THERAPIST METAMORPHOSIS: BEGINNER AND EXPERIENCED

PSYCHOTHERAPISTS’ JOURNEYS OF PROFESSIONAL THERAPEUTIC DEVELOPMENT

CHRISTINE LAIDLAW

209096015

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Supervisor: Prof. C. N. Hoelson
DECLARATION BY CANDIDATE

NAME: Christine Laidlaw

STUDENT NUMBER: s209096015

QUALIFICATION: Magister Artium in Clinical Psychology

TITLE: Therapist Metamorphosis: Beginner and Experienced Psychotherapists’ Journeys of Professional Therapeutic Development

DECLARATION: In accordance with Rule G4.6.3, I hereby declare that the above-mentioned treatise is my own work and that it has not previously been submitted for assessment to another university or for another qualification.

SIGNATURE: ___________________________

DATE: ___________________________
Acknowledgements

If you follow your bliss, you put yourself on a kind of track that has been there all the while, waiting for you, and the life you ought to be living is the one you are living.

Wherever you are – if you are following your bliss, you are enjoying that refreshment, that life within you, all the time.


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# Table of Contents

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
</tr>
<tr>
<td>List of Appendices</td>
</tr>
<tr>
<td>List of Figures</td>
</tr>
<tr>
<td>Summary</td>
</tr>
</tbody>
</table>

## Chapter 1: Introduction

The Broader Context of the Research        1  
International Research of Psychotherapists’ Professional Development 2  
South African Research of Psychotherapists’ Professional Development 3  
Structure of the Treatise                4

## Chapter 2: Theoretical Framework

Introduction                          5  
Key Concepts to Orientate Exploration of Psychotherapists 6  
   Developmental Milestones of Psychotherapists 6  
   Defining Expertise                         6
 
   Delineating Therapeutic Expertise         8

Models to Navigate Development of Psychotherapists 10  
   The Developmental Model of Psychotherapists 10  
   The Levels of Competency Model            14
 
   The Skill Development Model               15

Facets of Psychotherapists and Therapeutic Work 18  
   Career Levels                            18
 
   Theoretical Orientation(s) of Therapists 19
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primacy of the Therapeutic Relationship</td>
<td>22</td>
</tr>
<tr>
<td>Personal Characteristics of Therapists</td>
<td>23</td>
</tr>
<tr>
<td>Key Qualities and Ethical Values of Therapists</td>
<td>26</td>
</tr>
<tr>
<td>Key Skills of Therapists</td>
<td>27</td>
</tr>
<tr>
<td>Developmental Influences</td>
<td>28</td>
</tr>
<tr>
<td>Critical Incidents in Professional Development</td>
<td>31</td>
</tr>
<tr>
<td>Professional Sources of Influence upon Psychotherapist Development</td>
<td>33</td>
</tr>
<tr>
<td>Experience with Patients</td>
<td>34</td>
</tr>
<tr>
<td>Therapists’ Use of Personal Therapy</td>
<td>35</td>
</tr>
<tr>
<td>Supervision of Psychotherapists</td>
<td>37</td>
</tr>
<tr>
<td>Mentoring of Psychotherapists</td>
<td>41</td>
</tr>
<tr>
<td>Ongoing Professional Development</td>
<td>42</td>
</tr>
<tr>
<td>Approach to Therapeutic Process</td>
<td>45</td>
</tr>
<tr>
<td>Descriptions of Therapeutic Relationship Stances</td>
<td>45</td>
</tr>
<tr>
<td>Empowerment/Strength-based Approach</td>
<td>46</td>
</tr>
<tr>
<td>Metaphors of the Therapeutic Process</td>
<td>46</td>
</tr>
<tr>
<td>Complexity of the Therapeutic Process</td>
<td>50</td>
</tr>
<tr>
<td>Evaluation of One’s Therapeutic Work</td>
<td>51</td>
</tr>
<tr>
<td>Conclusion</td>
<td>53</td>
</tr>
</tbody>
</table>

**Chapter 3: Research Methodology**

Introduction                                                   54

Epistemology of Social Constructionism                         54

Research Method: Qualitative Approach                          56
The Self of the Researcher 57
Ethical Considerations 58
Selection of Participants 59
Data-gathering Procedure 62
Data-gathering Tool: Semi-structured Interviews 62
Data Analysis of Texts 64
Data Verification 67

Chapter 4: Findings 70
Developmental Influences 70
    Hard-won Meanings: Motivations for Becoming a Psychotherapist 71
    Formative Experiences: Taking a History 75
    Wounded Healer: Therapists’ Own Emotional Scarring 78
Theoretical Orientation(s) 88
    Constructing a Personal Theoretical Framework 88
    Matching the Know-how to the Need 94
    Theoretical Differences 96
    Systemic Ways of Thinking: The Butterfly Effect 98
    Getting a Grip on Theory 100
    Beyond Book Knowledge 102
Personal Qualities 107
    Primacy of the Therapeutic Relationship 108
    The Chameleon-like Therapeutic Stance 109
    Concocting a Palatable Therapist Self 115
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Essence of Therapists</td>
<td>119</td>
</tr>
<tr>
<td>Other Personal Variations</td>
<td>120</td>
</tr>
<tr>
<td>The Imperfect Therapist</td>
<td>121</td>
</tr>
<tr>
<td>Curiouser Curiouser: Welcomed Interloper</td>
<td>123</td>
</tr>
<tr>
<td>Having an Intuitive Feel for People</td>
<td>125</td>
</tr>
<tr>
<td>Not Taking Oneself Too Seriously</td>
<td>126</td>
</tr>
<tr>
<td>Appreciating Diversity</td>
<td>127</td>
</tr>
<tr>
<td>Ministering to the Soul</td>
<td>128</td>
</tr>
<tr>
<td>Steering an Ethical Course</td>
<td>130</td>
</tr>
<tr>
<td>Approach to Therapeutic Process</td>
<td>131</td>
</tr>
<tr>
<td>Word Pictures of the Talking Cure</td>
<td>131</td>
</tr>
<tr>
<td>Complexity of the Therapeutic Process</td>
<td>144</td>
</tr>
<tr>
<td>Immeasurable Change: Evaluation of One’s Therapeutic Work</td>
<td>148</td>
</tr>
<tr>
<td>Shifts in Felt Competency</td>
<td>156</td>
</tr>
<tr>
<td>Bursting Bubbles: Naivety to Groundedness</td>
<td>158</td>
</tr>
<tr>
<td>Thrown in the Deep End to Swimmingly Well: Trepidation to Anticipation</td>
<td>161</td>
</tr>
<tr>
<td>Handing Over the Reins: Empowering the Client</td>
<td>163</td>
</tr>
<tr>
<td>Loosening Up: Rigidity to Flexibility</td>
<td>165</td>
</tr>
<tr>
<td>Influences on Professional Growth</td>
<td>167</td>
</tr>
<tr>
<td>Learning from Direct Experience with Patients</td>
<td>168</td>
</tr>
<tr>
<td>Therapists’ Use of Personal Therapy: “I would be in that chair”</td>
<td>170</td>
</tr>
<tr>
<td>A Bird’s Eye-view: Supervision of Psychotherapists</td>
<td>173</td>
</tr>
<tr>
<td>Mentoring of Psychotherapists</td>
<td>179</td>
</tr>
</tbody>
</table>
Hungry to Grow: Ongoing Professional Development 181

Constructing a Professional Identity 182

Drawing the Line: Negotiating the Personal and Professional 182

The Never-ending Revolving Door: Increased Self-awareness 183

Switching Off…and Going Home: The Therapist’s Own Life 185

The Never-not Changing Psychotherapist 187

Challenges to Practice 188

Psychology as a Business: Constrained by Managed Care 188

A Psychologised Society and the Stigma of Psychology 189

My Personal Journey 190

The Researcher in the Mirror: My Self-reflexivity in the Research 190

Chapter 5: Conclusion 194

Introduction 194

Overall Findings 194

Limitations of the Current Research 197

Recommendations for Future Research Directions 198

References 201
List of Appendices

Appendix A: Interview Guide 233
Appendix B: Information Letter 235
Appendix C: Informed Consent 237
Appendix D: Thematic Analysis: Categories, Main Themes and Subthemes 243
Appendix E: Ingredient List of the Participants’ ‘Recipe’ for a Master Therapist 245
Appendix F: Established Psychologist Participant K’s Metaphor 248
Appendix G: A Narrative Reflection on My Personal Development as a Therapist 250
List of Figures

Figure 1: Leary’s Interpersonal Circumplex Model  
252
Summary

This research aimed to trace the development of psychologists as therapists within a South African context. Two distinct career levels were explored in relation to a competency model, a skills development model, and a developmental phase model of psychotherapists’ professional development. Through purposive sampling five intern psychologists and six registered psychologists with at least seven years post-qualification client contact were selected according to the inclusion criteria of the study. Through semi-structured interviews, couched in the social constructionist position, the participants’ experiences were thematically analysed. In addition, the researcher’s own personal journey of developing as a psychotherapist was reflected upon.

The current research study found that a number of aspects fostered the development of psychotherapists. Across the two career levels the life experiences of participants particularly featured events that were personally wounding or placed the participant in the helper role. The theoretical orientation(s) of participants were voiced as influential in their development, yet the ability to adjust their theoretical orientation to clients’ needs was of overriding importance.

Participants emphasised forming a strong therapeutic relationship with clients as the centrepiece of psychotherapy and depicted the therapeutic process using diverse metaphors. No key differences in use of metaphors emerged between intern and established psychologists.

Catalysts for professional growth included personal therapy, ‘unforgettable cases’, group supervision and, in the case of established psychologists, continuing professional development workshops.
Shifts in competency were recognised by intern psychologists as they gained more experience, namely, dissolution of naivety, a decrease in anxiety regarding their clinical work, a greater flexibility in the therapeutic process, a decreased sense of inappropriate responsibility for clients’ progress, and an ongoing process of negotiating the interface of their personal and professional lives. Established psychologists spoke of having gained more confidence through their years of practice and yet experienced moments of anxiety which they found fostered humility. Limitations of the study and potential future research directions were outlined.

Keywords: training of psychologists, psychotherapist development, social constructionism, thematic analysis
Chapter 1:
Introduction

The Broader Context of the Research

In the profession of psychology there is mounting pressure upon researchers and therapists to demonstrate and implement evidence-based treatments in therapeutic work with clients (American Psychological Association, 2006). Following an extensive review, Wampold (2001) concluded that the treatment chosen is less a determinant of the outcome of psychotherapy than the individual therapist chosen. Orlinsky, Rønnestad, and Willutzki (2004), and Wampold confirmed earlier findings within person-centred research (Rogers, 1957) that the therapeutic relationship in of itself influences the outcome of the therapeutic endeavour. Furthermore, the personal and professional qualities of the therapist were found to impact the outcome of therapy (Baltes & Smith, 1994, cited in Orlinsky & Rønnestad, 2005; Goldstein, 1962; Guy, 1987; Page, 1999).

With this in mind the professional development of psychologists should be a key priority, alongside specific therapeutic procedures, when investigating the effectiveness of therapy (Neufeldt, 1999). Dawes (1994) disagrees, arguing that the field of psychotherapy is “too ill-structured” to lend itself to the study of what differentiates a novice therapist from an expert therapist. Similarly, Epstein (1995) proposes that studies regarding the effectiveness of psychotherapy and its practitioners are flawed.

Mair (1997) argues that psychotherapy as a healing endeavour is a popular delusion that is not questioned in society and therefore continues to succeed in exploiting vulnerable individuals. She states:

throughout history communities have had their designated experts in healing (...) always there has been an expectation that the healer will be able to do
something that will be effective. Psychotherapists depend upon this expectation (…). They exploit the mystique of the expert healer (…) its true foundation is on the myth of knowledge (pp. 87-88).

**International Research of Psychotherapists’ Professional Development**

Internationally, Thomas Skovholt and Michael Rønnestad, since the early 1990s have set out to track the professional development of psychotherapists. In their seminal work, *The evolving professional self: Themes in counselor and therapist development*, Skovholt and Rønnestad (1995) conceptualised eight stages of therapist development over the lifespan, from one hundred interviews with therapists living in the United States of America (USA). Within the eight stages, which may span forty or more years, Skovholt and Rønnestad identified key themes that embodied each stage of development. Subsequently, their eight stage model has been collapsed into a parsimonious six phase model (Goodyear, Wertheimer, Cypers, & Rosemond, 2003; Skovholt & Rønnestad, 2003).

Orlinsky and Rønnestad (2005) point out that previous studies on the professional development of psychologists have predominantly been conducted within the USA or Europe and have largely focused upon psychologists-in-training (e.g. Barton, 2002; Bischoff, 1997; Bischoff & Grater, 1987; Hersch & Poey, 1987; House, 2007; Howard, Inman, & Altman, 2006; Johns, 1996; Karter, 2002; Paris, Linville, & Rosen, 2006; Whitmire, 1991). Other work has focused on collating experienced therapists’ narratives (Burton, 1972; Dryden & Spurling, 1989; Kottler, 1986; Mullan, 1996; Roehlke, 1988; Rosenthal, 2006; White, 1997). Woodcock (2005) explored the professional development narratives of four Canadian school counsellors who had prior training in educational psychology or social work using Skovholt and Rønnestad’s (1995) model.

Sakai and Nasserbakht (1997) proposed establishing an interface between counselling development models and cognitive science models of expertise to adequately inform the
professional development of psychotherapists. Promisingly, in the USA, professional development beyond training has become a focus in terms of identifying the cognitive, relational and emotional characteristics which epitomise master therapists (Skovholt & Jennings, 2004).

**South African Research of Psychotherapists’ Professional Development**

Thus the current research undertaking was deemed relevant in the South African context for firstly there has been to date, limited research on South African psychologists’ professional development (Knight, 2004). For example, Viljoen (2004) examined young South African psychotherapists’ well-being. From a postmodern perspective the personal journeys of therapists-in-training have been explored (Hall, 2004; Lloyd 2009; Nabal, 2009) and from an ecosystemic perspective Dlamini (2005), Jansen (2001), Prentice (2001) and Richards (2003) described their personal journeys of training to be a psychologist within a uniquely African context. Haumann (2005) focused upon the impact of personal therapy on the professional development of eight psychodynamic therapists from a relational/intersubjective model. Brown (2008) described psychotherapy and training within a government psychiatric hospital setting in South Africa. Wozniak (2009) explored the professional identity and training of sangoma-clinical psychologists and how they managed their dual membership in both the Western and African healing systems within the South Africa context. Orlinsky and Rønnestad (2005) have collected quantitative data in South Africa to contribute in future to their ongoing international study of psychotherapist development.

This current study adopted a qualitative approach to provide comprehensive and rich accounts of psychologists’ professional therapeutic development. Here the development of therapists was explored, from their own perspective, by looking at two distinct career levels namely therapists-in-training in contrast to established therapists in face-to-face interviews.
Structure of the Treatise

Chapter 1 has introduced the broader context of the current research, describing the international research of psychotherapists’ development and recent exploratory research within South Africa. In Chapter 2 the theoretical underpinnings of the current research will be delineated. Firstly, the main concepts of the current study will be defined. Secondly, models that conceptualise the professional development of psychotherapists will be explicated. Thirdly, facets of professional development of psychotherapists as identified in previous research will be outlined to serve as starting points for the current study. In Chapter 3 the research methodology will be explicated. Firstly, the research epistemology and research design will be outlined, including the goals of the research. A description of the sample and sampling method will also be provided. Secondly, the content and process of data collection will be traced, followed by a description of the method of thematic analysis used to explore, extract and interpret the research data. Thirdly, in line with the chosen research methodology, the self-reflexivity of the researcher will be documented. Chapter 4 will present key exemplars of the findings and discuss these findings of beginner and experienced psychotherapists’ journeys of development within the South African context. Lastly, Chapter 5 will offer a conclusion of the research findings and identify the limitations of the current research as well as propose potential directions for future research.
Chapter 2:

Theoretical Framework

Introduction

This chapter outlines the focus of the current study, that of the professional development of psychotherapists in South Africa. Firstly, the three main concepts of the current study: ‘development’, ‘expertise’ and ‘therapeutic expertise’ will be defined. Secondly, three models have been drawn upon to conceptualise the professional development of psychotherapists which will be explicated, namely, Howell’s competency model (1982), the skill acquisition development model (Dreyfus & Dreyfus, 1986; Dreyfus 2001), and Skovholt and Rønnestad’s (1995, 2003) developmental model of psychotherapists across the career lifespan. Thirdly, facets of professional development of psychotherapists as identified by Skovholt and Jennings (2004), and Orlinsky and Rønnestad (2005) were employed as starting points for the current study. These include firstly, the career levels of psychotherapists, theoretical orientation(s) of therapists, the therapeutic relationship, and the personal characteristics, ethical values and key skills of therapists. Secondly, development facets were explored namely developmental influences of therapists, and professional sources of influence of therapists. Finally, in terms of facets, psychotherapists’ approach to the therapeutic process was described. The definitions, developmental models, and facets of psychotherapeutic work outlined in the following chapter provided potential coordinates for the direction taken by the current study of professional development of psychotherapists within the South African context.
Key Concepts to Orientate Exploration of Psychotherapists

Developmental Milestones of Psychotherapists

The *Shorter Oxford English Dictionary* (2002) defines development as a ‘gradual unfolding’, a ‘fuller working out’, ‘maturation’, ‘growth’, ‘evolution’ and as involving a ‘stage of advancement’, an ‘elaboration’, or ‘to bring out all that is potentially contained in’ (pp. 661-662). Specifically, in the discipline of psychology, Reber and Reber (2001) define development as an irreversible sequence of changes or a process of maturation over a lifespan of an individual. Importantly, Reber and Reber (2001) add that generally development involves a positive, “progressive change leading to higher levels of differentiation and organisation, with increases in effectiveness of function, maturity, sophistication, richness and complexity” (p. 195). Lerner (1986) points out that development is a theoretical concept that is understood as tracking systematic, adaptive and progressive change over time. Conceptually, milestones are understood as markers of events or stages upon the road of life (*Shorter Oxford English Dictionary*, 2002). In essence, the current study tracked key markers of the gradual unfolding of advancement of therapists along their developmental pathways which can be likened to white water river rafting and arduous mountain-hiking (Skovholt, Grier & Hanson, 2001).

