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EXPLORING TRAINEE PSYCHOLOGIST'S SELF-CARE PRACTICES AT THE UNIVERSITY OF KWAZULU-NATAL, SOUTH AFRICA.

BY

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Dissertation Submitted in Partial Fulfilment of The Requirements for The Clinical Psychology Master's Degree in The School of Applied Human Sciences.

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DECEMBER 2021

DECLARATIONS

I Thobile Nkosi, hereby declare that this research report, except where otherwise designated is my original research work. The contribution of other authors has been rightfully acknowledged through proper citations and referencing. The sole purpose of this research report is partial fulfilment of the requirements for the Clinical Psychology Master's Degree in the School of Applied Human Sciences, University of Kwazulu-Natal, Howard College. This research report has not been submitted for any examination or degree for this, or any other institution.

17 December 2021

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ACKNOWLEDGEMENTS

I owe my sincere gratitude to the several people who supported me during the period of conducting this study. It is through their constant support and encouragement that I have successfully accomplished this research project.

I am predominantly indebted to:

- My supervisor Ms. Ntombekhaya Mtwentula for her role, guidance, support and wisdom that aided me in conducting this research.
- My grandmother Treazer Sihlangu, for her support, sacrifices and devotion to ensure that I went to school, and accomplish all my dreams and goals.
- My family, friends and colleagues for their support, and encouragements.
- Most importantly, all trainees who participated in this study, sacrificing their time amid their busy schedules, and the COVID-19 pandemic.

ABSTRACT

Self-care is a crucial culture that mental health practitioners need to embrace to promote their overall well-being. The application of self-care among trainee psychologists is foundational in establishing sustainable wellness and professional development for health professionals. Trainee psychologists are expected to deal with the global impact of the burden of mental health, while they manoeuvre their own professional development. The training process alone is marked with multifaceted cases that require prominent levels of alertness, critical thinking and self-awareness. Such skills are often affected by, stress, burnout and an imbalanced personal, and professional life. This may result in professional impairment. The primary purpose of this study was to explore and describe experiences of trainee psychologists' level of engagement in self-care practices, to promote their mental health care. In conducting this study, a qualitative research approach was adopted. To gain a rich insight on the participants' experiences; a semi-structured interview guide was used to interview Seven University of Kwa-Zulu Natal trainees who were enrolled in a master's clinical psychology programme. Data collected for this study were interpreted and analysed using the Health Belief Model as a conceptual framework.

Findings from this study demonstrated that trainees, in the programme, experienced challenges that included poor completion of the research component, poor supervision alliance, detrimental power dynamics, difficulties in transitioning from coursework to internship, and difficulties in balancing professional life and personal life. These challenges, negatively impact the trainees' mental health. However, adopted self-care strategies such as exercise, personal therapy, socialising and spirituality, contributed positively to their mental health. Support was the widely preferred coping skill adopted by trainees. The findings suggest that educating trainees about self-care practices can be a vital part of helping trainees to establish a sustainable mental wellness culture.

Keywords: burnout, compassion fatigue, mental health, self-care.

LIST OF TABLES

LIST OF ABBREVIATIONS

CF	Compassion Fatigue
HBM	Health belief Model
MHCPs	Mental Health Care Providers
UKZN	University of KwaZulu Natal
VT	Vicarious Traumatization

CHAPTER ONE

1.1.Introduction

The psychology profession is deeply involved in human interaction and can be one of the most satisfying jobs (Bozgeyikli, 2011). The profession is rooted within the context of the human society and is intertwined with most phenomena that capitalise humanity (Jordaan et al., 2007a; Roothman, 2010). Resultantly, for long, self-care has been regarded as fundamental for psychology professionals (Richards et al., 2010; Skovholt & Trotter-Mathison, 2014; Dattilio, 2015; Dorociak et al., 2017). However, not all health practitioners (thus, psychologists for this study) practice the culture of self-care (Barnett & Cooper, 2009).

Owing to its intensity and nature, the psychology profession is emotionally demanding (Jordaan et al., 2007a; Roothman, 2010). Winnicott (1960), argue that one of the key competency skills that psychologists possess is the ability to create a holding or containing environment for people in distress. This is a space in which an individual feels safe to explore their psychological difficulties (Sharf, 2015). Psychologists take care of others, that is; they deal with human suffering, people's predicaments and support their problem solving (Roothman, 2010). These tasks are achieved through empathy and understanding, with the provision to contain emotional responses of traumata (Jordaan et al., 2007a; O'Connor, 2001b). Unfortunately, providing this service habitually predisposes mental health care providers (MHCPs) to innumerable emotional and psychological risks (Loeve, 2017).

Responding to the psychological risks that health professionals face, there has been growing interest in the discussion of the importance of self-care among health professionals (Barnett et al., 2007; Barnett & Cooper, 2009; Larkin, 2015; Mayorga et al., 2015; Mills et al., 2017; Posluns & Gall, 2020; Richards et al., 2010; Zahniser et al., 2017). A large body of research has indicated several occupational hazards for those who provide services that benefit others in the health profession (Larkin, 2015; Mills et al., 2017; Sanchez-Reilly et al., 2013). The professional hazards include, experiencing, "burnout, moral distress, compassion fatigue, and poor clinical decisions which adversely affect patient care" (Sanchez-Reilly et al., 2013, p.1). Enforcing these hazards are, ethical regulations that compel service providers to practice in a manner that restrict hardship to others or the self to benefit the other (Sanchez-Reilly et al., 2013; Wise et al., 2012).

Self-care practice has been authorised nationwide, through discipline-specific professional canons (Canning et al., 2005; Mills et al., 2017; Palliative Care Nurses New Zealand, 2014). Research shows strength in self-care strategies, proving the efficacy in promoting the culture of self-care especially the prevention of compassion fatigue among MHCPs (Stamm, 2010). Arguably, the proficient quality of life is interconnected with the constructive and destructive facades of the role as a facilitator or service provider. It is indisputable that most MHCPs innately embrace a positive aspect as facilitators, and this is reinforced by compassion satisfaction. However, empirical research shows that the destructive is more likely to outweigh the constructive (Ray et al.,2013; Wagaman et al., 2015).

While there are a range of factors contributing to the lack of self-care among MHCPs, Barnett and Hillard (2001), posits that many psychologists tend to feel invulnerable to emotional and mental health difficulties. Hence, MHCPs are highly likely to be at risk of developing distress (Barnett & Cooper, 2009). O'Connor (2001b) noted a common trend among MHCPs that suggests that they are more prone to distress and impairment after they enter the profession or, experience traumata while in the profession. Hence, Baker (2003) argues that the culture of self-care for MHCPs should be accentuated as a preventive strategy.

In South Africa, psychology is an ingrained profession. Although it is a still young profession in view of formal training in the sub-disciplines; the profession has gained recognition as significant in the public health sector (Kakuma et al., 2010; Pillay et al., 2013). Relatively, counselling psychology as a sub-discipline is not fully conventional in accommodating the multi-diversity of South Africa regardless of ethnicity gaps in the scope of training, and the practice of professional clinical and counselling psychology (Bantjes et al., 2016). Extensive empirical research has focused on the development, and evaluating the implementation, and dissemination of the profession; in closing the marginalisation gap that was imposed by the apartheid system (Cooper & Nicholas, 2012; Ngcobo & Edwards, 2008; Pillay & Siyothula, 2008). For example, during the apartheid era, psychological services promoted discrimination based on racial differences and overlooked South Africa's cultural differences (Ngcobo & Edwards, 2008). The disparities under-emphasised the cultural diversity that existed within the country. This created mistrust regarding the need for the profession among minority groups.

Cooper and Nicholas's (2012) study shows that the apartheid system caused disparities; in terms of who were qualified to undertake the role of a psychologist and limiting access to

psychological services. In addition, they maintained that a transformed psychology profession had the potential to play a substantial role in addressing mental health challenges that were faced in South Africa (Cooper & Nicholas, 2012). Baker (2012) further highlighted a gap concerning attention on novices' outlooks, awareness, and understandings of various traumas. Nonetheless, the existing literature highlights the significant role that education and training programmes play in creating this awareness of the danger of overlooking trainees' mental health, and aggregate novice' MHCPs understanding of self-care (Newell & McNeil, 2010).

1.2. Rationale

Self-care plays a crucial role in maintaining a professional standard and optimising fruitful service delivery to beneficiaries of the health care sector. According to Wise et al. (2012), self-care is an ethical imperative in the health profession, and an obligation to all MHCPs and others. Across literature, there seem to be a consensus that self-care is crucial for health professionals (Barnett & Cooper, 2009; Dattilio, 2015; Rupert & Dorociak, 2019; Walsh, 2011). Yet, empirical research shows that there is a general tendency of health professionals overlooking their own mental health (Dattilio, 2015; Rupert & Dorociak, 2019; Walsh, 2011). International studies on self-care practice have well documented the benefits of engaging in self-care practices (Lynch et.al., 2016; Miller et al., 2017; Sansó et. al., 2015). A study by Rupert and Dorociak (2019) found that self-care among practicing psychologists is marked as a valuable ongoing preventative practice that may reduce risk for burnout and stress by promoting their overall well-being. Furthermore, the findings revealed that self-care is attributed to, "professional support, professional development, life balance, cognitive awareness, and daily balance" (Rupert & Dorociak, 2019, p. 1).

In the South African context, mental health services are characterised by the heavy burden of workload and intensified by a constant scarcity of mental health practitioners (Marais & Petersen, 2015). The field is flooded with challenges such as heavy workload, burnout, lack of support and shortage of staff (Sobekwa & Arunachallam, 2015). Universally, researchers have extensively documented the South African experiences of MHCPs in the public sector (Gockel et al., 2013; Guse, 2010). But there has been limited research on self-care practices amongst MHCPs in South Africa. Thus, this study is essential in closing the existing gap in this area. Furthermore, the study is useful in identifying challenges experienced in relation to trainee psychologists' self-care.

Barnett and Cooper (2009) highlighted that the culture of self-care is a core competency skill that graduate students need to recognise directly. Furthermore, a need for more focus on novice psychologists was emphasised because they are more likely to adopt the culture of self-care as part of their professional identity (Barnett & Cooper, 2009). Research within the concept of self-care has been conducted, but there is limited research that has focused on trainee psychologists' understanding of and their experiences in relation to the concept (Bettney, 2017; Glennon et al., 2019; Gockel et al., 2013). Available research has predominantly focussed on professionals who are registered under the broad spectrum of health and related work (Glennon et al., 2019; Posluns & Gall, 2020;). It is also notable that there are limited South African studies on the topic at hand. Consequently, there is a strong need to explore experiences of trainee psychologists, to combat the gaps highlighted above. Moreover, research in the South African context will provide a better understanding of common challenges experienced by trainee psychologists within the various training institutions. Thus, this study intends to explore trainee psychologists' experiences of practising self-care, to promote and enhance their mental health.

Another subject of interest in this study is to raise awareness on the importance of self-care for trainee psychologists. It is pivotal for novice psychologist to acknowledge; their subjective vulnerabilities, stressing the need to seek support, and practice enduring prevention (Barnett & Cooper, 2009). As maintained by Myers et al. (2012), studies such as the current one, are important to report to training institutions and students, so that they may create and implement effective ways of combating the challenges that come with the profession and promote psychological well-being of trainees. Furthermore, the culture of self-care will further benefit students to better understand themselves as they build their personal identity within the profession (El-Ghoroury et al., 2012).

1.3.Aim of the Study

The aim of this study was to explore and describe experiences of trainee psychologists' level of engagement in self-care practices to promote mental health care.

1.4.Objectives

- To explore the self-care practices employed by trainee psychologists to promote mental health care in their training programme.

- To explore the challenges experienced by trainee psychologists in practicing self-care and promoting mental health.
- To explore support structures available to promote self-care and mental health care in the mater's psychology programme.

1.5.Research Questions

- What self-care practices do trainee psychologists employ to promote mental health care in their training programs?
- What are some of the challenges experienced by trainee psychologist in practicing self-care and promoting mental health?
- What are the support structures available to programs promote self-care practices and mental health?

1.6.Dissertation Outline

This dissertation consists of six chapters. Chapter one outlines the introduction, rationale, motivation, aim, objectives of the study, research questions, and the dissertation outline. Chapter two provides a discussion of the relevant existing literature that relates to the concept of self-care. The chapter pays much attention to discussing self-care relative to the potential risk factors that come with the role of being a health practitioner. Furthermore, the chapter outlines common barriers that hinder psychologists from practising the culture of self-care. The chapter ends with a deeper discussion of Health Belief Model (HBM) as the adopted theoretical framework of this study. Chapter three discusses the methodology utilised for this study. The chapter discusses the; research design, methods of data collection and data analysis procedure, employed to carry out the study. Furthermore, the chapter provides detailed ethical considerations that were pertinent in conducting and writing-up this study. Chapter four thematically presents the findings from this study. Then, Chapter five goes on to provide a detailed discussion of the findings, by integrating these to the existing literature and constantly being guided by the Health Belief Model to interpret and comprehend the findings. Finally, Chapter six concentrates on the conclusion of the research outcomes, implications, and the limitation of the study. Recommendations for future research are also discussed in Chapter six.

CHAPTER: TWO LITERATURE REVIEW

2.1. Introduction

This chapter will provide a literature review concerning the concept of self-care. The chapter will also note the importance of self-care within health professions, especially in the field of psychology. The chapter will further discuss the potential dangers that may surface due to the lack of practising self-care, relative to the nature of the psychology training programme. Existing protective measures are also discussed in this chapter. Lastly, the health belief model is discussed as the theoretical framework of this study.

2.2. Self-Care

Self-care is broadly conceptualised as a phenomenon characterised by a range of activities aimed at endorsing one's well-functioning (World Health Organization [WHO], 1984). This entails durable quality in one's professional functioning in excess of time, and in the face of subjective stressors. According to Barnett and Cooper (2009), the core proficiency of professionals is rooted in ongoing self-care. Barnett et al. (2005) argued that self-care is an essential element in averting distress, burnout and impairment. Thus, should be considered as an ethical requirement and a professional identity, rather than a mere indulgence. This is in line with American Psychological Association (APA) ethical standards which stipulates the moral obligation for all MHCPs to do good and no harm to patients when providing services (APA, 2002; Wise et al., 2012). Williams et al. (2010) perceived self-care as any proceeding of behavioural engagements undertaken to reduce emotional distress experienced by professionals when working with clients in a therapeutic environment.

Figley (2002) indicated that, in light of attending to the needs of the clients, the knowledge and practice of self-care are fundamental to maintaining a balanced professional quality of life. This includes a holistic view, such as emotional, spiritual and physical needs. Maslach (2003) study on stress associated with work show the efficacy of balancing professional identity and personal life through, sustaining physical health, setting feasible professional objectives, and maintainable social support. In harmony, is the work of Catlin-Rakoski (2012) on therapists' perceptions of self-care which indicated that, burnout symptoms are usually the result of an imbalanced boundary setting between the professional and personal

life of MHCPs. Dean and Kickbusch (1995) defined self-care as a concept that embodies a collection of health-related resolutions and maintenance accepted by individuals on their own behalf. According to Stamm (2010), a proficient quality of life is interconnected to the positive and negative facets of the role as a MHCP. The positive facet entails all the pleasure or benefits associated with providing service as a service provider (Hooper et al., 2010). For example, the pleasure one experience when helping others in their time of need. While the negative facet is linked to the dissatisfactions that comes with the role as a facilitator (Ray et al., 2013; Wagaman et al., 2015). This includes all potential health risk factors that comes with being a MHCP.

2.3. Potential Health Risk Factors

Psychotherapy is a demanding vocation that is entangled with numerous potential mental health risk factors. Empirical research in the discipline of psychology indicates the countless difficulties inherent in the psychotherapist's role (Neumann & Gamble, 1995; Killian, 2008; Pakenham, 2015). Mental health practitioners are susceptible to emotional stress, compassion fatigue, burnout and vicarious trauma (Killian, 2008). According to Killian (2008) addressing these health risk factors s essential in promoting wellness among health professionals. This was respectively discussed below:

2.3.1. Emotional Stress

The term stress is a multifaceted phenomenon associated with numerous theoretical models (Biggs et al., 2017). In this study, the work of Lazarus (1966 cited in Ally, 2014; Myers et al.,2012) is adopted which referred to stress as hazardous instability of the biological and psychological functioning because of unfavourable life circumstances. This is in line with the work of Hepker (2007) which designated that stress is any pressure that tempers with the mental or physical aspect beyond its range of ability. Thus, an individual will experience tension subjectively because, it influences all aspects of one's well-being (Hepker, 2007). Notably, it is significant to note that, not all people will experience stress the same, but different stressors play a huge role in how each individual experiences it (Hepker, 2007).

Within the context of MHCPs, the widely documented stressors in the clinical psychology training programme stem from the; academics, research, clinical, and professional demands (Pakenham & Stafford-Brown, 2012). These stressors vary from; difficulties in transferring theoretical work, to clinical practice, and to establishing rapport with clients (Pakenham & Stafford-Brown, 2012). Moreover, psychology training is composed of,

continuous evaluations, highly demanding clinical, academic, and research work. These require long hours of work, concurrent with switching between various characters and uncertainties that are innate in clinical psychology practice (Pakenham, 2015). Barnett and Cooper (2009) posit that MHCPs are more susceptible to elevated stress because the practice itself is characteristic to a sense of vulnerability to mental health difficulties. Pakenham (2015) added that personal vulnerabilities and the barricades to seeking support when clinically distressed is experienced as other broader factors that makes psychologists to experience elevated stress.

The chief competency skills of a psychotherapist include the ability to be empathic and understanding. Psychologists are trained to have the capacity to hold emotional responses in the face of reported trauma and robust emotions (O'Connor, 2001b). Such competency skills can cause psychologists to experience emotional exhaustion and distress. Subsequently, a sudden decline in the services rendered to clients can emerge because of the stress they experience as MHCPs (Jordaan et al., 2007b). Numerous empirical research show that stress has detrimental effects on a psychologists' level of attention and concentration. These comprises a decline in decision-making skills, effective communication skills and other related physical health complications (Enochs & Etzback, 2004; Miller et al., 1988; Spickard et al., 2002).

2.3.2. Compassion Fatigue

In general, mental health professions predispose health practitioners to the risk of compassion fatigue (CF). CF refers to distinctive stressors prevalent in caregiving professions (Branch & Klinkenberg, 2015). The pioneer of the concept, CF, is Joinson (1992), who proposed that CF resulted from nurses' declined capability to nurture. This was a finding from a study that focused on nurses who were working in the emergency nursing department (Hunsaker et al., 2015; Branch & Klinkenberg, 2015). Following the work of Joinson and Figley (1995 cited in Cocker & Joss (2016), Cocker and Joss (2016) postulated that CF refers to secondary traumatic stress reaction after caring for traumatised individuals. In other words, it is the tension that is after experiencing emotional congruency between a traumatised individual and the aider (Cocker & Joss, 2016).

In defining CF, Figley (1995) proposed that, CF is characterised by two main components which are burnout and secondary traumatic stress. Burnout is defined as a remarkable emotional exhaustion, feelings of disconnection and professional inadequacy

(Wagaman et al., 2015). It results from demanding, and emotionally charged relationships with clients, such that an individual can no longer fulfil the most basic personal and professional responsibilities or duties (Boyas et al., 2012). Secondary traumatic stress includes, conducts and reactions that manifest because of indirect exposure of traumatic event experienced by trauma caregivers (Branch & Klinkenberg, 2015).

In the past decade, CF is often an unclear nomenclature in the health profession field. The concept is often used interchangeable with concepts such as burnout, secondary trauma stress and vicarious trauma (Craig & Sprang, 2010; Stamm, 2010; Zeidner et al., 2013). A standard dissimilarity between burnout and CF is that burnout usually displays a steady inception whereas CF may take place abruptly (Hunsaker et al., 2015). Cocker and Joss (2016) also note that burnout is often used interchangeable with concepts such as compassion fatigue, vicarious trauma and secondary trauma stress. However, Cocker and Joss (2016), insinuate that burnout only relates to state of physical and mental exhaustion caused by a worn-out ability to cope with one's ordinary settings. Newell and MacNeil (2010) view burnout as directly resulting from the clients' presenting problems. But others suggest that there is a strong relationship between the working environment and greater risk of burnout experiences (Catlin-Rakoski, 2012; Mor Barak et al., 2001). Common signs of burnout displayed by most professionals include taking excessive days off from work, lack of punctuality, lack of energy, and not following through on job-related responsibilities (Newell & MacNeil, 2010). Alkema et al. (2008) argued that burnout has a potential of manifesting in form of; negative self-concept, destructive attitude towards work and decreased sense of nurturing due to the feelings of hopelessness, depersonalisation and emotional exhaustion.

Secondary traumatic stress has been understood as a potential hazard that a service provider sustains when they are empathically engaged with individuals or patients who would have suffered traumatic experience (Branch & Klinkenberg, 2015; Figley, 1995; Zeidner et al., 2013). Secondary trauma is characterised by psychological distress and posttraumatic stress symptoms resulting from serving trauma survivors (Salloum et al., 2015). Generally, people who suffer from secondary trauma stress display similar symptoms of posttraumatic stress disorder. They may display an increased sense of arousal, while some may exhibit avoidance symptoms (Salloum et al., 2015).

Vicarious traumatization (VT) is a concept intricately linked to secondary trauma stress and was coined by McCann and Pearlman (1990). According to McCann and Pearlman (1990),

VT is defined as the alteration that take place within a professional who works on trauma related cases. VT is classified as the product of empathic engagement and recurrent emotionally intimate interaction with individuals who have experienced traumatic events (McCann & Pearlman, 1990; Sansbury et al., 2015; Zeidner et al., 2013). VT is often related to mental, schematic, and further psychological effects (Craig & Sprang, 2010; Sprang et al., 2007). McCann and Pearlman (1990) proposed that helpers who have alterations in cognitive schemas and belief systems, are at risk when they work working with trauma. According to Sansbury et al. (2015, p. 115), the alteration that transpires when working with trauma cases entails altered, "memory systems and cognitive schemas associated with five need areas: safety, dependency or trust, power, esteem, and intimacy". These alterations give rise to substantial disturbances in the professional's; sense of meaning, world view and identity (Craig & Sprang, 2010; Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995).

