preconceived ideas of the researcher (Braun & Clarke, 2006). Braun and Clarke's (2006) step-by-step framework for thematic analysis was used in this research.

Firstly, the researcher familiarised herself with the breadth and content of the data. Then, initial codes that related to the research question were generated. These codes were then grouped together to create for themes. The validity of the individual themes was checked to ensure that they were an accurate reflection of the meanings depicted in the overall data set. The themes were defined and further refined to ensure that each theme was fitted to answering the research question. Rich extracts were used to provide evidence when the report was produced.

Ethical Considerations

Ethical approval was granted from the Ethics Committee of the University of Cape Town (UCT) Department of Psychology. The interviews and focus group took place at convenient locations for the participants. Two separate consent forms were distributed in this study: one for the students (Appendix C) and one for the trainers (Appendix D). The consent form was discussed, and all participants had the opportunity to ask questions. This ensured that the participants truly understood the consent form. No identifying information has been used in this research study and participants have been given a pseudonym to protect their identity. Tolich (2004) argues that internal confidentiality could be compromised when participants are connected to each other which could decrease autonomy. This is important to acknowledge in this research project because the trainers could recognise what students have said in their private interviews. The potential for breached internal confidentiality was

recognised, and precautionary measures were implemented to ensure that the quotations used in this research did not expose the students in any way.

Results and Discussion

The analysis of trainers' and students' experiences of the PGDIP in Psychotherapy is divided into two sections. The first section will discuss the three broad themes that were yielded from the focus group with the trainers and the second section will present the four core themes that were generated from the interviews with previous students. These themes and their connection to previous literature will be discussed below.

Trainers' Experiences of Delivering the PGDIP in Psychotherapy

Themes emerging from the focus group with trainers related to the complexity of creating a course for non-specialist professionals, the neglect of basic mental health skills in non-specialist undergraduate degrees and the barriers to accessibility of the course. The participants explained how there were several discussions that took place to develop a course that would benefit non-specialist professionals. Despite developing a comprehensive course, the participants believed that selection criteria and cost of the course are barriers to enhanced accessibility of the course.

Creating a course for non-specialist professionals. The participants spoke about how they were involved in creating a course that would be suitable for non-specialist professionals. The shift from focusing on specialists to non-specialist professionals was largely driven by a broader call from the Department of Psychiatry and Mental Health at The University of Cape Town because there was a belief that the PGDIP in Psychotherapy could be a useful space for non-specialist professionals in mental health.

> *So, we had thought interns, we thought psychology type people, but the department was saying what about other professional groups: registrars, occupational therapists etcetera* (Miranda)

> *Other professionals not only psychologists also pitched a reading group. Honing ideas about how the PGDIP could be a useful space in the broader department of psychiatry… that initial meeting was quite diverse in terms of the audience and the disciplines that people had different needs or expectations* (Fiona)

Two participants explained these "different needs or expectations" (Fiona) as sometimes being a point of tension between the role-players from psychiatry and psychology. This concurs with Kazdin and Blase (2011) who highlight that each mental health

professional has a model of clinical training which could interfere with the development and implementation of new ways to deliver training programmes in mental health.

> *I remember when we had those first meetings it was also almost a bit of a dichotomy with the psychologists actually emphasising, it came down to emphasising psychological process. You know, what is happening between the therapist and the client. Um, and the psychiatry folk was really into evidence based intervention and that translated more into the psychological methods, different methods and techniques* (Brandon)

> *It took me quite a while to realise that what I regard as psychotherapy and what psychiatry regards as psychotherapy is not the same thing* (Miranda)

As the course became open to non-specialist professionals, four participants acknowledged a subsequent shift in the theoretical focus of the course from specific psychotherapy theory to a broader understanding of basic counselling skills:

> *We had to do quite a big shift ourselves. We realised that being masters trained, plus a lot of experience, we have a particular perception of what counselling should look like. Um and the course reflected that. It was a much more psychologically based course with theories, different theoretical frameworks embedded in the whole course, but we had to actually shift from having those particular streams to just looking at basic therapeutic competencies* (Miranda)

> *We started off with a much more theoretical course. Wanted to introduce people to the psychodynamic thinking and recognising issues of transference and countertransference…So ya what we have done is less theory, more naming of concepts and trying to recognise but not thinking about how to use a psychodynamic approach in the therapy. Rather it is about understanding. A better understanding of psychopathology and when to refer* (Linda)

> *Teaching them how to be human amongst other humans and then how to deal with other people* (James)

> *Ya but also just how to learn to be with another person. Um to be able to listen, be able to reflect* (Nadine)

Although basic counselling skills have become a focus of the course, four participants believed that emphasis should be placed on ensuring that these skills are used within a non-specialist professional scope of practice due to ethical reasons, potential medical legal problems and patient safety.

> *The value for me is that somebody coming in through the process of engagement in the course, and learning and reflecting at the end of it even if they are not at that skill level, to be able to know that this is actually what I can't do. That is also for me an important, that part is frightening* (Nadine)

> *That is quite a big focus hey, teach people not to do this, certain things. They leave the cause with a greater sense of what they shouldn't be doing* (Miranda)

> *It is possible to an extent to shape counselling behaviours to make appropriate eye contact, have a look at your tone of voice, be very aware of what you say to the person, it's about giving advice, um it's about getting very concrete outcomes here are the guidelines and do lots of shaping, lots of work the person might work. But the moment that you go to a more rigorous, complex therapeutic relationship some people frankly I don't think will be able to do it. So, it's almost for me there feels like there is a need to stratify two different trajectories here. Where part of the task shifting I think is the former, where people need to have very concrete, basic listening skills. But the problem that I have experienced is that some of the former guys end up, you know, they are almost required to do psychotherapy and they simply can't* (Brandon)

> *And they can be harmful. That's the worry* (Linda)

In relation to being aware of professional boundaries, the participants expressed how developing students' personal self-reflection skills was considered as an important component of the course as well. Four participants explained how non-specialist professionals were exposed to this type of thinking through the course.