Defining Expertise

Expertise is derived from the Latin *experiri* which is understood as “experienced in” or “having experience of”. As such, expertise is associated with an accumulated set of relevant experiences and knowledge of a particular field which can be meaningfully drawn upon when required, and is regarded as wisdom and intuition (Skovholt & Jennings, 2004). Frensch and Sternberg (1989) define expertise as “the ability, acquired
by practice and experience, to perform qualitatively well in a particular task domain” (p. 158).

Chi, Glaser and Farr (1988), in their sample across the cognitive sciences of physics and mechanical sciences, found seven key facets that were embodied by experts. Experts demonstrated specialist knowledge through years of being in a particular field. Experts were also capable of integrating vast amounts of information into meaningful patterns and wholes. Due to their ability at integrative understanding and synthesis experts were faster when applying their skills, displayed an automaticity in relation to knowledge and were regarded as possessing superior memory by means of chunking information (Anderson, 1993). Experts were also found to examine and represent problems at a deeper level that captures the principles of issues. Furthermore, experts avoided premature closure, preferring to examine problems from multiple angles before arriving at a solution. As such, experts embraced complexity and depth yet identified the core elements of issues and thereby demonstrated thoroughness when implementing solutions. Finally, experts were found to be aware of their own limitations and could accurately judge the possibilities and difficulties they were facing when problem-solving.

Selinger and Crease (2002) and Overholser (2009) propose that being regarded as an expert relies upon being recognised as such by an audience and not merely the acquisition of a certain skill level, for expertise is inherently linked to power and authority dynamics.
Delineating Therapeutic Expertise

Procidano, Busch-Rosnagel, Reznikoff, and Geisinger (1995) conceptualise professional competence in psychotherapy as “a complex multidimensional construct that includes both applied skill and psychological fitness” (p. 426).

Previous research (e.g., Jennings, Hanson, Skovholt & Grier, 2005; Skovholt & Rønnestad, 1995, 2003) suggests that therapists undergoing masters-level training are in the process of being equipped to demonstrate conscious competence. On the other hand, established therapists having internalised their training and personalised their therapeutic model, appear to display unconscious competence in their therapeutic work.

Orlinsky et al. (1999) have specifically defined therapeutic expertise as being evident when a therapist understands what happens moment-by-moment in a consultation and demonstrates precision, subtlety and finesse in his/her work with clients. Additionally, an expert therapist is also said to possess the ability to develop other therapists (Orlinsky et al. 1999). Hillerbrand (1989) highlights the cognitive domain of therapeutic expertise, where an expert therapist is able to recognise interpersonal relations, identify and understand incoming information, and integrate relevant information into a conceptualisation of the client that will bring about useful solutions.

Shaw and Dobson (1988) have identified four key skill areas that define therapeutic competence in relation to the client’s readiness for change namely: the utilisation of a theoretical framework to inform interventions, a good clinical memory, skillful application of therapeutic interventions, and incisive judgment of “dose” and “timing” of implementing the appropriate intervention (Prochaska, DiClemente & Norcross, 1992). Meichenbaum (2004) delineated the core tasks exemplified by expert
therapists as developing a therapeutic alliance, educating the client regarding their problems and possible solutions, reconceptualising problems to nurture hope, illuminating the client’s coping skills, encouraging the client to conduct personal experiments of new ways of being in the world, nurturing the client’s sense of agency by highlighting themselves accomplishing their own changes, and conducting relapse prevention. Fook, Ryan and Hawkins (1997) hold that therapeutic expertise requires one to be able to tolerate ambiguity, and be flexible and influential in chaotic situations. Similarly, Skovholt and Rønnestad (1995) highlight the importance of therapists possessing an awareness of complexity and being committed to being highly congruent in terms of their personal and professional selves. Overall, therapeutic expertise is characterised by an embracing of complexity, a greater attentiveness to the relational dynamics and emotional reactions in the therapeutic space, a broader knowledge of the therapeutic process as opposed to being constrained by specifics, and possessing a sense of confidence and clarity in understanding the problems of clients (Overholser, 2009; Sakai & Nasserbakht, 1997; Skovholt & Jennings, 2004). Bourg (1986) adds that psychological fitness in terms of ethics, professional values, and psychological health of the therapist need to be addressed together with therapeutic competence.

Veach, Bartels and LeRoy (2002) emphasise that there are terminal qualifications in the profession of psychotherapy but no terminal skill level and therefore psychotherapists need to formulate and sustain an active, tailor-made professional development plan for their career life (Skovholt, Grier, & Hanson, 2001). Selinger and Crease (2002) point out that “expertise is always a process of becoming” (p. 270). Expertise, across fields that involve mastering complex tasks, requires at least ten
thousand hours of practice (Ericsson, Krampe & Tesch-Römer, 1993). With this in mind, Hayes (1985), and Skovholt, Rønnestad and Jennings (1997) report that the gap between novice and expert in general professional development literature, can be pitched at ten years. Specifically, Najavits (1993) defines a year of therapeutic expertise as twenty hours of direct client contact per week, which would amount to one thousand hours a year excluding a fortnight of leave. Therefore the current study focused on two phases of Skovholt and Rønnestad’s six-phase model (2003) of professional therapist development - namely the advanced student phase and the experienced professional phase. These two career cohorts have been chosen for simplified sampling and easier delineation of key differences in relation to comparisons with the Competency Model (Howell, 1982).

Models to Navigate Development of Psychotherapists

The Developmental Model of Psychotherapists

Skovholt and Rønnestad’s (2003) professional therapist development model has delineated the following six phases for psychotherapists across the careerspan namely: the lay helper, beginning student, advanced student, novice professional, experienced professional, and senior professional.

The lay helper phase is regarded as the pre-training period where an unqualified person offers help to others by utilising their natural relational skills. Generally, the lay helper quickly pinpoints problems and provides support and advice to the individual in distress based upon his/her own experience. Difficulties encountered may include over-involvement and a lack of investigation and reflection on the part of the helper. The beginning student phase starts when one enters the exciting yet challenging training context to become a therapist. Generally, the beginning student is vulnerable and
dependent on support of elders in the profession as the student wrestles with self-doubt as to whether he/she is suited to the profession. In consultation with clients the beginning student may feel anxious and heavily reliant upon imitating models and techniques in their therapeutic work. Imperatively, the beginning student needs to retain an attitude of openness to learning in order to acclimatise to the complexities of therapy to enhance their professional growth. The **advanced student phase** is characterised by the student at an internship placement under formal supervision, where he/she is expected to perform at a basic professional level. Advanced students tend to have internalised high standards for their work performance which is seen in their careful and thorough approach to therapeutic work. Furthermore, advanced students typically have an increased internal focus on evaluating their therapeutic work and yet continue to prioritise supervision which at times may need to hold the independent-dependency tensions experienced by the advanced student.

After qualifying as a professional, three phases of development were identified by Skovholt and Rønnestad (2003). The **novice professional phase** has been delineated as the first five years after having qualified as a psychotherapist. Novice professionals are depicted as being in a “process of shedding and adding” (Skovholt & Rønnestad, 2003, p. 17) to their conceptual and behavioural repertoire as therapists. Novice professionals, free of formalised evaluation processes, experience a sense of freedom and initially set out to confirm their training as therapists. However, when the novice professional is confronted with unexpected professional challenges a period of inadequacy and disillusionment may follow which engenders deeper self-exploration and matching of oneself to a suitable professional environment. Novice professionals also move towards
expressing their personality in their work, integrating the personal and the professional aspects of self more comfortably as well as appreciating the importance of the therapeutic relationship in managing the complexity of the therapeutic process. The *experienced professional phase* has been estimated to stretch between at least five years and twenty/twenty five years of practice. Experienced professionals generally have had a range of clients in different work settings. Furthermore, the experienced professionals verbalise enjoying a congruent therapeutic role and a theoretical system that comfortably fits with their personhood. The therapeutic relationship is regarded as the centerpiece of the therapeutic process and is actively drawn upon to bring about therapeutic change whereas techniques, when utilised, are more flexibly applied. Experienced professionals have developed “boundaried generosity” (Skovholt & Rønnestad, 2003, p. 22) where they demonstrate a fine-tuned level of involvement, and enjoy an effective support-challenge style with their clients. Though experienced professionals speak of trusting their clinical judgment, this is balanced with a sense of ‘not-knowing’ and therefore remaining open to new learning. In this phase psychotherapists speak of sharing their learning by mentoring and supervising the younger generation in the field. Interestingly, experienced professionals turn to related fields, such as literature, theatre or religion for inspiration in their therapeutic work and make use of their internalised mentors, from earlier years, to self-reflect. Importantly, to be effective in their work, experienced professionals access their accumulated experience to inform new work and as such tailor their interventions using prior knowledge actively with contextual information. The *senior professional phase* is delineated as the psychotherapist being in practice for at least two decades.

Senior professionals, in light of losses, experience a keen sense of the limitations of what
can be achieved in a therapeutic process and in turn come across as more modest. Additionally, a greater sense of self-acceptance is experienced by senior therapists.

Of particular relevance for the current study, Skovholt and Rønnestad (2003) outline the advanced student phase as incorporating intern psychologists who are in the process of completing their formal training to qualify as psychologists and have less than eighteen months of client contact; whereas experienced professionals can be categorised as having over seven years of client contact from their first client consultation in training.

Furthermore, Skovholt and Rønnestad (1995, 2003) characterise therapists-in-training as experiencing a sense of bewilderment and anxiety (Rubin, 1989; Yogev, 1982) and ‘stage-fright’ (Nutt Williams, Polster, Grizzard, Rockenbaugh & Judge, 2003) followed by calmness and temporary security as therapists-in-training find themselves adapting to the uncertain role of therapist. Therefore, at this time their attention is focused upon assimilating information from a variety of sources and rigidly mastering the basics in practice. Effectiveness is gauged from client feedback and the reactions of one’s supervisor (Bindler, 1993).

Therapist anxiety is linked to the presenting therapeutic challenges exceeding the therapist’s skills at hand (Orlinsky & Rønnestad, 2005). Blow, Sprenkle and Davis (2007) and Fouad (2003) point out that intellectual ability and the linear, rational, academic, and writing skills that enabled novices to access their career choice of psychotherapy are not the only skills that make for effective therapy. This disparity can perpetuate beginner anxiety and novices experiencing a sense of incongruence between their perceived self possessing good lay helping skills and the effectiveness required of a professional therapist.
Novice therapists have been found to experience notable distracting self-awareness, especially negative self-talk during sessions and as a consequence were perceived by clients as less helpful, despite the novice therapists being fully focused upon the unfolding session (Nutt Williams, et al., 2003). Novice therapists also reported distracting feelings of being lost or anxiety. In stark contrast therapists inhabiting the experienced professional phase were reported to enjoy satisfaction and a sense of hope as they flexibly worked within an evolving personal therapeutic framework. Experienced therapists were also found to pay attention to the big picture in terms of processing information into complex yet meaningful patterns (Jennings, Hanson, Skovholt & Grier, 2005; Sakai & Nasserbakht, 1997). Additionally, experienced therapists reported mainly distracted self-awareness in terms of outside distractions of a personal nature during consultation and of having distracting feelings of attraction or boredom in relation to clients. Both novice and experienced therapists reported in-session feelings of anger, frustration and irritation toward clients (Nutt Williams et al. 2003).

**The Levels of Competency Model**

Alongside Skovholt and Rønnestad’s (2003) developmental model of therapists’ career lifespan, the current research incorporated the levels of competency model as outlined by Howell (1982). The first level is *Unconscious Incompetence* where the practitioner is not even aware that they do not have the necessary set of skills and do not recognise their mistakes. Following this is *Conscious Incompetence*, where one is aware of one’s mistakes and is eager to acquire the necessary skills but lacks the ability to practice skillfully. A trial and error approach is adopted which amounts to mechanical-analytical problem-solving wherein parts are isolated to make sense of data. *Conscious*
Competence is when the practitioner can carry out tasks effectively, however it requires a concerted awareness to accomplish the tasks (Robinson, 1974). A thoughtful-analytic approach is applied to evaluate evidence and select a feasible solution with the necessary rationale. Unconscious Competence is when the practitioner has mastered the skills to such an extent that the tasks at hand are done with such finesse that the process appears effortless. Information is interpreted as a gestalt or pattern without conscious deliberation and responses to complex situations become spontaneous. Finally, Unconscious Supercompetence refers to the rare peak experience of performance as a result of flow. These practitioners have given themselves and all their resources over to their performance in order to achieve a harmonious integration that produces a sense of euphoria (Csikszentmihalyi, 1990). Orlinsky and Rønnestad (2005) add that optimum involvement can be achieved when therapeutic challenges closely match therapists’ skills and provide opportunities for skills to be exercised fully, and even stretched to new levels in consultations with clients. The subjective experience of the therapist is one of flow: “intense absorption, finely calibrated responsiveness, and keenly felt satisfaction, generally accompanied by a withdrawal of awareness from extraneous situational cues and diminution of reflective self-consciousness” (Orlinsky & Rønnestad, 2005, p. 45).

**The Skill Development Model**

The skill development model of Dreyfus and Dreyfus (1986) ties in with the levels of the competency model (Howell, 1982), as suggested by McPherson (2005). Dreyfus and Dreyfus (1986) trace increases in expertise based upon education levels and experience. Five levels of professional development were formulated. Namely, at the Novice level the practitioner relies heavily on rules to guide practice. The Advanced
Beginner has some experience and employs overall abstract, global characteristics in their decision-making process. At the Competent level the practitioner knows what to look for and can anticipate possible outcomes. The Proficient level is characterised by practitioners that are able to quickly distil information and focus one’s attention upon the critical aspects of a situation. Lastly, the Expert is defined as operating from an intuitive level wherein one draws upon their deeply embedded experience and accumulated wisdom to spontaneously make sophisticated formulations and create new practices across various contexts (Jennings, et al., 2005). As such “the learner progresses from detached, abstract and consciously analytic behaviour in a situation, to involved, skilled behaviour which is based on unconscious and intuitive recognition of similarities with past experiences” (Fook, et al., 1997, p. 401). To progress through the five levels, McPherson (2005) notes that individuals need to possess the capacity to move through “the fire or ordeal of excessive complexity” (p. 711). Depictions of the five-level skills acquisition model include learning to drive or playing chess (McPherson, 2005).

Subsequently, Dreyfus (2001) has added two levels to the skill development model namely, Mastery and Practical Wisdom. McPherson (2005) and Selinger and Crease (2002) explicate that the Mastery level involves a commitment to ongoing learning and is characterised by the professional, after being exposed to the developed style of a mentor/coach, going on to create their own personal vision. The Practical Wisdom level draws upon Aristotle’s notion of phronesis which has been understood as an intellectual virtue aimed at organising practical and ethical values. Phronesis, as such involves the blending of insight and perceptiveness with the commitment and responsiveness of the individual to coherently articulate his/her expertise to others.
Dall’Alba and Sandberg (2006) in reviewing Dreyfus and Dreyfus’ model (1986) argue that a vertical dimension needs to be added which encourages ongoing critical reflection on practice (*embodied understanding of practice*) that is taking place in step with the horizontal dimension of increased skill with experience. Similarly, Locke and Covell (1997) agree that Schön’s (1983) ongoing reflection-in-action model is vital to effectively respond to the ambiguous situations that psychotherapists encounter.

McPherson (2005) proposes that the new levels of Mastery and Practical Wisdom involve heightened self-awareness, an enhanced sense of personal integrity and reflexive understanding as well as an authentic commitment to absorbing interpersonal cultural styles in which one is situated. A helpful depiction of the seven-level model is of the process involved in making a musical instrument which requires the ability to be sensitively attuned to feedback (McPherson, 2005). Furthermore, Practical Wisdom (*phronesis*) implies that such expertise embodies the practitioner’s shared standards of intrinsic excellence or recognised moral virtues. As such the practitioner demonstrates practical and morally skilled perceptiveness and a reflexive grasp of the relevant features of the situation, including the people involved while demonstrating personal coherence, integrity, unlimited care and constant commitment as well as acknowledging our human interdependence (McPherson, 2005) or the principle of *ubuntu*.

Interestingly, Sheets-Johnstone (2000) points out that progressive skills acquisition relies upon foundational embedded skills not directly related to the skill being acquired. For example learning the art of ballet relies on the foundational skills of body movement acquired in infancy; and often one’s unique life experiences will enhance one’s skill acquisition in a specific domain.
Facets of Psychotherapists and Therapeutic Work

To examine the professional developmental process of becoming a therapist, Orlinsky and Rønnestad (2005) conceptualised the professional identity of psychotherapists being constituted by their professional training in mental health, chosen theoretical orientation, and current career level.

Career Levels

Six career cohorts were used by Orlinsky and Rønnestad (2005), according to the training system in the United States of America, namely: novices who have had less than one and a half years of client contact; apprentices who have had one and a half years to three and a half years of experience. Graduates have had three and a half years to seven years of client contact while established therapists have practiced for seven to 15 years. Goldberg (1992) regards those who have been in practice for 15 to 25 years in practice as seasoned therapists. After 25 years of client contact one is regarded as a senior therapist in the field. The current exploratory study will focus upon therapists who would be categorised according to Orlinsky and Rønnestad (2005) as novices and those who have become established therapists or even a subsequent career level.