In distinguishing vicarious trauma from secondary trauma, Salloum et al. (2015) noted that; vicarious trauma is rooted in theory and denotes typically to the cognitive modifications subsequent from comprehensive contact to trauma survivors rather than the experience of trauma symptoms. By comparison, CF varies from VT in that, compassion fatigue can occur with minimal to significant contact with individuals. Yet, VT merely arises when working directly with traumatized individuals (Sansbury et al., 2015). Indicators of VT can vary from decrease in empathy to, symptoms related to posttraumatic stress disorder (Cosden et al., 2016).

In defining CF, this study borrows the definition by Turgoose and Maddox (2017) which shows that compassion fatigue is characterised by the antagonistic effects of exposure to traumatising encounters that prohibits one's ability to feel empathy for others. The high prevalence of CF is correlated to professionals' ability of being attuned to clients or patients' emotions and expressing empathy, thus, placing health professionals at greater risk (Hunsaker et al., 2015). Moreover, Hunsaker et al., 2015) maintained that CF can be argued to be caused by one's ability to feel empathy. Given the nature of the profession, the therapist's role is about establishing relationships and connection. Thus, propel professionals to engage and promote empathetic connections with clients (Catlin-Rakoski, 2012). However, such interactions can result in dissatisfaction in a professionals' work and decrease the level of service and attention in their work.

2.4. Common Challenges and Stressors Faced by Trainee Psychologists

2.4.1. Trainee anxiety

The psychology profession has high emotional demands from the psychologists, this may result in the professionals being emotionally overcharged (Proţi, 2016). Hence, it is not surprising that trainee psychologists face numerous challenges that trigger; anxiety, insecurity and doubt (Ronnestad et al., 2019). This is also supported by Woodside et al. (2007) who maintained that the psychology profession is branded with myriad of uncertainties. Early literature, which focused on the nature of clinical psychology training, demonstrate that the profession is stressful and full of ambiguities that have detrimental effects on the mental health (Cushway, 1992; Pica, 1998). On daily basis, trainees are confronted by complex issues that include ethical dilemmas, and complex clinical presentations that may include those with symptoms that do not fit the diagnostic criteria (Pica, 1998). Such complexities have a potential to create elevated levels of anxiety (Pica, 1998). In addition, psychotherapy is also characterised by ambiguous outcomes when working with patients or clients.

From the initial stages of training, trainees are engrossed on cultivating their knowledge, and attending to the needs of their clients. This requires; understanding their academic and theoretical work, practically applying what they learn from the classroom in their practical work, and the demand for constant self-awareness to enhance their personal and professional growth. Arguably, these requirements demand high levels of self-realisation, and can provoke the feelings of self-doubt, which may lead to disruption in concentration and performance. Such feelings can cause negative emotions including apprehension, discouragement, and irritation (Ally, 2014). Thériault et al. (2009) argued that, although, experiencing self-doubt and incompetence can be detrimental; it can also be considered vital in helping trainees to develop their professional identities. However, the feelings may only yield these positive outcomes if the trainees perceive them as impermanent and manageable.

Furthermore, literature indicate that trainees experience challenges in transitioning from theoretical to practical work (Proti, 2016; Skovholt & Rønnestad, 2003). Consistent with these findings, Cartwright and Gardner (2016) noted that theoretical work differs from practice, because the nature of therapeutic work is uncertain. The work requires trainees to change their attitude, cognitive capacity, emotional and interpersonal relations. Corey (2005) further pointed out that, novice counsellors have grand expectations, and they often lean towards the

perfectionist's continuum, which leaves little to no room for error. In their study of struggles for the novice counsellor and therapist, Skovholt and Rønnestad (2003), noted that students that were accepted in the training programme were selected based on intellectual excellence in academics, hence trainees are fixated with proficiency goals. Conversely, mastering theoretical work does not translate directly to the density of therapeutic practice. Resultantly, trainees are often preoccupied with self-efficacy and their performance (Cartwright & Gardner, 2016; Orlinsky & Rønnestad, 2003; Skovholt, 2012). Skovholt and Rønnestad (2003) also linked the confusion amongst trainee's sense of insecurity related to performing tasks to their supervisors' theoretical inclination. Trainees are highly likely to operate in accordance with what they consider appropriate for their supervisors, without fully understanding the material.

2.4.2. Training Programme

Obtaining the qualification of psychology, generally, requires patience and perseverance, due to the long process that a trainee must undertake. In South Africa, trainees in the counselling psychology and clinical psychology programmes must go through a series of selection phases irrespective of institutions that they will attend. The journey is linked to several stressors that predisposes trainees to a wide range of health risk factors (Roothman, 2010). Trainees experience a great deal of anxiety to qualify for the master's programme since there are limited training spaces available. In South Africa, although varying per institution, the general selection process includes individual interviews, group interviews, role play, and essay writing. At the University of Kwa Zulu Natal, the selection process consists of; one day of individual interviews and group interviews. From these interviews, often, only 14 students are accepted in the master's programme, which includes counselling and clinical students combined. The duration of the programme is two years, which is broken down into two components: first year being coursework and second year being an internship.

After they succeed in the selection phase, students enter into the first year of master's studies, which entails; attending seminars, various presentations, community project, clinical work at the school clinic under close supervision, examination and a research component which can be carried over to the following year if it is not completed in the first year of master's (Pillay et al., 2013; Roothman, 2010). At this stage, trainees are exposed to clinical cases and many of them experience their initial encounter with clients. Research indicates that the initial interview between a novice psychologist and client is the one of the most stressful events in the psychology career (Roothman, 2010; Thériault et al., 2009). This is because trainees will

be always under evaluation and strict scrutiny by their supervisors. Furthermore, the pressure to master therapeutic skills subject trainees to be more anxious when interacting with clients (Roothman, 2010).

Trainees are not only faced with the dilemma of dealing with the clients' psychological issues; they are also exposed to the reality of practising psychology within the South Africa context. Ally (2014) noted that, South African practitioners and trainees face unique challenges, because the context calls for practitioners to work with culturally diverse, and multilingual clients who usually come from unfavourable contexts of underprivileged, and under-resourced communities. Additionally, Pillay and Kramers-Olen (2014, p.365) described clinical psychology training as, "South African clinical psychology training is negotiating the impact of destructive apartheid policies, along with globalisation and the intricacies of an African (South African) psychology". Hence, there is an appeal for more ethnic and all-inclusive approaches in professional psychology (La Roche & Maxie, 2003; Mkhize, 2004 as cited in Ahmed & Pillay 2004).

Advancing to the next phase of psychology training is even harder. The second year of training entails seeing clients' fulltime in a more formal manner, because at this phase trainees are contracted by employers for a period of a full year. The number of cases build up in number, and trainees are exposed to more complex cases, especially in the hospital setting. During the second year, clinical psychology trainees rotate several hospitals, and the academic clinical work entails; attending seminars, case presentation, regular supervision, intern meetings, attend workshops and exposure to forensic cases (Roothman, 2010). All these activities provoke anxiety, thus, placing trainees at risk of developing health issues.

2.5. Self-Care Strategies

The benefits of a practitioner's self-care are well documented and, although limited, there is empirical literature, which addresses the counsellor's self-care strategies (Godfrey et al, 2011; Moore et al., 2011). The approaches differ according to personal preferences. The practice of self-care can be initiated for personal gains, or can be work related, as would be recommended in a professional, formal or informal setting (Godfrey et al., 2011). Godfrey, describes this as follows:

> "*Perspectives on self-care differ between healthcare professionals and the general public, and between healthcare professionals in different disciplines and different roles.*

As different professions view self-care within the framework of their own perspectives" (Godfrey et al., 2011, p.4).

Moore et al. (2011) indicated that there are several techniques to practice self-care. The techniques include physical wellness, healthy eating habits, spiritual wellness, psychological wellness such as journaling, and social support.

2.5.1. Physical Wellness

Physical wellness is one of the common methods used to practice self-care. The physical aspect of self-care is usually defined as action that involves bodily activity (Carroll et al., 1999; Tamura et al., 2008). This can be achieved by participating in sports, exercise, and domestic everyday activities (Henderson & Ainsworth, 2001). Research has shown that physical activity has proven to be effective in promoting the culture of self-care and contributes largely to the prevention of compassion fatigue. According to Callaghan (2004), engagement in physical activity has been associated with the reduction of anxiety and depression symptoms, which are common signs of compassionate fatigue. Lustyk et al. (cited Londono, 2017) indicate that there is a strong relationship between physical activity, better health and improved quality of life.

Among social work students, who also engage in counselling, similar to psychology trainees, Moore et al. (2011) found that most students struggled to engage in physical activity due to long hours of work and highly demanding workload. However, the findings also show a substantial number of benefits in those that engaged in physical activity. Some students in this study reported that, the benefits of physical exercise included reduced boredom and an enhancement in personal self-care (Moore et al., 2011). In addition, engaging in physical activity appears to be a vehicle for change in self-perception of our self-image, which in turn improves self-esteem and self-confidence (Fox, 1999). Sparling and Snow (2002) noted that many people believe that there are no benefits to short spurts of activity, nonetheless studies show that there are benefits from minor efforts of physical activity that is performed in small intervals throughout the day. Additional to engaging in regular physical activity; eating a healthy diet, maintaining a healthy weight, getting adequate sleep, and sustaining relationships are beneficial to one's health. There are studies that have shown that if the two; physical health, and healthy eating habits, are adopted effectively, individuals would earn a balanced health

lifestyle (Mayorga et al., 2015). However, it is noteworthy that individuals struggle with adopting healthy lifestyle behaviours as a permanent part of their daily routine.

2.5.2. Psychological Wellness

Taking care of people's mental health requires a sound mind and self-consciousness from the mental health service providers. This can be achieved through attending to their own mental health as mental health service providers, by incorporating the psychological aspect of self-care. One of the methods that have been seen as effective in practising self-care psychologically, is seeking professional help from a qualified mental health professional. Given the challenging nature of the therapeutic relationship between the psychotherapist and their clients, who face their own psychological difficulties; it is recommended that the psychotherapist examines the benefits of their own counselling (Richards et al., 2010). Research shows that personal counselling for practitioners in the mental health profession is advantageous, and is recognised for enriching their personal, professional growth, and self-awareness (Macran et al., 1999; Richards et al., 2010). A study by Macran et al. (1999) also added that, personal counselling for psychotherapists helps the therapeutic relationship between their clients and themselves, because they also become more aware of transference-countertransference between them and their clients.

While personal psychotherapy has shown to be significant, literature has also shown that regular supervision when working with clients, is fundamental. It is easy for practitioners to be overly immersed in the world of their clients, without realising that they are no longer helping the clients but undertaking self-healing through the clients. Therefore, supervision allows practitioners to remove themselves from the situation and take on an unfamiliar perspective in understanding the complexities that will be presented by the clients in therapy (Macran et al., 1999).

Another method that is useful for psychologists in caring for their mental health, is the use of journaling. According to Mayorga et al. (2015), journaling can be helpful in dealing with stressful events. A study by Boud (2001) showed that journaling served as an instrumental way of understanding emotional processes through reflection. This is in accord with the study that was conducted by Bradley et al. (2013), which explored creative approaches for promoting counsellor self-care. Bradley et al. (2013), noted that journaling was a creative method of improving mental health because counsellors reflected on their own cognitive processes, and

this improved their professional stance, while keeping record of their journey as service providers. Hubbs and Brand (2005) indicated that, reflective journaling serves as a medium gain insight on cognitive processes by exploring internal thought processes to monitor their well-being. Furthermore, Bradley et al. (2013) noted that creative activities can not only be limited to journaling, but any form of creativity may serve as means to practising self-care such as the use of poetry, music, and creative art.

2.5.3. Spiritual Wellness

Spiritual wellness is another form of self-care practice, which is used in various health fields. It is a practice that integrates psychological philosophies and religious beliefs. There are various techniques that are used to promote spiritual wellness. One of the common strategies used is meditation (Duncan & Weissenburger, 2003). Meditation is practised by different religions, and it cuts across cultural customs (Cyr, 2017). According to Ospina et al. (2007) meditation is a general term that is used to define a range of activities that share diverse features, although dissimilar in substantial conducts according to purpose and practice. Meditation has been associated with stress reduction and enriched physical wellness. Other studies in meditation show a relationship between meditations and improved; physiological, mental, and sociological functioning (Mayorga et al., 2015).

Additionally, a technique known to improve self-care is the practice of mindfulness. Mindfulness can be defined as, “a psychological state of awareness, a practice that promotes this awareness, a mode of processing information, and a characterological trait” (Davis & Hayes, 2011, p. 198). The concept originates from Buddhist contemplative practices. However, it is revised and is incorporated in psychology as part of the collection of treatment techniques. Mindfulness practices and skills are designed to enhance participants' ongoing awareness of their; sensory experiences, thoughts, feelings, somatic sensations, and actions (Shapiro et al., 2007). Literature has indicated that the practice of mindfulness enhances well-being (Baer, 2003; Grossman et al., 2004).

2.5.4. Social Support

Social support structures have an influence on an individual’s overall well-being. People rely on social connections to achieve a sense of belonging. People are connected to families, and communities where they share collective goals. Research indicates that social support is a core element of professionals in mental health care (Galek et al., 2011; Sun et al.,

2020; Zhang et al., 2020). Social support can be defined as any means of connection or resources that can aid or provide comfort in time of distress (Clark et al., 2009). It is an asset of coping with everyday life through solidarity, and the actualisation that one is cared for. Social support systems include family, friends, colleagues, mentors, and supervisors (Clark et al., 2009; Posluns & Gall, 2019). Research on mental health for practitioners show positive results on the impact of subjective and professional social support in self-care. According to Barnett et al. (2007), there are various mediums available that mental health providers often use as means of social support, and they include peer support, individual, and group supervision, seminars and personal therapy.

At a personal level, social support includes immediate family, friends, and personal counselling (Coster & Schwebel, 1997; O'Connor, 2001a; Stevanovic & Rupert, 2004). This is an essential component of self-care trainees, as they interact with their loved ones, and people who are close to them as individuals. Personal self-care approaches consist of prioritising close interactions with family, friends and colleagues (Sanchez-Reilly et al., 2013). It is crucial that self-care goes beyond subjective and professional boundaries to achieve overall well-being (Cleary et al., 2020).

A study on stress and barriers of wellness among psychology graduates, found that personal support is the go-to stream of support for most graduates as they found it to be most effective way of dealing with stress (El-Ghoroury et al., 2012). Another study by Kuyken et al. (2003), that was conducted on trainee clinical psychologists' adaption and professional functioning, found that personal support yields; high self-esteem, easier adaptation, and reduced anxiety and depression. William and Kemp (2020) noted that dissatisfaction in personal social support has a potential risk of developing mental health issues that can be detrimental to both personal and professional life, thus, creating the likelihood of dysfunctional work environment. This is in line with the work by Cicognani et al. (2009), who linked job satisfaction to the influence of interactions between individuals at a workplace.

According to Coster and Schwebel (1997), professional support is significant in providing valuable contributions to diverse clients' presenting problems. Drawing from the work of Figley (2002) on burnout, professional support is vital in combating possibilities of burnout. This includes consulting colleagues and other specialists in the field (Figley, 2002). Cultivating psychologists on the subject of burnout and self-care approaches aids counsellors to recognise their own and their colleagues' symptoms, thus reducing latent harm that could be

caused to their clients (Figley, 2002). High on the hierarchy of self-care strategies by proficient psychotherapists is professional and peer supervision. It is recommended as the most significant and useful coping method in practising self-care (Thériault et al., 2015). In addition, it has been found to decrease feelings of incompetence and self-doubt (Thériault et al., 2015). Zahniser et al. (2017) show that professional support is beneficial for clinical psychology trainees because it boosts their; professional development, academic work, and reduce their stress and anxiety levels.

2.6. Resilience as a Protecting Factor

The value of resilience in a person's life has been widely researched, and empirical research on the subject has rapidly evolved (Herrman et al., 2011; Skovholt et al., 2001). Mental health care providers may, despite their training and skills acquired, find themselves struggling to cope with the pressure and challenges associated with their job description. Balancing self-care and maintaining professional life can be demanding, and emotionally draining, thus it requires resilience, to avoid impairments in the caring process (Skovholt et al., 2001). Resilience is best applicable and conceptualised as a progressive process or a dynamic dimension rather than as a fixed product or trait (Yates et al., 2015). Resilience further conveys a connotation of optimistic or classic progressive adaptation, despite exposure to clear danger or hardship (Yates et al., 2015). Accordingly, recognising development of resilience necessitates clear operative descriptions of both; hardship and positive adaptation or proficiency (Yates et al., 2015). Additionally, Yates et al. (2015) highlighted that contemporary model of resilience overtly identify that adversity and competence, and the processes that underlie them, may vary across levels of analysis within and across cultures.

A study on resilience and coping experiences among psychology masters' students indicated that resiliency varies in terms of; struggle experiences, personal resilience experiences, life management experiences and study experiences (Edwards et al., 2014). A literature review that was conducted by McCann et al. (2013) on resilience within the health professions, indicated that health professionals possess different processes and characteristics to identify the individual and contextual resilience enhancing qualities, and coping. The study shows that, psychologists depend on numeral factors to maintain resilience. These comprise, "age, gender, work-life balance, recreational activities (exercise, hobbies, vacations), personal, and professional values, and having a sense of purpose" (McCann et al., 2013, p.68). Whereas, among counsellor's, self-compassion plays a role in improving well-being. Findings from

social work studies proposed that resilience is attributed to factors such as age, sex, balancing work life and professional life, subjective and professional identity and quality of supervision support (McCann et al., 2013).

Osborn (2004) recommended that it is more beneficial to emphasise nurturing and building resources that will endorse psychotherapists' resilience, rather than to focus on the notion of stress and the state of exhaustion. Houpy et al. (2017) posits that nurturing resilience is a favourable way to alleviate adverse effects of stressors, avert burnout, and aid scholars to prosper after their demanding experiences. This is in line with the work of Tjeltveit and Gottlieb (2010), who maintained that building resilience and challenging susceptibilities is an ethical imperative among psychologists. Decreasing susceptibilities and improving resilience necessitates an appropriate balance of care for service providers and their clients (Tjeltveit & Gottlieb, 2010).

2.7. Theoretical Framework: Health Belief Model (HBM)

In this study, the comprehensive model that was employed for understanding self-care practices of mental healthcare providers is the Health Belief Model (HBM). HBM is a theoretical approach that relates to the relationship between health and health behaviour (Abraham &Sheeran, 2005). HBM originates from the work of Hochbaum in the early 1950's (1952) and of late noted as a systematic technique to explore and predict pre-emptive health behaviours (as cited in Champion, 1999; Hochbaum et al., 1952; Janz & Becker, 1984; Jones et al., 2015; Orji et al., 2012; Rosenstock, 1974a; 1974b). Abraham and Sheeran (2005) noted that health behaviours are subject to individuals' determination to avoid an illness or healing from it. This motivation is based on the beliefs that the person holds about illness and confidence that they hold in taking necessary measures to achieve that goal. The underlying focus of the model postulates that personal beliefs and perceptions influence health seeking behaviour.

Given that the current study aimed to explore trainee's perceptions on self-care strategies that promote mental health, HBM was suitable for the study. This is because, HBM also, focuses on the relationship between health and health behaviour. Notably, HBM have its own flaws such as that, it lacks reliability in predicting future behaviours (Carpenter, 2010). However, model is useful in examining and elaborating change and preservation of health behaviour and functions as a directional structure for health behaviour interventions (Glanz et

al, 1997). The model is valuable in the current study to provide understanding of the perceptual benefits and barriers to practicing self-care among trainee psychologists. This allowed the researcher to explore challenges that are experienced by trainees in the training programme and understand how the available structures aid trainees in promoting self-care and mental health.

HBM highlights four main constructs that influence heath and health behaviour; perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers (Maio et al., 2007; Orji et al., 2012; Rosenstock, 1974a; 1974b). The model also expands to embrace two additional notions; namely the cues to action and self-efficacy (Champion & Skinner, 2008; Gates, 2015). This will be described in detail below:

2.7.1. Perceived Susceptibility

Perceived susceptibility is characterised by prospects of HBM as person attributes to subjective liability to developing the health condition (Champion, 1999; Hochbaum et al., 1952; Rosenstock, 1974a; 1974b). In other words, it is defined as principles that an individual holds, relative to the effects of a particular illness or condition to their life. These include a comprehensive approach in understanding the challenges that a disease or condition can cause. For example, one would consider the clinical, medical, financial, and social implications. Champion and Skinner (2008) emphasised the importance of considering emotional and economic burdens when examining the seriousness of a disease or condition. The combination of vulnerability and severity has been characterised as perceived threat.

2.7.2. Perceived Severity

Perceived severity refers to the beliefs about the seriousness and sequelae that a particular condition has (Champion, 1999; Champion, & Skinner, 2008; Hochbaum et al., 1952; Janz & Becker, 1984; Jones et al., 2015; Rosenstock, 1974a; 1974b). Rosenstock (1974a) maintained that individuals show broad discrepancies in their perceptions about the probability of suffering from a condition that can be detrimental in their health. Thus, their perceptions of susceptibility to a particular disease differs. The scale of severity is broad and varies from; low, moderate to severe. Perceived susceptibility and severity having a robust cognitive element are at least moderately reliant on knowledge (Rosenstock, 1974a).