> *It's also reflected our emphasis on process, and the student's individual capabilities, It's reflected in the way that we teach. It is very much focussed on self-reflection and each person thinking about their own situation* (Linda)

> *I think that's where the meaningful part of the PGDIP* [lies]. *There has been a space for that self-reflection and there has been some tools around assisting people to do the process work, or at least think about that side of things* (Fiona)

> *Ya it is about self-reflection but there are different approaches that share so much common ground. It is also about the core, very fundamental, very basic ability to be able to hold somebody else's thoughts and feelings in mind and to be able to self-reflect and to be self-aware and to self-regulate. And unless you have those very fundamental human skills, you can't go ahead and start implementing more sophisticated therapeutic techniques* (Brandon)

> *When we select them, in our head we know what we are going to be doing…We then put them into this space which may feel like an incubator to them. For some people if that's their orientation or if they are open to it, it can be a very meaningful experience. For others, I think that it could be frightening* (Miranda)

The participants' experiences highlight how professionals in the field of mental health had to shift from their own psychotherapy framework to design a course for non-specialist professionals. This shift required an expansion of their professional capacity, as not only were they specialists who provided service delivery, but they also were trainers and supervisors of non-specialist professionals. This describes the important role that specialists play in capacity building in the task shifting process (Hanlon et al., 2014). The inclusion of specialists training non-specialist professionals is aligned with expanding the mental health workforce through task shifting (Bradley & Drapeau, 2014).

The participants seemed to suggest that something fundamental is lost by focusing on psychotherapeutic techniques only; rather this course placed emphasis on counselling skills, relatedness skills and being conscious of personal aspects such as working within work boundaries and developing self-reflection skills. The emphasis on basic counselling skills is aligned with previous research where non-specialist professionals were trained to be able to provide basic counselling (Murray et al., 2011; Patel et al., 2011). Working within professional boundaries, a core component of this course, is also reflected in the task shifting literature, as non-specialist professionals are taught referral pathways that can be activated when they reach the limits of their own competencies (Patel et al., 2011).

However, the focus on developing self-awareness amongst non-specialist professionals is not widely discussed in the task shifting literature, although self-reflection is perceived to be

an important skill in training programmes for psychologists (Knapp, Gottlieb, & Handelsman, 2017).

Neglect of basic mental health skills in non-specialist degrees. Through the trainers' experiences of teaching non-specialist professionals over the past four years, there was a common perception that the students did not enter the PGDIP in Psychotherapy with basic mental health skills, which was concerning for the trainers. As non-specialist professionals who have taken the course included nurses, social workers and primary health care doctors, the trainers expected that basic mental health skills would have been covered in their undergraduate degrees. However, the non-specialist professionals entered the course with lower skills than expected:

> *We have taken for granted that professionals with nursing, or medical degrees, or social workers would have basic skills. Not even competency levels, but just basic skills in listening and reflecting and we found that, that was even um absent you know from their level of competency. So, we almost had to start from ground zero* (Nadine)

> *Here were people, social workers, nurses, psychiatric nurses…But you go like oops. You assume a particular level of competency and you go and do the workshop and you realise that there isn't that level of competency, it doesn't exist* (James)

> *I think for me the problem is that in those* [non-specialist] *degrees my perception from the two diplomas actually is that there is an under-emphasis on basic empathic listening skills and actually bringing that side of a health professional, I mean a health professional, is always interacting with a human being so that should be a ground zero set of competencies* (Miranda)

The participants' experiences of realising that non-specialist professionals did not have basic mental health skills before entering into the course is problematic in a country that is emphasising task shifting. This is because the majority of people who need mental health care in LMICs enter the health care system at primary level, where nurses, social workers and doctors work (Mendenhall et al., 2014). Three participants expressed how they believed that there needs to be curriculum transformation, for example with nurses, to include more emphasis on basic mental health skills:

I have a very strong sense like with nursing for example that we have to go back to the nursing colleges, and look at the curriculum and that is where basic counselling skills belong (Brandon)

Maybe instead of doing the PGDIP we should be teaching in nursing colleges (Linda)

Some transformation of curricular include, transformation, focus on physicality to mental health…but those courses should take it upon themselves to include trainers who are competent in teaching the mental health side (Miranda)

However, the participants expressed that transformation at curricular level would be challenging because they believed that including mental health skills in non-specialist degrees is not a priority in South Africa:

They need to be convinced that that is important. That's the problem. Psychology is the first thing that is to go when the curriculum is tight (Linda)

That's the tension around the indicators, quantitative versus qualitative, parallel stuff that's happening all the time. You know the outcomes. Which outcomes are recognised, you know, which ones are deemed important (Fiona)

So, do we come back to the fact that psychological, mental health side is a neglected area? (Miranda)

The irony is that it's mental health. It's working in a health context where that relatedness is important (Nadine)

The findings highlight that there was a belief that basic mental health skills are not comprehensively covered in non-specialist degrees, which is not uncommon in LMICs as mental health is not always a priority (Singla et al., 2017). These findings concur with a study conducted by Lund and colleagues (2010) in South Africa who found that in the provinces of Gauteng and Kwa-Zulu Natal, only 5.5% of training for doctors is devoted to mental health which does not seem to be enough time to develop basic mental health skills.

The low baseline skills of the non-specialist professionals that were observed by the trainers does not reflect the goal of the National Mental Health Policy which states that by 2015, all staff working in general health settings should have received basic mental health training and routine supervision (Department of Health, 2013). The fact that the participants

experienced nurses to have minimal skills is in contrast to the South African Nursing Council (n.d., as cited in Lund et al., 2010) which states that 21% of training at undergraduate level is focused on mental health. The findings provide insight into how mental health training, at the level of non-specialist professionals, continues to be limited in South Africa which is problematic given the fact that task-shifting requires non-specialist professionals to be able to provide basic mental health services.

Barriers to accessibility of the course. Even though the intention of including non-specialist professionals was to benefit the broader mental health field, the PGDIP in Psychotherapy has not been widely disseminated due to two main barriers that limit the accessibility of the course. Firstly, a potential barrier is the selection criteria, as the course is not open to everyone. The way the participants validated their belief for selection criteria varied. Three participants explained that there should be selection criteria because working in the mental health sphere is not "something that everyone can do, or should do" (Miranda).

> *Humanity is not injectable. You cannot inject human capabilities where it is not there… We don't have ten years to bring this person from poor relational skills, poor attachment styles, so the answer then is to select people appropriately for the work* (Miranda)

> *We still need to deal with the question about some people being able to do it and others not. It's not being precious it's a simple thing about some people can relate and other people can't* (Linda)

> *CBT is based on a collaborative worker relationship. Unless you have that going, forget about the techniques. But to get the collaborative working relationship you have to have unconditional positive regard, congruence, warmth and if that was missing we were stuck* (Brandon)

Three participants spoke about a more specific aspect of selection criteria which was that students were required to have a level 7 on the National Qualification Framework (NQF), which makes the course quite exclusive. The participants experienced a tension between acknowledging that the course could be excluding certain non-specialist professionals, but the participants felt that they are unable to provide the necessary resources should this selection criterion be dropped.