In light of the developmental phase model of Skovholt and Rønnestad (2003) and the career cohorts utilised by Orlinsky and Rønnestad (2005), the two distinct levels identified for the current study of psychologists as psychotherapists were the intern psychologist with less than eighteen months of client contact and the established psychologist with at least seven years of client contact after completion of training.
**Theoretical Orientation(s) of Therapists**

To begin looking at therapeutic work within the frame of professional development, the psychotherapist’s theoretical orientation or modality has been explicated from five or more options including psychoanalytic-psychodynamic, cognitive-behavioural, person centred/humanistic/gestalt, systemic or narrative orientations (cf. Lucock, Hall & Noble, 2006; Orlinsky & Rønnestad, 2005). Buckman and Barker (2009) point out that psychotherapists define their therapeutic work in terms of their theoretical orientation, as it is “the conceptual map used to understand their clients’ problems and to guide interventions” (p. 1). Norcross and Beutler (2000, p. 247) reflect that the array of theoretical orientations leads to psychotherapists being confronted with a “proverbial tower of Babel” with the risk of no clear direction.

Goodyear, Murdock, Lichtenberg, McPherson, Koetting and Petren (2008) found that in 2000 American counselling psychologists identified eclecticism (34, 3%), cognitive therapy (18.6%) and client-centered therapy (2.7%) as their primary theoretical orientation. As a second orientation, cognitive therapy was the most endorsed orientation (16.0%).

Simon (2006) argues that the therapist’s worldview needs to fit with the theoretical orientation adopted by the therapist to undergird the process of change in the therapeutic context, for the therapist’s self plays a vital role in therapeutic outcome. As such the therapist’s worldview “becomes a personalised vehicle for self-expression” (p. 299). In contrast, Johnson and Talitman (1997) argue that a good fit needs to occur between the theoretical orientation or therapeutic model and the client’s worldview. Blow et al. (2007) emphasise that a therapist’s enthusiasm and commitment to a
particular theoretical orientation will translate into an assured, authentic, and accurate implementation of the chosen model’s treatment approach.

In a survey of 103 Australian psychologists, Poznanski and McLennan (2003) found that the theoretical orientation of therapists is intimately related to the person of the therapist and not merely exposure to certain theoretical orientations during one’s training years. Furthermore, Poznanski and McLennan (2003) found that psychotherapists could be delineated in terms of subscribing to either a cognitive-behavioural orientation or a non-cognitive-behavioural orientation.

Arthur (2000) investigated how personality and cognitive-epistemiological traits of British clinical psychologists influenced their choice of theoretical orientation between a psychoanalytic or cognitive-behavioural model. Psychoanalytic therapists were found to be particularly sensitive to threat and to possess a desire to avoid pain, as well as being more aware of feelings of anxiety or depression. Psychoanalytic therapists were more intuitive, innovative, imaginative, and relied upon feeling to process knowledge. Furthermore, psychoanalytic therapists employed more holistic thinking and used symbolic and metaphorical thought processes. Novice psychoanalytic therapists (less than ten years of experience) were found to be less conventional, orderly, responsible and conscientiousness, yet prone to servility. However, these traits abated, as they became established psychoanalytic therapists. Similarly, Buckman and Barker (2009) found therapists of a psychodynamic or experiential orientation preferred the unstructured and symbolic aspects of therapy, appeared less forceful, and were more intellectually curious and attentive to inner feelings.
In contrast, cognitive-behaviourists were characterised by the desire to enhance life and therefore possessed more indications of emotional stability. Cognitive-behaviourists were found to be more self-actualised or independent and reportedly had less need for giving or receiving affection in relationships than psychoanalytic therapists. To make sense of information cognitive-behaviourists relied upon sensing and quantitative information and in turn were found to be conventional, conforming, objective, pragmatic, and realistic. Thinking was employed by cognitive-behaviourists as opposed to feeling in order to understand their patients. Cognitive-behaviourists, especially novices, attempted to fit new information into their pre-existing thinking system in a reductionistic manner. Novice cognitive-behaviourists were particularly conventional, orderly, and conscientious. Cognitive-behaviourists self-reported that they were more likely to stray from their theoretical orientation than reported by psychoanalytic therapists (Arthur, 2000). Similarly, Buckman and Barker (2009) found cognitive-behaviourist therapists were more conventional in their behaviour and outlook as well as being more purposeful and organised in implementing tasks.

Singaporean master therapists proposed that expertise is enhanced by exposing oneself to different schools of thought and integrating one’s accumulated knowledge in order to go beyond one’s current level of expertise (Jennings et al., 2008). Similarly, Aveline (2005, p.156) promotes emerging as a “mongrel rather than a thoroughbred” therapist as there is “no royal road to psychotherapy” in terms of overall preeminence or effectiveness of a distinctive theoretical orientation (Luborsky, Rosenthal, Diguer, Andrusyna, Berman, Levitt, Seligman, & Krause, 2002).
Yet Green (2004) argues that effective therapy is not a question of theoretical orientation. Rather, he states: “The main elements of successful therapy include a positive therapeutic alliance, a clear focus, a coherent problem formulation, and improvised techniques whose relevance to the previously established focus and formulation is readily apparent” (p. 1).

Green (2004) values the relational aspects of therapeutic work as the key in professional development. He recommends that training should focus upon the therapist using their emotions to form the therapeutic alliance and prevent possible ruptures in the alliance. Similarly, Hubble, Duncan and Miller (1999), and Norcross (2002) argue that the enterprise of therapy goes beyond specific theoretical orientations.

**Primacy of the Therapeutic Relationship**

Jennings et al. (2008) distinguish between viewing the therapeutic relationship as a necessary condition for the therapeutic process as opposed to the relationship being the therapy and the source of healing for clients. Hubble et al. (1999) estimated that 30% percent of therapeutic change can be attributed to the relationship/alliance established between the client and therapist, whereas 15% percent of therapeutic change relies upon the therapeutic model or techniques implemented. Thomas (2006) found that therapists attributed 35% of therapeutic change to the client-therapist relationship and 16% of therapeutic change to the therapy model or techniques chosen. Clients were found to attribute 29% of therapeutic change to the client-therapist relationship established and 28% to the model or techniques employed. Importantly, the therapeutic relationship established was deemed the highest contributor to change in individual and family therapy. More conservatively Beutler, Malik, Alimohamed, Harwood, Talebi and Noble
et al. (2004) attribute the therapeutic relationship as contributing 10% to 20% to outcome. Najavits and Strupp (1994) found that the therapeutic relationship regardless of technique is the vehicle for effecting change, yet therapists were found to hold onto their preferred techniques and interventions regardless of whether it would be beneficial or not for clients.

With the primacy of the therapeutic relationship in mind, Aveline (2005) and Maroda (2010) reveal that expertise, alongside ethics, is demonstrated when practitioners can assess whether they are a “good match” for a client and proceed or refer accordingly.

In terms of a meta-theory regarding therapeutic expertise the following factors have been identified as key to the development of therapeutic expertise namely experience, the therapist’s personal qualities, openness to change, cultural competence, and comfort with ambiguity (Jennings, Goh, Skovholt, Hanson & Banerjee-Stevens, 2003).

**Personal Characteristics of Therapists**

“The person of the therapist is a crucial factor in the success of therapy” (Wampold, 2001, p. 21). Luborsky, McLellan, Woody, O’Brien and Auerbach (1985) found that the major agent of effective therapy is actually the personality of the therapist, for from this stems the formation of an effective, warm, and supportive therapeutic alliance with clients. Blow et al. (2007) point out that psychotherapy cannot be solely understood through a medical lens of assessing the efficacy of treatment by comparing the effectiveness of psychotherapy models, for different psychotherapy models are, unlike pills, heavily reliant on the characteristics of the professional administering the treatment. Aveline (2005) and Orlinsky and Howard (1986) along similar lines attribute
successful therapy to the therapeutic bond formed between therapist and client above any interventions.

Jennings and Skovholt (2004) have identified a three-pronged formulation of an expert therapist. Firstly, on a cognitive level, master therapists embrace complex ambiguity, possess insatiable curiosity and a love of learning, demonstrate profound understanding of the human condition, and are guided by this accumulated wisdom. Secondly, in terms of the emotional dimension of personality, master therapists display deep self-acceptance, humility, high self-awareness, quiet strength, an intense will to grow, vibrancy, and a passion for life. Thirdly, in the relational dimension, master therapists intensively engage with others, possess acute interpersonal perception, work from a nuanced ethical compass of virtue ethics, demonstrate generosity within limits towards clients, employ varied relationship stances, and are open to feedback. Jennings and Skovholt (2004) found that this portrait of an American master therapist bears striking similarities to self-actualised individuals (Maslow, 1956; Rogers, 1961) and inspiring leaders (Barber, 1977).

Following the heritage of Carl Rogers, Jennings et al. (2008) found that Singaporean master psychotherapists emphasised the personal characteristics of being empathic, non-judgmental, and deeply respectful towards clients as foundational in building safe and effective therapeutic encounters. Lum (2002) argues that increased congruence on the part of the therapist is fundamentally linked to therapeutic competence. In this vein Jennings and Skovholt (2004) caution that mastery in therapeutic work does not amount to becoming a “technique wizard”. As “expertise is
not about narrow skill development. It is becoming, over a long time, fully human” (p. 140).

Dewane (2006) speaks of the therapist’s use of self as involving the therapist’s personality, belief system, relational dynamics, anxiety, and self-disclosure. Furthermore Dewane (2006) sees the effective therapist as a blend of their professional and personal selves in the consulting room. Similarly, Edwards and Bess (1998) argue that thoughtful integration of one’s professional knowledge and skill with one’s personal self will determine the effectiveness of using one’s self to assist clients. Baldwin (2000) and Lum (2002) argue that the use of self has shown itself to be the most important factor in developing the therapeutic relationship.

In recognition of the interaction between personal growth and skill development and the importance of the therapeutic alliance, Aponte and Carlsen (2009) have developed a supervision instrument that focuses upon developing psychotherapists in mastering the use of self in their work with clients. The Person-of-the-Therapist Model (POTT) involves trainees recognising their signature themes and working with themselves in direct relation to their clinical work in order to transform their personal vulnerabilities into clinical assets (Aponte & Carlsen, 2009; Aponte, Powell, Brooks, Watson, Litzke, Lawless & Johnson, 2009). In a similar vein Briggs, Fournier, and Hendrix (1999) advocate incorporating the person of therapist factors (e.g. physical and emotional health, maturity, intelligence, and social skills) into the family therapist skills checklist used by supervisors in assessing trainees’ competency. Lum (2000) promotes the use of Satir’s systemic brief therapy training programme which includes trainees working through their personal concerns using the Personal Iceberg Metaphor to develop
their use of self in their clinical work. Aveline (2005) points out that “the person of the therapist is not all important but, without the therapist, there would be no therapy” (p. 162). With this in mind the current study focused on both the personal and professional dimensions of the developmental pathways of becoming a psychotherapist.

**Key Qualities and Ethical Values of Therapists**

In acknowledgment of the impossibility of a value-free psychotherapist, Carlson and Erickson (1999), in light of social constructionism, have endorsed exploration of value stances by trainees to foster accountability in their clinical work with clients. Jennings, Sovereign, Bottorff, Mussell and Vye (2005) investigated the ethical values of American master therapists and found that congruent relational connection in all spheres of their life, autonomy of the client, beneficence, non-maleficence, clinical competence, humility, commitment to professional growth, openness to complexity or ambiguity, and self-awareness were held in order to practice ethically. Jennings et al. (2008) found humility to be particularly elevated in Singaporean master therapists, which is likely reflective of Asian cultural values of modesty and collectivism together with humility acting as impetus for further openness to progressively advance in clinical acumen.

Kernes and Kinnier (2008) found that 20% of American psychologists voiced unsolicited disdain regarding spiritual issues being explored within the therapeutic context despite clients’ expressed need to discuss spiritual/religious concerns. Uniquely, Satir addressed the spiritual concerns of American clients (Lum, 2002). Contemporary Singaporean master therapists were found to adopt a broad spiritual mindset in their therapeutic work and actively addressed the varied spiritual needs of clients within the therapeutic context (Jennings et al., 2008).
Furthermore, Singaporean master therapists (Jennings et al., 2008) and South African case studies (Clarke, 2002; Jansen, 2001; Richards 2003; Wozniak, 2009) have highlighted the importance of being cognisant of working in a multicultural context and the need to adjust one’s orientation and models to effectively work in such a melting pot of diversity. In terms of having cultural competence, Blow et al. (2007) emphasise that: “when working with diverse populations, therapists need to be prepared through education about a specific group and sensitivity to unique issues within a group, and have an awareness of and control over their own biases and issues” (p. 306).

**Key Skills of Therapists**

The professional development of therapists is inextricably linked to the enhancement of their therapeutic skills (Jennings et al., 2008; Orlinsky & Rønnestad, 2005). Jennings and Skovholt (2004) have conceptualised therapeutic skill along the three main dimensions of cognitive, relational and emotional skills. In a composite manner, good therapists can be described as authentic, energised, insightful, well-meaning and dedicated helping professionals (Jennings & Skovholt, 2004). Orlinsky, Brendel, Kolbert and Foster (2002) set out that higher stages of cognitive development enhance therapeutic ability in terms of empathic communication, autonomy, flexible methods, cultural competence, ethical decision-making and greater self-knowledge and awareness. O’Byrne and Goodyear (1997) found that compared to novice psychologists, experts gather more information from clients to enable them to discern the underlying structures of the presenting problem. Expert psychologists were also found to focus less on the crisis-orientated and surface aspects of the presenting problem than on the client’s characteristic level of functioning to inform the management of a current crisis. As such,
experts were found to make better distinctions between relevant and irrelevant aspects of clients’ problems. Spengler and Strohmer (1994) found that therapists’ capacity for cognitive complexity influences their clinical judgment. Martin (1990) critiques skills acquisition as not sufficient to equip psychotherapists with an adequate knowledge base that is contextually nuanced to effectively apply their therapeutic approach.

Skovholt et al. (2001) regard psychotherapy as a ‘high-touch profession’ wherein the psychotherapist engages in “the caring cycle” of empathic attachment, active involvement, and felt separation with clients which by implication involves many occupational hazards for the psychotherapist including Wheelis’ (1956) “compassion fatigue”.

Developmental Influences

_The childhood home from which each of us journeys is as much a matter of one’s destiny as it is of one’s heritage – R.D. Romanyszyn (1982)_

Compellingly, White (1997) asks, “But what about the life of the therapist?” (p. 17) and Fouad (2003) also raises the question of, “Who am I and how do my life experiences influence my effectiveness as a therapist?” (p. 84). Discourses of psychotherapy and discourses within the therapeutic context shape the life of the therapist and “these discourses have real effects not just in structuring the therapist’s participation in the therapeutic context and in the production of therapeutic ‘truth’, but also in how the therapist relates to their own life – in the shaping of the therapist’s relations with the world, in the constructions of the therapist’s accounts of personal development” (White, 1997, p. 124). Importantly, Fouad (2003) argues that in training more attention needs to be paid to how novice therapists wish to negotiate their clinical work in relation to their
personal lives and to be provided with guidance as to how to set boundaries between one’s “practitionerself” (Skovholt & Rønnestad, 2003), and one’s personal self. In terms of a proposed personal-professional nexus of professional development, Gubrium and Holstein (2003b) point out how the self, in light of postmodernism, has become to be regarded as fluid and polysemic yet in need of interpretation in order to remain comprehensible. Karter (2002) reported that often therapists regard the profession not merely as employment or work but as a vocation or calling. In an attempt to delineate professional development from the personal development of therapists, Johns (1997) defined professional development as “the extension of skills and knowledge through training, reading, reflection and research” (p. 24). Whereas the personal development of the therapist involves the process of attending to one’s own needs to enhance one’s ability to be with one’s clients. Savickas (2002) points out that in embarking upon a career one seeks to implement a concept of oneself, and with career advancement an increasing stabilisation and congruence between the internal self promptings to be a helper and the external world of the helping profession occurs.

Henry, Sims and Spray (1971, 1973) found that commonalities in childhood experiences foster a yearning to be a therapist and to pursue the “curious calling” (Sussman, 1992) of being a healer in the “the fifth profession” of psychotherapy. Mullenbach and Skovholt (2000) traced how childhood experiences influenced the professional development of therapists whereas Bogart (1999) focused more broadly on how therapists’ personal histories led them to certain conclusions about people and the process of change within therapy.
Orlinsky and Rønnestad (2005) found that 48% of therapists acknowledge that they chose the profession in psychotherapy in part to explore and resolve their own experiences of distress.

According to Farber, Manevich, Metzger and Saypol (2005) childhood experiences of therapists included being socially or culturally marginalised which kindled a focus on one’s internal processes and the need to heal self and others; having a loving but somewhat overprotective mother; and a witnessing and experiencing of more painful experiences, especially loss and trauma, with an acute awareness of the resulting distress.

Those who became therapists also demonstrated a high level of psychological mindedness which involves the astute ability to reflect on the meaning and motivations of oneself and others’ behaviour, thoughts and feelings and involves curiosity, introspection, sensitivity, together with observation and interpretative skills, and an ability to read between the lines (Farber, 1985). Kernes and Kinnier (2008) found that psychology as a profession also provides psychotherapists with a credible platform to further agendas for social justice and human rights (e.g. Brown, 2005; Jordan, 2009; Myers Avis, 2006).