2.7.3. Perceived Benefits

Perceived benefits denote a person's personal view on the significance or effectiveness of recommending a healthy behaviour to offset the perceived danger (Orji et al., 2012). A person's action is influenced by the beliefs that they hold about the condition or disease and directs the plan of action towards dealing with the perceived threat. For instance, a person may be aware of their own vulnerabilities and seriousness to a particular health condition but refuse to accept any recommended health actions to eradicate the perceived threats because they do not believe on the actions that are provided. Accordingly, people who hold their ideal dogmas in predisposition and rigorousness are not expected to agree with taking any indorsed action, unless if they also recognise the action as possibly beneficial in dealing with the threat.

2.7.4. Perceived Barriers

Perceived barriers entail the individual's personal calculation of the complications, or the interferences, allied with the objective behaviour (Orji et al., 2012). It is pivotal to note that individuals may not take any plausible actions regardless of them being aware of the effectiveness of the action, and its benefits. This may be the result of perceived barriers of acting. Barriers may include financial constraints, pain and discomfort associated with treatment or action. Such barriers may push a person away from attaining the desired action.

2.7.5. Cue to Action

A person's belief about the seriousness of a condition or illness, and their perceived predisposition, and benefits informs a force to act, thus, it may necessitate a 'cue to action' (Orji et al., 2012). These cues vary from internal, such as, the perceived physical state to, external factors, such as personal interactions or information received. Rosenstock (1974a, p.333) noted that a person:

> *"…with relatively little acceptance of susceptibility to or severity of a disease, rather intense stimuli would be needed to trigger a response. On the other hand, with relatively high levels of perceived susceptibility and severity even slight stimuli may be adequate".*

2.7.6. Self-efficacy

Drawing from the work of Bandura (1997), the concept, "self-efficacy," was integrated into HBM framework as it is postulated that, one needs confidence in one's ability to compliance (Rosenstock et al., 1988). Self-efficacy is defined as the belief that one can effectively implement a behaviour that can yield positive outcomes (Bandura, 1997). In simple terms, self-efficacy refers to one's capability to effectively act (Bandura, 1977). This component emphasises that, believing in one's capability to take essential action boosts one's confidence that function as a catalyst to stimulate one to initiate, and endure the action. These self-beliefs about people's capacity, influences; how they behave. Furthermore, the expectations of personal efficacy determine whether coping behaviours will be initiated, how much effort will be spent, and how long they will be sustained in the face of obstacles and adverse experiences (Bandura, 1977; Tarkang & Zotor, 2015).

2.8. Summary

Self-care is one of the most crucial practices in the helping professions. Literature in this chapter suggested that self-care practices offer health practitioners a way to positively safeguard psychological conditions such as compassion fatigue, burnout, and vicarious trauma in their careers. In this chapter self-care is discussed as a comprehensive approach that includes spiritual wellness, physical wellness, psychological wellness, and social support. However, it is noteworthy that there is still a significant gap in empirical research to strongly recommend self-care. The existing empirical research also shows that it remains a challenge for most practitioners to practice self-care owing to a variety of unforeseeable barriers. These barriers vary per practitioner; however, the consequences are detrimental to practitioners and their patients. Lastly, HBM was chosen as a conceptual framework for this study.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter discusses the methodology that was employed to conduct this study. The chapter provides a discussion of the; research approach adopted, sampling methods, the process of data collection, and analysis. Furthermore, the measures that were taken to ensure this study's; reliability, validity, and ethical appropriateness in conducting this study, are discussed in this chapter. Lastly, a summary of the chapter is presented.

3.2. Research Design

3.2.1. Qualitative Study

In conducting this study, a qualitative research design, which is interpretive in nature, was employed. Babbie and Mouton (2001) mentioned that qualitative research design is the fundamental methodological approach in studies that aim to interpretively comprehend contextual meaning of experiences through concentrated descriptions of accounts. Qualitative research design measure's objective theories and scrutinise the interactions between variables. This is achieved through a holistic view and the interconnected nature of descriptions to comprehend meanings through the lens of the subjects of the study in relation to the phenomena (Hennink et al., 2010; Marshall & Rossman, 2014). Thus, this research design was suitable for the current study which sought to explore subjective experiences of trainee psychologists on the culture of self-care and the coping strategies that are adopted by trainee psychologists. Additionally, qualitative research design enabled trainee psychologists to express, in detail, the costs of neglecting selfcare in the field of psychology as a student and professional psychologist.

Accordingly, trainee psychologists provided an in-depth descriptive narrative of their subjective experiences in their training journey, and their level of engagement in self-care activities which were expressed through social interactions with their environment, own behaviour, language and emotions. This approach allowed the researcher to rely on the participants' expressed experiences, to interpret the data and understand their; worlds, context and meaning of their accounts. This is in line with core characteristics of qualitative approach, which points out that realities are manifold because they are socially constructed (Yilmaz,

2013). The researcher's role was to view these realities from the insider's perspective, with empathetic understanding.3.3. Sample and Sampling Methods

Purposive sampling was employed in this study, to select participants at the University of KwaZulu-Natal, Howard College. Purposive sampling is an intentional selection of a participant due to the characteristics the participant possesses (Etikan et al., 2016). Purposive sampling is a non-random method that does not prerequisite basic theories or conventional number of respondents. Purposive sampling was suitable for this study because it enabled the researcher to deliberately seek specific characteristics, with the intent to develop analysis and emerging theory (Lewis-Beck et al., 2003). The trainee psychologists were relevant for this study because they were currently in the training programme and had the knowledge and necessary experience. According to Yin (2011), purposive techniques are convenient in studies that aim to facilitate predictable richness and application of information pertaining to the research.

The inclusion criteria for this study were, students in the master's training programme, registered for either counselling psychology or clinical psychology at the University of KwaZulu-Natal, Howard College. Psychology students from Pietermaritzburg campus were excluded in the study due to geographical constraints. The final sample consisted of seven volunteering master's students enrolled in the clinical psychology stream, with no segregation to gender and racial biases. Although counselling students were part of the inclusion criteria, only clinical psychology students volunteered to participant in the study. 3.4. Procedure

3.4.1. Entry into the Research Site

A gatekeeper's permission to interact with the targeted research population was requested, and a permission letter was granted in April 2019 by the University of KwaZulu-Natal Registrar (see Appendix A). Permission to interact with current trainee psychologists via e-mail, was requested through an e-mail from the Clinical/Counselling Masters Programme Director. The researcher also requested an ethical clearance from the University of KwaZulu-Natal ethics committee before conducting the study. The ethical clearance certificate was obtained in September 2020 (see Appendix B).

The researcher sent out invitations to participate to all University of KwaZulu-Natal students who were enrolled in the master's counselling and clinical programme via e-mail after receiving the ethical clearance certificate. Seven participants responded and showed interest in

the study. The invitation provided trainees with information regarding the study's purpose, procedure, and consent forms (see Appendix C) with the researcher's contact details.

3.4.2. Data Collection Instrument

The study adopted semi-structured interviews (see Appendix D) as a data collection tool. In qualitative research, interviews are largely used techniques for data collection, with semi-structured interviews as the widely adopted interview method (Kallio et al., 2016). Semi-structured interviews mostly require a certain level of prior knowledge of studies in the research topic area because the interview questions are grounded on preceding knowledge (Kelly et al., 2010). According to Stuckey (2013), one of the advantages of semi-structured interviews is that they provide rich set of directives for researchers and can afford consistent, comparable qualitative data. The questions are determined beforehand and framed to cover the focal subject of the study as well as presenting a focused structure for the dialogue throughout the interviews with the chance to probe for more information.

The semi-structured interview technique was appropriate for this study because the questions were uniform but also left a room for flexibility, to ensure that the researcher collected rich and descriptive information about participants' experiences of the culture of self-care (Cohen & Crabtree, 2006). The inclusion of open-ended questions in semi-structed interviews allowed participants to express themselves without restrictions on the focused area (Fontanella et al., 2006).

3.4.3. Data Collection Process

The data collection process entailed recruiting voluntary participants. Proceedings of data collection began after the attainment of the ethical clearance certificate. The ethical clearance certificate was issued after South Africa was hit by the COVID-19 pandemic. The researcher experienced delays in the ethical application process and data collection due to the pandemic. For recruitment, participants were informed about the study using invitation letters that included the consent form, an explanation of the process of voluntary participation, their right to confidentiality, and anonymity. Furthermore, the researcher informed all participants about their rights to pull out of the study, should they feel uncomfortable during the interviews. Since data was collected during the COVID-19 pandemic, participants were given options to either seat in for a face-to-face interview at their own preferred space or to participate via visual interviews using the Zoom virtual interviews platform. All interviews were conducted face-to-

face because all seven participants were comfortable meeting for safe individual interviews. The researcher followed the COVID-19 South African regulations; sanitising, maintaining social distance during the interviews, and all participants, and the researcher were wearing face masks to minimise possible transmission of the virus.

The interviews were conducted in English since it is the universal language and a medium of instruction in the master's programme. The interviews were conducted at a convenient place for all participants (at their own arranged space and time), and the interviews lasted 25-40 minutes. This was done to permit the obligatory privacy and participants' autonomy during the interviews. Data was collected in a period of one week because the researcher relied on the participants' availability. The interview schedule consisted of open-ended questions and follow up questions for clarity purposes, and for information that was more descriptive, it was used as a guide. During data collection, a digital audio recorder was used to ensure that the information that was provided by the participant was appropriately captured.

3.4.4. Data Analysis

Thematic data analysis technique was adopted in this study. It is a technique for; classifying, analysing, unifying, unfolding, and reporting themes that originate within the data set (Braun & Clarke, 2006; Nowell et al., 2017). Thematic data analysis is arguably one of the widely used methods in qualitative research, though it lacks extensive literature compared to other methods such as, "grounded theory, ethnography, and phenomenology" (Nowell et al., 2017p 2). Many authors have questioned the method's rigorousness since there is no clear consensus on how researchers can thoroughly apply the technique (Attride-Stirling, 2001; Boyatzis, 1998; Nowell et al., 2017; Tuckett, 2005). Conversely, Braun and Clarke (2006) maintained that thematic analysis is a valuable technique for examining the standpoints of diverse research participants, highlighting resemblances and variances, and producing unforeseen insights. In the current study, thematic data analysis furnished the researcher with new insights and perceptions that were obtained from the data. The researcher generated personal insights of participants' experiences of self-care and their promotion of mental health through identifying common themes.

The researcher followed the recommended six phases of thematic analysis outlined by Brauna and Clarke (2006), to be able to rigorously analyse the experiences of trainee

psychologists. The six-phase process involved: (1) familiarisation, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. The phases are further described below:

Familiarising with Data

At this phase, the researcher familiarised herself with the data collected. This required the researcher to listen to the audio-recordings and make comments, this process was repeated several times. In this process, the researcher also transcribed the collected data, listened to audio-recordings, read and reread the data, to ensure that she understood the concepts and language that was used by the participants to create meaning from their experiences.

Generating Initial Codes

The second phase entailed identifying common language and words to create initial codes. As the researcher immersed herself with the collected data, she highlighted similarities on the transcripts and manually colour coded similar extracts. This permitted the researcher to gather significant codes to inform potential themes, which was the succeeding phase.

Searching for Themes

Organising codes into latent themes preceded, where common data extracts were coded. This involved comparing responses, and "gathering all data relevant to each potential theme" (Vaismoradi et al., 2013).

Reviewing Themes

The next phase entailed revising the identified themes and subthemes. The researcher had to examine if the recognised themes worked in accordance with the generated data extracts. This allowed the researcher to note whether the entire data set was congruent, producing a thematic map. Reviewing themes further enabled the researcher to name and define themes, which was the next step.

Defining and Naming Themes

After she reviewed the themes, the researcher refined data extracts of each specific theme. Themes and subthemes were categorised, named and defined, to fit the common narratives that were conveyed by the trainees. This phase was pivotal because it captured the core meaning of each generated theme.

Producing the Report

The final phase entailed the researcher producing a report of the collected data. This was achieved by reflecting on findings of the study and forming integrated accounts about trainee psychologists. In addition, this phase, propelled the researcher to compile examples from selected extracts, and linking back the analysis to research questions, pertinent literature, and theoretical framework to draw conclusions (Braun & Clarke, 2006; Vaismoradi et al., 2013).

3.5. Reliability and Validity

Qualitative research follows various procedures to achieve reliability and validity to maintain the study's trustworthiness, although numerous critics are hesitant to accept the reliability of qualitative research (Shenton, 2004). According to Singh (2014), validity and reliability surge transparency and lessen chances to insert researcher biasness in qualitative research. The criterion of validity refers to, "…the degree to which a study supports the intended conclusion drawn from the results" (Yin, 2003 cited in Singh, 2014, p. 83). The criterion of reliability denotes the prospect that any other investigator can reproduce the study and produce identical results (Singh, 2014). However, maintaining neutrality is essential in ensuring the reliability and validity of the study (Golafshani, 2003). The work of Lincoln and Guba (1985) showed strength in guaranteeing rigour in naturalistic work, and it proposed making use of four constructs, namely, credibility, transferability, dependability, and confirmability.

3.5.1. Credibility

Credibility denotes the truthiness of the research findings including the participants views, understanding and representation, as observed by the researcher, and how it is linked to reality (Polit & Beck, 2008. According to Cope (2014), the credibility of a study in qualitative research requires that the researcher take their own stance of an observer, thus in relation to their own experience as a researcher. Moreover, the researcher is required to authenticate the research conclusions with the respondents (Cope, 2014). This requires that the researcher demonstrates the level of engagement and methods of observation in the study to support the level of congruence and reality (Cope, 2014; Shenton, 2004). Guba and Lincoln (1989) posit that a qualitative study is determined when the accounts of human experience are directly recognised by entities that share similar experiences. Hence for this study, the researcher

thoroughly engaged with the collected data by repeatedly listening to the recordings, reading and re-reading transcripts to ensure that the researcher captured what the participants reported, and that the findings are a true representation of what the participants said.

3.5.2. Transferability

Nowell et al. (2017, p.3) noted that, transferability discusses the "generalisability of inquiry". This means that, the results of one group or population can be transferred to a similar group (Cope, 2014). In quantitative research, it is relatively easy to generalise the research results to a broader population (Ally, 2014). However, also in qualitative research, it can be difficult to transfer the findings owing to contextual factors. This is because, qualitative research has a strong reliance on the context in which the study is conducted. Hence, the criterion of transferability in qualitative research, notes it as fundamental that the researcher provides an extensive description of his or her study site, so that other researchers who try to transfer the findings to their own context can make informed judgements (Alim, 2002; Lincoln & Guba, 1985). In the current study, the researcher provided an in-depth description of the study site in the methodology section. This includes the characteristics of the; sample, instruments used to conduct the study, and the data collection processes that were followed.

3.5.3. Dependability

Dependability refers to the extent to which the findings are consistent when reapplied on another study. In ensuring dependability in the current study, the researcher ensured that the research process was rational and observable, by clearly documenting the entire procedure (Tobin & Begley, 2004). This allows other researchers conducting comparable studies, to yield similar data in their studies should they replicate the study in the same context.

3.5.4. Confirmability

Confirmability is concerned with the degree to which the findings of a study could be found by other investigators (Korstjens & Moser, 2018). It is about establishing that findings and interpretations of the results are not fabrications of the inquirer's mind. The researcher needs to provide assurance that the findings are evidently derived from the data (Korstjens & Moser, 2018; Moon et al., 2016). To ensure that this was achieved, the researcher provided sufficient information about the research process, as well as maintaining neutrality using self-reflexivity when conducting interviews. This enabled the researcher to avoid biasness and

sustaining uniformity in the process of data collection. Furthermore, the researcher relied on audio recordings to ensure that what was transcribed are the participant's words, as they were transcribed verbatim.

3.6. Reflexivity

To ensure that the researcher-maintained neutrality in the current study, she adopted reflexivity. In qualitative studies, reflexivity is considered one of the most significant components of research (Berger, 2015; Macbeth, 2001). This approach is a continuing process that encompasses reflections to ceaselessly construct one's understanding and social realities (Barrett et al., 2020). It entails acknowledging the possibility of bias in studies because of the researcher's position, and influence in the context (Barrett et al., 2020).

Given that the researcher in the current study was a trainee in the master's clinical psychology programme at the University of KwaZulu-Natal, it was essential for the researcher to consider her position in the study. Firstly, the researcher acknowledges that her position may have influenced the participants' profile in the study. For example, only clinical psychology students were more comfortable to voluntarily participate in the study. This may have lead counselling psychology students feel excluded in the study, while clinical psychology students may have felt compelled to participate in the study because the researcher is in the same programme. Moreover, the clinical psychology students may have responded in a manner that they thought was appropriate for the study.

Secondly, the researcher recognises that her subjective experiences in the training programme may potentially influence the processes of the study. For example, the researcher shared similar challenges that were experienced by some of the participants in this study, in relation to the completion of dissertation component. Thus, the researcher had to collaborate closely with the supervisor to review; the study design, the questions design, and the analysis of the data collected. To maintain neutrality, the researcher continually discussed the research process and data analysis with her supervisor, to review the results, and minimise the researcher's bias by having someone other than the researcher to look at the data (without revealing confidential information). Lastly, the researcher further recognises that her role as the interviewer may have influenced the participants responses. Some participants may have held back information in fear of possible judgements they might receive from the researcher, as a colleague. However,

the researcher ensured to establish rapport with the participants to ensure that they felt comfortable to participate in the study without being judged.

3.7. Ethical Considerations

Institutional ethical clearance was attained from the University of KwaZulu-Natal's Humanities and Social Sciences Ethics Committee (see Appendix B: HSSREC/00001804/2020), to ensure that the study did not impose potential danger to all participants. An appropriate ethical protocol was applied as noted by Webster et al. (2013), that ethical considerations are the foundation of any research conducted, particularly when human beings are involved. This was addressed by ensuring that all participation in the study was voluntary, as stipulated in the consent form. The completion of the consent form was a prerequisite for participation. According to Ashcroft et al. (2007) it is pivotal for researchers to respect participants' rights to make enlightened choices about their lives, hence, clear distribution of information about the research process was prioritised prior to engaging with participants in this study.

Accordingly, the researcher adhered to informed consent, and maintained confidentiality, and anonymity in the study. Participants were first informed about the purpose of the study before being requested to take part. Consent was obtained in both writing and verbal. The consent forms were stored securely at the researcher's office locker. The researcher took note that some of the questions could evoke emotional discomfort to some of the participants. Thus, participants were well-informed that the researcher could organise a referral to the University of KwaZulu-Natal Campus Counselling services (a free service for all enrolled University of KwaZulu-Natal students), should the interview trigger emotional distress and participants happen to need psychological counselling during or post interviews. However, none of the participants required this service when the research was conducted. Participants were also informed that they had a right to pull out from the study at any point, without any consequence. This was to ensure that no participants experienced any harm from the study as it is the researcher's duty to ensure non-maleficent (Wassenaar, 2006).

3.8. Summary

The methodology adopted in this study were discussed in this chapter. Seven trainee clinical psychologists were considered to partake in this study. The researcher thoroughly explained the research procedures and measures taken to address the issue of trustworthiness

of the study. Ethical considerations were broadly explored to ensure that the study did no harm to participants.

CHAPTER FOUR: RESEARCH FINDINGS

4.1. Introduction

This chapter show the results of the current study. A brief demographic data is provided, to elaborate the characteristics of the participants. Furthermore, the findings of the study are presented thematically. Six broad themes emerged from the collected data, the themes are; (1) trainees' understating of the concept of self-care and mental health, (2) self-care coping strategies employed by trainees to promote self-care and mental health, (3) challenges experienced by trainees that influences trainee's mental health, (4) trainees' perceived barriers to practise and promote self-care, (5) support structures that are available for trainees within the programme, and (6) trainees' perceived protective factors of mental health. Each of the themes entails a few sub-themes (see Table 2, below).

4.2. Demographics Information

The sample for this study consists of seven master's clinical psychology students (n=7) at University of KwaZulu-Natal, Howard College. The study included all South African races as follows; Indian (n=1), White (n=1), Black (n=4), and Coloured (n=1). Five (n=5) of the participants were females and two were males (n=2). During the time of conducting this study, half of the participants were enrolled into their internship year, and the other half had completed internship but currently completing the research component of their clinical psychology training.

Table 1. Demographic Information

	Gender	**Race**	**Age**
Participant- 1	F	W	27
Participant- 2	M	C	25
Participant -3	F	B	28
Participant- 4	F	B	26
Participant –5	F	I	24
Participant -6	F	B	29
Participant -7	M	B	30

Note: F=Female; M=Male; B=Black; W=White; C=Coloured; I=Indian.

4.3. Themes Presentation

The following section outline's themes and subthemes that emerged from this study's data (see summary in Table 2). Each theme is further explained in-depth, using extracts from the data that was collected.

Table 2. Summary of Emergent Themes

THEMES	SUB-THEMES
Theme 1: Trainee's Knowledge of Self-Care in Mental Health	
Understanding Concept of Self-care	
Theme 2: Coping Strategies Employed by Trainees to Promote Self-care and Mental Health	
	(i) Physical fitness
	(ii) Personal psychotherapy
	(iv) Spirituality and meditation
	(v) Engaging in social activities
Theme 3: Challenges Experienced by Trainee Psychologists That Impacts their Mental Health	
Academic Challenge(s):	(i) Completing the research component
Professional Challenge(s):	(i) Power dynamics
	(ii) Difficult supervisor-supervisee Relationship
	(iii) Transition from coursework to Internship
Personal Challenge (s):	(i) Balancing professional life and personal life
Theme 4: Barriers to self-care Among Trainees	(i) Time constraints
	(ii) Financial constraints
Theme 5: Support Structures Available for Trainees	(i)Peer consultation
	(ii) Social support from loved ones
	(iii) Supervision
Theme 6: Trainees Perceived Protective Factors	(i) Resilience
	(ii) Self-awareness
	(iii) Personal and Professional growth

4.3.1. Theme 1: Trainees' Understanding the Concept of Self-Care and Mental health

Overall, the data indicates that, majority of the participants (P1, P2, P3, P5 & P7) had adequate knowledge about, self-care and mental health care. Both males and females were aware about the significance of practicing self-care to promote mental health as training practitioners. This is illustrated below:

> *"self-care in general, for me, it implies to the practices and acts that you take in order to uhm, improve you're your well-being"* (Participant 7).