> *You must remember that we almost insist on they must have NQF level 7…And 7 is at least an honours in psychology which cuts out almost all of your*

psychiatric nurses so you are cutting out. If you are wanting to reach that level then you need that RPL [recognition of prior learning] *stuff coming into play and we don't do RPL basically right so we are also a bit stuck* (James)

And again, its time, effort, and energy (Nadine)

It's difficult for us to get to a point of sustainability for university standards so that they can assist us with additional resources to put in the effort that RPL would need (Miranda)

The cost of the course was considered another barrier by four participants, as it is impossible to expand the reach of the course because the majority of non-specialist professionals struggle to afford it:

It's not R30 000, it's R46000 (James)

That's ridiculous. Really? Well you see, I think that that is outrageous. If we want to reach people in the health section, why don't we just go and select nurses and lay counsellors who need extra training (Linda)

I think you have raised an important question Linda about accessibility. And around reach. Because we have developed this course over the past I don't know how many years to target health professionals. But we have not been able to really expand on what we feel is a really good course you know what it has to offer. Because of accessibility. The financial constraints is huge (Nadine)

I mean the cost is the biggest thing. Having it come through UCT we are cutting out most of the people most of the people who we would like to target the course can't afford it (Miranda)

The participants explained how they felt like they were "a bit stuck" (James) because they knew that the course was not able to reach the majority of non-specialist professionals that the course was created for, however, they do not have the necessary resources to expand the course. Selecting students who have the potential to work in the field is similar to Murray and colleagues' (2011) apprenticeship model, where non-specialist professionals are selected if they have potential to be a counsellor with interpersonal skills, and a desire to work in the field of mental health. The broader selection criteria for the PGDIP in Psychotherapy also concur with Singla and colleagues' (2017) systematic review of training for non-specialist

professional's where selection criteria did include communication skills and general interpersonal skills.

However, the specifications of a NQF level 7 when selecting students is a unique finding within the literature for training of non-specialist professionals. This selection criterion seems to be in contrast to the original aim of the course, as it limits several non-specialist professionals from accessing the course. The requirement of a NQF level 7 is considerably higher than the expectations of non-specialist professionals engaging in task shifting, specifically lay counsellors and community health care workers. Murray and colleagues (2011) expect task shifting trainees to have only high school education. Singla and colleagues (2017) also indicated that of the 13 trials that reported educational levels in their systematic review of task-shifting training programmes, 30.8% had up to a postgraduate education, but nearly one quarter (23.1%) reported that they only had primary education, and one trial included literate non-specialist professionals although they had no formal schooling (Singla et al., 2017).

At the same time, the participants described how challenges to accessibility could be overcome if there were more resources. The challenge of resources in training non-specialist professionals is noted by Murray and colleagues (2011) and Mendenhall and colleagues (2014) who believe that any model of training for non-specialist professionals that is more than a once off training is time intensive which requires commitment and resources which are often challenging to find. However, training non-specialist professionals in this way is considered to enhance the sustainability of training outcomes (Hanlon et al., 2014; Mendenhall et al., 2014; Murray et al., 2011).

Experiences of Past Students of the PGDIP in Psychotherapy

Themes emerging from interviews with the past students of the PGDIP in Psychotherapy related to key factors contributing to the learning process, application of knowledge in the workplace, intrapersonal journeys and recommendations. Overall, the students' experiences highlight that the course content was beneficial for non-specialist professionals as they continue to apply their learnings in their everyday practice at work.

Key factors contributing to the learning process. The participants described two key processes that enhanced their learning experiences in the PGDIP in Psychotherapy. Six participants valued the focus on the application of theory in the course. For example, two participants explained how videos allowed them to see theory being brought to life:

You see counselling in practice. It's not just like the theory with all the words like solar, etcetera but you actually could see that this is what is happening in counselling (Anke)

I think that the sort of the videos that we watched. That I found quite helpful because that just gave a bit of context and it allowed you to visualise a lot of things that were explained in the actual class (Kyle)

Two participants appreciated the fact that there were opportunities for real-life application of the theory that was based on their own cases from work. This theoretical application was supervised by the trainers who provided input to this endeavour.

There was times that we could bring case discussions, and because I'm working here and I see cases all the time we were able to bring those cases and discuss them. And I suppose it was the application. The application of the theory, applied to a case really helped one to process the theory and to interrogate it (Joan)

You need to do your homework at clinic, and then you can go back to class and say this was my case and then you can make the links between the theory and the practical. If you had a struggle at clinical level, the fact, and course convenor was present to really help you and see what you doing and that you are on the right track (Anke)

Although three other participants also valued the focus of application of theory in the class, they believed that there could have been even more emphasis on application of cases and more in-depth interactions about case studies.

I would have liked more case examples…they often asked us for examples but then I would have liked them to give us [case examples] (Nathalie)

I would have appreciated maybe having the lecture notes before and maybe having the case studies and analysis you know being dealt with. We had a lot of time to discuss, with, but I think clinical case studies and application of the theory during the class would have made it even more juicy (Nadia)

Perhaps some added focus on implementation but there was already quite a strong focus on that (Gareth)

All seven of the participants spoke about the value of using a small group as a teaching mode. The participants expressed different ways about the way in which using a small group promoted learning. The small student numbers in the course was considered by four students as being conducive to facilitating interactive and intense discussions:

We had active classes, group work and even one on one. The fact that we were a small group nobody could hide (Anke)

It was a small group, I think we were about six in our class…it was very easy to interact with the other students and the lecturers (Gareth)

The teaching, interaction on the day was great. Because we were a small group we could ask questions we could interact (Joan)

We were often three students in the class with three lecturers there. It was a once in a lifetime opportunity for very intensive teaching (Andrea)

Two participants believed that the small group resulted in a space where they felt comfortable to participate in the class:

It was just sort of an open environment where you could ask questions and get feedback straight away. In a bigger class I don't think that you would be able to go as in depth (Kyle)

We had the opportunity to reflect and what I think was really nice was that because it was a small group I felt comfortable in sharing…I think it was because it was a small environment and it wasn't a threatening one (Nathalie)

The fact that individuals who formed the small group came from different backgrounds was valued by four of the participants. This facilitated a different type of learning, where the participants believed that they could learn from their colleagues.