Other motivations for becoming a therapist, identified by Farber (1985), included earlier intellectual curiosity, particularly in the humanities, often in conjunction with an enjoyment of reading and enthusiasm for learning being cultivated. Furthermore, an interest in understanding people had been stimulated in would-be psychotherapists by a significant adult role model. Having benefited from a lay healing relationship or a course of personal therapy can also instigate a desire to offer others the “talking cure” that benefited them. The healing profession also offers attractive benefits of having a meaningful impact in the lives of others, personal autonomy, intimate yet safely defined
involvement with others, intellectual stimulation, and freedom to be who one is (Farber et al., 2005)

More potentially negative motivations include pursuing the influential role of healer to compensate for feelings of impotency and inferiority (Jones, 1913; Page, 1999). Additionally, therapists may strive to vicariously have their emotional, intimacy, growth, self-healing, and affirmation needs (e.g. Ellis, 2005) met through their clients due to a lack of “good-enough mothering” (Winnicott, 1953) in their own childhood wherein they were often cast in the role of being a parentified child, mediator or confidante of others (Miller, 1981). Furthermore, becoming a therapist can be a form of sublimating aggressive and sexual urges for example allowing voyeuristic tendencies to be met through the socially sanctioned endeavour of the therapeutic disclosure/confessional space (Farber et al., 2005; Kahr, 2005).

Critical Incidents in Professional Development

*What do we live for, if it is not to make life less difficult for the other?*- George Eliot (1956)

Critical incidents are understood as significant positive or negative historical or current life experiences that have influenced one’s development as a therapist. Such events act as developmental turning points for the therapist (Lee, Eppler, Kendal & Latty, 2001; Skovholt & McCarthy, 1988). For example Mullenbach and Skovholt (2000) posed the following question to therapists: “Discuss a critical incident that occurred in your professional career and talk about how it impacted you”. Therapists constructed a critical incident by reflecting upon events in relation to their thoughts, convictions, perceived contradictions or ambiguity, feelings, values, comfort levels, limitations, and theories related to chosen events which influenced their professional identity. Howard, et
al. (2006) highlight that critical incidents impact the therapist’s view, and effectiveness of the therapeutic process, professional identity of oneself as a therapist and one’s view of the profession.

Skovholt and McCarthy (1988) found that therapists identified the following critical incidents: learning about limits, accepting imperfections, being betrayed, loved or nurtured, an experience becoming a therapeutic niche, surpassing the insecurity or helplessness of inexperience, chance encounters, and working through unfinished business. Skovholt and McCarthy (1988) emphasised that a willingness to learn from the event influenced whether an event became a critical incident for therapists. Roehlke (1988) adds, in a Jungian sense, that critical incidents can be regarded as synchronistic events which run alongside the therapist’s personal process of individuation. Such timely events become essential for the professional development of the therapist. Similarly, Jennings et al. (2008, p. 517) note that Singaporean expert therapists regarded “life as a laboratory” for professional growth and were deeply immersed in “learning from living”. The experts were actively seeking diverse experiences that stretched them as individuals and opened up new vistas of experiences which through dedicated processing would enhance their self-awareness.

Cormier (1988) argues that generally beginner therapists’ critical incidents are mediated through the training environment of the fledging professional, whereas post-training critical incidents are predominantly external circumstances and one’s internal responses. Lee et al. (2001) and Howard et al. (2006) found that beginner therapists reported feelings of powerlessness and inadequacy as well as doubts regarding their competence and career choice when confronted with clients and complex treatment
issues. Yet beginner therapists also reported incidents wherein they experienced a sense of competence and feelings of excitement following a successful therapy session. Lee et al. (2001) found that beginner therapists’ concerns were not only related to confidence regarding their clinical experience but also incorporated multiple stresses in their daily lives. Such broader influences contributed to how the therapists viewed themselves and were found to impact the self of the therapist. Jennings et al. (2008) report that Singaporean master therapists confessed periods of self-doubt and regarded these as a necessary and welcomed impetus to further grow their clinical expertise.

**Professional Sources of Influence upon Psychotherapist Development**

Overall, across the career lifespan, Orlinsky and Rønnestad (2005), and Orlinsky, Botermans and Rønnestad (2001) found that direct experience of therapy with clients was rated as the strongest positive influence on professional development, followed by participating in formal supervision and receiving personal therapy. These influences form the major triad of positive influences on therapist professional development. However, for novice therapists formal supervision (mean = 2.4 where current development ranged from 0 to 3) was reported to be slightly more influential than direct experience of therapy with clients (mean = 2.3 where current development ranged from 0 to 3) (Orlinsky & Rønnestad, 2005). Furthermore, novice therapists were the most likely to rate highly the positive influence of informal case discussion with peer colleagues.

In a United Kingdom survey, Lucock, Hall and Noble (2006) found that trainee clinical psychologists rated textbooks, journals, current and previous supervision, professional training, client characteristics, and case formulation as the most influential in their clinical practice. However qualified psychotherapists rated major life events,
personal therapy, providing supervision to others, conferences, and teaching and training others as their highest sources of influence. Training, clinical supervision and personal therapy were considered influential aspects that needed to be researched further to improve therapeutic practice. In terms of theoretical orientation, evidence-based literature was utilised predominantly by cognitive-behaviour therapists whereas despite 39% having had personal therapy it was not regarded as influential on their clinical practice, possibly due to their personal therapy not being of a cognitive-behavioural orientation. In stark contrast all psychodynamic and person-centred therapists in the survey made use of personal therapy which was deemed an inherent requirement of training and was seen as highly influential on clinical practice.

To spearhead professional therapeutic development Orlinsky and Rønnestad (2005) found that therapeutic expertise is founded on possessing the basic relational skills or the “natural talent” of those who enter the field. Beyond a talent to relate to others, therapists need a broad theoretical orientation that is able to encompass the range of clients they will see, adequate supervision, and a supportive clinical milieu in order to enjoy a sense of efficacy in their work and provide a climate for flow experiences. In reflecting upon clinical training, Rogers (1939) emphasised beyond an aptitude for a graduate qualification, clinical psychologists need to possess “the ability to make warm human contact” and show “an interest in people as individuals and a profound but not exaggerated desire to be of help to others when they demand help” (p. 141).

**Experience with Patients**

Kiviligian and Quigley (1991) have noted that experience and expertise hold a conceptual and practical relationship to each other. According to their international
study, conducted in Germany, United States of America, Norway, and South Korea, of 4
923 respondents, Orlinsky, Botermans and Rønnestad (2001) found that nearly two thirds
of the sample rated direct clinical experience with clients as the most salient influence in
their professional development. However, Neufeldt, Karno and Nelson (1996) emphasise
that extensive experience with clients does not necessarily translate to therapeutic
expertise. Rather expertise hinges upon the therapist employing a self-reflective stance
towards their experiences in order to transform their exposure to clients into expertise.
Similarly, Singaporean master therapists prioritised experience as an essential component
of expertise (Jennings et al., 2008), in that it takes an extended period of time to develop
and store useful information from which to work and a storehouse of experiences to
respond from. The Singaporean master therapists closely linked experience to maturity
yet cautioned that the mere advance of years does not necessarily amount to the
development of wisdom (Jennings et al., 2008).

**Therapists’ Use of Personal Therapy**

*One must still have chaos in oneself to be able to give birth to a dancing star -
Friedrich Nietzsche (1909).*

The practice of psychotherapy since inception has underscored the importance of
the therapist seeking out their own therapy in order to work more effectively with their
clients (Freud, 1937/1964). Similarly, Rogers (1939) saw novices securing assistance in
analysing their own problems and gaining insight as a “very definite and necessary part
of the training of a clinical worker” (p. 142).

In an American study, Mahoney (1997) found that 87.7 % psychotherapy
practitioners reported having engaged in personal therapy. In 2000, 83% of American
counselling psychologists confirmed having made use of personal therapy during their
careers and regarded it as an important prerequisite for working as a counselling psychologist. Norcross, Karpiak and Santoro (2005) found that 75% of American clinical psychologists reported in 2003 that they had made use of personal therapy during their careers.

In the footsteps of Freud (1912) advocating personal therapy for “psychoanalytic purification” in their therapeutic work, Henry et al. (1971, 1973) found that therapists of a psychodynamic orientation report being influenced by their personal therapy. Within a South African context Haumann (2005) investigated the impact of current personal therapy on the professional development of eight psychodynamic therapists from a relational and intersubjective model. Haumann found that the notion of the wounded healer featured prominently in her sample. She tentatively attributed this to asking the participants their reasons for choosing the profession of psychology and their motives for entering personal therapy for the first time. Similarly, Lageman (1986) speaks of the healer/patient archetype that exists in client, therapist and supervisor alike and Farber (1985) draws the parallel between psychotherapist and shaman in that, in order to be a healer, one has had to have gone through an initiation of personal suffering. Similarly, within the South African context, African cultures have diviners (isangomas) who provide supernatural explanations and herbalists (inyangas) who provide traditional medicine for illness and distress. To become an isangoma one has to be called by the ancestors and undergo certain rites of passage and apprenticeship (Kale, 1995). Norcross, Strausser-Kirtland and Missar (1988), and Binder (1993) suggest that personal therapy facilitates the internalisation of the healer role when the therapist embarks upon being a patient.
Closely aligned to personal therapy is the level of self-awareness of psychotherapists. Jennings et al. (2008) found that the self-awareness of Singaporean master therapists enabled them to confront their unique limitations and growth areas as well as informing their understanding of the therapeutic dynamics between themselves and their clients, which is often referred to as the therapist’s countertransference or as part of the therapist’s congruence (Lum, 2002). Similarly, Skovholt et al. (2001) endorsed self-awareness of psychotherapists in terms of warding off stagnation and bolstering their longevity in the profession.

**Supervision of psychotherapists**

Ericsson, Krampe and Tesch-Römer (1993) define deliberate practice as highly structured activities that have been found most effective in improving performance in a particular field. Ideally, improved performance is hinged upon adequate feedback wherein identification of errors, specific instruction, and better strategies or remedial training are provided by an individualised supervision process of sensitive scaffolding to more complex tasks (Ericsson et al., 1993), and regular observation of consultations (Binder, 1993). Deliberate practice is distinguished from unfocused interaction, paid work, and observation, rather it involves engaging in tailor-made activities designed to improve performance (Ericsson et al., 1993). Importantly, Ericsson et al. (1993) highlight that work does not necessarily afford one the opportunity to try alternative strategies and to engage in learning to improve one’s performance. Rather, optimal practice time should be set aside to enhance expertise through focused attention on practice activities that can maximise feedback and information regarding corrective action. Lum (2002) proposed triad work which provides the trainee with the opportunity
to explore their strengths and vulnerabilities in each of the three positions of client, therapist, and observer.

Singaporean master therapists highlighted the dearth of supervision opportunities within their context and felt that the lack of feedback hindered the honing of their clinical skills (Jennings et al., 2008).

Barrett and Barber (2005) and Briggs, Fournier and Hendrix (1999) argue that initially supervision approaches predominantly focused on professional development (e.g. Stoltenberg, McNeill & Delworth, 1998). Promisingly, professional development models are evolving into more broad-based models that also incorporate the executive skills, emotional and cognitive/perceptual developmental level as well as the personal maturation of the supervisee and seek to match supervisees’ developmental needs with customised supervisory interventions (e.g. Kegan, 1994; Pratt, 1998; Yogev, 1982). Rogers (1939) points out the potentiality of supervision in providing the therapist with some insight into their own problems and their reactions to certain issues of others.

Briggs et al. (1999) see the evaluation function of supervision based on collaboration or co-construction (Caldwell, Becvar, Bertolino & Diamond, 1997), between the supervisor and supervisee in order to provide concrete examples and clear yet open-minded feedback from which future goals can be formulated as a baseline for improvement. However, Caldwell et al. (1997), and Yogev (1982) acknowledge that the mantle of responsibility and evaluation function of supervision can create a rather creatively tenuous relationship. Caldwell et al. (1997), and Edwards and Chen (1999) recommend adopting a collaborative stance in supervision even as far as the supervisor adopting the “not-knowing position” or “non-expert role” of postmodernism.
In light of the need to scaffold therapeutic competency, Binder (1993) proposed the implementation of anchored instruction of declarative (principles) and procedural (actions) knowledge of clinical skills prior to introducing supervision. Supervision of casework has been found to be best suited to refining of therapeutic skills and elaborating procedural knowledge after a foundation of relevant and active engagement in simulations of therapeutic contexts has been consolidated. Similarly, Norcross and Beutler (2000) outline a five-step integrative training approach which includes: cultivating fundamental relationship and communication skills to forge an emerging therapeutic relationship, immersion into the systems of psychotherapy and change principles, supervised practica of carefully selected diverse cases, teaching a coherent model of treatment decision-making and the construction of therapeutic strategies, and finally, reflective experience within an internship setting. Regarding the time involved in developing competence, Norcross and Beutler (2000) encourage supervision as a lifelong commitment, as therapists are lifelong learners, in order to offer fluid and creative treatment options to clients.

Lageman (1986) advocates that supervision needs to be a genuine dialogue between the supervisor and supervisee where the supervisee benefits from the therapeutic wisdom of the supervisor and a continual expansion of the supervisee’s therapeutic capabilities is subsequently achieved through a “master-apprentice education” (Binder, 1993, p. 305). To circumnavigate the dazzle-effect, Binder (1993) encourages supervisors to talk their supervisee through the cognitive and affective processes of their superior clinical understanding and proposed actions so that the supervisee can vicariously experience the processes that led to useful clinical observations and
recommendations. However, Binder (1993) acknowledges unpacking unconscious competence to reveal its intricacies step-by-step is indeed the challenge facing supervisors.

Binder (1993) reports that supervision in terms of the “parallel process” model of re-enactments appearing in the supervisor-supervisee relationship of the therapist-client relationship which need to be understood, have found an affinity with the transference-countertransference concepts of psychodynamic-orientated supervisors. Similarly, Rodenhauser (1994) depicts the developmental stages and interrelationships of supervisor, supervisee/therapist and patient as a mutually influencing “supervisory triangle” (p. 1). Whereas Sakai and Nasserbakht (1997) highlight how the psychotherapist development models (e.g. Stoltenberg, 1981) account for the dynamic shifts in the supervisee-supervisor relationship, from a need for explicit direction/dependency, to an ambivalence regarding input, to independent practice. Rogers (1939) recommended that during training, interns should be given an increasing load of responsibility in step with the amount of challenge required to cultivate the most growth in trainees. The frequency of supervision consultations should be to the extent of warding off insecurity or panic on the part of the trainee whereby at the end of the internship year the trainee is capable of being reasonably independent in their clinical work. In contrast, Fouad (2003) highlights an ongoing tension between rigidity/explicit structure and ambiguity/freedom for uniqueness experienced by supervisees as they progress in their professional development as psychotherapists.

Nutt Williams et al. (2003) report how novice therapists feel that their supervisor is in their head in terms of evaluating and observing their performance. Lum (2002), in
the spirit of Satir and Banmen (1983) and Reik (1948), advocate the therapist engaging in
internal monitoring of their own internal processes during consultations and developing
their inner attention and intuition by using their “inner/third ear” or “inner eye”.
Casement (1985, 1990) and Cashdan (1988) speak of experienced therapists relying upon
their internal or inner supervisor during session which may reflect the internalisation
process of supervision.

Mentoring of Psychotherapists

*My interest does not lie in raising parrots that just rehash their ‘master’s voice’,
but rather in passing the torch to independent and inventive, innovative and
creative spirits. –Victor Frankl (1984, p. 177).*

Warren (2005) delineates mentoring as an intricate personal process that provides
protégés/mentees with opportunities for academic and professional achievement,
 networking, guidance, greater self-confidence and support. Mentoring finds its roots in
Homer’s *Odyssey* where Ulysses assigned Mentor the duty of watching over his son
Telemacchus (Lageman 1986; Warren, 2005). The relationship that evolved between the
erolder man and young (less experienced) man has been delineated as disciple/master,
teacher/student or sorcerer/apprentice where in the spirit of generativity (Erikson, 1963)
the wise guide or founding father acts as a gatekeeper to the profession (Warren, 2005;
Wright & Wright, 1987) and passes his legacy onto a younger generation (Yalom, 2001).
Farber et al. (2005) highlight how significant adult figures acted as mentors or role
models that inspired individuals to pursue a career in psychotherapy. In 2000, 65% of
American psychotherapy graduates reported having benefited from mentorship during
their training (Clark, Harden & Johnson, 2000).
Warren (2005) highlights the possibility of dual relationships or negative power issues developing in the asymmetrical relationship of mentoring which imbues significant responsibility. With this in mind, Lageman (1986) argues that a mentor’s responsibility does not amount to growing the mentee but rather to be “a catalyst in the process of growth” (p. 62) and to provide a real experience as opposed to merely dispensing wordy formulas behind a restrictive persona.

Mentoring as such provides the opportunity for the fledging therapist to sit on the shoulder of a therapeutic giant in order to capture the future of psychotherapy that one day he/she will alone inhabit. In terms of the process of mentoring a separation point (Warren, 2005) is reached where, in a sense, the younger therapist needs to “kill their Buddha” (Knopp, 1976). For example, Carl Jung broke away from Sigmund Freud to establish his own school of thought (Wright & Wright, 1987). Less dramatically mentees may bid farewell at the turn in the road in ways similar to Dante taking leave of Virgil in *The divine comedy* (Gargiulo, 1999; Lageman, 1986), and Dorothy clicking her own shoes in *The wonderful wizard of Oz* (Baum, 1900/2010; Cashdan, 1988).