> *"self-care is what one needs to do in order to ensure that their mental health resources are keep intact and that they take care of themselves to ensure that they are healthy physically and mentally"* (Participant 5).

Two participants (P6 & P2) reported that, self-care in the context of being a psychologist related to the awareness of oneself. Participants understood self-care as a holistic practice that involves preserving and understating one's functionality. That is, understanding your emotional, psychological, spiritual, and physical well-being. This is shown in the below extracts:

> *"Self- care in my perspective is the ability to take care of yourself not just physically but emotionally, psychologically, and spiritually as well. Uhm If you are looking at the context of being a psychologist is the ability for you to be able to be aware of your own emotions, not just your patient's emotions, not just your client's emotions but how you deal with problems, how you cope with problems and how you then move from that in a more positive manner"* (Participant 6).

> *"Self-care for me relates to the domain of functioning where you need to be aware of where you at in your life, what is your demands, what is your needs. Everything pertaining to the self and integrating all those elements to work for you at the current time in your life and maintain a balance"* (Participant 2).

Most participants (P1, P2, P3, P4, P7) expressed that taking care of one's mental health is a crucial part of taking care of one's overall health. It was reported it entails; one's mental status, mental well-being, and coping with everyday life, as indicated below:

"I think mental health care has to do with your mental status, mental being, your thought process, your cognition, just how you able operate in your everyday life mentally" (Participant 1).

"involves psychological and emotional wellbeing of an individual so that would be encompass, uhm, anything that has to do with mental health care. If you are able to take care of your psychological and emotional wellbeing" (Participant, 7)

4.3.2. Theme 2: Coping Strategies Employed by trainees to Promote Self-Care and Mental Health

4.3.2.1. Physical Activity as a Coping Strategy

Physical activity was noted as the most common activity that was employed by most participants in the study, to promote self-care and mental health. Almost all participants reported that engaging in physical exercise was helpful and served as a protective factor to cope in the programme and manage stress, as demonstrated below:

"*I found that for me self- care took a lot of physical form in a sense this year. In a sense that I utilise physical fitness as my main protective factor to contribute to better self-care… working out daily and not working out with a goal for weight loss or specifically to build a certain physique but also incorporating the mental benefit you get from working out"* (Participant 2).

"*And then I think like other things like exercise, I go to gym"* (Participant 1)

"I found cycling was quite helpful as well…like a cycling machine at home" (Participant 5).

"*I think at the moment, uhm what I'm trying to do is to work out, uhm, I joined the gym, uhm, I work out for about five days a week*" (Participant 7)

4.3.2.2. Personal Therapy as Coping Strategy

Most of the participants (P1, P2, P4, P5, P6) reported that they had an encounter with a professional psychologist or counsellor prior, and during their training process. Participants in the study shared positive experiences of personal therapy. One participant reported that

personal therapy was helpful in dealing with the pressure that comes with the master's training programme. Participant 1 expressed that personal therapy helped her in dealing with the emotional burden that comes with the nature of the profession. She further expressed that as a training psychologist, one needs someone who can be objective in helping you process and deal with the emotional and psychological burden that can arise from providing psychological services, she explained below:

> "*So, the ways in which it is helpful is, first, that it takes the emotional strain off you because as an intern you are very new and very young to the idea or the concept of taking on people's stories, taking on their emotional pain, psychological burden and so you don't always realise like how it sort of affects you. I almost feel like in a sense it's kind of like bruises your soul to a certain degree and so, I think to be able to process and work through that it's very important to have someone whose objective…. I ended up going onto antidepressant. I had to go see a psychiatrist and that was very helpful for me as well"* (Participant 1).

> *"At first, I would go for therapy for like maybe twice in a month. But now I've seen I needed it more, so I go every week… my cousin ended up moving in with me because of how and what I was going through. So, at least when I come back, I don't have to like to come back I don't have to be like alone. I think if I had to come and be alone, I'd be more like depressed"* (Participant 4)

> *"I was last year; I saw a psychologist for a few sessions because I felt like I just couldn't manage it. Medically, I had to be put on more medication, I am taking 3 tablets, I'm now on 4 tablets. Not psychiatric tables but medical tablets to do with my two medical conditions, but my two medical conditions go hand in hand with the hormonal fluctuations and the hormonal fluctuations are due to stress levels. And the problem that when there's too much of fluctuations and with my two medical conditions, it puts me at a greater risk of developing things such as… I don't know depression and anxiety, and this is what I am trying to prevent"* (Participant 5)

Two participants (P2, P5) reported that they were not seeing a psychotherapist at the time of the interview. However, they reported positive contributions that therapy has. Participant 2 expressed that the experience of professional psychotherapy taught him how to better balance and handle challenges that are encountered in everyday life. While another participant expressed it helped her deal with pressure that comes with the programme.

"*Currently, no* [when asked if he is currently seeing a consultant/specialist], *but I have in the past seen a psychologist, a counselling psychologist. And it did contribute to bringing me to the level of where I am right now. To be able to balance and manage thing things effectively. I think it also taught me to understand that challenges will come your way. However, you have the skills and resources to get through it"* (Participant 2).

"*I saw a psychologist for a few sessions because I felt like I just couldn't manage it* [deal with the pressure that comes within the training programme]" (*P*articipant 5).

"I see a psychologist once every two months and that has been helping me since last year because there are a lot of times where you think I can do this [referring to dealing with the pressure*], I've got this and then when you are in that therapy room you realise I actually don't…a lot of my colleagues, got to a point where some of them had to go see a psychiatrist, some of them have been diagnosed with depression because of the pressures of that. And I've started seeing how it was changing me as a person. Even in my relationships I've started being snappy, I wasn't happy anymore, I wasn't sleeping, started getting insomnia and it, it was changing who I was as a person"* (Participant 6).

4.3.2.3.Engaging in Leisure Activities

The findings from the study revealed that participants use various activities to cope with the pressure that comes with the training. When participants were asked how they managed or deal with the pressure that comes with the master's training programme, they reported to had employed different strategies. One participant reported that she has found music and singing to be useful in helping her release stress. She also reported that dancing and cooking was helpful:

"…one thing that keeps me going is listening to music and singing. I find that it is a huge stress reliever. As well as I find cooking, if I have the music on and if I'm cooking, I dance while cooking so anything related to music. I find it helpful. I would like to say sleep helps with self-care but that doesn't mean that I am sleeping well and to be honest I'm not. So, from a self-care perspective, I think that one beneficial thing is listening to music, singing along, dancing along, anything related to releasing stress in that form of way" (Participant 5).

Another participant reported that he found reading as helpful in dealing with the pressure that comes with the training. The participant expressed that being updated on the recent work within the field and networking with others in the field is helpful in reducing anxiety. These are demonstrated in the extracts below:

> *"Just to ease off a bit of pressure. I'd say most people who study psychology read. You read whatever you come across, just to keep abreast with the changes because psychology holds that if you do not read, you are a danger to this field. And to deal with the pressure, you must read, you must network with people in the field, who have certain ideas of how the field is becoming. It keeps on evolving, a bigger part of it. Soon will be somewhat digitalised"* (Participant 7).

Another participant reported that she found that taking some time out of the professional life and engaging in things you find pleasure in is useful. Thus, she expressed that going to the beach and being surrounded by nature helped her cope with the pressure.

> *"Okay, so starting with self-care I am a person that loves water. I love the ocean. I love the beach. I love nature in general. So, what I do is I would take myself away from the busy life, I would take myself away from the city life*" (Participant 6).

4.3.2.4.Spirituality and Meditation

It seemed that spirituality and religion play a crucial role in some participants lives. Two participants expressed that spiritual support and prayer benefited them in coping with the pressure that comes with the profession and master's programme, as explained,

"*…there is a lot of spiritual support, you know, prayers. I pray"* (Participant 4). Additionally, another participant found meditation to be useful.

> "*I would take myself away from the city life. Away from people and just go to the ocean and meditate and just be by myself and to be aware of what is happening with my body"* (Participant 6).

4.3.3. Theme 3: Challenges Experienced by Trainees That Influences Trainee's Mental Health

4.3.3.1. Professional Challenges

The professional challenges that were experienced by the participants in the current study included power dynamics, which seemed to be the driving force on the nature of the

relationship between the trainees, and their supervisors. The findings revealed that existing power dynamics affected the way trainees; perceived the working environment, and their relationships in the work environment. Some participants expressed feeling confined, and having a little room for error, and appraisal in their interactions with their supervisors. This was demonstrated below:

> *"…well, one of my supervisors was extremely high up in terms of hierarchy and had specific rigid ways of conducting themselves. And that made it hard to make leeway for learning or to have leeway for error because you always felt that you are never going to do anything correctly. And even with the skills that you feel you mastered, it's away from you because subjectively according to this specific person, you haven't been working the correct way"* (Participant 2)

> "*I personally think it's a power dynamic because like, like I said there is the resources are there or we told the resources are there* [referring to support available for trainees] *but it's, it's your perception of, if this is what I ask… then this person who is in power of my profession or who is in charge basically your… my professional life, I mean if you don't pass your internship then you are doomed* [explaining how seeking support can negatively impact trainees*]*" (Participant 3).

> "*… I was being treated different from other interns. I felt victimised in a way like belittled, you see. Even when feedback was given to me in what given in a very demeaning way. Even whatever I am trying to do uhm was seen as not sufficient and I feel like I was being attacked every time... Like, whatever efforts that I make, I felt like my supervisor was constantly looking for mistakes in my work*" **(**Participant 4).

4.3.3.2. Academic Challenges

The data revealed that academic challenges are common within the training programme. Most participants (P1, P2, P3, P4, P5, P6, P7) expressed their concerns about the structure of the master's programme. They mentioned that it is difficult to balance coursework, and the research component of the programme, which makes it difficult to complete both components in just one year. Participant 1 elaborated below:

> "*I don't think the research project is properly structured or given enough time. So, with the lack of structure, I think it becomes a norm where students know that they don't have to finish the research project in that first year. So, they go along in the first year,*

and they think, okay, I'm going to finish it in my internship year, and that almost always becomes impossible" (Participant 1)

"*...the way the degree is structured is somewhat tricky. The first year of master's uhm you do your course work and research is there and you don't get to finish your research in time then you must carry it over to the internship year and that's another issues. When you get there its work, work, work, you get little time to no time uhm to look at your research and then you can't start with your community service because you now must finish your research. For me, I think this should have been a two-year master's programme. The first year is course work and the second year is research then you start your internship and then you go on for community service then you start working. Cause right now you have this gap year, which could have been avoided if you did your… uhm… masters in two-year sort of, if it was structured in that way, it was two years course work and then your research, internship, you write your board exam then to community service. It should have been a smooth ride. But now it's a huge issue*" (Participant 7).

Some participants indicated that academic challenges go beyond the structure of the master's programme. Most of the participants reported experiencing difficulties to transmit the theoretical work that they learnt during coursework into practice. Three participants emphasised the importance of theory, however, they stated that one needs to understand that the theory requires a great deal of skills such as being able identify when it is useful and integrating it to different contexts:

"*I learned that the theory is important, but uhm sometimes making theory practical can be particularly challenging, so it's easy to read a manual and see ukuthi* [meaning that] *it tells you session one does this, session two do this, first, three hours do this. First, 30 minutes do this. But when there is a real-life person in front of you, therapy can always take a different direction from what you have planned it to be. So, you need to balance that out in your mind, to be able to balance your theory, academics and the stuff that you have learned. Your human interaction ability as well, your ability to able to determine what the patient needs at once* [explaining that therapy requires more than learned theory. One also needs to incorporate interpersonal skills to suit the patient's needs]. *Not to put therapy, not to take a theory out but to balance it out, and to be able to identify things from, from a human perspective, professional human*" (Participant 3).

"*I think academically it's the kind of mismatch, the lack of a transition of using all this Westernised knowledge we've obtained in undergrad to our local, unique and diverse context. A lot of what we are taught and asked to apply as professionals is evidently correct and has a good evidence base however it doesn't always work out itself that way. So, it's been challenges to adapting the academic work that we've learned towards our context more specifically*" (Participant 2).

Although occasional, Participant 4, below, reported that language can be a barrier within the field of psychology, mostly for the minority groups in the geographic area. The participant reported that some patients experience difficulties to express themselves using English in therapy. Hence, there could be loss of meaning in the interaction between the psychologists, and patients. This creates more anxiety for novice psychotherapists. Participant reported that because of language barriers, she spends more time in trying to understand the patient to avoid losing meaning of what the patient is trying to express. This is reported to create limited time to engage in leisure time because most effort is poured in understanding their work, Participant 4 explained:

"So, I think with language, it becomes better when you can understand [the language]. *Like, there are patients when they come to therapy, and they can't speak English. There are so many things that you can miss. Whereas, when the person can express themselves in their own like native language, they can go deeper and say, you know,* [patient telling the psychologist what they have been experiencing] *this is how I'm feeling and you know, this is what has been happening.*"

4.3.3.3. Personal Challenges

Participants reported that there overlaps between their professional and personal life. Hence, most of them reported experiencing difficulties in trying to find a balance between the two. All participants reported that they had difficulties in attempt to separate their work and personal life due to the workload within their training. Most participants felt that they had little time to engage in social activities in their personal lives. Some reported that they often pushed everything that had nothing to do with work aside and focussed on their academic and professional life. As demonstrated below:

"it's hard. And I don't think we will ever find the balance between the three, academic life, professional life and personal life. I think it's just an ongoing process. Whoever does find the balance, lucky them." (Participant 7)

"I haven't been as socially as I used to do. I am not an extrovert, I'm in no way sociable as in like really outgoing but I keep in contact with the people that means a lot to me and I've sort of tried to put myself, I would say, push myself away from that because I feel as though I don't want people to see how much…uhm…I've been affected by this and I don't want people to see me as this person who is now backtracking. Medically I look different, I feel different, and I feel that my friends and colleagues are all going to notice this when I see them. That's why I've stopped using social media…I just feel like I don't have a time for all of these [Referring to social activities]*"* (Participant 5).

Furthermore, some participants reported that they experienced difficulties in managing their emotions, especially anxiety, owing to the workload and time constraints within the training programme. The programme was associated with anxiety and being in the training escalated participants' anxieties, because the nature of the profession was reported to have various ambiguities:

"I think anxiety is a personal challenge that I always faced or always had to deal with. So, I think coming to the master's programme obviously exacerbate that anxiety because it's a situation where you can…It breeds anxiety. And if you are already prone to anxiety it can maybe make it worse. So, I think that was a personal challenge where there's just so much anxiety that you can get ill. I got quite sick on a few occasions in the first master's programme. You can become disorganised if you feel anxious or you cannot perform the way you want to" (Participant 1).

4.3.4. Theme 4: Trainees' Perceived Barriers to Practise and Promote Self-Care

In the findings it appeared that some participants felt that they had limited amount of time to devote to their training. Time constraints and intense workload seemed to hinder trainees from effectively engaging in self-care practices. This varied from financial resources to subsiding social life to engage in academic and professional life. One participant reported having limited time to spend with his family because he relocated and could not visit home more often. Another participant reported spending limited amount of time during leave days because of the research component that needed her attention:

"I did try to go to the gym (laughs) but, then because of the amount of work that I have to do, I ended up putting that aside and not really doing it most of the time" (Participant 4).

"I almost never ever had time to do anything other than just work or go through whatever it was given to me to read or whatever research I had to do. There was almost everything that occupied my time had to do my study towards M1or my internship" (Participant 5)

"I think it depends on whether you are relocated and all of that …but for me it was just four or five times a year. And then I did try to sort of keep contact with my girlfriend. If I say contact it sound bad, uhm… what's the better term to use/ but we continued to see each other enough, because I think we needed that" (Participant 7).

Most participants (P1, P2, P4, P5, P6) reported that, attending personal therapy is helpful as noted above. However, personal therapy is expensive to maintain. One participant revealed that engaging with a psychotherapist was strongly dependent on one's financial stability. Participant 1 expressed that she had to stop seeing a psychotherapist because it was expensive, she reported:

"*Because I have been on my dad's medical aid because that is a factor to bear in mind whether you have the financial resources to do any of this kind of stuff because you do need finances...I was on a really good medical health scheme, but other people might not be able to do that because they might not have the finances. Uhm even now my funds have been used up this year...*" (Participant 1)

4.3.5. Theme 5: Support Structures that are Available within the Programme

4.3.5.1.Peer Consultation for Support

As means of a support structure, peer consultation was common amongst trainees, and the findings revealed that participants strongly agreed on this. All participants reported that consulting with a colleague is one of the effective ways for support as trainees. They felt that their peers could understand their experiences, because they are also in the same system. This is evident in the extract below:

"Secondly, I think the major protective factor for me in terms of self-care was my colleagues this year. We very much leaned on each other, heavily for support and identified and you know, just tracked for each other…. major big part was collaborating with my colleagues in terms of processing everything together, finding a common ground. Sometimes even having disagreements that led to a bit more clarifying understanding of stuff" (Participant 2).

"*Support structure at work it's definitely would have to be my colleagues… because we are all going through the same experience, we might be at distinct levels, we might be at various levels, we might be taking things differently but at least we all know that we all in the same boat*" (Participant 3).

"And also with my colleagues, they also have been like supportive, trying to ensure to that… You know, what? Let's try to be like positive, do whatever we have to do until the end of the year" (Participant 4).

"*colleagues' uhm and I think that's the thing that can really help you. I mean, last year, when it was the worst year of our lives, I can remember having really good laughs, really good times because the people who were going through it with me understood it and we could rely on each other, we could laugh, we could joke, and we could see each other every day and speak about what we are feeling. We didn't have to put it away. We didn't have to or brush under the carpet and put it under the carpet*" (Participant 5).

4.3.5.2. Social Support from Loved Ones

Participants reported spending time with their loved ones as helpful in dealing with the pressure that they endured from the training programme. All participants shared similar sentiments about interacting with family and friends to deal with the pressure. They expressed that family and friends were their source of support which helped in diverting their minds off their busy and stressful occupation.

"During this training, I have received a lot of support from my friends, from my family" (Participant 4).

"For me, I like spending time with people socially, so going out with people…friends for coffee. Going out watching movies with friends or just visiting them. I think it's important to have people to talk to" (Participant 1).

"And I think more overall in terms of one of the main aspects of self-care that I've found to help my life is my family and maintain a good relationship with my family. They my based support system... I have a good small group of friends that I interact with regularly, I've tried to keep that up to at least once a week of seeing a special friend, be it an hour or half an hour, even the entire day" (Participant 2).

4.3.5.2.Supervision

While supervision was noted as one of the available support structures for trainees in the master's training programme, most participants reported that their discouraging experiences with supervision made it difficult for them to want to use their supervisors. The lack of supervision alliance between supervisors and trainees discouraged help-seeking behaviour among trainees. The findings show an indication that the difficult supervisor-supervisee relationship triggered emotional distress among participants. Most of the participants stated that they felt that they were treated unfairly and that some of the supervisors appeared to take personal dislike in them. One participant expressed that his supervisor was focused on their shortcomings, with a little appraisal. Additionally, Participant 6, below, reported feeling belittled and victimised by her supervisor.

"if you have a supervisor, someone you need to go to for advice, for assistance, who is emotionally and I would say this proudly, abusing you, you know, it's not easy because this is someone who is literally holding your career in their hands, they can write a report about you that you are incompetent, you, you not stage-appropriate, you not ready and you don't become a psychologist, you get kicked out of the programme. So now having to deal with those things is an excessively crucial factor. Yes, the adjustment is a grandiose thing, I get that, but you adjust to things very easily but, if you have on a day-to-day basis just with the intention to, you know, to get you out, to put you out of and things like that. It really affects you" (Participant 6)

"*I think what I've faced like now what I am facing is how I was being treated differently from other interns. I felt victimised in a way, like belittled, you see. Even when feedback*

was given, it was in a very demeaning way. Whatever I am trying to do is seen as not sufficient. And I felt attacked every time. Like, whatever efforts that I make, I felt like my supervisor is constantly looking for mistakes in my work" (Participant 4).

4.3.6. Theme 6: Trainees Perceived Protective Factors of Mental Health

4.3.6.1. Resilience

Although most participants reported experiencing difficulties during their training, they have somehow found the training process to be fruitful in their development by building in them, resilience. This was illustrated below:

> *"It gives you resilience at the end, but it takes away certain things that you wouldn't need in this field. That's the part where I would say it breaks you. And then it builds you up. You are never complete in this field; it builds you up until you decide to stop being a psychologist or you retire, or you die. But the building up part is always there*" (Participant 7).

> *"I think I have looked at it like in a sense that changes, change is good and we always changing as a person"* (Participant 4).

> *"I think when you come out of the master's programme you do feel stronger. I think it's almost as if you kind of get broken apart and then you get put together and your kind of a different person where you maybe feel a bit more confident in situations or you just be able to handle certain types of stress better, so that is a good thing"* (Participant 1).