So, we came from various places and we had very different approaches but there was a richness in that (Joan)

I got a view of a lot of different views and experiences. So, I think that that was very helpful now when in my future when I will need to work with people from a different training backgrounds (Gareth)

> *I think that it's a nice experience hearing from a nurse and a doctor you get sort of um ya of the medical profession but different roles and different jobs so that was very good* (Nathalie)

> *We had a class where there were a group from different sectors…so we had a spectrum of different people working in the health sector and each one coming with their own experiences as well and own cases so that was cool* (Nadia)

These findings surrounding the learning process are consistent with other studies that have been conducted on training non-specialist professionals internationally. The fact that the participants experienced the course as being more interactive than didactic is reflective of Murray and colleagues' (2011) apprenticeship model for training non-specialist professionals in LMIC's, as in their model, for every half an hour of didactic teaching, there is one hour of application. Students believed that application of theory facilitated the learning process which concurs with Bennett-Levy's (2006) perspective that a mix of strategies to bring real life examples into the classroom enhances understanding of psychological theory. All of the participants valued using a small group as a teaching mode, because it allowed for intense discussions that were facilitated by individuals feeling comfortable to share examples. This finding is aligned with Pieterse, Lee, Ritmeester, and Collins (2013) who argue that the smaller the group, the greater the personal attention which makes the students feel more guided and comfortable with exploring practical and personal examples. However, the value of learning from other non-specialist professionals as a by-product of the inherent multi-disciplinary nature of the course is not something that seems to be reflected in existing task-shifting literature.

Application of knowledge. The participants considered the course to be valuable as they have been able to apply several aspects that they have learned to their work contexts. The participants spoke about this application of knowledge in different ways. The only specific theoretical framework that was spoken about in terms of application was cognitive behavioural therapy (CBT):

> *It really helped me, just to concretise the CBT. I do mostly CBT because historically I am a clinician, it is what I was trained in and you know what I am familiar with…We were given really great tools to use which I continue to use in practice now* (Joan)

There are some principles of CBT that we can do. We might not practice CBT 100% as per say, but if there is a patient with negative thought patterns, so we can do all the exercises with the patient etcetera (Anke)

The course content is applicable. And various aspects of it, so for example there were example there were things that I had taken from CBT and in a small way could come and apply here (Nadia)

I think the CBT and the DBT we did, and stuff formed a great foundation for me to build upon especially now working in sports psychology (Kyle)

Three participants spoke about their application of basic therapeutic competencies which related to basic counselling skills, listening skills and informed ways of questioning:

Even seeing patients just on a clinical level, there is always some sort of psychological manifestation where you can offer some therapeutic work from your basic competence in counselling skills, so it makes your work much, much easier (Anke)

I would say the stuff that I use most often currently, is the basic therapeutic competencies because that is easy to implement: empathetic listening, active listening, those types of skills is a bit easier to implement in a very quick session (Gareth)

I am coming in from a GP perspective and the skills that I was trying to learn, and am still trying to learn, are more just the methods of questioning, methods, methods how to approach in realm of a short consultation (Nadia)

Even though some of the participants spoke about specific examples of applying certain modules that they had learned in the PGDIP in Psychotherapy, six of the participants believed that it was valuable to have a broad theoretical repertoire to draw from, to understand what theory was applicable and for whom:

I also realise that sometimes you have an eclectic approach where you need to do CBT but you need to have some psychodynamic from where the patient comes from (Anke)

The theory about knowing about the whole range and spectrum is important, that we were taught that theory, because now one can select what is actually most applicable (Nadia)

Even though I probably look at doing things more the CBT/DBT, way it was still quite a nice challenge for me to try and understand and grasp those terms that were spoken about in the other frameworks that we learnt about (Kyle)

The first part is psychoanalytic and that was very relevant to what I do. Obviously, the CBT part was very relevant (Joan)

I think for me it's about being more aware of the different therapies like the CBT who is it appropriate for, and often it's just like, a lot of different types of therapies and what works best (Nathalie)

But what I enjoyed more was the theory and learning about the different modalities and learning how to conceptualise patients and people differently from purely a biomedical perspective (Gareth)

The examples of application of knowledge highlight that the participants found the content of the course relevant to their work settings. The application of CBT was the method that was referenced most when speaking about application which is not uncommon amongst non-specialist professionals: as Singla and colleagues (2017) suggest that behavioural modalities are the most common type of modalities which are applied by non-specialist professionals. The use of basic counselling skills is considered an important aspect of training non-specialist professionals in task shifting as referred to above in section one of the data analysis.

However, the fact that non-specialist professionals were exposed to a spectrum of theory contrasts Singla and colleagues (2017) who state that almost three quarters of the trials (n = 18) in their systematic review relied on specific manualised treatment strategies to train non-specialist professionals. Although the participants placed value on knowing a broad range of theory, Kazdin (2016) suggests that moving towards one or two forms of treatments that can be applied to multiple settings makes the scaling up of training programmes more feasible.

Intrapersonal journeys. All of the participants spoke about their experiences of developing self-awareness and self-reflection, which they believed was a valuable aspect of the course. However, the participants experienced the process of developing self-reflection in

different ways. Andrea found self-reflection to be “exhausting” and “definitely emotional”. However, she mentioned that she was accustomed to this type of thinking as she has been in personal therapy:

> *I mean it is always quite challenging. But I was very used to it from my own process and so ya I was well indoctrinated before that* (Andrea)

In contrast to this, Nadia had never been exposed to self-reflection in her previous learning experiences or in personal therapy. For Nadia, learning about herself was “surprising”:

> *I went in thinking maybe that I was going to come do things for my patients, go and do an upgrading on my professional skills and I learnt a lot more about myself* (Nadia)

Three participants spoke about their experiences of developing self-reflection as being something that was challenging. However, they still believed that it was a valuable experience to go through:

> *Self-reflection it is difficult… I also had to look at my personal life, my personal growth and my personal experiences and there were times in the course which I felt that I could be vulnerable and authentic and sometimes when I couldn’t because it was my own transference that was happening* (Anke)

> *Ya it was good. I was challenged* (Joan)

> *To be honest I am not big on the whole self-reflection thing. Um but like psychodynamics and all of that it was a challenge and I took it on and I embraced it and I am probably better for it now* (Kyle)

Two participants believed that their intrapersonal journeys were positive, and they did not experience it as challenging:

> *I think, think that it was good. There was certainly a space for us to share and I think sometimes, it sort of brought stuff up in ourselves and what have you* (Nathalie)

> *I found very useful and I enjoyed that because it is the whole thing you can only help, you know, be effective if you can reflect on what you are doing and on your own strengths and weaknesses* (Gareth)

Despite these findings that highlight that the participants had varying views of their intrapersonal journeys, four of the participants explained that self-awareness has helped them in their current practice as they are aware of the positionality of themselves in relation to others:

> *It helped me to be fully present with the patient, to offer that containment and be aware of transference and countertransference* (Anke)