Kernes and Kinnier (2008) found that American psychologists in academic settings reported finding the most meaning in mentoring trainees. Skovholt, Grier and Hanson (2001) reported that American expert therapists value having a “professional greenhouse” which includes receiving peer and mentor support as well as mentoring others during one’s career. Singaporean master therapists also highlighted their reliance upon professional elders (Jennings et al., 2008). Backfield (1996) found that most therapists’ mentors were their own personal therapists. In this light, Lageman (1986)
acknowledges the considerable overlap of supervision, mentoring and even personal therapy within the profession of psychology.

**Ongoing Professional Development**

“It is only after you have qualified (...) that you have a chance of becoming an analyst. The analyst you become is you and you alone; you have to respect the uniqueness of your own personality- that is what you use” (Bion, 1987, p. 15).

In response to Wilfred Bion, Gabbard and Ogden (2009), when reflecting upon their maturational experiences as psychoanalysts, emphasised the importance of striving to find one’s own voice or style, to offer therapy that bears one’s personal watermark.

Senior therapists, Gabbard and Ogden (2009), have proposed four aspects of psychic growth that inform the process of becoming a therapist. Firstly, therapists need to think or dream their lived experience in the world in order to learn from their experience and enjoy personal growth. Here a second person, often one’s personal therapist, is recommended to facilitate one in making the “unthinkable thinkable” (p. 312). Secondly, and in dialectical tension, therapists need solitary time to make sense of their work. Thirdly, therapists need to create personal, symbolic meaning in the ongoing process of becoming a therapist, as such “dreaming oneself more fully into existence” (Ogden, 2004, p. 858). Fourthly, therapists need to do psychological work with their disturbing thoughts. To explicate this process Gabbard and Ogden (2009) draw on the container-contained metaphor of psychotherapy (Bion, 1962, 1970). As such therapists need to deal with their own disturbing lived experiences (the contained) that may hinder their capacity to think as a therapist (the container), especially when confronted with distressing consultations.

Furthermore, Gabbard and Ogden (2009) highlight eight maturational experiences that facilitate the development of therapeutic identity. Firstly, developing a voice of
one’s own involves a dialectical tension between inventing oneself anew and yet creatively internalising and using one’s emotional ancestry of authority figures (parents or supervisors). Secondly, in presenting clinical issues to a supervisor, the therapist is confronted with his/her insecurities, anxieties and ‘not knowing’ which moulds one’s professional identity towards humility, self-curiosity and acknowledgement that self-analysis is a lifelong endeavour. Additionally, supervision also provides a container when therapeutic work becomes overwhelming. Thirdly, one’s therapeutic work with clients becomes the primary vehicle for self-analysis, in that a therapist’s work initiates unflinching personal examination of oneself and the therapeutic process. Fourthly, Gabbard and Ogden (2009) propose that writing, and by implication thinking, about one’s clinical work fosters growth in the therapist. Fifthly, improvisation with each client is encouraged, for maturation is linked to the therapist increasingly allowing themselves to be “carried by the music of the session” and for the therapy to be ‘alive’ (p. 323). Sixthly, embracing therapeutic errors alerts therapists of the need to remain vital and original in their work as opposed to adopting a contrived therapeutic style. Seventhly, Gabbard and Ogden (2009) link personal experiences along life’s journey as informing one’s therapeutic work, as the maturational process of becoming a therapist occurs both within and outside of the consultation setting. Finally, maturity also involves the therapist becoming aware of their fears of ‘growing up’ as a therapist and one’s attendant defences in relation to one’s therapeutic development and the uncertainty, ambiguity and confusion that is inherent in the therapeutic endeavour. Furthermore, professional development also involves coming to terms with one’s personal shadow and the parts of oneself that hate the vocation. Eloquently, Gabbard and Ogden (2009) thus provide a
rationale for the major triad of direct experience with clients, supervision and personal
therapy significantly impacting therapist development.

**Approach to Therapeutic Process**

**Descriptions of Therapeutic Relationship Stances**

A large constituent of psychotherapists’ accounts focus on the nature of their
therapeutic work with clients and their relational manner or therapeutic style with clients
(Leary, 1957; Orlinsky & Rønnestad, 2005). Sullivan, Skovholt and Jennings (2005), and
Jennings et al. (2008) found that master therapists constructed the therapy relationship as
an optimal balancing of a safe and yet challenging relationship; one which imbues “tough
love” (Aveline, 2005). According to Jennings et al. (2008) a master therapist embodies
heightened sensitivity to responding to the client’s needs and collaborating with the
client. Additionally, master therapists were found to appropriately challenge clients by
using their own self and engaging with the client in directing the therapy together with
adopting an objective stance to provide the client with interpretations, information and
evaluation of the process. Thus Sullivan et al. (2005) found that master therapists were
flexible, and employed *dynamic sizing* of the client (S. Sue, 1998) and a plasticity of self
(Aveline, 2005) in the relationship stances that they adopted with diverse clients and at
different points of a therapeutic relationship. For example Norcross, Geller and Kurzawa
(2001) identified thirteen potential therapeutic styles and found that therapists were more
likely adopt less detached, less guarded, more effective and warm therapeutic styles with
therapist-patients than with other patients. Beutler, Malik, Alimohamed, Harwood,
Talebi and Noble (2004) found that the therapist’s optimism and friendliness was
consistently linked to a favourable therapeutic outcome. Blow et al. (2007) found that the
therapist adjusting their relationship stance to titrate the anxiety of the client, in keeping it at a moderate level, facilitated the change process in therapy.

**Empowerment/Strength-based Approach**

In light of postmodern theoretical orientations and the positive psychology movement, Singaporean master therapists focussed on bolstering and amplifying the inherent internal resources of clients and used them to address “problems” (Jennings et al., 2008). Lum (2002) highlights that American Satir model therapists intentionally focus on accessing and strengthening the resources of the client.

**Metaphors of the Therapeutic Process**

Mair (1997) criticises the reliance of psychology on its use of analogies such as the steam engine, telephone exchange, and computer to understand human behaviour. However Frank (1989) points out that: “psychotherapy transpires in the realm of meaning (…) in contrast to facts, meanings cannot be confirmed or disconfirmed by the objective criteria of the scientific method” (p. 144).

Sullivan et al. (2005) found that American master therapists employ core metaphors, symbols or images in an effort to describe their role in therapy and the therapeutic process, or the client’s experience of therapy (Etchison & Kleist, 2000). Kelly and Howie (2007) advise prompting participants to identify a word or metaphor to describe their professional development in the practice of psychotherapy. For example being wrung out and spun dry in a washing machine, as such a process of cleansing: “It’s washed me clean. I feel spun dry and ready. Being spun about in a washing machine is a ‘bloody awful’ thing. It’s also very cleansing, if you can hack it, and I think I have” (p.
Squire (2005) points out how qualitative research includes visual material that ties in with the implications of metaphor as word pictures. Gargiulo (1999) identified the elusive purpose of the metaphor as that which in its expression evokes something else, to promote deep meaning and a felt resonance. Metaphors inherently relocate the centre of meaning of that which it describes to another illuminating location. Similarly, Boone and Bowman (1997) relayed that “metaphors allow individuals to experience and understand one thing in terms of another” (p. 313). Metaphors form part of the human tradition of stories, anecdotes, myths, riddles, parables, koans and fairytales of various cultures (Boone & Bowman, 1997).

Therapists, of various theoretical orientations, employ metaphors which are embedded in cultural narratives to depict the problems of the client and/or describe the healing process needed (Boone & Bowman, 1997). Metaphors depict the therapeutic process as a balancing act or dancing in step (Jennings et al., 2008), story-telling, a combination of attending, witnessing and waiting (Cox & Theilgaard, 1997). Other metaphors of the therapeutic process include: walking the streets of one’s past, journeying through the dark forest of our pathologies (Gargiulo, 1999), cave exploration (Small, 2000), choosing the red pill in order to journey through the matrix (Mischoulon, & Beresin, 2004), transformation or metamorphosis, death and resurrection (Lageman, 1986), solving a philosophical puzzle (Kernes & Kinnier, 2008), filling in the missing pieces of the picture/puzzle, and being a filter for the client’s experiences (Ehrenberg, 1992; Skovholt & Jennings, 2005).

The therapist has been depicted as a midwife assisting the psychological birthing process of the client or a poet voicing a vision for the client (Lageman, 1986), as well as
an “artist” (Sinai, 1997), “wilderness guide”, “helper”, “good mother”, “good parent”, “doctor for emotional wounds”, “detective like Columbo”, “coresearcher of client’s experience”, or “archer with a quiver filled with arrows of techniques” (Skovholt & Jennings, 2005, p. 39), as well as a “second fairy godmother at one’s christening” (Jennings, Sovereign, Bottorff, Mussell & Vye, 2005, p. 39). The therapist has also been regarded as an Aeolian harp (Cox & Theilgaard, 1997), or navigator utilising maps of the mind (Cox & Theilgaard, 1997; Lageman, 1986) or gardener cultivating a “growth promoting climate” (Rogers, 1961).

Many metaphors stem from the canon of psychological theory. Therapist and patient are regarded as “fellow travelers” on a journey (Jennings et al., 2008; Wilmer, 1964; Yalom, 2001). In the Freudian sense the psychoanalyst is seen as an archeologist of a patient’s earlier history who in one’s excavations must uncover layer after layer of the patient’s psyche, before unearthing the deepest, most valuable treasures of the patient (Pankejeff, 1971). Another metaphor Freud spoke of is exorcism in terms of psychoanalysis involving the struggle of conjuring up one’s half-tamed demons (1905). Psychoanalysis is also deemed to be adversarial in nature as seen in the game of chess as a mock war (Freud, 1913). Freud also highlighted the psychoanalyst needing to possess the precision and decisiveness of a surgeon in carefully controlling the invasiveness level of talk therapy (Ivey, 2010; Stepansky, 1999). Interestingly, Freud (1900) did not see himself primarily as a “man of science” but as a conquistador (an adventurer) who embodied the qualities of curiosity, daring and tenacity.

1 With this in mind it is tempting to wonder had Sigmund Freud lived in this era whether he would identify with the fictional character Indiana Jones (1981).
Mitchell (1988) critiques various metaphors throughout the history of psychotherapy including the Freudian idea of the patient being a beast in need of taming (Phillips, 1999) or in contrast, a baby in need of “good-enough mothering” (Winnicott, 1953). Instead, Mitchell (1988) promotes the notion of a “relational matrix” where one weaves and unravels their ties to others. Similarly, the therapeutic process has been depicted as “an endlessly complex tapestry woven of interactions, emotions and value judgments” (Jensen, 2007, p. 382).

Najavits (1993) investigated the key theoretical metaphors that psychotherapists utilise to understand the therapy process. Task-orientated or professional metaphors included teaching, acting, sales, technical, science, detective work; or therapy as art or healing. Primal and fantasy metaphors involved handling wastes, play, war or a spiritual/religious quest (Kernes & Kinnier, 2008). Metaphors of taking responsibility depicted the therapeutic process as hard labour or parenting. Intellectual metaphors included writing a novel and philosophical dialogue. Metaphors from therapists themselves included honesty, a process, focusing total attention another person, just a job, apprenticeship, conducting an orchestra2, magic, or as altered states of consciousness (meditation, dreamwork, suspending time and intuition) and travel (on a voyage together, explorer/guide).

Keiley and Piercy (1999) in the tradition of narrative therapy (Epston & White, 1995) conceptualise the professional development of a therapist as a “rite of passage”. Johns (1997) and Knopp (1976) regard the process of therapist training as a journey of discovery, an inductive approach where process is emphasised. Along the lines of John

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2 Theodore Millon (1997) employs the metaphor of conducting an orchestra to depict his Synergenistic Psychotherapy model which epitomises an integrative model of psychotherapy.
Bunyan’s literary classic *Pilgrim’s progress* (1678/1978) senior therapist, Wilmer (1964) depicts the *Odyssey of a psychotherapist*:

I have drawn a picture of a fantasied land through which hopeful psychotherapists journey. Only a few of the pitfalls, dangers, and allegorical tasks are shown. In a pilgrimage of mutual acculturation the therapist and the patient are fellow travelers. Both may fail, and both are beset by difficulties. The particular tasks and labors of the therapist reflect his orientation (…). The therapist enters the gates to the Land of Psychotherapy through the Wall of Defense, past the Watchtower of Resistance (…). If he passes this trial, the traveler trudges down a great open valley and finds himself in the Desert of Despair. Without water, plodding through the shifting sands of uncertainty and bewilderment, he makes his way toward the setting sun. But alas, his vexed odyssey is not yet over. A flock of swallows wing by on their way to the Forest of the Giveups (…). The final allurement must be passed and even then the traveler must not look back. He must go forward (…), [to] the green and open meadows known to man as the Great Plains talk. On this solid ground the final journey can be begun. Yet, I would remind the weary traveler on his odyssey of the words of the wise man: "To travel hopefully is better than to arrive, and true success is in labor." Only then can the therapist, with the patient, achieve the true Promethean gift (pp. 902-903).

**Complexity of the Therapeutic Process**

Holloway and Wampold (1986) and Jennings and Skovholt (2004) found that as therapists develop and gain experience their ability to tolerate, accept and integrate a more complex conceptual framework becomes apparent. McQuaide (1999) highlights that theories of how to do therapy and stories about therapy are “messy processes”, each one a unique tapestry.

As such professional growth involves the therapist learning to balance the polarities inherent within therapeutic work namely competence/inadequacy, dependence/autonomy, emotional strength/emotional vulnerability, contact/withdrawal, and power/helplessness (Cormier, 1988).
Evaluation of One’s Therapeutic Work

Eells (1999) found that “effective therapists appear to be strong believers in the psychotherapy process” (p. 315). Skovholt, Grier and Hanson (2001) acknowledge that the complexity of helping relationships often makes for elusive measures of success and that often psychotherapists struggle to incorporate normative failure as part and parcel of being in the healing professions. Professional functioning can be understood as comprising of client change, recognition from others (for example supervisors or colleagues), expert knowledge of content and the quality of relationship processes. However, Skovholt, Grier and Hanson (2001) found that therapists tend to solely evaluate their work in terms of client change which is not within their direct control.

According to Orlinsky and Rønnestad (2005) therapists’ caseloads in Germany, USA, Norway, Switzerland, Spain, Portugal, and South Korea, ranged from one to 23 clients or more. Whereas Mahoney (1997) found that the current caseload carried by American therapists amounted to an average of 18 clients.

Newman (1983) points out that the therapists’ evaluation of the therapeutic experience is as important and reliable as other sources of evaluation such as client or independent observer’s impressions. Orlinsky and Rønnestad (2005) argue that the core of psychotherapists’ development is revealed in how they construct their therapeutic work with their patients; as therapeutic work and professional development of psychotherapists share a close reciprocal relationship of influence. Orlinsky and Rønnestad (2005) found those who had a theoretical orientation, as opposed to no salient orientation, experienced less distressed practice. Interestingly, therapists who used more than one theoretical orientation in their work, in the sense they were eclectic in orientation, were found to
experience more healing involvement with clients.

Orlinsky (2005) found that therapists with less than five years of experience were more likely than experienced therapists to experience disengagement or distress in their therapeutic work. According to Orlinsky and Rønnestad (2005) novice therapists with less than 18 months of therapeutic practice gauged the quality level of their development as psychotherapists in their careers as follows: low (35.9%), moderate (38.7%), and high (25.3%). However, the majority expressed low or moderate levels of therapeutic mastery, while only a small minority (2.5%) expressed a high level of therapeutic mastery. Over half (57.6%) of established therapists (with at least seven years of practice) reported having experienced high levels of development, and after 25 years of practice 76.2% of therapists reported having experienced high levels of development. In terms of therapeutic mastery, most established therapists (69.5%) reported moderate levels of mastery, while after 25 years of experience 49.5% of therapists reported high levels of mastery and 45.7% of therapists reported moderate levels of mastery. Overall, therapists at different stages of their career report different degrees of “therapeutic maturity”. Thus, perceived mastery of therapy is positively related to the number of years that a therapist has been in practice (Orlinsky and Rønnestad, 2005).

Furthermore, Orlinsky and Rønnestad (2005) examined psychotherapists’ experience of their therapeutic work with the following descriptors: ‘effective’, ‘challenging’, ‘disengaged’, or ‘distressing’. A key finding was the results between the self-reported feelings of accomplishment in assisting clients (effective practice) in contrast to feelings of failure, being overwhelmed or feeling unable to assist clients with their problems (distressing practice). Orlinsky and Rønnestad (2005) found a large
proportion of novice psychologists reported effective practice (45.6%) whereas as many as 19.1% experienced distressing practice. Effective practice was experienced by 55.8% of established therapists and 65.2% of those in practice after 25 years in the profession. Distressing practice was experienced by 5.2% of established therapists and 3.3% of therapists with 25 years or more in practice. Overall, there is a trend for effective practice to be increasingly experienced and for distressing practice to decrease along one’s career path (Orlinsky & Rønnestad, 2005, p.148).

Conclusion

In sum, the qualitative dimension of the current South African study afforded the participants the opportunity to refer to their overall experience of professional development, spanning their personal life story in conjunction with their first contact with clients to their current therapeutic work and future aspirations. From a stance of cumulative experience, as emphasised by Orlinsky and Rønnestad (2005), the participants of the current study were asked to look at how and in what directions they had developed since they began their work as psychotherapists. Their level of attained proficiency was also explored, albeit tentatively, in the findings of the current study.
Chapter 3:

Research Methodology

Introduction

The following chapter serves to outline the research methodology utilised in the current study. Due to the dearth of research on psychotherapists’ professional development in the South African context, the current exploratory study is couched in a qualitative social constructionist epistemology. Furthermore, this chapter will elaborate upon key features of the qualitative research paradigm employed in the current study namely: the self-reflexivity of the researcher, purposive sampling, semi-structured interviews, Tesch’s (1990) model of thematic analysis of data, and Guba and Lincoln’s (1985) guidelines for data verification. Lastly, the ethical considerations of the current research study will be stipulated.