4.3.6.2. Self-Awareness

The findings also revealed that the training process brings a sense of self-awareness. The participants reported that they felt exposed through constant evaluations and scrutiny in the programme. The participants demonstrated to had become better aware of things that work for them in the programme. Some stated that they felt naked, and their weaknesses were exposed but they learnt to consume the good experience and accumulated lessons from the bad experiences. Some participants reported using self-awareness to filter out the unconstructive feedback, and others reported changes in their perspectives. This was elaborated in the extracts below:

"it's just that all your weaknesses, your personal characteristics get exposed. Because in another type of job you aren't, you may not be tested as a person. So, like if you sat in front of a computer, your personality is not being evaluated. But when you are a psychologist or a trainee psychologist and you get put into a room with a patient, then you are the one who is being exposed and being judged and being evaluated…. Because sometimes you can go through certain things where you sort of being judged in a sort of way that isn't really a 100 percent you or doesn't feel represents you, who you are, and you know you shouldn't be. And when you come out of that, sort of a filter, you take the constructive, positive feedback to grow in an effective way but to leave the other stuff aside doesn't relate to you. And I think that's a difficult thing to navigate" (Participant 1).

"I think in the interview phase of the programme, break you a bit. Then you get into the programme, the first year of it, break you completely cause you. I'd say your life gets into a non-existing state. Your personal life it's like it doesn't exist whatsoever. You lose girlfriends, boyfriends in that space. You lose friends and become a loner. You just become, you feel somewhat naked, so to speak. And then it builds you up. You become tougher to emotional insults, psychological insults. I'm just using the term insults a bit loosely. Uhm, but when I use it, I mean emotional trauma, psychological trauma. You become, I don't want to use immune, but you develop this tougher skin cause the field takes away whatever vulnerability" (Participant 7).

4.3.6.3. Personal and Professional Growth

The findings revealed that trainees grew in various capacities, but mostly at personal and professional levels. Participants recognised their growth within the training programme, and some reported that they learnt significantly about themselves their emotions. For example, Participant 1 said:

"On a positive note, I did learn to be more regulated or more professional in my conduct. So, I think I don't know because you get so paranoid about being judged and evaluated. You learn to present yourself in a certain way so that you don't seem unprofessional or seem like you don't know what you are saying. So, I think that's a positive thing. You gain some emotional maturity which affects your behaviour because

it affects how you interact with supervisors or patients. You learn to do that on a more professional level."

4.7. Summary

This chapter reported on the challenges that trainee psychologists encounter within the master's clinical psychology training programme. All participants demonstrated that there are positive contributions from the programme, concerning their personal development. However, there are also significant challenges that come with the role of providing mental health services. The challenges are in distinct levels, but mostly; individual, professional and academical. Nevertheless, trainees' psychologists developed coping strategies through practicing self-care. These strategies were reported to help them deal with the pressure and the hazardous working environment. The reports from the participants were based on their experiences and provided in-depth information about their personal encounters.

CHAPTER FIVE: DISCUSSION

5.1. Introduction

This chapter will discuss the current study's findings along with the existing literature on self-care culture among trainee psychologists. To structure and evaluate the results of this study, the Health Belief Model (HBM) theoretical framework was employed. As mentioned on previous chapters, the HBM proposes that; perceived susceptibility, perceived severity, and cues to action influences a person's perceptions on threat (Rosenstock, 1974b). Subjective perceptions on threat to an illness, perceived benefits, and perceived barriers, enhance the prospect of an action that follows (Jones et al, 2014).

5.2. Perceived Susceptibility

According to Hochbaum et al. (1952), perceived susceptibility refers to an individual's held beliefs of the probability of contracting a certain illness or condition. This entails views, and behaviours that a person exhibit with regards to the impact an illness or condition would have on their life (Maio et al., 2007). The construct further evaluates the individual's knowledge of the possible results after contracting a condition (Gorin & Arnold, 1998).

Concerning perceived susceptibility, findings from the current study suggest that trainee psychologists hold fair knowledge on self-care and its significance among mental health practitioners. All participants were able to distinguish the difference between self-care and mental health. Lack of or little knowledge on self-care, its role on mental health, and perceived susceptibility to mental health related conditions, may influence the trainee psychologists to improve their adaptation of the recommendations to practice self-care. Among mental health professionals, promoting self-care, and mental health wellness is crucial in cultivating quality life. It also helps in averting complications (mental health related issues), but it could be neglected if practitioners do not perceive themselves as being at risk, thus they remain vulnerable.

Most of the participants in the study believed that they were at risk of developing a psychological condition. They all acknowledged that the psychology profession generally, predisposes practitioners to mental health complications. Based on the findings from the current study, it can also be argued that the nature of work, and the demand to provide mental health services is associated with emotional distress among psychology trainees. Commonly,

the trainee psychologists may face; emotional distress, anxiety, burnout, sleeping difficulties, low mood, and lack of concentration. The intensity of the workload, and the prescribed roles of being a psychologist places a heavy emotional burden among trainee psychologists. This is in line with the findings from previous literature. Tay et al. (2018) postulated that mental health complications may be disproportionately prevalent among mental health professionals. Factors such as depression, substance abuse, relationship problems, and isolation are common amongst psychotherapists, and are marked as common push factors to help seeking behaviour (Dearing et al., 2005).

According to HBM, people are likelier to seek help, if they see themselves as susceptible to illness (Matabane, 2015). This was evident in the current study. When participants perceived themselves as emotionally distressed, they reportedly practiced self-care more frequently to eliminate or lessen their vulnerability. Noteworthy, all participants had educational background on self-care, and mental health related issues, since it is a core feature of their training process in the master's training programme. Globally, the concept of self-care is introduced to psychology students at postgraduate level in various teaching, and training institutions (Viskovich & De George-Walker, 2019). However, the under-deployed, early development of self-care skills, "…maybe due to psychology students not being identified as psychologists in training until master's level degrees" (Viskovich & De George-Walker, 2019: p.109). Although, participants in the study did not reveal the extent to which they received training on self-care, most of them implemented and incorporated self-care strategies to cope with the challenges that they encountered. Trainees' knowledge on the implications of specific conditions, play a significant role in promoting and enhancing self-care.

Overall, participants in this study made few references to their susceptibility to mental health related issues but focused heavily on the experience or severity of symptoms once they occur. The finding suggests that when one is amid a crisis, susceptibility alone is not the driving force to promoting, and enhancing self-care or help-seeking processes. However, knowledge on susceptibility and perceived benefits of action to eliminate a condition, plays a significant role in one's acceptance of their condition and encouraging help seeking behaviours. To conclude, it seems that acquiring adequate knowledge, plays a significant role in promoting and enhancing self-care among psychology trainees.

5.3. Perceived Severity

The health belief model ascertains that the impact of illness or condition is perceived differently by individuals (Rosenstock, 1974a). This means that the severity of a condition is measured by associated negative costs of anticipated or present ramifications. In other words, perceived severity addresses subjective beliefs of the seriousness of the condition and the costs that the condition may impose on one's health, and overall well-being (Champion & Skinner, 2008; Jones et al., 2015). These consequences include medical, clinical, social, and economic factors (Metta, 2016; Taylor et al., 2007). In the context of the current study, understanding the trainee's perceptions of the health and social consequences of mental health related problems among practitioners is imperative because, trainees who perceive the threats as serious are likely to be motivated to apply preventative strategies to promote self-care, and mental wellness.

The participant's narrative from this study revealed that there are prominent levels of anxiety that are associated with perceptions of weakness, or inability to cope with the master's training programme. Promotion or practice of self-care among trainee psychologists is pointedly high when they are experiencing severe signs or symptoms of mental health related problems. During the training, trainee psychologists experience negative emotional changes (such as elevated levels of anxiety, and low mood) and behavioural changes (such as lack of sleep, isolation, loss of appetite, and changes in weight). However paradoxical, somatic symptoms, and decline in academic performance serve as a premonition for the trainee psychologists to find a way to eliminate the threat.

Findings from the current study suggest that, although trained; to recognise, and identify the signs of distress, the social or academic outcome of a mental health condition that they experience during their training is of high concern, rather than clinical implications that bare associated with the condition. Severity is linked to, academic performance, physiological reactions, and coping ability. Trainee psychologists are overwhelmed, and anxious most of the time during training. Part of the causes of the anxiety are feelings of pressure to be in control of their anxiety and avoid being perceived as weak or not coping in the field. Such pressure might instigate reluctance to seek help among trainee psychologists.

Issues of confidentiality related to influence in academic career is a common challenge noted in literature (Dearing et al., 2005; Skovholt & Rønnestad, 2003). A study by Gulliver et al. (2010) found that youth are reluctant to seek professional help when in crisis, because of;

perceived lack of privacy or breach of confidentiality, stigma, or embarrassment. For example, trainee psychologists may feel embarrassed to seek treatment in fear of being perceived as weak, and lacking sustainability within the profession. Hence, based on the findings from the current study, trainee psychologists may feel the need to always display perfection, and bravery in their work to their, facilitators, supervisors, employers, and patients. It appears that mental health related problems are indirectly a persistent threat to their career, or professional lives.

Similarly, early research by Beck (1976) on an independent counselling programme for social work students found that, students were hesitant to seek professional help at the counselling centre in fear of possible links between the centre, and their training institution. The students were concerned that being a client at the autonomous counselling centre may jeopardise their future training opportunities at the centre (Dearing et al., 2005).

While the promotion of self-care, and mental health well-being is of great concern among mental health practitioners in general; there appears to be a marked shift towards perceiving mental health related issues as a threat once the symptoms of a particular condition are perceived as severe. This is consistent with the HBM model which argues that perceived severity of symptoms largely predicts help-seeking (Van Voorhees et al., 2006). One of the major drivers of mental health challenges that are experienced by trainee psychologists is the intensity of work, yet they have limited amount of time to balance their social and professional life. However, trainee psychologists are more likely to engage in self-care practices when they are in crisis. It is not astonishing that severe experiences of mental health related problems often lead to the recognition that an action is needed, given that these are professionals under training.

5.4. Perceived Benefits

Perceived benefits examine the person's beliefs on the value of the endorsed action, to lessen the risk of a particular health condition (Metta, 2016; Taylor et al., 2007). The health, and social benefits of promoting self-care, and mental health can be durable stimuli to establishing; sustainable self-care, coping strategies, optimise clients' welfare, and the indorsed ethical standards. Positive health behaviours are more likely to be accepted by entities who hold the view that the behaviour will effectively reduce the severity and susceptibility of the perceived threat (Orji et al., 2012).

Findings from the current study suggest that trainee psychologists engage in various self-care practices to cope with their daily stressors while they go through the training programme. For example, physical exercise is used as means of taking care of the physical body and relieving daily stress. In this view, the promotion of self-care, and mental health is upheld in anticipation of eliminating emotional discomfort, and/or stressors. However, it is noteworthy that it is a major challenge for trainee psychologists to make time to engage in self-care practices. Their evaluation of benefit of the course of action is perceived in a positive light, thus, the action to health is seen as effective.

Furthermore, based on the current study's findings, it appears that trainee psychologists have a tendency of employing coping strategies that are similar to those that are documented in many previous studies. Like previous studies, the common strategies that emerged from the current study include engaging in physical activities, social engagements, spirituality, meditation, and personal psychotherapy. These strategies were recorded in early research findings by Mahoney (1997), who revealed that the dominion of self-care included practices such as meditation or prayer, regular physical workout, reading, vacations, hobbies, and artistic enjoyments.

Literature notes that taking upon the role of psychotherapists necessitate preparations from personal and professional level (Thériault et al., 2009). Furthermore, empirical research indicates that the role of providing mental health services predisposes psychotherapists to occupationally linked psychological problems (Posluns & Gall, 2020; Shapiro et al., 2007). Thus, practising the culture of self-care is an advantageous component to complement in one's journey of practising psychology. Factors such as job satisfaction, managing stressors that comes with the demand as well as balancing personal and professional life, are benefits of mental health, and signs of well-functioning in the profession (Colman et al., 2016; Posluns & Gall, 2020; Zahniser et al., 2017)

All participants in the current study, accurately identified coping strategies that they found helpful in their personal and professional lives. Each participant outlined strategies that they employed to deal with the pressure that comes with the training and eliminate the prevalence of emotional distress. This is consistent with results that were reported by Posluns and Gall (2020), that the self-care techniques decrease risks of experiencing burnout among mental health practitioners. Furthermore, Colman et al. (2016) revealed that adopting, and implementing self-care strategies was associated with greater well-being. The study by

Zahniser et al. (2017) maintained that engagements in selfcare in clinical psychology students is associated with; low stress levels, positive affect, flourishing, better academic, and clinical performance.

Most participants in the current study reported that personal therapy helped them in shaping their career development, and personal life. Although, this technique was not frequently employed by participants in the current study; they noted it as one of the ideal strategies that are helpful in dealing with the pressure that they experienced within the training programme. A South African study that was conducted by Ally (2014), presented similar findings, were trainees reported that professional psychotherapy was convenient because it made them better aware of how personal issues influenced their practice. The study further revealed that personal therapy was useful in helping trainees to work on their personal, and professional challenges (Ally, 2014).

Participants of the current study further reported that psychotherapy helped them with emotional regulation. Consistent with the findings of the current study is an international study that was conducted by Wilson et al. (2015), who found that personal therapy provided trainees with emotional support, which helped them to manage, or deal with their emotions. Moreover, personal therapy was found to be advantageous in their professional development, as it shaped their professional identity, and clinical practice. A systematic review and meta-synthesis on mandatory personal psychotherapy for training psychotherapists revealed that personal therapy was useful in; developing self-awareness, provision of emotional development, enhancing confidence in clinical skills, and helped with stress management (Murphy et al., 2018).

Interestingly, most trainees in the current study reported seeking professional help only when they were experiencing somatic symptoms such as, when they were; feeling depressed, vegetative symptoms, and when feeling as though they were out of control of their lives. This supports the argument that health professionals are more likely to seek help only when they are experiencing depressive symptoms (Siebert & Siebert, 2007). Similarly, Wilson et al. (2015) found that participants generally waited until they were in crisis before starting therapy. In the current study, the advantage of personal therapy was that it enabled participants to promote mental health care and preventing or minimising experiences of psychological conditions. However, there were identified barriers that varied from personal needs, and challenges to professional hindrances. Collectively, the perceived barriers and perceived net benefits are assumed to be the reason for people's readiness to act (Hall, 2012).

In summary, the participants' accounts support, and concur with HBM which posit that the benefits can overshadow barriers and instigate health seeking actions. Most participants were motivated to engage in self-care strategies when the perceived benefits outweighed the perceived barricades. Factors such as the desire to expand knowledge, and balance personal, and professional life, coping with daily stressors, and functioning optimally in the programme, were some of recorded perceived benefits among participants. Disengagement in practising self-care related to time constraints resulted in negative perception of the sustainable promotion of self-care efficacy.

5.5. Perceived Barriers

Perceived barriers refer to subjective evaluation of impediments that are associated with an adopted health action (Nicholson et al., 2017). In the context of the current study, perceived barriers entail participants' estimations of the level of difficulties that are associated with practicing or promoting self-care. These include emotional, economical, psychological, and social costs (Champion & Skinner, 2008). Furthermore, perceived barriers evaluate individuals' willingness to adopt an action or intervention after considering the odds of success and possible negative outcomes that are linked to accepting the intervention (Metta, 2016; Nicholson et al., 2017; Taylor et al., 2007). An example of this construct in the current study is the challenges of ensuring confidentiality, relative to seeking help. Trainees may fear or delay seeking professional psychotherapy if there is no guaranteed confidentiality, because they will be subject to social implications such as the stigma that is attached to mental illness within their communities. This may discourage their will to adopt an action.

In the current study a few perceived barriers were identified, and the findings were consistent with previous research (Czyz et al., 2013; Dyrbye et al., 2008; Garcia-Williams et al., 2014;). The findings of this study showed that the barriers that hinder trainee psychologists to adopt the culture of self-care included having to juggle academic work, financial constraints, and time constraints due to intense workload (Czyz et al., 2013; Dyrbye et al., 2008; Garcia-Williams et al., 2014). Findings from the current study suggested that the master's programme is not tailored to suit their schedules and is time consuming. This finding resonates with a study that was conducted in South African by Ally (2014), on emotional stresses and coping mechanism among trainee psychology students, which revealed that novice psychologist experience elevated levels of emotional stress owing to excessive workload which occupies their entire lives during training.

Related to the master's training programmes' high workload, one of the professional and personal-related challenge that was cited by participants was the completion of the research component. The participants felt that it was barely possible to complete their dissertations in record time, because of the intensive workload in the programme. At the University of KwaZulu Natal, training clinical psychologists are expected to complete; a 12months long internship, coursework, and a dissertation within their two years of training. However, most trainees do not complete their dissertation in record time, hence they must add another year of study.

The challenges of completing a dissertation among clinical psychology students is well documented in South African. Pillay et al. (2013) reported on the implications of the incomplete dissertations among trainee clinical psychologists in the health systems. This is in accord with another study that was conducted in South Africa by Pillay and Kritzinger (2007), on clinical psychologists' experiences of completing a dissertation as a component in their training programme. The study found that most trainees could only complete their dissertations after a period of about three years (Pillay & Kritzinger, 2007). This underling challenge delays trainees from graduating, and it creates a shortage of health practitioners who are intended to serve the country through community service (Pillay et al., 2013; Pillay & Johnston, 2011). The challenge of incomplete dissertations during the beginning of internships has also been noted in the United States of America (USA) (Pillay & Johnson, 2011). Krieshok et al. (2000) found that approximately 68% of all interns in the USA start their internship without a complete dissertation.

Another barrier that the current study noted is the financial cost in promoting self-care, and mental health. Statistics South Africa (2010 as cited in Wolff, 2014, p. 138), also notes that, the costs of psychotherapy sessions are, "…a barrier in terms of accessibility for many South Africans". This concurs with another study that was conducted in South Africa, on the use of psychological resources in Black communities. The study reported that the costs of psychological services is one of the key barriers in service utilisation. It is also necessary to note other barriers that hinder the utilisation in Black communities, and these include, "…the stigma of mental illness, lack of knowledge, affordability of treatment, lack of trust, impersonal service and lack of cultural sensitivity" (Ruane, 2010, p. 214). Likewise, some participants in the current study expressed that they could not access psychological services as often as they would like to, because the services were too expensive.

Finally, of concern regarding perceived barriers is the lack of support. This was noted by participants of the current study. Most participants expressed that they did not feel enough supported in their training process. Their grievances related to poor supervisor-supervisee relationships. While supervision alliance and managing supervisor-supervisee relationships might not be recognised as a direct barrier to self-care, it can be hypothesised that the dynamics involved can indirectly impact on participant's decision making such as, help seeking behaviour when experiencing difficulties in the training programme. This was evident in the current study, where trainees openly stated that they relied heavily on peer consultation than supervisors, because they did not want to be seen as weak, and not coping with the training programme. According to Bernard and Goodyear (2009), supervision is crucial, and it effectively prepare professional counsellors. It involves an affiliation constructed on; respect, trust, and safety (O'Hara, 2014). Therefore, informing participant's health action.

In conclusion, although participants in the current study alluded to limited obstacles compared to benefits, it seems that participants recognise, and believe that the gains of the promotion of self-care outweigh perceived barriers. However, owing to their tight schedules, their efforts to maintain the promotion of self-care are delayed. Furthermore, the current study's findings revealed that it is hard for the trainee psychologists to balance the gaps between their professional, and personal life. This makes it difficult for them to find time to engage in meaningful self-care practices. The lack of support, and poor working alliances between the supervisors, and trainees makes it difficult for them to seek assistance, which could be helpful in lessening the amount of pressure that they experience.

5.6. Cues to action

Cues to action entail the stimulus that activate or motivates one's readiness to adopt a health action or intervention (Champion & Skinner, 2008; Rosenstock, 1974a). The current study reveals that the desire to sustain a state of good health is influenced by few factors. The perceived benefits, and adequate knowledge on the subject prompted participants in the current study, to engage in self-care practices, however, it was not enough to sustain the culture of practising self-care. For instances, in the current study, most participants' primary cue of action stemmed from internal triggers where trainees were, ideally, not coping well within the training programme. The data revealed that few participants started attending psychotherapy after presenting with somatic symptoms that were associated with depression. In line with these findings is a study, by Norcross et al. (2008, p. 1375), that explored psychotherapists who

abstained from personal therapy. The findings from this study show that predicted circumstances that would influence seeking personal psychotherapy entailed, grief, inadequate functioning, and end of a relationship.

On the other hand, external triggers such as recommendations from support structures are sufficient to influence cue to action (Champion & Skinner, 2008). In the current study it appears that social support plays a significant role in promoting self-care. The participants in the current study believed that available supportive structures increased their health motivation through references, and for some, through observation of the advantages, and disadvantages of self-care, from their colleagues. The findings propose that witnessing a colleague in distress or not coping in the training programme, have a strong influence on trainees' decision making. The fear of incompetency among trainees motivated them to sustain stability in their lives, holistically. Furthermore, the findings highlighted the need, and role of provision of adequate support in the training process to aid trainees in finding balance, and sustaining the promotion of self-care, and mental health as novice practitioners.

According to literature, social support is a crucial part of everyday life, especially when highly susceptible to stress (Galek et al., 2011; Sun et al., 2020; Zhang et al., 2020). Studies on the topic of mental health revealed that having a support system influences one's success to recovery, or treatment adherence (Corrigan & Phelan, 2004; Chronister et al., 2013; Dai et al., 2016; William & Kemp, 2020). Social support is also associated with feelings of comfort, connection and professional development (Zahniser et al., 2017). The participants believed that their supervisor relationship, time management, and a balance between professional, and personal life were significant requirements for adopting self-care behaviours.