> *Concepts such as transference and countertransference, and to be aware of that and the self-reflection, so that's the stuff that I am using more* (Gareth)

> *I think about things a bit differently now. Um a lot more sort of aware of what I am thinking if that makes sense. Maybe more insightful into myself and others around me* (Kyle)

> *It is something that I try to do now. And also, I, you know it's always been part of my, when you finished part of a consultation – wash your hands and wash your mind. Because the next person is about to arrive. I extend that quite a bit now and also reflect on the other aspects um not only the physical stuff but just the interaction that had taken place* (Anke)

These findings suggest that students considered their intrapersonal journeys to be an important part of the PGDIP in Psychotherapy. For some of the participants, the development of self-awareness was a by-product of their training which concurs with Pieterse and colleagues' (2013) model which aims to develop self-awareness in counsellors and psychotherapists. Self-awareness allowed the participants to recognise their own emotions, acknowledge personal reactions to patients and judge their competencies within their own scope of practice, which concurs with Knapp and colleagues (2017) emphasis on developing self-examining psychotherapists. However, the intrapersonal journeys of non-specialist professionals working in the field of task shifting is not something that has been thoroughly emphasised in the literature. Nevertheless, self-reflection has been viewed as important for the development of professional expertise in the field of mental health (Bennett-Levy, 2006; Knapp et al., 2017; Pieterse et al., 2013), so it is a benefit that self-reflection did occur for this group of non-specialist professionals. Furthermore, self-reflection is important because the quality of treatment may suffer, and patients could be harmed, if non-specialist professionals are not aware of these feelings (Knapp et al., 2017). The students' experiences also line up with the trainers' emphasis on developing self-awareness in the course.

Student recommendations. The students had some recommendations for the PGDIP in Psychotherapy. The recommendations ranged, with the only common sub-theme in this section being about theoretical recommendations. Two participants believed that additional modules could have been included:

> *I would have liked to include some group therapy…It is usually therapeutic for many people and it is the way that we have to go* (Joan)

> *I would have liked them to have run through the DSM… It's alright to say okay DSM and look up symptoms but I would have liked just a little bit more* (Nathalie)

Four students mentioned how the balance of theory in the course could be improved by condensing some sections and spending more time on main psychological concepts:

> *What they could have done maybe slightly differently was that some things they spent too long, and some things spent too little on. They spent a long, long time on CBT but on psychodynamic they didn't spend* (Nathalie)

> *There were a few things that were kind of put in for completeness sake…mindfulness and motivational interviewing…it wasn't useful for my work at the time. It wasn't done in depth enough to be useful and, so I would rather have had more depth on the bigger topics maybe, but it is a small criticism* (Andrea)

> *In the evidence based practices there was quite a few lectures that were very short. So I guess, I can't implement those modalities that I received a forty minute lecture on* (Gareth)

> *I think that the ethics part could have been a lot shorter. We could have condensed that maybe had a longer psychodynamic concept that section.* (Nadia)

The participants recommendations about the theoretical balance of the course indicates that while they do place value on having a broad therapeutic repertoire as mentioned in a theme above, they believe that the course could re-consider the structure of time spent on certain modules.

Students spoke about several miscellaneous recommendations which related to different aspects. In terms of assignments, Joan and Nathalie believed that they could have been better coached for the assignments. Anke suggested the development of a PGDIP manual that could be handed out at the beginning of the year, so that it could be read before lectures and it could be something that was kept afterwards, and she also suggested that the course should be better marketed. Andrea thought that it would have been beneficial to have continued support after the completion of the course. Kyle explained how it would be beneficial for the course to be accredited with the HPCSA, although he did acknowledge that this would probably be impossible.

Conclusion

The experiences of the trainers highlight several processes that are involved in creating a course in psychotherapy for non-specialist professionals. The trainers explained how the PGDIP in Psychotherapy placed emphasis on basic therapeutic competencies rather than specific psychotherapy theory, which is common for non-specialist professional training. However, the emphasis on developing self-reflection in students in the course is a unique finding for training non-specialist professionals, as these introspective skills are more commonly associated with psychotherapy training for psychologists in the literature. The trainers believed that the broader call for task shifting in policy and literature in South Africa is not reflected in the undergraduate curriculum of non-specialist professionals which is something that the participants believed should be advocated for. The PGDIP in Psychotherapy has not been accessed by the broader non-specialist target group due to the NQF level 7 requirement and the cost of the course.

The experiences that the students shared demonstrated that the emphasis on application of knowledge and the mode of learning in a small group enhanced their learning experience. The emphasis on application of theory in the course is similar to other training programmes for non-specialist professionals, where providing opportunities for the application of theory is prioritised. The students' experiences further highlight how the PGDIP in Psychotherapy helped them develop their skills and apply their knowledge in various work contexts. CBT and counselling skills were specifically noted as being useful in their ongoing work which is reflected in the task-shifting literature. However, the fact that the students believed that it was valuable to have a broad therapeutic repertoire is different to the standardised manualised treatment methods that are often employed to train non-specialist professionals. The intrapersonal journeys that came about through the emphasis placed on self-reflection by the trainers had continued relevance for the students. The recommendations

that students provided to improve the course mostly related to theoretical improvements, with several miscellaneous recommendations that related to admin, follow up courses and assignment preparation. However, no drastic changes were recommended as all of the participants had a positive overall experience of the course.

This research has explained the complex process of training non-specialist professionals from the experiences of the trainers, whilst understanding the actual learning process and implementation of such learnings from the students' experiences. This research has highlighted that the PGDIP in Psychotherapy for non-specialist professionals involved multiple role players and was multi-faceted training that promoted several dimensions of learning: learning about basic mental health theory, learning about working within professional boundaries and learning about oneself. This research has also shown that while the PGDIP in Psychotherapy was valuable for the non-specialist professionals who completed the course, the PGDIP in Psychotherapy has not been accessed by the broader non-specialist target group. Developing ways to train more non-specialist professionals that decreases barriers and enhances accessibility of the PGDIP in Psychotherapy to expand the mental health work force needs to be explored.

Limitations

The way in which the students described their experiences varied in depth and richness. The students may have been more forthcoming if I asked them to complete more objective measures of their experiences. However, this research aimed to understand subjective experiences of students and trainers rather than more objective measures of what students have actually learned from the course, or how their work has changed as a result of the course, which could have been a useful supplement if there was more time and resources.