Epistemology of Social Constructionism

Fonow and Cook (1991) clarify that epistemology refers to one’s “assumption about how to know the social and apprehend its meaning” (p. 1). This study adopted the postmodern relativist epistemological position of social constructionism which advocates that reality consists of a fluid set of social constructions (Terre Blanche & Durrheim, 1999). Thus, there is a social basis in what we take to be knowledge. Social constructionism highlights how perceptions, ideas and attitudes have developed over time within a social and community context; and how the individual extracts, constructs and negotiates meaning(s) from within society, (social institutions and social interactions) and
its cultural narratives, by means of language processes (Coyle, 2007; Doan, 1997).

McLeod (2003) explains:

> Personal identity is a product of the history of the culture, the position of the person in society and the linguistic resources available to the individual (…). From a social constructionist perspective, narrative represents an essential bridge between the individual experience and the cultural system. We are born into a world of stories. A culture is constructed around myths and legends (…) that have existed long before we are born (…). We construct a personal identity by aligning ourselves with some of these stories, by ‘dwelling within’ them. (p. 234).

Jankowski, Clark and Ivey (2000) highlight that social constructionist theory intersects with qualitative methodology by virtue of the shared emphasis upon self-reflexivity and the “not knowing” position. Reality cannot be proved in terms of valid research, but rather reality is constructed by each individual in a unique way which brings forth knowledge rooted in experiences. Similarly, Doan (1997) stresses that social constructionism allows the researcher to critically engage with the experiences of the participant so as to inform professional disciplines of human experience. Constructing and representing social reality is difficult as it involves “the rich and messy domain of human interaction” (Brunner, 1991, p. 4). Social constructionists seek out stories that are based on a person’s lived experience, one wherein each participant has their own voice. This ties in neatly with the concepts and goals of the current research study. This research set out to explore the experiences of therapists in terms of the discourse of professional development, and to uncover how such constructions could indeed contribute to the practice of psychotherapy in South Africa.
**Research Method: Qualitative Approach**

Britten (2000) and Babbie and Mouton (2001), advocate that to realise a legitimate answer to the research questions posed, the researcher must fit the method or blueprint of a study to the goals of the research rather than using a particular method because research has always been done that way or because of a technique’s popularity.

Firstly, the main reason for choosing a qualitative approach was due to the emergent and exploratory nature of the research questions which were to focus upon aspects of therapeutic development and the identity that practitioners had constructed. As such the research was conducted with the intention of discovery and understanding rather than attempting verification (Ambert, Adler, Adler & Detzner, 1995; Patton, 2002). As Babbie and Mouton (2001) and Coyle (2007) note, the primary goal of research studies using the qualitative research paradigm is to describe and understand human behaviour contextually and idiographically, by means of in-depth ‘thick’ descriptions (Denzin, 1989) rather than seeking explanations of human behavior. As such qualitative methods are used to understand complex human phenomena. Qualitative research allows the study of participants’ lives from their own perspective (the ‘emic’/‘insider’ perspective), and therein the researcher provides participants ample space to voice their viewpoints in their unique context (Banister, Burman, Parker, Taylor & Tindall, 1994; Holloway, 1991).

Secondly, the qualitative interview, by offering an exploration of the participants’ subjective reality, lends itself to thematic analysis. A thematic analysis of the data, by means of an inductive approach, generates themes which provide understandings of therapists’ experiences (Crossley, 2007). Such methodology values the capture and discovery of meanings and permits the study of themes and motifs (Neuman, 1997). The
themes and interpretations generated remained closely reflective of the participants’
responses and conceptualisations, in an attempt to stay true to the meanings of the
participants themselves and the distinctive purpose of the qualitative research paradigm.

Thirdly, though the emphasis of the current research centred upon the themes of
the participants’ experience, the language nuances employed by the participants were also
attended to. As Wetherall and Maybin (1996) point out: “Language is not a transparent
medium for conveying thought but actually constructs the world and the self through the
course of its use” (p. 220). Accordingly, we construct our social reality by means of our
communication processes (Gergen, 1998; Littlejohn, 1992). Besley (2002) holds that
language frames one’s definitions of self and how one makes meaning of one’s world and
experiences. “Language and other symbolic systems mediate thought and place their
stamp on our representations of reality” (Brunner, 1991, p. 3). Therefore the analysis
also took into account that the transcribed interview needed to be held in and understood
as a dialogue between the predominantly telling participant and listening researcher.

The Self of the Researcher

As this social constructionist study values the subjectivity of the participants, the
study also acknowledged that the subjectivity of the researcher inescapably and deeply
influences the research (Ambert et al., 1995; Coyle, 2007; Jarveluoma, Moisala & Vilkko,
2003). After all, the researcher was an active presence and co-constructor of knowledge
with the participants, as such interviewer and participant were co-researchers (Britten,
2000; Etchison & Kleist, 2000) or co-authors of the story told by the participant
(Polkinghorne, 1996). The participants, the researcher, and the research context influence
each other in a reciprocal manner (Ambert et al., 1995). The experiences relayed by the
participant are influenced by the researcher and the anticipated reader(s) of the text. Holloway and Jefferson (2000, p. 3) point out that the researcher is not a “neutral vehicle” that can provide uncontaminated knowledge from “God’s eye view” or “a view from nowhere”, rather the researcher actively makes known his/her own position in the research undertaken. Cohen and Crabtree (2008) emphasise the need for the research to demonstrate immersion and self-reflection on the part of the researcher.

Jankowski et al. (2000) define self-reflexivity as: thinking about one’s experience with and the understanding of the phenomenon, the participants’ understanding of the phenomenon, and one’s own ongoing sense-making process (p. 242). For example, the current researcher is positioned demographically similar to the participants in career yet different in terms of age; as a result these aspects amongst others are likely to impact the interpretations and results of the study (Burck, 2005). Thus in the tradition of qualitative research, the subject positioning and reflexivity of the researcher became a critical point of discussion (Ambert et al., 1995; Gubrium & Holstein, 2003a; Whitemore, Chase & Mandle, 2001).

**Ethical Considerations**

Research ethics formed an integral part of the methodology of this study as especially in professional therapeutic development of psychologists, one is confronted with issues that are sensitive both in personal meanings to the participants and their relevance to the participant’s professional therapeutic context (Health Professions Council of South Africa, 2004). Therefore, with sensitivity in mind (Whitemore et al., 2001), the research was conducted in a conversational style that fostered a non-intrusive approach.
Firstly, the research was conducted with the permission of the Nelson Mandela Metropolitan University Faculty of Research, Technology and Innovation Committee. Secondly, informed voluntary consent was obtained from the participants (see Appendix B and C). The letter of consent acknowledged that the participant could withdraw at any time from the research being undertaken. In addition, the participants were informed that the interview being conducted would be voice-recorded, transcribed and following completion of the study that the recording would be erased. Thirdly, in the interest of the limits of confidentiality, the participants were informed that the transcriptions could possibly be included in the appendix of the final work with all identifying remarks and names absent as the participants were referenced by means of a pseudonym (a letter of the alphabet).

**Selection of Participants**

The non-probability sampling strategy of purposive sampling was utilised to enable the researcher to obtain participants to be included in the sample in accordance with the exploratory nature of the research outlined. Patton (1990) emphasises that purposive sampling enables the researcher to select potentially “information-rich” participants as such “good examples for study, good interview subjects” (p. 182) which allowed for in-depth research. The participants represented a theoretical population; they were spokespersons for the research inquiry. However, the participants were not representative of the entire population of South African psychotherapists and therefore the findings of the interviews cannot be generalised to this population (Graziano & Raulin, 2000; Henning, van Rensburg & Smit, 2004). Yet qualitative research can provide in-depth and contextualised analysis that esteems the complexities and
ambiguities of individuals’ representations as opposed to seeking generalisations (Crossley, 2007). The sampling procedure entailed the researcher contacting the intern psychologists at Nelson Mandela Metropolitan University and established psychologists known to the Psychology Department of Nelson Mandela Metropolitan University. Additionally, a psychologist, who organises continuing professional development activities in Port Elizabeth, acted as an informant (Babbie & Mouton, 2001), providing the researcher with contact information of potential established psychologist participants for the current study.

Previous qualitative studies of professional development of psychotherapists had small samples that constituted of one (e.g. Folkes-Skinner, Elliot, & Wheeler, 2010); eight (e.g. Wolgien & Coady, 1997), nine (e.g. Jennings et al., 2008), twelve (e.g. Rønnestad & Skovholt, 2001) to the landmark study of one hundred participants (Rønnestad & Skovholt, 1995). The sample size of the current study constituted eleven participants of five intern psychologists with less than two years of client contact and six psychologists who had over seven years of post-qualification therapeutic contact with clients. All participants were registered with the Health Professions Council of South Africa as either intern psychologists (supervised practice) or psychologists registered in the clinical, counselling or educational categories.

Demographically, the five intern psychologists can be described as follows: Participant A was a white, single, female intern clinical psychologist in her early twenties. Participant B was a white, single, female intern clinical psychologist in her late twenties. Participant C was a white, engaged, female intern counselling psychologist in her early twenties. Participant D was a white, engaged, female intern counselling
psychologist in her early twenties. Participant E was a white, married, gay, male intern counselling psychologist in his early thirties. All intern psychologists were completing their training at Nelson Mandela Metropolitan University (NMMU) in 2009.

Demographically, the six established psychologists can be described as follows:

Participant F was a white, married, female clinical psychologist in her forties working in private practice. Participant G was a black, single, female clinical psychologist in her early thirties working in a hospital setting. Participant H was a white, married, disabled, male educational/clinical psychologist in his sixties with a doctorate working in private practice. Participant I was a white, married, female educational psychologist in her fifties working in private practice. Participant J was a white, single, female clinical psychologist in her fifties working in private practice. Participant K was a white, married, female counselling psychologist in her forties working in private practice. Four established psychologists, F, G, H, and K, completed their training at the University of Port Elizabeth (now NMMU) and two established psychologists, I and J, completed their training at Rhodes University.

In essence, the interviews endeavoured firstly, to provide an overall idea of what the therapist’s perceptions were regarding their professional therapeutic development. Secondly, the sample size was chosen to achieve enough depth without compromising on breadth with the intention of allowing the individual differences and similarities of the participants to come to light. Saturation point in the current research was judged by the researcher (Holloway, 1997; Kumar, 2005) to have been reached by the fourth participant of the intern psychologist participants and was checked by interviewing a fifth participant whereas saturation point was reached by the fifth participant of the established
psychologists and was checked by interviewing a sixth participant, which confirmed similar responses to participants interviewed earlier.

**Data-gathering Procedure**

Procedurally, suitable potential participants were contacted telephonically or invited in person. Potential participants were provided with information requesting their participation in the research study and an appropriate time scheduled at their consultation premises (see Appendix B). Jennings et al. (2008) emphasise that therapists are exemplars and therefore can be informants regarding the practice of psychotherapy. On receipt of their signed informed consent (see Appendix C), a semi-structured, face-to-face interview was conducted in English for approximately an hour in duration, and recorded by means of a dictaphone. The participants were also informed that should they wish feedback about the results of the study it would be made available.

**Data-gathering Tool: Semi-structured Interviews**

To collect the research data from each of the participants, semi-structured interviews of approximately an hour in duration were undertaken. The interview allowed face-to-face responses to open-ended questions which, by means of a tape recording and transcription, supplied the study with textual data that is potentially rich in meaning (Bradburn, 1983; Denzin & Lincoln; 1984). The interview method was chosen as the research aimed at investigating the language, experience, and unique reality of therapists from their own descriptions (Jones, 1985). By adopting an interview style which provided flexibility in terms of its broad questions, it was hoped that the verbal exchange would be regarded as collaborative by the participants (Rosenthal & Rosnow, 1991). Sudman and Bradburn (1974), found open-ended questions for sensitive issues tend to
elicit higher levels of reporting by participants as they are at liberty to expand on their responses and to express their feelings, thoughts and understandings spontaneously (Campbell, 1950). In essence, the study provided an interview space wherein the participants were encouraged to describe their understanding of the elements at play with regards to their experiences in relation to their professional development.

Additionally, semi-structured interviews were deemed beneficial as they provided the opportunity to establish rapport, trust, and cooperation needed to probe sensitive issues (Rosenthal & Rosnow, 1991). Semi-structured interviews also provided an opportunity for the participants to seek clarification in their interpretation of the questions and the format allowed flexibility in the questions asked, for the interviewer could determine the amount of probing required (Rosenthal & Rosnow, 1991). After inviting the participant to tell of their experiences using a main question or a “grand-tour question” (Holloway, 1997) (see Appendix A), the researcher was not constricted to a series of questions but rather focused on following the participant’s lead and probing deeper into interesting aspects that arose (Smith & Eatough, 2007). Burck (2005), and Patton (1987, 2002) advise constructing an interview guide/protocol of a list of issues or areas that are to be explored wherein the researcher aims to cover the same material with all participants yet the interviewer is free to change the structure of the interview to match the participant’s style and to follow their feedback to unpack particular meanings further. Prompts consisting of open-ended questions were used to assist the participant in discussing their therapeutic development. These follow-up questions were employed to facilitate the participant to expand upon the insights that they were verbalising in the interview.
The advantages of using qualitative methodology are clear: interviews are able to generate more in-depth comprehensive answers to questions and unearth additional aspects that may not have been anticipated by the researcher or even the participants.

The interview was initiated following the grand-tour question: Tell me about the main aspects that have led you to become the therapist you are at present? (Orlinsky & Rønnestad, 2005). This open question encouraged the participants to start sharing their therapeutic development experiences at a self-designated point. The subsequent potential prompt questions of the interview protocol (see Appendix A) were designed to highlight professional development of psychotherapists across career levels as delineated by Orlinsky and Rønnestad (2005). The questions were derived from the literature on psychotherapist development and expertise (Cormier, 1988; Hersh & Poey, 1987; Howard, Inman & Altman, 2006; Jennings & Skovholt, 2004; Jennings, Sovereign, Bottorff, & Mussel, 2005; McLeod, 2003; Johns, 1996; Mullan, 1996; Mullenbach & Skovholt, 2004; Orlinsky & Rønnestad, 2005; Roehlke, 1988; Skovholt & McCarthy, 1988; Skovholt & Rønnestad, 1995; Whitmire, 1991).

**Data Analysis**

In postmodernity, the interview is defined as an endeavour that amounts to readings of a text, wherein the researcher attempts to locate meaning and make interpretations which esteem the unique and subjective, and focus upon interrelations as opposed to discovering the ‘truth’ and causality (Gubrium & Holstein, 2003a). From diverse options, the texts (the transcripts of the interviews), underwent a thematic analysis from the social constructionist position. The data were analysed by extracting themes (Denzin & Lincoln, 1994; Neuman, 1997).
This exploratory study emphasised an inductive approach for the researcher immersed self in the participants’ experiences in order to connect and familiarise herself with each participant’s story (Kelly & Howie, 2007) and identified the themes that were meaningful to the participants (De Vos & Fouche, 1998). However, it must be noted that this inductive immersion did not exclude deduction completely, for theoretical perspectives of therapeutic development acted as a compass to navigate meaningful directions of the participants’ responses in terms of the research aims. As Berg (1995) testifies: “the relationship between a theoretical perspective and certain messages involves both inductive and deductive approaches” (p. 180). The inductive analysis procedure used was outlined by Patton (2002) and is similar in nature to the procedure used by Jennings and Skovholt (1999) to investigate professional development of psychotherapists.

Tesch’s (1990) eight-step approach was implemented to analyse the research data in a comprehensive manner. Firstly, the researcher read through all eleven transcripts in two sets (five intern psychologist participants and six established psychologist participants) to obtain a sense of the data collected and to initiate the process of generating ideas about the information gathered. Secondly, the researcher randomly chose one interview transcript from each set and started to annotate the meanings underlying the responses given. The researcher then chose another transcript from each set randomly and implemented the same process of annotation. Thirdly, a list of provisional themes was compiled. Similar themes (units of meaning) were made into clusters, and possible major and minor themes were outlined. Fourthly, with the list as an organising scheme, the researcher then returned to all the transcripts and began to
carefully highlight and code all appropriate segments of the text. Concepts were drawn and coded from an individual sentence or even paragraph of the text. Concepts were then organised to identify distinct themes or patterns which placed the concepts into a meaningful coherent whole. Importantly, a theme is a crystallisation of what participants conveyed in their words. Themes are established by “bringing together components or fragments of ideas or experiences which often are meaningless when viewed alone” (Leininger, 1985, p. 60). How the themes cohered reflects the researcher’s subjectivity and rigour in tandem with the current knowledge base of the field (Leininger, 1985).

Fifthly, to organise related themes, categories were constructed. Finally, interlinked categories were identified and formed domains of the research which extensively organised the data collected and allowed for formulations about the subject matter to be made. Sixthly, the categories were sorted in alignment with the research topic. Seventhly, each category was analysed to generate meaningful discussion points and were reflected as theories. Finally, the researcher reviewed the data and checked if recoding was required.

The shuttling process between parts/aspects and wholes of the data was carefully implemented. For “one arrives at a better understanding of the parts through analysis of the global meaning, and one arrives at a better analysis of the global meaning through analysis of parts” (Skovholt & Rønnestad, 1995, p.148). Marshall and Rossman (1995) caution that data analysis in qualitative research is not a clear-cut process rather: “data analysis is the process of bringing order, structure and meaning to the mass of collected data. It is a messy, ambiguous, time-consuming, creative and fascinating process. It does not proceed in a linear fashion; it is not neat” (p.111).
Similarly, Holloway and Jefferson (2000) emphasise that research into lived experience is inherently imbued with subtlety and complexity which needs to be acknowledged and embodied in the research process chosen.