In summary, the findings from the current study suggest that the external stimuli work as one of the main agents to the promotion, and sustainability of the culture of self-care. The level of vulnerability, and disruption in the functionality of the professional, and personal life serves as a motivation to adopt, and action among trainees. Furthermore, the study reveals that increasing trainees' motivation through training, and improving supervisor-supervisee alliance can provide grounds for promoting the culture of self-care

5.7. Self-efficacy

Self-efficacy in HBM denotes, the strength of a person's confidence in their own aptitude to respond to different, or challenging situations, and cope with any related

impediments (Tarkang & Zotor, 2015). In the context of the current study, self-efficacy means, the confidence in one's aptitude to practice self-care. Trainee psychologists need to believe that the practice, and promotion of self-care is an achievable, and sustainable action that serves as a determinate of mental health promotion.

Most of the participants' confidence in their ability to practice self-care, and motivation to health action was noted to stem from personal resilience which was instigated by the support that they receive from their support structures within, and outside of the training programme. It seems that the support available for participants played a significant role in fuelling perceived feasibility of promoting self-care, and noting the beneficial outcomes of practicing, and promoting mental health. Most of the participants noted that supervision alliance was essential in building their confidence in the master's programme, and associated barriers such as fear of seeking assistance or help when they were in need, due to power dynamics that were involved, and the lack of support from supervisors.

Literature shows that supervision serves as a frame of support structure for clinicians in the context of professional development (Lizzio et al., 2009). This is characterised by supervisors' provision of comfort, credit, reassurance, and endorsement to supervisees (Lizzio et al., 2009). With that said, literature recognise that supervision has its own challenges (Lizzio et al., 2009). This was evident in the current study, were most trainees expressed feeling intimidated, victimised, and controlled in supervision, but receiving limited support from their designated supervisors. An international study that conducted by Wulf and Nelson (2001) on the ways that psychology predoctoral supervision experiences shaped their professional development, revealed that the supervisors' interpersonal qualities had significant influence on trainees' developmental. Trainees in the current study, reported experiencing emotional difficulties post interaction with non-confirming supervisors, who constantly criticised them, and provided limited affirmation. Such experience may have influence on trainees' self-esteem, and confidence in general.

On a personal level, confidence is associated with personal resiliency. Participants of the current study reported that, the challenges that they experienced during training helped in building their resilience. Edwards et al. (2014), in a study that they conducted in South African, investigating trainee's experiences of resilience in the master's program as well as the coping mechanism employed to manage the workload, provided interesting findings on resilience. Personal resilience experiences emerged as one of the four broad themes that entailed working

actively towards achieving the desired goal and acknowledging one's own strengths and weaknesses. Edwards et al. (2014, p. 174) study revealed that:

> *"Personal resilience experiences included viewing the course as a challenge, getting personal therapy from a psychologist, motivation, drive, determination, perseverance, hard work, gratefulness for the opportunity, enjoying the experience, insight into the level of study for personal, academic and social development, personal insight into one's strengths and development areas, realising the value of the course, realising one's potential, having a positive attitude, being more autonomous, realising that help from others was available, experiencing value and learning through suffering to build greater empathy for clients, appreciation of family support, allowing time to recuperate after situations perceived as negative, experimenting, realising and appreciating one's growth, being emotionally detached when necessary, gaining personal insight, taking time off to find oneself and positive self-talk."*

Relating to the personal attributes, self-awareness plays a significant role in trainees' self-efficacy. Self-awareness is recognised as a vital aspect of psychotherapy (Williams & Fauth, 2005). Participants identified self-awareness as one of the benefits that are acquired in their clinical training journey and indicated that the training process contributed significantly to their personal, and professional development. In other words, trainee psychologists, who saw growth in their training, were more likely to feel confident, and positive about their abilities to achieve their desired goals. This is consistent with previous studies on the role of self-awareness on medical students, and therapists (Benbassat & Baumal, 2005; Williams & Fauth, 2005). Williams and Fauth's (2005) study on therapists' self-awareness, and management strategies, revealed that therapists' self-awareness was constructive, and not only associated with enhanced clients' interpersonal experience in therapy but also positive emotions that are experienced by therapists in sessions. A study by Richard et al. (2010), revealed that there is a correlation between self-awareness, and mindfulness. Coleman et al.'s (2018) study revealed that clinical psychology training is linked to personal growth, increased self-awareness, and mindfulness.

In summary, support received and subjective experiences in the training programme are the determinant factors for trainee psychologists' confidence in the promotion, and practice of self-care. The current study revealed the positive impact of support, working alliance, and that participants who felt supported were more likely to believe in their abilities and adopt a health

action. Poor support is associated with feelings of doubt, and fear of seeking help because trainees do not want to appear as weak and not coping with the programme.

CHAPTER SIX: CONCLUSION AND LIMITATIONS

This chapter will outline the conclusions of the current study and discuss the implications of the findings. The study highlighted the challenges that are encountered by trainee psychologists in practising self-care. The findings provided insight into available support structures that aid in promoting self-care, and mental health care in the psychology training programme.

6.1. Summary of the findings

Using HBM as a theoretical framework, the study explored trainee psychologists' self-care practices to promote their mental well-being. According to HBM, trainees who have an elevated sense of perceived susceptibility and severity, positively, consider the consequences and benefits of health actions. These trainees are likely to establish rational levels of health motivation, and self-efficacy, thus, they are prone to participate in health promoting behaviours (Valjee, 2000).

The findings of the current study revealed that, while trainees employed different self-care approaches, all participants acknowledged the importance of practicing self-care. Although opposing in gradation, a perceived threat existed for all trainees. Trainees reported general concerns that were related to their mental health. The concerns attributed to background knowledge that they acquired in their training journey and highlighted the vulnerabilities that are associated with the role of being a helper in their careers. Whilst self-care is a recommended practice for all mental health service providers, the educational background or knowledge about the concept alone is inadequate to motivate trainees to regularly practice the culture of self-care. Concerns were raised about the lack of support and time constrains to facilitate and sustain the culture of self-care in the training programme. The trainees attributed this barrier to poor structuring of the master's psychology programme, and lack of adequate support. These barriers fed into the challenges that they experienced in the programme.

Commonalities were seen in challenges that were experienced by trainees, such as: poor supervision alliances, difficulties experienced in completing the dissertation component, balancing their personal, and professional life. The identified challenges had an impact on trainees' evaluations of the perceived benefits, and barriers to adopting the health action. This

supported HBM's predictions that, low health motivation is linked to a health action that is perceived as an inconvenience in someone's behaviour.

6.2. Recommendations

6.2.1. Recommendations for future master's training programme

In light of the identified challenges that are experienced in the training programme, it is prudent that the challenges experienced are addressed to promote wellness and self-care amongst trainees. It is recommended that training institutions explore the challenges that are experienced across all master's psychology programmes. This will inform institutions, if there is a need to consider tailoring or reconstructing the master's programmes, according to students' needs as per programme (for instance, increasing the duration of the programme). The implication to expand the programme to accommodate the research project would lighten the workload in the programme, thus, allowing trainees to effectively engage in all prescribed work. The easing of the workload would allow trainees the benefit to prioritising self-care engagements without pressure to perform. Furthermore, incorporating self-care culture in the programme, by introducing a module, or activity by focussing on the practitioners' mental health wellness will encourage trainees to actively promote their mental health wellness. Teaching trainees about the ways to reinforce the culture of self-care in their early careers will, "influence those with lower self-efficacy through modelling" (Perez-Calhoon, 2017, p. 112).

Support is an imperative component of promoting self-care and enhancing mental health. Thus, a thorough transition within the programme will be beneficial to master's students. Well-orienting trainees from the previous year about their expected role will enable a smooth transition from theoretical work to practical work. This will aid and ease the overwhelming feelings of anxiety, and uncertainty in novice psychologists, and create an effective working environment that would allow trainees to freely use the opportunity to gain experience, grow, and boost their self-confidence during the process of their career development.

6.2.2. Recommendations for Future Research

The findings in the study show an indication of a need for further research on the topic. The study shows that there is limited research on self-care amongst trainee psychologists. Thus, this is indicative of the gap in literature relating to the challenges that are experienced and are

barriers to the implementation of the culture of self-care. Future research on barriers that overshadow the benefits of the promotion of self-care, must explore the extent to which the flexibility of the master's programme can be beneficial to trainees' sustainable culture of self-care since it has been found that the structure of the programme is time constraining. Understanding the main challenges that are experienced by trainees will help training institutions to identify areas to improve and enhance trainees' experiences in their training journey.

The influence of support structures has been highlighted as a pertinent component of the programme and trainees' experiences. A study on the effectiveness of support in promoting self-care, and the dynamics of working alliance in supervisor-supervisee relationships will be beneficial in assessing and understanding the actions that are required to equip trainees to effectively grow and finding a balance between their professional and personal life.

6.3. Limitations

The sample of the current study was limited to limited experiences of the trainees that were enrolled in the master's training clinical psychology programme at the University of Kwa-Zulu Natal. This sample may not be a true and universal representation of the training institutions and is a limitation in this study. Thus, cautious interpretations of the findings are needed, in generalising these findings to other master's psychology settings. Moreover, the study presented with an under-representation of master's counselling trainees. All participants were in the master's clinical programme. This was due to the availability of trainees that were invited to participate in the study. Future research should consider expanding the population that includes participants that are enrolled in all master's psychology programmes, to further explore the commonalities within the master's counselling, clinical, educational and research psychology programmes.

Another limitation of the study to note is trustworthiness of the findings. Because the data in the study was collected qualitatively, it is crucial to consider the role of the researcher. This is due to the likelihood of the researcher's bias when interpreting the findings. Lastly, this study was conducted during the COVID-19 pandemic, thus, it is pivotal to note that the setting may had exacerbate challenges that were encountered by trainees.

REFERENCES

Abraham, C. & Sheeran, P. (2005). The health belief model. *Predicting health behaviour*, 2,28-80.

Ahmed, R. & Pillay, A. L. (2004). Reviewing clinical psychology training in the post-apartheid period: Have we made any progress? *South African Journal of Psychology*, *34*(4), 630-656. https://hdl.handle.net/10520/EJC98294

Alim, L. (2002). Qualitative Method. *Ahfad Journal,* 19(1), 62.

Alkema, K., Linton, J. M., & Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *Journal of Social Work in End-of-Life & Palliative Care*, *4*(2), 101-119. https://doi.org/10.1080/15524250802353934

Ally, Z. (2014). *Emotional stresses and coping among first year trainee clinical and counselling psychologists: a qualitative study of students' experiences and perceptions* (Doctoral dissertation, University of KwaZulu Natal, SA). http://hdl.handle.net/10413/13148

American Psychological Association. (2002). Monitor on psychology (Vol. 33). The Association. Available at; [https://www.apa.org/monitor/mar02], (Accessed; 12 November 2021).

Ashcroft, R. E., Dawson, A., Draper, H., & McMillan, J. (Eds.). (2007). *Principles of health care ethics*. John Wiley & Sons.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative. *Qualitative research*, *1*(3), 385-405. https://doi.org/10.1177%2F146879410100100307

Babbie, E. and Mouton, J. 2001. The practice of social research. Cape Town: Oxford University Press.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review.Clinical psychology: *Science and practice*, 10(2), 125-143. https://psycnet.apa.org/doi/10.1093/clipsy.bpg015

Baker, A. (2012). Training the resilient psychotherapist: What graduate students need to know about vicarious traumatization? *Journal of Social, Behavioural, and Health Sciences*, *6*(1), 1-12. https://doi.org/10.5590/JSBHS.2012.06.1.01

Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. American Psychological Association. Available at; [https:// doi.org/10.1037/10482-000], (Accessed; 12 November 2021).

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioural change. *Psychologicalreview*, *84*(2), 191. https://psycnet.apa.org/doi/10.1037/0033295X.84.2.191

Bantjes, J., Kagee, A., & Young, C. (2016). Counselling psychology in South Africa. *Counselling psychology-quarterly*, *29*(2),171-183. https://doi.org/10.1080/09515070.2015.1128401

Barnett, J. E. & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology Science and Practice*, *16*(1), 16-20. https://psycnet.apa.org/doi/10.1111/j.1468-2850.2009.01138.x

Barnett, J. E. & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistance programs for psychologists. *Professional Psychology: Research and Practice*, *32*(2), 205. https://psycnet.apa.org/doi/10.1037/0735-7028.32.2.205

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice*, *38*(6), 603a. https://psycnet.apa.org/doi/10.1037/0735-7028.38.6.603

Barnett, J. E., Johnston, L. C., & Hillard, D. (2005). Psychotherapist Wellness as an Ethical Imperative. In L. VandeCreek & J. B. Allen (Eds.), *Innovations in clinical practice: Focus on health & wellness* (pp. 257–271). Professional Resource Press/Professional Resource Exchange.

Barrett, A., Kajamaa, A., & Johnston, J. (2020). How to be reflexive when conducting qualitative research. *The clinical teacher*, *17*(1), 9-12.

https://doi.org/10.1111/tct.13133

Beck, D. L. (1976). A counselling program for social work students. *Social Casework*, *57*(10), 651-655. https://doi.org/10.1177%2F104438947605701006

Benbassat, J. & Baumal, R. (2005). Enhancing self-awareness in medical students: an overview of teaching approaches. *Academic Medicine*, *80*(2), 156-161.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative research*, *15*(2), 219-234.

https://doi.org/10.1177%2F1468794112468475

Bernard, J. M. & Goodyear, R. K. (2009). Fundamentals of clinical supervision (4th ed.). Upper Saddle River, N.J.: Pearson.

Bettney, L. (2017). Reflecting on self-care practices during clinical psychology training and beyond. *Reflective Practice*, 18(3), 369-380.

https://doi.org/10.1080/14623943.2017.1294532

Biggs, A., Brough, P., & Drummond, S. (2017). Lazarus and Folkman's psychological stress and coping theory. *The handbook of stress and health*, 349-364.

Boud, D. (2001). Using journal writing to enhance reflective practice. *New Directions for Adult and Continuing Education*, 90, 9-17.

Boyas, J., Wind, L. H., & Kang, S. Y. (2012). Exploring the relationship between employment based social capital, job stress, burnout, and intent to leave among child protection workers: An age-based path analysis model. *Children and Youth Services Review*, 34(1), 50-62. https://doi.org/10.1016/j.childyouth.2011.08.033

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Bozgeyikli, H. (2011). Observation of Turkish School Counsellor's Life Quality. *International journal of Academic Research*, *3*(4).

Bradley, N., Whisenhunt, J., Adamson, N., & Kress, V. E. (2013). Creative approaches for promoting counsellor self-care. *Journal of Creativity in Mental Health*, 8(4), 456-469.

https://doi.org/10.1080/15401383.2013.844656

Branch, C. & Klinkenberg, D. (2015). Compassion fatigue among pediatric healthcare providers. *MCN: The American Journal of Maternal/Child Nursing*, *40*(3), 160-166.

doi: 10.1097/NMC.0000000000000133

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Callaghan, P. (2004). Exercise: a neglected intervention in mental health?. *Journal of psychiatry and mental health nursing*, 11 (4), 476-483.

https://doi.org/10.1111/j.1365-2850.2004.00751.x

Canning D, Yates P and Rosenberg J. P. (2005) Competency standards for specialist palliative care nursing practice. Available at: http://www.pcna.org.au/images/documents/competystds.pdf. (Accessed; 12 December 2021).

Carpenter, C. J. (2010). A meta-analysis of the effectiveness of health belief model variables in predicting behaviour. *Health communication*, *25*(8), 661-669.

https://doi.org/10.1080/10410236.2010.521906

Carroll, L., Gilroy, P. J., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. *Women & Therapy*, 22(2), 133-143.

https://doi.org/10.1300/J015v22n02_10

Cartwright, D. & Gardner, M. (2016). Trainee difficulties with therapeutic engagement: a qualitative study of in-session critical incident. *South African Journal of Psychology*, 46(2) 254– 265. https://doi.org/10.1177%2F0081246315605679

Catlin-Rakoski, S. (2012). *Therapist's perceptions of self-care*. Counsellor Education Master's theses. 123. Retrieved from http://digitalcommons.brockport.edu/edc_theses/123

Champion, V. L. & Skinner, C. S. (2008). The health belief model. Health behaviour and health education: Theory, research, and practice. *Professional Counselling*, 5(4), 45 65.

Champion, V. L. (1999). Revised susceptibility, benefits, and barriers scale for mammography screening. *Research in nursing & health*, 22(4), 341-348.

https://doi.org/10.1002/(SICI)1098-240X(199908)22:4%3C341::AID-NUR8%3E3.0.CO;2-P

Chronister, J., Chou, C. C., & Liao, H. Y. (2013). The role of stigma coping and social support in mediating the effect of societal stigma on internalized stigma, mental health recovery, and quality of life among people with serious mental illness. *Journal of Community Psychology*, *41*(5), 582-600. https://doi.org/10.1002/jcop.21558

Cicognani E, Pietrantoni L, Palestini L, & Prati, G. (2009) Emergency workers' quality of life: the protective role of sense of community, efficacy beliefs and coping strategies. *Social Indicators Research*, 94: 449. https://doi.org/10.1007/s11205-009-9441-x

Clark, H. K., Murdock, N. L., & Koetting, K. (2009). Predicting burnout and career choice satisfaction in counselling psychology graduate students. *The Counselling Psychologist*, 37(4), 580–606. https://doi.org/10.1177%2F0011000008319985

Cleary, M., Schafer, C., McLean, L., & Visentin, D. C. (2020). Mental Health and Well-Being in the Health Workplace. *Issues in Mental Health Nursing*, 1-4.

https://doi.org/10.1080/01612840.2019.1701937

Cocker, F. & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *International journal of environmental research and public health*, 13(6), 618.

https://doi.org/10.3390/ijerph13060618

Cohen, D., & Crabtree, B. (2006). Qualitative research guidelines project. http://www.qualres.org/HomeSemi-3629.html

Coleman, A. M., Chouliara, Z., & Currie, K. (2018). Working in the field of complex psychological trauma: a framework for personal and professional growth, training, and supervision. *Journal of interpersonal violence*, *36*(5-6), 2791-2815.

https://doi.org/10.1177%2F0886260518759062

Colman, D. E., Echon, R., Lemay, M. S., McDonald, J., Smith, K. R., Spencer, J., & Swift, J. K. (2016). The efficacy of self-care for graduate students in professional psychology: A meta-analysis. *Training and Education in Professional Psychology*, *10*(4), 188. https://psycnet.apa.org/doi/10.1037/tep0000130

Cooper, S. & Nicholas, L. (2012). An overview of South African psychology. *International Journal of Psychology*, *47*(2), 89-101. https://doi.org/10.1080/00207594.2012.660160

Cope, D. G. (2014). Methods and meanings: credibility and trustworthiness of qualitative research. In *Oncology nursing forum*, 41(1).

Corey, G. (2005). *Theory and practice of counselling and psychotherapy* (6th ed.). Belmont, CA: Thomson Brooks/Cole.

Corrigan, P. W. & Phelan, S. M. (2004). Social support and recovery in people with serious mental illnesses. *Community mental health journal*, *40*(6), 513-523.

https://doi.org/10.1007/s10597-004-6125-5

Cosden, M., Sanford, A., Koch, L. M., & Lepore, C. E. (2016). Vicarious trauma and vicarious posttraumatic growth among substance abuse treatment providers. *Substance abuse*, *37*(4), 619-624. https://doi.org/10.1080/08897077.2016.1181695

Coster, J. S. & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice*, 28(1), 5.

https://psycnet.apa.org/doi/10.1037/0735-7028.28.1.5

Craig, C. D. & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping*, *23*(3), 319-339. https://doi.org/10.1080/10615800903085818

Cushway, D. (1992). Stress in clinical psychology trainees. *British journal of clinical psychology*, 31(2), 169-179. https://doi.org/10.1111/j.2044-8260.1992.tb00981.x

Cyr, S. C. (2017). Spirituality Within Reach: A Pathway through Meditation. https://aura.antioch.edu/etds/486

Czyz, E. K., Horwitz, A. G., Eisenberg, D., Kramer, A., & King, C. A. (2013). Self-reported barriers to professional help seeking among college students at elevated risk for suicide. *Journal of American college health*, *61*(7), 398-406.

https://doi.org/10.1080/07448481.2013.820731

Dai, W., Chen, L., Tan, H., Wang, J., Lai, Z., Kaminga, A. C., Li, Y., & Liu, A. (2016). Association between social support and recovery from post-traumatic stress disorder after flood: a 13–14-year follow-up study in Hunan, China. *BMC public health*, *16*(1), 1-9. https://doi.org/10.1186/s12889-016-2871-x

Davis, D. M. & Hayes, J. A. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy*, *48*(2), 198.

https://doi.org/10.1111/ap.12157

Dean, K. & Kickbusch, I. (1995). Health related behavior in health promotion: utilizing the concept of self-care. *Health Promotion International*, *10*(1), 35-40.

https://doi.org/10.1093/heapro/10.1.35

Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005). Predictors of Psychological Help Seeking in Clinical and Counselling Psychology Graduate Students. *Professional Psychology: Research and Practice*, *36*(3), 323.

https://psycnet.apa.org/doi/10.1037/0735-7028.36.3.323

Dorociak, K. E., Rupert, P. A., Bryant, F. B., & Zahniser, E. (2017). Development of the Professional Self-Care Scale. *Journal of Counselling Psychology*, *64*(3), 325-334.

https://doi.org/10.1037/cou0000206

Duncan, L. & Weissenburger, D. (2003). Effects of a brief meditation program on well-being and loneliness. *TCA Journal*, 31(1), p. 4. Retrieved on November 19, 2020, from http://www.questia.com/read/1P3-374616341/effects-of-a-brief-meditationprogram on.