This research also had a relatively small sample that was drawn from a particular training programme for non-specialist professionals. This small sample is linked to the small number of students who have completed the course thus far and the small number of trainers who are involved in the course. Further, the group of students in this study were different to lay counsellors/community based mental health workers who generally have no post-school education or clinical background, and so conclusions about the training do not apply to all non-specialist mental health professionals.

Reflexivity acknowledges the impossibility of remaining outside of one's subject matter while conducting qualitative research (Willig, 2013). Therefore, the researcher acknowledges that her own values, experiences, interests or beliefs could have shaped the research process (Willig, 2013). I am a white, middle class, female student. My student

position at UCT could have been perceived as being too involved with the institution (especially from students' perspectives) which could have limited students' disclosure. The positionality of the researcher in terms of power differentials should also be acknowledged (Di Cicco-Bloom & Crabtree, 2006). In the focus group, I was a lot younger and less experienced in comparison to the professionals in the room which could have influenced how I engaged in the focus group.

Epistemological reflexivity encourages the reflection of assumptions of experiences that have been made in this research study (Willig, 2013). The use of IPA in this research involved a double hermeneutic as the participants described their experiences and then the researcher interpreted these experiences (Smith et al., 1999). Although the goal was to get close to the participants personal world, it was impossible to do this completely because access into the participants' personal world could have been complicated by the researchers own conceptions that have been used to do the interpretative activity which is required for this theoretical framework.

Recommendations for Future Research

Given the small size and the fact that this research was based on a specific sample of non-specialist professionals, it would be interesting to compare the experiences of the PGDIP in Psychotherapy to other training programmes for non-specialist professionals in South Africa. Further research also needs to be done to find ways to place more emphasis on basic mental health skills in the undergraduate curriculum of non-specialist professionals in South Africa.

This research has indicated that the development of self-awareness was considered as an important factor in the course by the trainers and the students. More research needs to be conducted to understand the value of self-reflection in non-specialist professionals. This would be important to explore because the development of self-reflection skills often requires supervision, which is not readily available for non-specialist professionals. More research in this regard could indicate the feasibility of placing emphasis on self-awareness in training non-specialist professionals, as additional resources are often required to support this endeavour.

Recommendations for the PGDIP in Psychotherapy

This research has highlighted that key learning factors, such as emphasis on application of theory and the mode of learning in a small group, promoted learning for the students. The continued emphasis on these key learning factors in the PGDIP in Psychotherapy would be beneficial for students. Should the course be expanded, research

should be done to think of ways to expand the course, without completely losing the small group experience that was so valuable for the students.

It would be beneficial to develop a guide for other training programmes for non-specialist professionals in South Africa. The findings of this study which relate to key learning processes, the value of self-reflection, training priorities of the course and application experiences could inform this guide. However, to expand the reach of the PGDIP in Psychotherapy to benefit more non-specialist professionals, the trainers could further explore the implications of dropping the NQF level 7 requirement. Finding more feasible and sustainable ways to finance the course could also be considered.

References

Alem, A., Kebede, D., Fekadu, A., Shibre, T., Fekadu, D., Beyero, T., . . . Kullgren, G. (2009). Clinical course and outcome of schizophrenia in a predominantly treatment-naïve cohort in rural Ethiopia. *Schizophrenia Bulletin, 35,* 646 – 654. doi: 10.1093/schbul/sbn029.

American Psychological Association. (2006). Evidence-based practice in psychology: APA presidential task force on evidence-based practice. *American Psychologist*, *61*, 271-285. doi: 10.1037/0003-066X.61.4.271.

Bartoli, E., Keisha, L., Bentley-Edwards, A., Michale, A., & Ervin, A. (2015). What do white counsellors and psychotherapists need to know about race? white racial socialisation in counselling and psychotherapy programs. *Women & Therapy*, *38*, 246 – 262. doi: 10.1080/02703149.2015.1059206.

Bennett-Levy, J. (2006). Therapists skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, *34*, 57 – 78. doi: 10.1017/S1352465805002420.

Binder, J. L. (1993). Is it time to improve psychotherapy training? *Clinical Psychology Review*, *13*, 301 – 308. doi: 10.1016/0272-7358(93)90015-E.

Bolton, P., Neugebauer, R., Verdeli, H., Clougherty, K., Wickramaratne, P., Speelman, L., …Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda: A randomised controlled trial. *Journal of the Medical Association, 18,* 3117 – 31124. doi: 10.1001/jama.289.23.3117.

Bradley, S., & Drapeau, M. (2014). Increasing access to mental health care through government-funded psychotherapy. *Canadian Psychology, 55,* 80 – 89. doi: 10.1037/a0036453.

Bradshaw, D., Norman, R., & Schneider, M. (2007). A clarion call for action based on refined DALY estimates for South Africa. *South African Medical Journal, 97,* 438 – 440.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101. http://dx.doi.org/10.1191/1478088706qp063oa.

Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D. J., Williams, D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African stress and health study. *Journal of Psychiatric Services*, *62*, 774 – 781. doi: 10.1176/appi.ps.62.7.774.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685 – 716. doi: 10.1146/annurev.psych.52.1.685.

Cooper, S. (2007). Psychotherapy in South Africa: The case of Mrs A. *Journal of Clinical Psychology*, *63*, 773 – 776. doi: 10.1002/jclp.20392.

Cozby, P. C. (2009). *Methods in behavioral research* (10th ed.). Boston, MA: McGraw-Hill Higher Education.

Department of Health (2013). National Mental Health Policy Framework (2013 – 2020). Retrieved April 13, 2017, from https://www.health-e.org.za/wp-content/uploads/2014/10/National-Mental-Health-Policy-Framework-and-Strategic-Plan-2013-2020.pdf.

De Vos, A. S., Strydom, H., Fouche, C. B., & Delport, C. (2011). *Research at grass roots: For the social sciences and human services professions* (4th ed.). Pretoria, South Africa: Van Schaik.

Di Cicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, *40*, 314-321. doi: 10.1111/j.1365-2929.2006.02418.x.

Hanlon, C., Luitel, N., Kathree, T., Murhar, V., Shrivasta, S., Medhin, G., . . . Prince, M. (2014). Challenges and opportunities for implementing integrated mental health care: A district level situational analysis from five low-and middle-income countries. *PLOS ONE,* 9(2), 1 – 12. doi: 10.1371/journal.pone.0088437.

Kakuma, R., Minas, H., van Ginneken, N., Desiraju, K., Morris, J. E., Saxena, S., . . . & Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. *Lancet*, *378*, 165 – 1663. doi: 10.1016/S0140-6736(11)61093-3.

Kazdin, A. E. (2016). Closing the research-practice gap: How, why and whether. *Clinical Psychology Science and Practice*, *23*, 201 – 206. doi: 10.1111/cpsp.12155.