**Data Verification**

In response to the authenticity of the data along with representativeness of the texts analysed, Berg (1995) points out that qualitative research does not set out to test causal relationships between variables. Henning, van Rensburg and Smit (2004) clarify that the underpinnings of qualitative research, unlike quantitative research which stresses validity, reliability and generalisation, are based upon four issues of trustworthiness namely credibility, dependability, transferability and confirmability as explicated by Guba and Lincoln (1985). Similarly, Whitemore et al. (2001) advocate evaluating qualitative research primarily in terms of credibility (reflecting participants’ experiences plausibly), authenticity (the emic perspective allowing for subtle differences), criticality (critical appraisal of data) and integrity (recursive and ongoing checks leading to humble findings).

Following Guba and Lincoln (1985), credibility or truth value implies that the research undertaken was conducted in a way where the participants’ experiences were accurately identified and described in a believable way. The in-depth descriptions of the research remain embedded within the data collected so that one can easily see how the researcher arrived at the descriptions; as such each step of the research process has been outlined in a transparent manner. Links between the research data and the researcher’s interpretation have been elucidated explicitly and excerpts from the verbatim transcripts have been incorporated to demonstrate how interpretative links were arrived at.
(Whitemore et al., 2001). Dependability refers to “the coherence of the internal process and the way the researcher accounts for changing conditions in the phenomena” (Bradley, 1993, p. 437). Here the researcher acknowledged working with the uniqueness of the phenomena and accounting for these differences or changes, which by implication demanded an ongoing refining of the researcher’s understanding of the research undertaken. Dependability also rested upon upholding Mason’s dictum of being “thorough, careful, honest and accurate” (2002, p. 188) in the collection and analysis of the data, for example through systematic and comprehensive coding. Transferability refers to the extent to which the findings of this research can be applied beyond the bounds of the current research study. However, Poggenpoel (1998) emphasises that, in line with qualitative research, the burden of transferring the research findings to another research context does not primarily rest with the researcher of the current project. To aid a potential future researcher a complete set of data analysis documents have been kept on file and are available upon request. Access to the audit trail will potentially aid other researchers in transferring the conclusions of this research to other similar research projects. Furthermore the researcher prioritised explicitly communicating the selection procedures and demographics of the sample of the current research as well as outlining the procedural steps of the current research undertaken. Confirmability of the research centred on whether the results of the research, despite the explicit subjectivity of the researcher, could be confirmed or endorsed as relevant by other researchers and here the data was evaluated in light of similar research conducted in the field of therapeutic development through performing a literature review (Bradley, 1993; Whitemore et al., 2001).
The current research stressed the qualitative values of good craftsmanship and honest communication. Thus the current research addressed the question of trustworthiness in terms of methodology: By using certain methods, is this research investigating what it set out to investigate? In a sense the soundness of the research rests upon competence and precision being evident in the research undertaking. Secondly, the current researcher committed herself to ensuring the coherence of the current research by ensuring that the current research has an internal logic and consistency in terms of its knowledge statements (Henning, van Rensburg & Smit, 2004). This was achieved by means of a “continuous recursive process of shuttling between categories of analysis and raw data” (Harbison, 2007, p. 147). Other strategies included checking for researcher effects by prioritising the reflexivity of the researcher. The viability of patterns was prioritised by the researcher actively scanning the research for contrasts and comparisons by cross-checking her mind-maps drawn of the data from each participant. Furthermore, conclusions were consistently held up against previous research in the field, and sampling decisions, for example eleven participants, were carefully decided upon to ensure adequate immersion was achieved (Poggenpoel, 1998).
Chapter 4:

Findings

The interview data indicated that intern psychologists and established psychologists in the Eastern Cape of South Africa possessed both commonalities and differences in the following eight categories: developmental influences, theoretical orientation(s), personal qualities, approach to therapeutic process, shifts in felt competency, influences on professional growth, constructing a professional identity, and challenges to practice. Importantly, the self-report nature of the findings led to descriptions that attempt to reflect the eleven participants’ self-perceptions of their cumulative development as psychotherapists. The categories, main themes and subthemes have been organised in tabular form (see Appendix D).

Developmental Influences

*I felt like I had found the most comfortable pair of shoes in the world* (F).

The current study prioritised the exploration of the continually unfolding interface between the personal and professional development of psychotherapists as they advanced in their therapeutic work. The development of psychotherapists can be likened to embarking upon a protean journey of one’s mutually influencing personal-professional life (Small, 2000). In this sense psychotherapists, like the mythical Greek God Proteus, undergo ongoing personal and professional transformations of oneself in the face of crises along one’s career path:

Certain critical events have transformed me from a person with a rather ordinary perspective to someone who has come to appreciate the fragile nature of life with its rich tapestry of complicated ties and patterns (…). I have also come to recognise that my patients’ particular journeys, on which I
have accompanied them, have similarly contributed to and enriched my life in myriad ways (Small, 2000, p. 85).

Jensen (2007) explored connections between the personal and private life of the psychotherapist and the professional clinical work of the therapist. Drawing on three case examples of psychotherapists’ integrating their personal and professional knowledge, Jensen argued that personal experience and knowledge were decisive in the formation of psychotherapists. With this in mind, she emphasised that a “division between the place where knowledge is applied and the place where knowledge is acquired” (p. 378), is ill-suited to the profession of psychology. Psychotherapists’ personal knowledge contributed to their clinical work as psychotherapists’ personal life experiences held the capacity to shape or structure therapeutic work with clients. Along similar lines, Elkaïm (1997) spoke of the resonance between the personal experiences and professional work of psychotherapists, in that one aspect of life may influence another aspect of life, and as such “resonance occurs when the same rule or feeling appears to be present in different but related systems” (p. xxvii).

**Hard-won Meanings: Motivations for Becoming a Psychotherapist**

The array of motivations relayed by the current sample of South African psychotherapists to pursue the “curious calling” were found to coincide with both the potentially pathogenic “juicy real reasons” identified by Karter (2002), Sussman (1992), Mahrer (2005) and Norcross and Farber (2005). Whereas, the positively genuine “rich descriptions” for wanting to become a therapist were proposed by Carlson and Erickson (2001) and Skovholt and Starkey (2010). Additionally, the “historical roots” of the therapist have been unearthed by Kieley and Piercy (1999), and Timm and Blow (1999).
have viewed the life experiences of therapists through a positive lens as “resources” to be celebrated.

Intern psychologist, Participant B, explored potential motivating factors for deciding to become a psychotherapist. She proposed that being a psychologist is pursued as a career often out of self-interest, in that one embarks upon a journey of self potentially to bring about an understanding of self, “Psychology- studying it has been also very much a selfish thing; very much just self-discovery - understanding self to understand others”. Yet she cautioned that personal development should not be our primary motive for entering the helping profession of psychology. She stated, “eventhough we are gaining and growing (…) that mustn’t be our aim”. Participant B further relayed that possibly individuals who choose the profession of psychology were seeking some exchange of emotional intensity or intimacy, or to satisfy their fascination of pathology:

My mentor once said to me that, “We are emotional prostitutes!” (… ). We give so much of emotion. And, we give so much of our emotion to people. And, what do we get from that? What do want from that? Do we want an emotion? What is the reason for us being therapists? Why do we desire to be around emotion and intensity and pathology?” and, “I am sure we have all in some way tried to (…) quench our loneliness, perhaps, within a therapeutic relationship. Perhaps to feel a connection, an intimacy. That we don’t necessarily always feel in our [lives] - It’s very intimate in therapy.

Celenza (2010), Ehrenberg (1992) and Davies (1994) in their psychoanalytic relational therapy work, have spoken of the intimacy created in therapy and how therapists needed to be constantly vigilant in assessing their own needs and desires which could both disrupt and contribute to the therapeutic process with patients. Established psychologist, Participant F, confessed that her yearning for deep intimate conversation and connection is not the norm in day-to-day life:

I’m not very good at small talk (…) to sit and talk rubbish, sometimes I can do it, - “but this is too tedious I would rather go read my book” (…). I don’t
like lots of people but I find the one-on-one-intimate, I find that interesting, I get a kick out of it. It is very- It’s intimate. I find it hard to work here [in consultation] and then to go home and talk about traffic, you know, things. I love talking about personality development; that is so fascinating. You get used to having kind of intimate interactions with people.

Intern psychologists, B, and C, and established psychologists, F, and K, further shared their thirst for meaning, and understanding. In addition, Participant B expressed a desire to be near suffering:

I went to work in a drug rehab for two years (...) a lot of that was also aimed at understanding (...). I had a desire to be around suffering and pain (...). I wanted something extreme, and, also I wanted to challenge myself. So I went there, probably on my own little search for meaning.

Intern psychologist, Participant B, and established psychologist, Participant J, also confessed to a benign voyeurism or tourism of others’ lives. In a sense, therapists expressed wanting to be an explorer of people’s worlds and a desire to witness the “emotional nakedness” of clients (Karter, 2002) in their experiencing of feeling with clients:

I totally live myself into the experience. I’m probably a bit of a tourist in other people’s lives (...). And I love it. I love- I think I’m also very open to feeling and to feeling things and- if I can put it like that (...) I like to feel with someone (B).

Participants across career levels acknowledged that they often found themselves in a people-pleasing (A, D, and K), helper, or nurturer role (C, D, and G). Similarly to Kaslow (2005) who found that as a child she was “everyone’s trusted confidante”, participants across career levels found themselves in the position of sought-out confidante or mediator (C, D, and F), as such, “the little person who was told things” (F), prior to becoming professional therapists:

I relate very easily with others. I tend to be a good listener so people come to me with a lot of their issues or concerns or just to talk to me in general. So
that has been something that has been consistent throughout my life and then
based on that I have always seen myself in a helping profession (...), in my
life I have always been like the “Go to” type person (D).

Established psychologist, Participant G, also explored her internal dynamics
and highlighted the potential influence of “the rescuing part” of her personality and
her possibly perfectionist traits spurring her on to wanting things to be Pollyannaish:

[Wanting life] sort of good and well and healed and calm and happy. So, I
think that sometimes the need to probably rescue others is probably the need
to rescue yourself. I think that a lot of what I do is sort of like an indication of
what probably I needed, whether I needed help or rescuing or, you know,
calm and peace in my life then that led me probably to be a therapist.

Intern psychologist, Participant E, also acknowledged that psychology potentially
held the key to understanding human behaviour and power dynamics, “you can see
sometimes people are very skilled or powerful in getting what they want (...). I also
wanted to master that skill”. In line with the God complex (Jones, 1913), or shadow of
the therapist (Page, 1999), intern psychologist, Participant D, reflected how a destructive
thirst for power can motivate people to pursue a career as a psychologist:

I think alot of people tend to get almost a like God-complex when it comes to
therapy. And not see it is as helping the person to help themselves. But seeing
it as I’m gonna, you know, save this person’s life or I’m gonna, you know,
control what happens. And, to me that’s a very dangerous line to cross.

Carlson and Erickson (2001) challenged the negative “expert knowledge” views
of therapists’ motivations (Sussman, 1992) for choosing the career of psychotherapy,
“sometimes sincere desires to care for and help others are replaced by explanations of
some desire to make up for some pathology or dysfunction in trainees’ family of origin”
(p. 204). Carlson and Erickson (2001) on the other hand amplified the sacred life
experience, genuine desires, self-knowledge and the special skills of those that wish to be
therapists.
Formative Experiences: Taking a History

your history counts just like (…) when a patient comes in, you want a history because experience has something to do with your position that you sit in. So, obviously the person that I am now or the psychologist that I have become has something to do with the experiences of my life (I).

a good therapist is a person who has experienced life. Who’s aware of life around him or her (…) there’s got to be a rounded-offness (H).

In contrast to Mahrer’s (2005, p. 958) personal experience, of no recollection of key formative experiences, participants revealed “telltale events and childhood themes” that in a sense predisposed them to fulfil a healer role in society. Orlinsky and Rønnestad (2005) in their international study prioritised the formative experiences of psychotherapists across career levels as influential in psychotherapist development. Specifically, Skovholt and Rønnestad (2001) found that early life experiences continue to notably impact therapists who have been in practice for 25 to 56 years. Carlson and Erickson (2001, p. 210) proposed that experiences from the therapist’s life “invite them” into the field and “foster hopes and desires to care for others”, and such life experiences should undergo a “privileging” process within the therapeutic community, most likely the training context.

Eloquently, intern psychologist, Participant D, expressed the link between personal experiences and professional development that characterises the profession of psychology,

as a person you have your own frame of reference, your experiences that you have, and that allows you as a therapist to be able to relate to your clients, and which allows you to give more empathy, to give-get a better understanding of your client and that also helps you, maybe, to facilitate the change that they want to bring into their life.
Intern psychologist, Participant C, argued, in line with developmental psychological theory (e.g. Erikson, 1963), that one’s formative experiences fundamentally impact upon one’s identity as an adult. As such one cannot separate oneself from his/her upbringing or the influence of one’s parents as one’s values and morals are formed in this relational context.

In a similar vein, participants relayed how their childhood influenced their choice of becoming professional helpers. Intern psychologist, Participant D, attributed her focus on empowering people to reach their potential by the positive striving or achievement orientation inculcated from her parents, “it’s been pretty much in terms of my growing up instilled in me to be, to try be, the best that I can be”.

Carlson and Erickson (2001) proposed a reflective re-membering of memorable individuals in the therapists’ lives, who through their love and caring ‘championed’ the therapist’s desire to care for others. Intern psychologist, Participant B, attributed her helping orientation to her mother’s selfless helpfulness, and her curiosity of differences to her father sharing his interest in industrial psychology and anthropology with his children. Similarly to McCullough’s (2005) family ethic of helping those in need established psychologist, Participant G, reflected that she was drawn to becoming a psychologist by virtue of her mother’s influence in terms of the importance of being a nurturer and helper to others in society:

I’ve come from a family of helpers – my mom is a nurse so that influenced a lot in terms of what profession I was going to follow (...). My mom is herself a very nurturing person (...). She’s very caring and I think what she imparted in me about people is that you can care for people and you should be caring and kind and nice to people. And, that was kind of like a common thread she sort of had around the family, with her extended family and with my family. She instilled a lot of humanity in us as kids and in me as a person, and I think
because of her kindness I, therefore, sort of had that quality as quite prominent in my head. She did a lot of charity work [which] made me look at myself beyond just me on my own and (...) recognise that there is other people other than me and a wider range of people in the world.

Established psychologists, G and J, explored how they as children benefited from close contact, caring and intimate relationships which then potentially nurtured a desire to engage and assist others on an intimate basis:

I went to a private school. We were in smaller numbers, there was closer contact with people, there was a lot of relationships formed, a lot of trust (...) therefore I always appreciated relationships and what they mean and what they can be like and what they breed (...), we formed close bonds and that kind of carried me; that, you know, people do need people and ‘what happens to those people that don’t have people to help?’, therefore they come to therapists to help (...). I never really had a big circle of friends and, I think that kind of intimacy in relationships I appreciated it a lot and probably led me to believe that, you know, as therapists we then have that relationship with our patients that are very closely knit and very trustworthy so, you know, maybe a bit of transference here and there (G).

if I look at my development, look at myself at school, I was shy, I wasn’t one of the popular kids, I wasn’t part of a big group. I always liked the sort of two or three friends. That was where I felt comfortable. I didn’t even know about psychologists when I was growing up (...). [Later as a volunteer] I really enjoyed working with the children at that learning clinic, the remedial clinic. It was just me and the child and we would play and do things that would were helping the child. But it was fun. It was getting close and getting to understand the child. That was a unique experience for me. And, ja, that was something that I longed for (...). You find that connection and from that connection you know you get growth. Something is going to happen here. Just to get that connection. It’s just something I’m good at. I never realised that about myself until I started doing therapy. The, ‘ah, I can actually do this’ (J).

Established psychologist, Participant G, reflected on how her different roles, personal contact with diverse people and travels to places of human suffering had made it easier for her to work from a particular theoretical orientation, namely the systemic:
I think that my family background and the dynamics that had gone on there made me appreciate sometimes the dynamics that I see in (...) the systems that I work with (...) the challenges that I have gone through not only as a student, as a child, as a woman, as a partner have also made me appreciate and made me the therapist that I am (...). I don’t necessarily believe that everybody, a good therapist, has to go through all these things themselves (...). I think that for me, it is only but a bonus that I had to go through some of these experiences and it makes my understanding that clearer and my assertiveness levels that much higher and my sensitivity scope that much wider (...), the contact that I’ve had with people in all walks of life has then made me be able to appreciate this. I remember travelling to Sri Lanka after the tsunami and having to see what first-hand real human suffering is. I didn’t read it in a book, I saw it for myself and I had a greater understanding of what is to be able to be heartbroken, devastated as a human being. And, it was for me just the travelling, the contact that I’ve had with so many other people that, you know, builds you and builds your character.

Participants, B, C, and F, also relayed how art and literature served as inspiration in the pursuit of their career paths. Intern psychologist, Participant C, relayed that she has drawn inspiration from the film *Good Will Hunting* in demonstrating a sense of dedication towards her clients. Whereas Participant B, found that the Dutch post-Impressionist artist Vincent van Gogh ignited her interest in psychology as she wanted to understand how he saw the world and how others perceived their world. Established psychologist, Participant F, relayed how her interest in psychology was fanned by reading psychological works:

I would go to Exclusive Books and go look at the psychology section- read Freud and *Man and his symbols* [Jung] and Viktor Frankl’s *Man’s search for meaning*. I would read those things and think about them.