Dyrbye, L. N., Thomas, M. R., Massie, F. S., Power, D. V., Eacker, A., Harper, W., Durning, S., Moutier, C., Szydlo, D.W., Novotny, P.J. and Sloan, J.A., 2008. & Sloan, J. A. (2008). Burnout and suicidal ideation among US medical students. *Annals of internal medicine*, *149*(5), 334-341.

https://doi.org/10.7326/0003-4819-149-5-200809020-00008

Edwards, D. J., Ngcobo, H. S. B., & Edwards, S. D. (2014). Resilience and coping experiences among master's professional psychology students in South Africa. *Journal of Psychology in Africa*, 24(2), 173-178. https://doi.org/10.1080/14330237.2014.903065

El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, *6*(2), 122. https://psycnet.apa.org/doi/10.1037/a0028768

Enochs, W. K., & Etzbach, C. A. (2004). Impaired student counsellors: Ethical and legal considerations for the family. *The Family Journal*, *12*(4), 396-400.

https://doi.org/10.1177%2F1066480704267240

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics*, *5*(1), 1-4.

doi: 10.11648/j.ajtas.20160501.11

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3–28). The Sidran Press.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of clinical psychology*, *58*(11), 1433-1441. https://doi.org/10.1002/jclp.10090

Fontanella, B. J. B., Campos, C. J. G., & Turato, E. R. (2006). Data collection in clinical qualitative research: use of non-directed interviews with open-ended questions by health professionals. *Revista Latino-Americana de Enfermagem*, *14*(5), 812-820.

Fox, K. R. (1999). The influence of physical activity on mental well-being. *Public health nutrition*, 2(3a), 411-418. doi:10.1017/S1368980099000567

Galek, K., Flannelly, K. J., Greene, P. B., & Kudler, T. (2011). Burnout, secondary traumatic stress, and social support. *Pastoral Psychology*, *60*(5), 633-649.

https://doi.org/10.1007/s11089-011-0346-7

Garcia-Williams, A. G., Moffitt, L., & Kaslow, N. J. (2014). Mental health and suicidal behaviour among graduate students. *Academic psychiatry*, *38*(5), 554-560.

https://doi.org/10.1007/s40596-014-0041-y

Gates, N. L. (2015). *The Health Belief Model and Women's Adherence to a Cardiac Rehabilitation Program* (Doctoral dissertation, Faculty of Graduate Studies and Research, University of Regina).

Glennon, A., Pruitt, D. K., & Rouland Polmanteer, R. S. (2019). Integrating self-care into clinical practice with trauma clients. *Journal of Human Behaviour in the Social Environment*, *29*(1),48–56.

https://0-doi org.innopac.wits.ac.za/10.1080/10911359.2018.1473189.

Gockel, A., Burton, D., James, S., & Bryer, E. (2013). Introducing mindfulness as a self-care and clinical training strategy for beginning social work students. *Mindfulness*, *4*(4), 343-353. https://doi.org/10.1007/s12671-012-0134-1

Godfrey, C. M., Harrison, M. B., Lysaght, R., Lamb, M., Graham, I. D., & Oakley, P. (2011). Care ofself-care by other care of other: The meaning of self-care from research, practice, policy and industry perspectives. *International Journal of Evidence-Based Healthcare*, 9(1), 3-24. https://doi.org/10.1111/j.1744-1609.2010.00196.x

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, 8(4), 597–607. Retrieved from http://www.nova.edu.

Gorin, S.S and Arnold, J. (1998). Health Promotion Handbook. Mosby. St Louis. Green, L.W. and Kreuter, M.W. (1999). Health Promotion Planning (3rd ed.). Mayfield Publishing Company. London.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of psychosomatic research*, 57(1), 35-43. https://doi.org/10.1016/S0022-3999(03)00573-7

Guba, E. G. & Lincoln, Y. (1989). Fourth generation evaluation. Newbury Park, CA: Sage.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC psychiatry*, *10*(1), 113. https://doi.org/10.1186/1471-244X-10-113

Guse, T. (2010). Positive psychology and the training of psychologists: Students' perspectives. *SA Journal of Industrial Psychology*, *36*(2), 1-6. Retrieved from https://hdl.handle.net/10520/EJC89229

Hall, K. S. (2012). The health belief model can guide modern contraceptive behaviour research and practice. *Journal of midwifery & women's health*, *57*(1), 74-81. https://doi.org/10.1111/j.1542-2011.2011.00110.x

Henderson, K. A. & Ainsworth, B. E. (2001). Researching leisure and physical activity with womenof colour: Issues and emerging questions. *Leisure sciences*, 23(1), 21-34.

https://doi.org/10.1080/01490400150502225

Hennink, M., Hutter, I., & Bailey, A. (2010). Data preparation and developing code. *Chapter 9 in Qualitative Research Methods, Sage Publications*, 203-232.

Hepker, N. (2007). *A Qualitative Investigation into the Determinants of Perceived Stress by Intern Clinical/counselling Psychologists in Consultation with a Non-fatal Suicidal Client* (Doctoral dissertation, University of KwaZulu-Natal, Durban).

Herrman, H., Stewart, D. E., Diaz-Granados, N., Berger, E. L., Jackson, B., & Yuen, T. (2011). What is resilience?. The Canadian Journal of Psychiatry, 56(5), 258-265.

https://doi.org/10.1177%2F070674371105600504

Hochbaum, G., Rosenstock, I., & Kegels, S. (1952). Health belief model. *United states public health service*, *1*.

Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of emergency nursing*, *36*(5), 420-427. https://doi.org/10.1016/j.jen.2009.11.027

Houpy, J. C., Lee, W. W., Woodruff, J. N., & Pincavage, A. T. (2017). Medical student resilience and stressful clinical events during clinical training. Medical Education Online, 22(1), 1320187. https://doi.org/10.1080/10872981.2017.1320187

Hubbs, D. L. & Brand, C. L. (2005). The paper mirror: Understanding reflective journaling. *Journal of Experiential Education*, *28*, 60–71.

https://doi.org/10.1177%2F105382590502800107

Hunsaker, S., Chen, H. C., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of nursing scholarship*, *47*(2), 186-194.

https://doi.org/10.1111/jnu.12122

Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health education quarterly*, *11*(1), 1-47. https://doi.org/10.1177%2F109019818401100101

Jenkins, S. R. & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *15*(5), 423-432.

https://doi.org/10.1023/A:1020193526843

Jones, C. J., Smith, H. E., Frew, A. J., Toit, G. D., Mukhopadhyay, S., & Llewellyn, C. D. (2014). Explaining adherence to self-care behaviours amongst adolescents with food allergy: a comparison of the health belief model and the common-sense self-regulation model. *British journal of health psychology*, *19*(1), 65-82.

https://doi.org/10.1111/bjhp.12033

Jones, C. L., Jensen, J. D., Scherr, C. L., Brown, N. R., Christy, K., & Weaver, J. (2015). The health belief model as an explanatory framework in communication research: Exploring parallel, serial, and moderated mediation. *Health communication*, 30(6), 566-576. https://doi.org/10.1080/10410236.2013.873363

Jordaan, I., Fouche, P., Watson, M., & Spangenberg, J. (2007a). Burnout and its correlates in South African clinical and counselling psychologists. *Acta Academica*, *39*(1), 176-201.

Retrieved from https://hdl.handle.net/10520/EJC15368

Jordaan, I., Spangenberg, J. J., Watson, M. B., & Fouchè, P. (2007b). Emotional stress and coping strategies in South African clinical and counselling psychologists. *South African Journal of Psychology*, *37*(4), 835-855.

https://doi.org/10.1177%2F008124630703700411

Kakuma, R., Kleintjes, S., Lund, C., Drew, N., Green, A., & Flisher, A. J. (2010). Mental health stigma: What is being done to raise awareness and reduce stigma in South Africa? African Journal of Psychiatry, 13(2), 116-124.

https://doi.org/10.4314/ajpsy.v13i2.54357

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of advanced nursing*, *72*(12), 2954-2965.

https://doi.org/10.1111/jan.13031

Kelly, S. E., Bourgeault, I., & Dingwall, R. (2010). Qualitative interviewing techniques and styles. *The SAGE handbook of qualitative methods in health research*, 307-326.

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, *14*(2), 32-44.

https://doi.org/10.1177%2F1534765608319083

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120 124. https://doi.org/10.1080/13814788.2017.1375092

Krieshok, T. S., Lopez, S. J., Somberg, D. R., & Cantrell, P. J. (2000). Dissertation while on internship: Obstacles and predictors of progress. *Professional Psychology: Research and Practice*, *31*(3), 327. https://psycnet.apa.org/doi/10.1037/0735-7028.31.3.327

Kuyken, W., Peters, E., Power, M. J., & Lavender, T. (2003). Trainee clinical psychologists' adaption and professional functioning: A longitudinal study. *Clinical Psychology and Psychotherapy*, 10, 41-54. https://doi.org/10.1002/cpp.350.

La Roche, M. J. & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice*, 34(2), 180.

https://psycnet.apa.org/doi/10.1037/0735-7028.34.2.180

Larkin P. J. (2015) Compassion: The essence of palliative and end-of-life care. Oxford: OUP.

Lewis-Beck, M., Bryman, A. E., & Liao, T. F. (2003). *The Sage encyclopaedia of social scienceresearch methods*. Sage Publications.

Lincoln, Y. S. & Guba EG. (1985). Naturalistic Inquiry. New bury Park. Sage Publications.

Lizzio, A., Wilson, K., & Que, J. (2009). Relationship dimensions in the professional supervision of psychology graduates: Supervisee perceptions of processes and outcome. *Studies in Continuing Education*, *31*(2), 127-140.

https://doi.org/10.1080/01580370902927451

Loeve, J. L. (2017). *The secondary consequences of the helping profession: an exploration of trainee psychologist's attitudes and perceptions towards vicarious trauma* (Doctoral dissertation). http://hdl.handle.net/10413/16073

Londoño, L. M. H. (2017). *Exploration of Self-Care, Compassion Satisfaction, and Culture among Latina (o) Clinical Psychologists* (Doctoral dissertation, Union Institute and University).

Lynch, S., Greeno, C., Teich, J., & Delany, P. (2016). Opportunities for social work under the Affordable Care Act: A call for action. *Social Work in Health Care*, *55*(9), 651-674.

https://doi.org/10.1080/00981389.2016.1221871

Macbeth, D. (2001). On "reflexivity" in qualitative research: Two readings, and a third. *Qualitative inquiry*, *7*(1), 35-68.

https://doi.org/10.1177%2F107780040100700103

Macran, S., Stiles, W. B., & Smith, J. A. (1999). How does personal therapy affect therapists' practice?. *Journal of Counselling Psychology*, 46(4), 419.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional psychology: Research and practice*, *28*(1), 14.

https://psycnet.apa.org/doi/10.1037/0735-7028.28.1.14

Maio, G. R., Verplanken, B., Manstead, A. S., Stroebe, W., Abraham, C., Sheeran, P., & Conner, M. (2007). Social psychological factors in lifestyle change and their relevance to policy. *Social Issues and Policy Review*, *1*(1), 99-137.

Marais, D. L. & Petersen, I. (2015). Health system governance to support integrated mental health care in South Africa: challenges and opportunities. *International journal of mental health systems*, *9*(1), 14. https://doi.org/10.1186/s13033-015-0004-z

Maslach, C. (2003). Job burnout: new directions in research and intervention. *Current directions in psychological science*, 12(5), 189-192.

https://doi.org/10.1111%2F1467-8721.01258

Matabane, P. R. G. (2015). *A qualitative investigation into the perceived benefits and barriers in accessing psychological services amongst first year university students* (Doctoral dissertation, University of KwaZulu Natal, South Africa).

Retrieved from http://hdl.handle.net/10413/14574

Mayorga, M. G., Devries, S. R., & Wardle, E. A. (2015). The Practice of Self-Care among Counselling Students. *Journal on Educational Psychology*, *8*(3), 21-28.

McCann, C. M., Beddoe, E., McCormick, K., Huggard, P., Kedge, S., Adamson, C., & Huggard, J. (2013). Resilience in the health professions: A review of recent literature. *International Journal of Wellbeing*, *3*(1).

McCann, I. L. & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of traumatic stress*, 3(1), 131-149. Retrieved from https://doi.org/10.1007/BF00975140

Metta, E.O. (2016) Health-seeking behaviour among adults in the context of the epidemiological transition in South-eastern Tanzania: A focus on malaria and diabetes [Groningen]: University of Groningen.

Miller, J. J., Lianekhammy, J., Pope, N., Lee, J., & Grise-Owens, E. (2017). Self-care among healthcare social workers: An exploratory study. *Social Work in Health Care*, *56*(10), 865-883. Retrieved from https://doi.org/10.1080/00981389.2017.1371100

Miller, K. I., Stiff, J. B., & Ellis, B. H. (1988). Communication and empathy as precursors to burnout among human service workers. *Communication Monographs*, 55, 250-265. https://doi.org/10.1080/03637758809376171

Mills, J., Wand, T., & Fraser, J. A. (2017). Palliative care professionals' care and compassion for self and others: a narrative review. *International journal of palliative nursing*, *23*(5), 219-229. https://doi.org/10.12968/ijpn.2017.23.5.219

Moon, K., Brewer, T. D., Januchowski-Hartley, S. R., Adams, V. M., & Blackman, D. A. (2016). A guideline to improve qualitative social science publishing in ecology and conservation journals. *Ecology and Society*, *21*(3).

http://www.jstor.org/stable/26269983

Moore, S. E., Bledsoe, L. K., Perry, A. R., & Robinson, M. A. (2011). Social work students and self-care: A model assignment for teaching. *Journal of Social Work Education*, 47(3), 545-553. https://doi.org/10.5175/JSWE.2011.201000004

Mor Barak, M. E., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis. *Social service review*, 75(4), 625 661. https://doi.org/10.1086/323166.

Murphy, D., Irfan, N., Barnett, H., Castledine, E., & Enescu, L. (2018). A systematic review and meta-synthesis of qualitative research into mandatory personal psychotherapy during training. *Counselling and Psychotherapy Research*, *18*(2), 199-214.

https://doi.org/10.1002/capr.12162

Myers, S. B., Sweeney, A. C., Popick, V., Wesley, K., Bordfeld, A., & Fingerhut, R. (2012). Self-care practices and perceived stress levels among psychology graduate students. *Training and Education in Professional Psychology*, *6*(1), 55.

https://psycnet.apa.org/doi/10.1037/a0026534

Neumann, D. A. & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy: Theory, research, practice, training*, *32*(2), 341. https://psycnet.apa.org/doi/10.1037/0033-3204.32.2.341

Newell, J. M. & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue. *Best Practices in Mental Health*, *6*(2), 57-68.

Ngcobo, H. S. & Edwards, S. D. (2008). Self-perceived multicultural counselling competencies in South African psychologists: A basis for practice guidelines. *Journal of Psychology in Africa*, *18*(4), 647-652.

https://doi.org/10.1080/14330237.2008.10820247

Nicholson Perry, K., Donovan, M., Knight, R., & Shires, A. (2017). Addressing professional competency problems in clinical psychology trainees. Australian Psychologist, 52(2), 121-129. https://doi.org/10.1111/ap.12268

Norcross, J. C., Bike, D. H., Evans, K. L., & Schatz, D. M. (2008). Psychotherapists who abstain from personal therapy: Do they practice what they preach?. *Journal of Clinical Psychology*, *64*(12), 1368-1376. https://doi.org/10.1002/jclp.20523

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meetthe trustworthiness criteria. *International journal of qualitative methods*, *16*(1). https://doi.org/10.1177%2F1609406917733847

O'connor, B. P. (2001a). Reasons for less-than-ideal psychotherapy supervision. *The Clinical Supervisor*, 19(2), 173-183. https://doi.org/10.1300/J001v19n02_10

O'connor, M. F. (2001b). On the aetiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice*, *32*(4), 345. https://psycnet.apa.org/doi/10.1037/0735-7028.32.4.345

O'Hara, C. (2014). The Relationships among the Experiences of Racial Microaggressions in Supervision, Traumatic Experiences, and the Supervisory Working Alliance in Professional Counsellors and Counsellors-in-Training. Dissertation, Georgia State University, 2014. Retrieved from https://scholarworks.gsu.edu/cps_diss/102

Orji, R., Vassileva, J., & Mandryk, R. (2012). Towards an effective health interventions design: an extension of the health belief model. *Online journal of public health informatics*, *4*(3). https://doi.org/10.5210/ojphi.v4i3.4321

Orlinsky, D. & Rønnestad, M. (2003). *The psychotherapist's perspective: Therapeutic work, professional development and personal life*. Washington, DC: American Psychological Association.

Osborn, C. J. (2004). Seven salutary suggestions for counsellor stamina. *Journal of Counselling & Development*, 82(3), 319-328. https://doi.org/10.1002/j.1556-6678.2004.tb00317.x

Ospina, M. B., Bond, K., Karkhaneh, M., Tjosvold, L., Vandermeer, B., Liang, Y., Bialy, L., Hooton, N., Buscemi, N., Dryden, D. M., & Klassen, T.P. (2007). Meditation practices for health: State of the research. *Agency for Health Care Policy and Research*, 155(155), 1-263.

Pakenham, K. I. & Stafford-Brown, J. (2012). Stress in clinical psychology trainees: Current research status and future directions. *Australian Psychologist*, 47(3), 147-155. https://doi.org/10.1111/j.1742-9544.2012.00070.x

Pakenham, K. I. (2015). Investigation of the utility of the acceptance and commitment therapy (ACT) framework for fostering self-care in clinical psychology trainees. *Training and education in professional psychology*, *9*(2),144.

https://psycnet.apa.org/doi/10.1037/tep0000074

Palliative Care Nurses New Zealand. (2014) A National Professional Development Framework for Palliative Care Nursing in Aotearoa New Zealand. Available at: http://www.health.govt.nz/system/files/documents/publications/national professionaldevelopment-framework-palliative-care-nursing-practice-nz-oct14.pdf.

Pearlman, L. A. & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized, 23, 150-177.

Perez-Calhoon, M. (2017). A mixed-methods study: Self-efficacy and barriers to participation in workplace wellness programs

Pica, M. (1998). The ambiguous nature of clinical training and its impact on the development of student clinicians. *Psychotherapy: Theory, Research, Practice, Training*, 35(3), 361. Retrieved from https://psycnet.apa.org/doi/10.1037/h0087840

Pillay, A. L. & Johnston, E. R. (2011). Intern clinical psychologists' experiences of their training and internship placements. *South African Journal of Psychology*, *41*(1), 74-82. Retrieved from https://hdl.handle.net/10520/EJC98620

Pillay, A. L. & Kramers-Olen, A. L. (2014). The changing face of clinical psychology intern training: A 30-year analysis of a programme in KwaZulu-Natal, South Africa. *South African Journal of Psychology*, *44*(3),364-374.

https://doi.org/10.1177%2F0081246314535683

Pillay, A. L. & Kritzinger, A. M. (2007). The dissertation as a component in the training of clinical psychologists. *South African Journal of Psychology*, *37*(3), 638-655. Retrieved from https://hdl.handle.net/10520/EJC98439

Pillay, A. L. & Siyothula, E. T. B. (2008). The training institutions of black African clinical psychologists registered with the HPCSA in 2006. *South African Journal of Psychology*, *38*(4), 725-735. https://hdl.handle.net/10520/EJC98507

Pillay, A. L., Ahmed, R., & Bawa, U. (2013). Clinical psychology training in South Africa: A call to action. *South African Journal of Psychology*, 43(1), 46-58. Retrieved from https://doi.org/10.1177%2F0081246312474411

Polit, D. F. & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice*. Lippincott Williams & Wilkins.

Posluns, K. & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counselling*, *42*(1), 1-20. https://doi.org/10.1007/s10447-019-09382.

Proţi, L. E. (2016). Challenges encountered by psychotherapists at the beginning of their practice. *Romanian Journal of Cognitive Behavioural Therapy and Hypnosis*, 3(1), 5-10.

Rake, C. & Paley, G. (2009). Personal therapy for psychotherapists: The impact on therapeutic practice. A qualitative study using interpretative phenomenological analysis. *Psychodynamic Practice*, *15*(3), 275-294. Retrieved from https://doi.org/10.1080/14753630903024481

Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology*, 19(4), 255-267. Retrieved from https://doi.org/10.1177%2F1534765612471144

Richards, K., Campenni, C., & Muse-Burke, J. (2010). Self-care and well-being in mental health professionals: The mediating effects of self-awareness and mindfulness. *Journal of Mental Health Counselling*, 32(3), 247-264. Retrieved from https://doi.org/10.17744/mehc.32.3.0n31v88304423806

Rønnestad, M. H., Orlinsky, D. E., Schröder, T. A., Skovholt, T. M., & Willutzki, U. (2019). The professional development of counsellors and psychotherapists: Implications of empirical studies for supervision, training and practice. *Counselling and Psychotherapy Research*, 19(3), 214-230. Retrieved from https://doi.org/10.1002/capr.12198

Roothman, B. (2010). *Burnout and work engagement among South African psychologists* (Doctoral dissertation, North-West University).