Kazdin, A. E., & Blase, S. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science, 6,* 21 – 37. doi: 10.1177/1745691610393527.

Kirkmayer, L. J., & Pedersen, D. (2014). Toward a new architecture for global mental health. *Transcultural Psychiatry*, *51*, 759 – 776. doi: 10.1177/1363461514557202.

Knapp, S., Gottlieb, M., & Handelsman, M. (2017). Self-awareness questions for effective psychotherapists: Helping good psychotherapists become even better. *Practical Innovations*. http://dx.doi.org/10.1037/pri0000051.

Lund, C., Kleintjes, S., Kakuma, R., & Flisher, A. (2010). Public sector mental health systems in South Africa: Inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatry Epidemiology, 45,* 393 – 404. doi: 10.1007/s00127-009-0078-5.

McGillivray, J., Gurtman, C., Boganin, C., & Sheen, J. (2015). Self-practice and self-reflection in training of psychological interventions and therapist skills development: a qualitative Meta-Synthesis Review. *Australian Psychologist*, *50*, 434 – 444. doi: 10.1111/ap.12158.

Mendenhall, E., De Silva, M. J., Hanlon, C., Petersen, I., Shidhaye, R., Jordans, M., . . . Lund, C. (2014). Acceptability and feasibility of using non-specialist health workers to deliver mental health care: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa and Uganda. *Social Science & Medicine*, *118*, 32 – 42. http://dx.doi.org/10.1016/j.socscimed.2014.07.057.

Murray, L. K., Dorsey, S., Bolton, P., Jordans, M., Rahman, A., Bass, J., & Verdeli, H. (2011). Building capacity in mental health interventions in low resource countries: An apprenticeship model for training local providers. *International Journal of Mental Health Systems, 5,* 1 – 12. Retrieved from: http://www.ijmhs.com/content/5/1/30.

O'Donovan, A., & Dyck, M. (2001). Effective training in clinical and counselling psychology: Not as simple as it sounds. *Australian Psychologist*, *36*, 92 – 98. doi: 10.1080/00050060108259640.

Patel, V., Chowdhary, N., Rahman, A., & Verdeli, H. (2011). Improving access to psychological treatments: Lessons from developing countries. *Behaviour Research and Therapy*, *49*, 523 – 528. doi: 10.1016/j.brat.2011.06.012.

Petersen, I., Lund, C., & Stein, D. (2011). Optimizing mental health services in low-income and middle-income countries. *Current Opinion in Psychiatry*, *24*, 318 – 323. doi: 10.1097/YCO.0b013e3283477afb.

Pieterse, A., Lee, M., Ritmeester, A., & Collins, N. (2013). Towards a model of self-awareness development for counselling and psychotherapy training. *Counselling Psychology Quarterly, 26,* 190 – 207. http://dx.doi.org/10.1080/09515070.2013.793451.

Saraceno, B., & Dua, T. (2009), Global mental health: The role of psychiatry. *European Archives of Psychiatry and Clinical Neuroscience, 259,* 109 – 117. doi: 10.1007/s00406-009-0059-4.

Schierenbeck, I., Johansson, P., Anderson, L., & van Rooyen, D. (2013). Barriers to accessing and receiving mental health care in Eastern Cape, South Africa. *Health and Human Rights*, *15*, 110 – 123. Retrieved from http://www.jstor.org/stable/healhumarigh.15.2.110.

Singla, D. R., Kohrts, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low-and middle income countries. *Annual Review of Clinical Psychology*, *13*, 5.1 – 5.33. doi: 10.1146/annurev-clinpsy-032816-045217.

Smith, J. A. (2004) Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*, 39-54. http://dx.doi.org/10.1191/1478088704qp004oa.

Smith, J. A., Jarmen, M., & Osborn, M. (1999). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, *11*, 261-271. http://dx.doi.org/10.1080/08870449608400256.

Swartz, L., Kilian, S., Twesigye, J., Attah, D., & Chiliza, B. (2014). Language, culture and task shifting – an emerging challenge for global mental health. *Global Health Action*, *7*, 1-4. http://dx.doi.org/10.3402/gha.v7.23433.

Tolich, M. (2004). Internal confidentiality: When confidentiality assurances fail relational informants. *Qualitative Sociology, 27,* 101 – 106. https://doi.org/10.1023/b:quas.0000015546.20441.4a.

van Ginneken, N., Tharyan, P., Lewin, S., Rao, G., Meera, S., Pian, J., . . . Patel, V. (2013). Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low-and middle-income countries. *Cochrane Database of Systematic Reviews, 11,* 1 - 367. doi: 10.1002/14651858.CD009149.pub2.

Williams, D. R., Herman, A., Stein, D., Heeringa, S. G., Jackson, P. B., Moomal, H., & Kessler, R. C. (2008). Twelve-month mental disorders in South Africa: Prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological Medicine, 38,* 211 – 220. doi:10.1017/S0033291707001420.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Berkshire, United Kingdom: Open University Press.

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Appendix A: Semi structured interview questions

- Perhaps you can start by telling me what made you decide to do the PGDIP in Psychotherapy? Probing questions will include: “Why did you chose this programme”, “what was happening in your working career that you decided to study further?”
- To what extent/degree was your expectations met? Probing questions will include: “What was not met?”, “What actions could you or the trainers have done to have met your expectations?”
- Could you tell me about your experiences of the PGDIP in Psychotherapy? Probe questions will again be used such as “how were the teaching methods”, “what about the theoretical frameworks?”, “How was the content of the course components?”, “How did you find the process/personal development aspects?”
- Did you experience any difficulties while taking the course?
- I am wondering if you have found the PGDIP in psychotherapy course content beneficial/relevant in your field work? Probing questions will be used such as “what aspect of the course has been most beneficial in your work?”, “what aspect of the course has not been useful”, “has the personal development aspect of the course had an impact on your work?”
- Can you think of any recommendations for the PGDIP in psychotherapy going forward? Prompting questions could include: “what needs to be improved?”, “what needs to be included?”, “what needs to be more focussed on?”
- That is all from my side, is there anything else that you would like to add?

Appendix B: Semi structured focus group questions

- Begin with introductions: How are each of you involved in the PGDIP in psychotherapy?
- Perhaps we also speak about why did the PGDIP in psychotherapy come about? Prompting questions will include "when did you realise that there was a need for this course?", "who was this programme developed for?"
- What is the aim of the PGDIP in psychotherapy? Prompting questions will include: "what was the original aim of the course and has this changed?",
- Can you tell me about your experiences of teaching the PGDIP in psychotherapy? "what have the challenges been with regards to training methods?", "what have the challenges been with regard theoretical frameworks?", "what have the challenges been with regard content of course components?", "what have the challenges been with regards to process issues in student development?"
- Do you have any recommendations for the PGDIP going forward?
- That is all from my side, is there anything else that you would like to add?