Rosenstock, I. M. (1974a). Historical origins of the health belief model. *Health education monographs*, 2(4), 328-335. https://doi.org/10.1177%2F109019817400200403

Rosenstock, I. M. (1974b). The health belief model and preventive health behaviour. *Health education monographs*, 2(4), 354-386. https://doi.org/10.1177%2F109019818801500203

Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. *Health education quarterly*, *15*(2), 175-183. Retrieved from https://doi.org/10.1177%2F109019818801500203

Ruane, I. (2010). Obstacles to the utilisation of psychological resources in a South African township community. *South African Journal of Psychology*, *40*(2), 214-225. Retrieved from https://doi.org/10.1177%2F008124631004000211

Rupert, P. A. & Dorociak, K. E. (2019). Self-care, stress, and well-being among practicing psychologists. *Professional Psychology: Research and Practice*, *50*(5), 343. Retrieved from https://psycnet.apa.org/doi/10.1037/pro0000251

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review*, *49*, 54-61. Retrieved from https://doi.org/10.1016/j.childyouth.2014.12.023

Sanchez-Reilly, S., Morrison, L. J., Carey, E., Bernacki, R., O'Neill, L., Kapo, J., Periyakoil, V.S., & Thomas, J. D. (2013). Caring for oneself to care for others: physicians and their self-care. *The journal of supportive oncology*, *11*(2), 75. Retrieved from https://doi.org/10.12788/j.suponc.0003

Sansbury, B. S., Graves, K., & Scott, W. (2015). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. *Trauma*, *17*(2), 114 122. https://doi.org/10.1177/1460408614551978

Sansó, N., Galiana, L., Oliver, A., Pascual, A., Sinclair, S., & Benito, E. (2015). Palliative care professionals' inner life: exploring the relationships among awareness, self-care, and compassion satisfaction and fatigue, burnout, and coping with death. *Journal of pain and symptom management*, *50*(2), 200-207. https://doi.org/10.1016/j.jpainsymman.2015.02.013

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and education in professional psychology*, 1(2), 105. Retrieved from https://doi.org/10.1037/1931-3918.1.2.105

Sharf, R. S. (2015). *Theories of psychotherapy & counselling: Concepts and cases*. Cengage Learning.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63-75. Doi: 10.3233/EFI-2004-22201

Siebert, D. C. & Siebert, C. F. (2007). Help seeking among helping professionals: A role identity perspective. *American Journal of Orthopsychiatry*, *77*(1), 49-55. Retrieved from **https://doi.org/10.1037/0002-9432.77.1.49**

Singh, A. S. (2014). Conducting case study research in non-profit organisations. *Qualitative Market Research: An International Journal*.

Skovholt, T. M. & Rønnestad, M. H. (2003). Struggles of the novice counsellor and therapist. *Journal of Career Development*, *30*(1), 45-58. Retrieved from https://doi.org/10.1177%2F089484530303000103

Skovholt, T. M. & Trotter-Mathison, M. (2014). *The resilient practitioner: Burnout prevention and self-care strategies for counsellors, therapists, teachers, and health professionals*. Routledge.

Skovholt, T. M. (2012). *Becoming a therapist: On the path to mastery*. Hoboken, NJ: John Wiley & Sons.

Skovholt, T. M., Grier, T. L., & Hanson, M. R. (2001). Career counselling for longevity: Self-care and burnout prevention strategies for counsellor resilience. *Journal of Career Development*, *27*(3), 167-176. https://doi.org/10.1023/A:1007830908587

Sobekwa, Z. C. & Arunachallam, S. (2015). Experiences of nurses caring for mental health care users in an acute admission unit at a psychiatric hospital in the Western Cape Province. *Curationis*, *38*(2), 1-9. http://dx.doi.org/10.4102/curationis.v38i2.1509

Sparling, P. B. & Snow, T. K. (2002). Physical activity patterns in recent college alumni. *Research Quarterly for Exercise and Sport*, June 2002. Retrieved from https://doi.org/10.1080/02701367.2002.10609009

Spickard, A. Gabbe, S. G., & Christensen, J. F. (2002). Mid-career burnout in generalist and specialist physicians. *Journal of the American Medical Association*, 288, 1447 1450. Retrieved from doi:10.1001/jama.288.12.1447

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, *12*(3), 259-280. Retrieved from https://doi.org/10.1080/15325020701238093

Stamm, B. H. (2010). *The concise ProQOL manual*. 2nd Ed. Pocat ello, ID: ProQOL.org.

Stevanovic, P. & Rupert, P. A. (2004). Career-Sustaining Behaviours, Satisfactions, and Stresses of Professional Psychologists. *Psychotherapy: Theory, Research, Practice, Training*, 41(3), 301. Retrieved from https://doi.org/10.1037/0033-3204.41.3.301

Stuckey, H. (2013). Three types of interviews: Qualitative research methods in social health. *Journal of Social Health and Diabetes*, *1*(2), 56-56. DOI:10.4103/2321 0656.115294

Sun, J., Sun, R., Jiang, Y., Chen, X., Li, Z., Ma, Z., Wei, J., He, C., & Zhang, L. (2020). The relationship between psychological health and social support: Evidence from physicians in China. *Plos one*, *15*(1), e0228152. Retrieved from https://doi.org/10.1371/journal.pone.0228152

Tamura, L. J., Vincent, W. L., Bridgeman, D. L., & Hanbury, R. F. (2008). Psychologists' Pursuit of Wellness Across the Life Span–Benefits and Barriers to Self-Care Practices. *American Psychological Association.*

Tarkang, E. E. & Zotor, F. B. (2015). Application of the health belief model (HBM) in HIV prevention: A literature review. *Central African Journal of Public Health*, *1*(1), 1-8. http://doi.org/10.11648/j.cajph.20150101.11

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. *Journal of Clinical Psychology*, *74*(9), 1545-1555. **https://doi.org/10.1002/jclp.22614**

Taylor, D., Bury, M., Campling, N., Carter, S., Garfied, S., Newbould, J., & Rennie, T. (2007). A Review of the use of the Health Belief Model (HBM), the Theory of Reasoned Action (TRA), the Theory of Planned Behaviour (TPB) and the Trans-Theoretical Model

(TTM) to study and predict health related behaviour change. *School of Pharmacy, University of London*, 1-212.

Thériault, A., Gazzola, N., & Richardson, B. (2009). Feelings of incompetence in novice therapists: Consequences, coping, and correctives. *Canadian Journal of Counselling and Psychotherapy*, 43(2). https://cjcrcc.ucalgary.ca/article/view/58957

Thériault, A., Gazzola, N., Isenor, J., & Pascal, L. (2015). Imparting self-care practices to therapists: What the experts recommend. *Canadian Journal of Counselling and Psychotherapy*, 49(4), 379–400. https://cjc-rcc.ucalgary.ca/article/view/61031

Tjeltveit, A. C. & Gottlieb, M. C. (2010). Avoiding the road to ethical disaster: Overcoming vulnerabilities and developing resilience. *Psychotherapy: Theory, Research, Practice, Training*, 47(1), 98. https://doi.org/10.1037/a0018843

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of advanced nursing*, *48*(4), 388-396. Retrieved from **https://doi.org/10.1111/j.1365-2648.2004.03207.x**

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary nurse*, *19*(1-2), 75-87. Retrieved from https://doi.org/10.5172/conu.19.12.75

Turgoose, D. & Maddox, L. (2017). Predictors of compassion fatigue in mental health professionals: A narrative review. *Traumatology*, 23(2), 172. Retrieved from https://doi.org/10.1037/trm0000116

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences*, *15*(3), 398-405. Retrieved from https://doi.org/10.1111/nhs.12048

Valjee, S. R. (2000). *A qualitative understanding of the health-seeking behaviour of adult in patients with multi-drug resistant tuberculosis in a public health sector setting* (Doctoral dissertation, University of KwaZulu Natal). South Africa. Retrieved from http://hdl.handle.net/10413/3913

Van Voorhees, B. W., Fogel, J., Houston, T. K., Cooper, L. A., Wang, N. Y., & Ford, D. E. (2006). Attitudes and illness factors associated with low perceived need for depression

treatment among young adults. *Social psychiatry and psychiatric epidemiology*, *41*(9), 746-754. https://doi.org/10.1007/s00127-006-0091-x

Viskovich, S., & De George-Walker, L. (2019). An investigation of self-care related constructs in undergraduate psychology students: Self-compassion, mindfulness, self awareness, and integrated self-knowledge. *International Journal of Educational Research*, *95*, 109-117. https://doi.org/10.1016/j.ijer.2019.02.005

Wagaman, M. A., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social work*, 60(3), 201-209. https://doi.org/10.1093/sw/swv014

Walsh, R. (2011). Lifestyle and mental health. *American Psychologist*, *66*(7), 579.Retrieved from https://doi.org/10.1037/a0021769

Webster, S., Lewis, J. & Brown, A. (2013). In J. Ritchie, L. Lewis, C. M. Nicholls & R. Ormston (Eds.). (2013). Qualitative research practice: A guide for social science students and researchers. London: Sage.

Williams, E., & Fauth, J. (2005). A psychotherapy process study of therapist in session self awareness. *Psychotherapy Research*, *15*(4),374-381. Retrieved from https://doi.org/10.1080/10503300500091355

Williams, I. D., Richardson, T. A., Moore, D. D., Gambrel, L. E., & Keeling, M. L. (2010). Perspectives on self-care. *Journal of Creativity in Mental Health*, 5(3), 320 338. https://doi.org/10.1080/15401383.2010.507700

Williams, N. E. & Fauth, J. (2005). A psychotherapy process study of therapist in session self-awareness. *Psychotherapy Research*, *15*(4), 374-381. Retrieved from https://doi.org/10.1080/10503300500091355

Williams, R. & Kemp, V. (2020). Caring for healthcare practitioners. *BJ Psych Advances*, 26(2), 116-128. doi:10.1192/bja.2019.66

Wilson, H. M. N., Weatherhead, S., & Davies, J. S. (2015). Clinical psychologists' experiences of accessing personal therapy during training: A narrative analysis. *InternationalJournal of Practice-based Learning in Health and Social Care*, *3*(2), 32-47. https://doi.org/10.18552/ijpblhsc.v3i2.238

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psycho-Analysis*, *41*, 585-595.

Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and well-being for psychologists: Re-envisioning the stress-distress continuum. *Professional Psychology: Research and Practice*, *43*(5), 487. https://doi.org/10.1037/a0029446

Wolff, A. (2014). The State of psychotherapy in South Africa: A legacy of Apartheid and western biases. *UC Merced Undergraduate Research Journal*, *7*(2). Retrieved from https://escholarship.org/uc/item/26q8c96t

Woodside, M., Oberman, A. H., Cole, K. G., & Carruth, E. K. (2007). Learning to be a counsellor: A prepracticum point of view. *Counsellor Education and Supervision*, 47(1), 14-28. **https://doi.org/10.1002/j.1556-6978.2007.tb00035.x**

World Health Organization. (1984). Health education in self-care: Possibilities and limitations (No.HED/84.1). *World Health Organization*.

Wulf, J. & Nelson, M. L. (2001). Experienced psychologists' recollections of internship supervision and its contributions to their development. *The Clinical Supervisor*, *19*(2), 123-145. https://doi.org/10.1300/J001v19n02_07

Yates, T. M., Tyrell, F. A., & Masten, A. S. (2015). Resilience theory and the practice of positive psychology from individuals to societies. *Positive psychology in practice: Promoting human flourishing in work, health, education, and everyday life*, 773-788.

Yilmaz, K. (2013). Comparison of quantitative and qualitative research traditions: Epistemological, theoretical, and methodological differences. *European journal of education*, *48*(2), 311-325. **https://doi.org/10.1111/ejed.12014**

Yin, R. K. (2011). Qualitative research from start to finish. New York, NY.

Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. *Training and Education in Professional Psychology*, *11*(4), 283-289.

Zeidner, M., Hadar, D., Matthews, G., & Roberts, R. D. (2013). Personal factors related to compassion fatigue in health professionals. *Anxiety, Stress & Coping*, *26*(6), 595-609. https://doi.org/10.1080/10615806.2013.777045

Zhang, H., Tang, L., Ye, Z., Zou, P., Shao, J., Wu, M., Zhang, Q., Qiao, G., & Mu, S. (2020). The role of social support and emotional exhaustion in the association between work-family conflict and anxiety symptoms among female medical staff: a moderated mediation model. *BMC Psychiatry*, *20*,1-9.

https://doi.org/10.1186/s12888-020-02673-2

APPENDICES

APPENDIX A: Gatekeeper's Letter

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18 April 2019

Miss Thobile Nkosi
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Howard College Campus
UKZN
Email: gnez08@gmail.com Mtwentulan@ukzn.ac.za

Dear Miss Nkosi

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN), towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

"Exploring trainee psychologist's self-care practices to promote and enhance mental health care".

It is noted that you will be constituting your sample by conducting semi-structured interviews with Master of Social Sciences in Counselling and Clinical Psychology Pragram on the Howard College campus.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book. Identity numbers and email addresses of individuals are not a matter of public record and are protected according to Section 14 of the South African Constitution, as well as the Protection of Public Information Act. For the release of such information over to yourself for research purposes, the University of KwaZulu-Natal will need express consent from the relevant data subjects. Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

[redacted]

MR SS MOKOENA
REGISTRAR

APPENDIX B: Ethical Clearance Letter

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

07 September 2020

Miss Thobile Goodness Nkosi (217045046)
School Of Applied Human Sc
Howard College

Dear Miss Nkosi,

Protocol reference number: HSSREC/00001804/2020
Project title: Exploring Trainee Psychologist s Self-Care Practices at the University of KwaZulu-Natal, South Africa
Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 24 July 2020 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 07 September 2021.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

[redacted]

Professor Dipane Hlalele (Chair)

/dd

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: http://research.ukzn.ac.za/Research-Ethics/

APPENDIX C: Informed Consent

Social Sciences, College of Humanities,

University of KwaZulu-Natal,

Howard College Campus,

Exploring Trainee Psychologist's Self-Care Practices at the University of KwaZulu-Natal, South Africa.

INFORMED CONSENT FORM

Dear Participant

My name is Thobile Nkosi. I am a student at the University of KwaZulu Natal, studying MA in Clinical Psychology. I am conducting a study with the aim to explore and describe trainee psychologist's self-care practices to promote and enhance mental health care at the University of KwaZulu-Natal, South Africa.

The main objective of the research is to document the students' culture of self-care through the exploration of their self-care practices and experiences to promote and enhance mental health care.

If you agree to participate in this study, you will be asked to have a 30- 45-minute interview with the researcher. All participants will be interviewed once; the interviews will be audio recorded. The information collected will be held in a password protected file accessible only the researcher and the researcher's supervisor.

Participation in the study is voluntary and anonymously; the information you provide is confidential. There will be no information gathered that can lead to your identity revealed. You are more than welcome to stop whenever you feel uncomfortable about certain subjects and ask questions. To conduct this research interview, you will be invited to sign a consent form. This form stands as proof and assurance that you are giving the researcher the permission to conduct the interview, following the procedure.

Please understand that the study is for educational purpose. Thus, there will be no payments received for participating in the study.

For further questions/concerns or queries related to the study, please contact the researcher, Thobile Nkosi or her supervisor Ms. Mtwentula on the contact details provided below. If you have any queries about the rights of research respondents, please contact the Humanities and Social Sciences Research Ethic Office: -

Contact Details:

Ms. Thobile Nkosi
Researcher
Cell: 062 617 3698
Email: gnez08@gmail.com

Ms. Ntombekhaya Mtwentula
Supervisor
Tel: 031 260 1087
Email: mtwentulan@ukzn.ac.za

Humanities and Social Sciences Research Ethics Administration
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X54001
Durban
4000
KwaZulu Natal South Africa
Tel: 031 260 4557-Fax: 031 260 4609
Email: HSSREC@ukzn.ac.za

Your participation in this study will be greatly appreciated.

DECLARATION:

I_____ (Full names of participants) hereby consent (i.e., agree) to participating in this study. I hereby declare that I have read the information and understand what my participation involves.

I understand that:

- Participation in this study is voluntary and I am not forced to participate. And I can pull out of this study or refuse to take part at any time that I wish without any negative consequences.
- I can refuse to answer a question at any time if I feel uncomfortable.
- I am guaranteed that all identifying information I give throughout this research study will remain anonymous to protect my identity in the reporting of the results of this study.
- There are no advantages or disadvantages associated with choosing to participate in this research or not participate.
- At any time, the tapes and transcripts will not be seen, heard, or processed by anyone, other than the researcher and her team.
- All the information obtained by the researcher will be stored securely.
- All the audiotape material obtained by the researcher will be destroyed after a maximum period of 5 years or archived.
- My name or other identifying information will not be used in the research report and a pseudonym or a randomly assigned number will be used in its place to guarantee my anonymity in all reports.
- I consent to the researcher's use of direct quotes from the interview in the research report and articles.

If you are willing to be interviewed, kindly indicate on the provided space below (by ticking as applicable):

	willing	Not willing
Audio equipment		
Note taking		

Signature of participant: _____ Date: _____

Thank you in advance for your cooperation.

APPENDIX D: Interview Schedule

Title: Exploring Trainee Psychologist's Self-Care Practices to Promote and Enhance Mental Health Care at the University of KwaZulu-Natal, South Africa.

1.a What do you understand about the concept of self-care?

1.b. What do you understand about the concept of mental health care?

2.a. What kind of activities do you engage in to promote self-care?

2.b. What kind of activities do you engage in to promote mental health care?

3. How often do you engage in those activities?

4. How do you balance your personal life and professional life?

5. Are you currently consulting any specialist to promote mental health care and self-care? If, so, how is it helpful?

6. What are some of the challenges do you face in the clinical and counselling master's programme in all aspect?

- Professional level?
- Academic level?
- Individual level?

7. How do you deal/manage with the pressure that comes with the clinical and counselling master's programme/training?

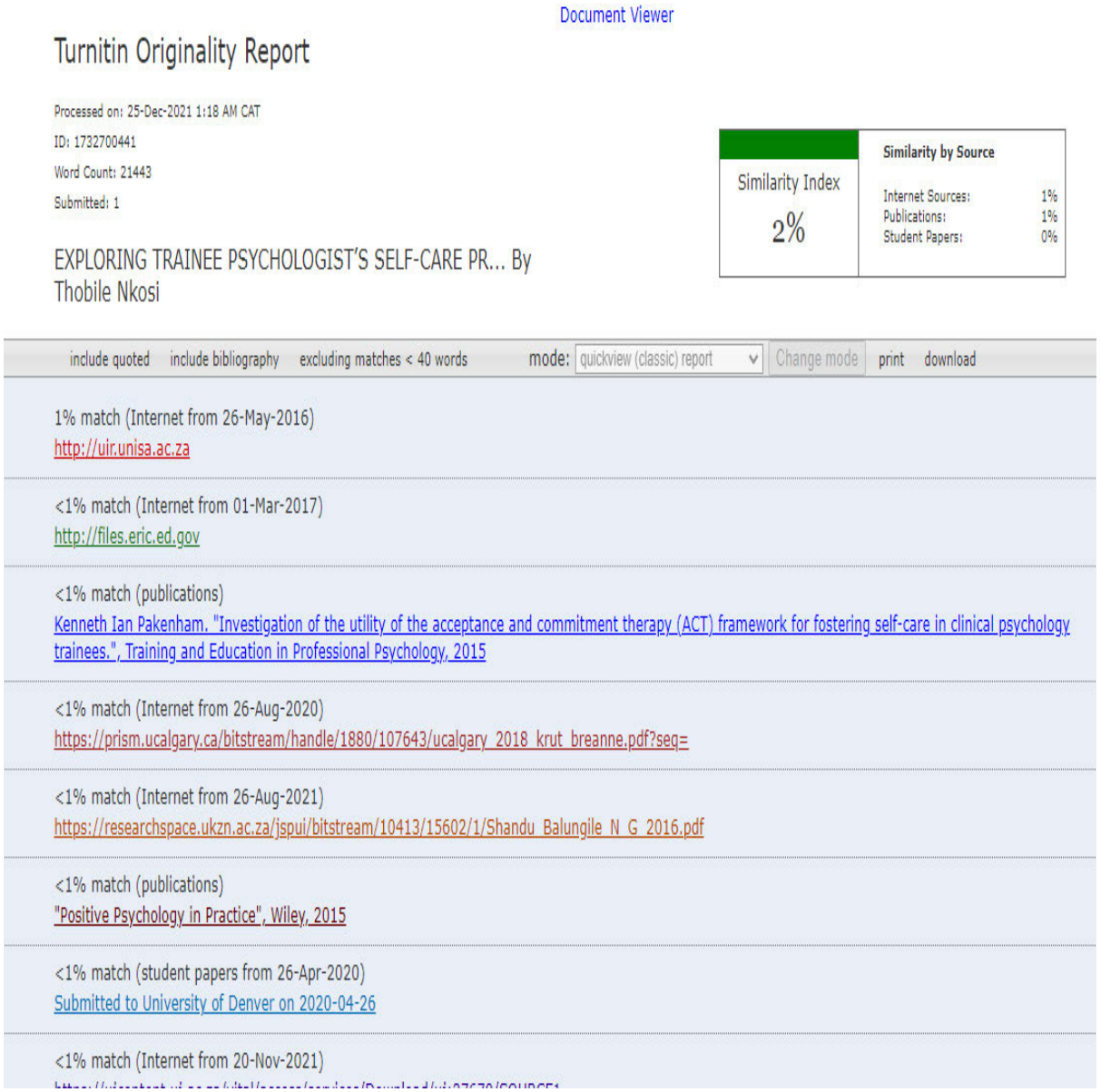
8. Have you noticed any emotional state and/or behaviour changes since the beginning of the programme/training? If yes, how so?

9. What do you think has contributed to these emotional or behavioural changes?

10.What is your support structure?

11. How often do you spend time with your loved ones (e.g., family, friends, etc)?

APPENDIX E: Turnitin Digital Receipt



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APPENDIX F: Proof of editing

12 December 2021

To Whom it May Concern

Re: Proof of editing

This letter serves to confirm that I have edited this thesis by **Thobile. G. Nkosi (Student Number: 217045046).**

The **title of the thesis** is: Exploring trainee psychologist's self-care practices at the University of KwaZulu-Natal, South Africa. **Submitted** to the The School of Applied Human Sciences, University of Kwazulu-Natal, Howard College, in partial fulfilment of the requirements for the Clinical Psychology Master's Degree.

In this thesis, I edited the following:

1. Language.
2. References.

Note: The student made further inputs after my language editing.

If there are any questions, do not hesitate to contact me.

Kindest Regards
Oncemore Mbeve
Doctoral Researcher, Wits, African Centre for Migration and Society (ACMS)
MA Psychology Research and Coursework, Wits University
BSW, Wits University
Email: oncemorembeve@hotmail.com
Cell: +27622028278