Appendix C: Consent form for students who have completed the Postgraduate Diploma in Psychotherapy

Information sheet and consent form

University of Cape Town

Consent to participate in a research study:

Formal evaluation of the postgraduate diploma in psychotherapy at the University of Cape Town, South Africa

Dear past student of the Postgraduate Diploma in Psychotherapy,

Research purpose

You are being invited to participate in a research study being conducted by myself, a psychology honours student from the University of Cape Town. My study aims to explore previous students' experiences and perceptions of the postgraduate diploma in psychotherapy at the University of Cape Town. The study will also explore issues experienced by trainers regarding implementing the different components of the postgraduate diploma at UCT. As you have been a student of the PGDIP in Psychotherapy, your views would be of great value to my study.

Research procedure

If you agree to participate in this study, you will be asked to take part in a semi-structured interview which will take about 60 minutes. The interview will be conducted at a place that is convenient for you, taking into account your availability. I will ask you questions that will address three key areas:

- Your expectations of the PGDIP in Psychotherapy
- Your experiences of the PGDIP in Psychotherapy
- Your recommendations for the PGDIP in Psychotherapy going forward

The interview will be audio-recorded in order to help the researcher remember the information. After the researcher has listened to the recording and written it down, the recording will be destroyed.

Possible risks

I do not anticipate any risks in this study but if you feel uncomfortable discussing aspects of the course, you can choose whether you would like to continue with the interview.

Possible benefits

The interviews will allow you the opportunity to truly express the ways the PGDIP in Psychotherapy worked or did not work for you. Once the research has been completed, it is my hope that the information will be used to inform future implementation of the PGDIP in Psychotherapy, so that it can possibly be improved going forward.

Voluntary participation

Your participation in this research is completely voluntary. You are free to refuse to answer any question. If you decide to participate, you are free to change your mind and withdraw from the research at any time. There will also be no consequences, should you wish to withdraw from the research.

Confidentiality and anonymity

Your name and any identifying details will not be used in the research report. This will be ensured by using a pseudo-name which you can make up. The interview recording will only be made available to Associate Professor Debbie Kaminer who is the supervisor of this research.

Contact details

For any study-related questions or problems please contact:

Tracy Plant (researcher) – 0823184355

Associate Professor Debbie Kaminer (supervisor) – 082 467 1223

Should you have any concerns about the ethical aspects of the study, please contact:

Rosalind Adams (UCT Department of Psychology) – 021 650 3417 or

Rosalind.adams@uct.ac.za

I have read the above and am satisfied with my understanding of the study. My questions about the study have been answered. I hereby voluntarily consent to participate in the research study as described.

Name of participant

____

______________________________ ______________________________

Signature of participant Date

I agree that the interview may be audio-recorded.

Name of participant

____

______________________________ ______________________________

Signature of participant Date

Appendix D: Consent form for the trainers of the Postgraduate Diploma in Psychotherapy

Information sheet and consent form

University of Cape Town

Consent to participate in a research study:

Qualitative evaluation of the postgraduate diploma in psychotherapy at the University of Cape Town, South Africa

Dear staff member of the Postgraduate Diploma in Psychotherapy at UCT

Research purpose

You are being invited to participate in a research study being conducted by myself, a psychology honours student from the University of Cape Town. My study aims to explore students' and trainers' perceptions of the postgraduate diploma in psychotherapy at the University of Cape Town. As you are an integral part of training programme, your views would be of great value to my study. Your views will help me to explore trainers' experiences of implementing the different components of the postgraduate diploma at UCT.

Research procedure

If you agree to participate in this study, you will be asked to take part in a focus group which will take about 60 minutes. The interview will be conducted at a suitable venue at Valkenberg at a time that suits all participants. I will ask you questions that will address three key areas:

- Your perceived aims of the PGDIP in psychotherapy
- Your experiences of teaching the PGDIP in psychotherapy
- Your recommendations for the PGDIP in Psychotherapy going forward

The interview will be audio-recorded in order to help the researcher remember the information. After the researcher has listened to the recording and written it down, the recording will be destroyed.

Possible risks

I do not anticipate any risks in this study but if you feel uncomfortable discussing aspects of the course, you can choose whether you would like to continue with the interview.

Possible benefits

There are no direct benefits to you participating in this study. However, the focus group will allow you to truly express your experiences and challenges when training students in the PGDIP in Psychotherapy. Once the research has been completed, it is my hope that the information will be used to inform future implementation of the PGDIP in Psychotherapy, so that it can possibly be improved going forward.

Voluntary participation

Your participation in this research is completely voluntary. You are free to refuse to answer any question. If you decide to participate, you are free to change your mind and withdraw from the research at any time.

Confidentiality and anonymity

Information obtained in this research study will be confidential. I will do everything that I can to maintain confidentiality in a group context. I cannot control what people will say outside of the focus of the group discussion, although I will ask all of the participants to keep the discussion confidential. The focus group recording will be made available only to myself and Associate Professor Debbie Kaminer who is the supervisor of this research.

Contact details

For any study-related questions or problems please contact:

Tracy Plant (researcher) – 0823184355

Associate Professor Debbie Kaminer (supervisor) – 082 467 1223

Should you have any concerns about the ethical aspects of the study, please contact:

Rosalind Adams (UCT Department of Psychology) – 021 650 3417 or

Rosalind.adams@uct.ac.za

I have read the above and am satisfied with my understanding of the study. My questions about the study have been answered. I hereby voluntarily consent to participate in the research study as described.

Name of participant (printed)

____

______________________________ ______________________________

Signature of participant Date

I agree that the interview may be audio-recorded.

Name of participant (printed)

____

______________________________ ______________________________

Signature of participant Date

PLAGIARISM
DECLARATION

1. I know that plagiarism is wrong. Plagiarism is to use another's work and pretend that it is one's own.

2. I have used the *American Psychological Association (APA)* convention for citation and referencing. Each contribution to, and quotation in, this assignment from the work(s) of other people has been attributed, and has been cited and referenced.

3. I acknowledge that copying someone else's assignment or essay, or part of it, is wrong and that this assignment is my own work.

4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

5. I acknowledge that copying someone else's assignment or essay, or any part of it, is wrong, and declare that this is my own work.

SIGNATURE _______________________