**Wounded Healer: Therapists’ Own Emotional Scarring**

“*Expertise is linked with experience but also with your ability to utilise that experience*” (H).
In line with Jung’s description of the Greek myth of the medicinal god Asklepios (1951), and the countertransference potential of the therapist’s wounding was explored by Sedgewick (1984) and Viljoen (2004), participants’ key milestones in their psychotherapist development included their deepest personal struggles. Skovholt and Starkey (2010) emphasised:

> to know and understand suffering on a personal level helps practitioners better understand client pain and suffering thereby increasing the practitioner’s capacity for empathy. Practitioners need to know the schema of grief; what it is, how it is expressed, how to enter it and how to be helpful in the healing process. (p. 129).

Movingly, established psychologist, Participant H, reflected on how his personal experience of disability has contributed to him being a therapist who can identify with the personal struggles of patients. He commented that he had drawn purpose as a therapist from the pragmatic help he received from a blind minister, a wounded healer himself, following his injury and how he aimed to help people in such a way that they leave a consultation having felt truly accepted and assisted:

> the other thing that I learnt in hospital was, all those years ago, when I was laying [paralysed] there, a man came walking down the middle of the hospital ward and I could see he was blind because he had a white stick and he was tapping, tapping (…), he went to the bed next to me and he just asked, “Can I see [Participant H]”, and the guy said, “No, I’m the next one”, you know, and he came tapping, and he was a minister. He was badly injured in the war and lost his eyes and whatever, but he never once, ever preached religion to me. But he asked me whether there was anything I needed (…), I was far from home (…) and he asked whether I wouldn’t want to come and have a cup of tea with him at church or after church, whatever it was, and I struck up quite a relationship and every Sunday I used to go to church but I didn’t go because of the so-called religion (…). He was just a decent, honest, good, practical, loving person. And that meant a lot to me as well (…), he took me for what I was. He didn’t know who I was. I was a complete stranger to him but he took me into their sort of congregation (…) and he just got people to look after me and take me out (…), here was a guy that just gave me practical support that I
needed at that stage of my life (...). I think he made a big impact on my life as well (...) tolerant of people’s needs, tolerant of what, how they act, react towards one (...) to accept that people can be in different places and in very dire circumstances and there is something you can actually do for them. There’s something you can actually do besides preaching or try tell them something. You can actually functionally help them or physically put them in a situation that they are better off when they walk out that room than they were when they came into the room basically.

Wolgien and Coady (1997) argued that the wounded healer paradigm offered a viable framework to understand how formative personal experiences of therapists contribute to their professional development. Wolgien and Coady (1997) found that therapists were seen to possess the gift of perspective and empathy in acknowledging the frailty of themselves and family members with difficulties and conflicts which enabled them to demonstrate empathy for clients’ presenting difficulties.

Carlson and Erikson (2001) spoke of honouring the wounding of psychotherapists within a social constructionist, particularly Narrative Therapy, framework where personal struggles were regarded as a “rite of passage” into the healing profession, which when embodied by psychotherapists could be a resource to be drawn upon in their work with clients. Established psychologist, Participant H, argued that psychologists need to have gone through their own hardship, an initiation or process of ‘life toughening’ in order to effectively understand vulnerability and know how to be resilient in order to assist others through their own life:

Unless you’ve gone through a bit of hardship, unless you know what discrimination is like, I think, you know, you just, I mean, you know yourself, you just have so many more experiences. And you see it from a different perspective I mean we all remain vulnerable. When one is disabled, more than other people, I suppose. (...) I think you become toughened to life. And, you understand more readily what other people also may or may not go through.
With the proviso of a personal opinion, established psychologist, Participant J, held that a key ingredient of a therapist is the presence of emotional scars and how one needs to have experienced woundedness in order to be an effective therapist. She further linked empathic woundedness with having experienced enough of life and as such not being a ‘spring chicken’, prior to becoming a therapist in order to benefit from embarking upon professional training as a therapist:

I would look at age (...) because for me I want to see your scars (...), I want to know how you got those scars. I want to know how those scars healed or didn’t heal. And, if they didn’t heal it’s not going to say you’re not going to be a good therapist (...). I just think that they’re too newly hatched at the age of twenty two, twenty three. They haven’t got scars yet.

Established psychologists, F, J, and K, reflected on how their argument for age as a potential indicator of life experience has been informed by their own experience towards professionalisation as a psychologist as their second career. Life experience was seen as related to the ability to be empathic and identify with psychological theory:

I was about thirty-three, when I started my Honours. You’ve been knocked around by life a bit. So when somebody comes to see you, (and they might not have the same knocks as you had but you know the feeling), you know that feeling of desperation. You know that feeling of, “I don’t know where to go”. I know, you know, that feeling of waking up at 3 o’clock in the morning and your life just seems pointless. If you’ve been there (...) you’re going to have empathy, you’re going to have understanding. Um, you would have gone to those dark places. You’re going to be afraid of those dark places, you’ve been there. So, you know, age for me is crucial. (...) it wouldn’t mean that, you know, a thirty-three-year-old is going to have all those things in place but there’s a better chance that they will and then, by virtue of their own woundedness, they can act with empathy and at least know what it means. And, they’re so receptive to the theory then because they have identification, “this is me I’m reading about” (...). It speaks to you. You’re going to grow as a therapist, you really are, because that’s come together for you (J).
people are different and I know that there are many good young therapists but I don’t think I would have been a good therapist at twenty five; not me, personally, I was too up and down and confused (F).

Similarly, established psychologist, Participant I, also related how she would place priority and credibility on life experience and the chronological age when choosing to consult a psychologist as a client or when selecting individuals to train as psychologists:

if you haven’t been successful in coping with your own challenges in life, then you can’t expect to help other people. That’s my opinion. I mean, it’s got to be some kind of a situation where you overcome your challenges, whether they be psychological or physical or whatever. It might be a combination thereof. And, if you do have the credibility (…) if you walk into two psychologists, the one person is a 45-year-old woman whose got a lot of experience, the other one’s a 22-year-old woman with no experience, who’s going to help you the most? It most likely will be the person who’s got-, the 45-year-old person with a lot of experience already. Not that the other person’s not good, or going to be good (…). But at that stage of her or his life, he doesn’t have the background, doesn’t have the knowledge to help the person (…). So how do you train someone to be a psychologist? It’s very difficult. To make a good therapist? I think you must be a little bit older because then at least (…) you’ve got your life experience.

In contrast to established psychologist participants of this study, F, I, J, and K, Schröder and Davis (2004) in their study of 102 psychotherapists, found that the age of the therapist does not protect against difficulties with clients, rather the more years that they had been in practice (professional experience) the less difficulties therapists encountered in their clinical work. As such, extensive life experiences were not necessarily an indicator of therapist competence. Similarly, Orlinsky and Rønnestad (2005) found in their study of 4 923 psychotherapists that practice duration as opposed to age indicated higher levels of career development.
Participant I also related that having children has enhanced her ability to build therapeutic rapport effectively with child clients. Established psychologists, F, and I, stated that having children enabled them to be more empathic with parents and do more effective therapy with parents. For example, Participant I conveyed that as an adult she became wounded as an adoptive parent and how it has sensitised her to the pain of clients’ who were parents:

It’s very good for me to have children, because the children help me with other children, I can relate to them (...) like one of the boys didn’t want to come and he sat down and he was very resistant and then he said something that sounded like Star Wars. And I went and got my Star Wars cards and his whole attitude changed (...) and now he says to his mom, “She is quite cool, hey?”

you’ve got to have a bit of experience. But then, you know, I had two kids and until I adopted my daughter, I didn’t know anything about pain with kids. Because if you adopt a child, you are adopting trouble. If you have a child you might get trouble but the chances are sort of much less, if you adopt a child you get trouble. And it is very good for you to get a huge amount of trouble as a psychologist because you are sitting with troubled parents and what I know from my daughter, I mean I had to go to Kenilworth (...) great they reduced me to absolutely nothing and then tell me my child has a problem which I can’t fix. That’s good, that’s what other parents feel like (...). Take me to a place where I am being pulled right through the ball and backwards, that the pain is vulnerable, that the control is completely gone. And then I know what your pain is like. How good is that? You wouldn’t wish it on your worst enemy. But, it’s very good for the psychologist because you cannot assume that you understand anything if you and I know you can’t be there. You can’t lose your mom and dad so that you can understand the pain. But I do think that when I’m talking to parents with very hard and difficult children, we have a bond.

Furthermore, Participant I referred to how effective similar life experiences contributed to success in substance abuse clinical work as one has the advantage being forthright:
If you go to Kenilworth, all of them are “ex” or married to “ex” drug addicts. Because they know (…) you can’t bullshit them, you can’t talk past, they are going to tell you, “that’s rubbish”. Because I think a big part of our job—I do facilitating—is feedback. You’ve got to give feedback to the person.

Established psychologists, H, and K, also held that one’s painful personal experiences can kindle an enthusiastic interest in a particular area of clinical work and enhance one’s credibility with clients. Participant H stated that his wounding instigated his own ingenuity in Sex Therapy:

I went into that field because when I was injured (…), I was 20 years old (…). I was told by the doctor that I would never, ever have sex again (…), So I had a burning desire to learn more about myself and as I learnt about myself, I then realised but hang on there is many more things (…). So, I developed all my own therapies to sort myself out and I was accustomed to doing that and I then I used to use that; so I developed a niche (…). If you’re not enthusiastic about what you want to do (…) it’s not going to have a positive outcome for anybody. You’ve got to actually have a strong need to want to say, “Listen, I really believe in the system or this really worked” (…). If you don’t have your own (…) enthusiasm for your product, then you can’t expect to sell that product to somebody else and you can’t expect them to benefit from it (…). I speak to you about the things that I know about, that I believe in. I’m not going to speak about things that I can’t relate to.

Established psychologist, Participant K, verbalised that her critical experience, that of infertility, propelled her into the profession and especially working within the specialty of women’s wellness:

I had one child and then after, when she was about four, I tried to fall pregnant again and I couldn’t fall pregnant. And, I went through about six years of infertility treatment during which time I also went to see a psychologist right at the end (…), it was a hugely traumatic time for me and I was angry with the world (…). I wasn’t realising at the time that I was actually mourning a loss of a child that I never had (…). After I had finished my treatment I said to my husband, “I would like to go back and study” (…) and I went and became a psychologist! (…) and I actually specialise in women’s wellness (…) maybe it has also like determined the kind of therapist I am because I really do understand when I have infertility patients (…) I can empathise with them.
Participant K conceded that she had considered the profession of psychology prior to her wounding experience however she found that it was her painful growth experience that was the real impetus that steered her to training as a psychologist:

it was something I thought of at school, “Oh, I would like to be a psychologist,” but I never went that route (…), if I had not have gone through that experience, I probably would not have become a psychologist. So, I’m almost grateful for that now, you know, that I did go through it because I mean I didn’t go on to have another child (…). I think this is why a lot of the gynaes that do know me (...) refer to me because they actually can see that I’m one of their like ‘failures’, in a sense, that still got on with life (…). I think my turning point was in the beginning, you know, why I became a therapist. I don’t think I particularly had another turning point in my life. There have been a lot of little growths, little branches off but nothing that’s been this major. I think I became a therapist (...) because of my growth.

Intern psychologist, Participant E, as a mature student, initially, traced his process of deciding upon becoming a psychotherapist in relation to choosing a degree between two interests namely, media and psychology. Participant E also spoke of potential underlying personal motivations for becoming a psychotherapist that included the challenges of coming out in terms of sexual orientation and how it potentially impacts familial relationships. His personal experience thus stimulated a desire to assist others through similar challenges:

to have in some places or some areas to have been alienated or emotionally abused as a teenager or as a child before that. And, I think also, being gay, also definitely, – you know, what it’s like for people to be nervous standing up for themselves, or will they be accepted, or living with this fear of not being accepted. And, also the challenge now to overcome lack of self-confidence. And, then what you need? (…). I think I feel like I’ve wasted many years of my life, because I was uncomfortable or could not accept that I was gay. And, then I felt I must use it for something or if I could help other people and not waste so many years. That was the motivation that I had to become a therapist. I had seen in my family (…), it’s sad when families lose out on family members because they don’t find a way to work things out or get along (…) I would like to help families do that.
Intern psychologist, Participant B, reflected how her earlier experience over two years of being a substance abuse counsellor contributed to her current training as an intern psychologist and how personal painful experiences had enhanced her therapeutic development:

A lot of bad things happened to, uh, patients as well as to myself. And, a lot of people overdosed (…). But, I think all of these things affect the way I was being developed (…). I think my process was very good for me as a person because I needed to go through that also to be a better therapist in a sense. I don’t think everyone needs to go through- You don’t have to be the wounded healer, but- I definitely did. Because- I built sandcastles in the sky and I think they all just crashed that year!

Yet despite her experiences through her BPsych practicum of working with children and her two years as a substance abuse counselor, Participant B, acknowledged she found that she no longer wished to work with the client populations consisting of children and substance users. But rather she was drawn to investing in other facets of psychotherapeutic work:

I think we must look at where we best, probably, work. Like what is the thing that best suits you. And then, go in that direction. It is going to be the best thing for the person and for yourself (…) what do you feel most drawn too? Because then you will be most effective in those areas. And I think it will change and grow as we get older and wiser.

In contrast, despite their young age, intern psychologists, A, C, and D, who entered Masters training immediately following their undergraduate years of psychology also referred to challenging life experiences. Participant C referred to family dynamics that forced her into the role of nurturer within her family context. Participant D pointed out that painful life experiences continue to influence her development as a psychotherapist as a family member’s illness impacted her current personal and professional development. Participant A referred to the development of self-reflection as
a result of coming to terms with the ramifications of her parents’ divorce as a young child and how it taught her to “be accommodating towards others”, managing chronic illness of her family members, and trying to find existential meaning in the loss of a friend and how “through life my awareness has expanded”. She argued that:

life experiences and particularly challenging ones, um, kind of pushed me to points where I needed to reflect on life and what’s happening and how can I derive meaning from this or how can I make this be seen in a positive light and learn from this (…). I can’t say of all the therapist that I am is in terms of life experience, but then yet again, ‘why do I, as a person, reflect on things like that and another person not?’(…). I think my reflective capacity has gotten me to a point to mature (…). I feel comfortable with myself at this point in time. I feel congruent (…) there’s not stuff there that’s floating around there, undealt with kind of things (…) I’m so aware of my life and things that happen so that I’m not biased when another person comes sits with me.

Additionally, Participant A pointed out that from a young age she was exposed to a sense of community involvement and humanitarianism within a church and school context.

Yet despite formative experiences shaping therapists, Participant A felt that the professionalisation of the psychologist role in one’s training years should be regarded as a watershed moment or key ‘technicality’ in becoming a psychotherapist. For without the postgraduate training any human being could inhabit a helping role that was seen as therapeutic:

I think every single individual on this planet can call themselves a therapist because we are relational human beings, we are in relationships with everyone and (…) just for example, a friend listening to you – that’s therapeutic.

Established psychologists, F, and J, spoke of the Jungian synchronicity of events in their lives that led them to becoming psychologists. Roehlke (1988) supported the
notion of “self-in-the world in which each person existed in a matrix of personally meaningful events” (p. 133), and that synchronistic events as such activate crucial phases of the individuation process for individuals (and psychotherapists). Participant J reflected that as she had been speaking “a whole lot of threads came together and were woven” and:

I’ve been so fortunate that I was in the right place at the right university at the right time. I know Rhodes has changed completely now. Um, I don’t know where I would have been if I hadn’t been there at the right time. And I’m so grateful for that.

Uniquely, established psychologist, Participant F, spoke of an internal event happening to her rather than a specific circumstance:

I kinda knew that was where I was going. It was kinda of just there (…). I can’t say something major happened in my life. But, I think something inside of me happened (…). It was an arbitrary thing, we- I was chatting to a friend and I said to him, “I want to go do Masters one day”, and he said, “Why, one day? Why not now?”, and I thought about that, and that is when I applied two months later to do it, um, it was just inside of me I could feel- it was around when I turned thirty- I could feel that I needed to kind of look at what my dreams were and to and to start doing them and not wait around.

**Theoretical Orientation(s)**

*a theoretical basis is important just to hang things on. (F)*

**Constructing a Personal Theoretical Framework**

Orlinsky and Rønnestad (2005) conceptualised psychotherapist development as including the psychotherapist’s theoretical orientation adopted in relation to their therapeutic work. Salient theoretical orientations included analytic-dynamic, cognitive-behavioural, humanistic, systemic, or other, as well as no particular orientation or more than two key orientations. Basseches (1997) emphasised that therapists needed to be attentive to how they were organising their knowledge, ideas and thinking related to their therapeutic work, as such their meaning-making activity, rather than merely acquiring
techniques to apply in consultations. Kieley and Piercy (1999) prioritised that the formulation of a personal approach to therapy be undertaken by psychotherapists during training which can be refined on an ongoing basis. Arguably, in order to understand the significance of theoretical orientation(s) of therapists one needed to acknowledge how the choice of theoretical orientation(s) is inextricably linked to the exposure to certain models during one’s training years. Intern psychologists interviewed having trained in Port Elizabeth at Nelson Mandela Metropolitan University referred to being trained in Person-Centred Therapy, Play Therapy, Object Relations, Cognitive-Behavioural Therapy, Transactional Analysis, Narrative Therapy, Systems Therapy, and cultivating interests in Postmodernism, Analytical Psychology (Jungian), Sandtray Therapy, Logotherapy and Gestalt Therapy.

Established psychologists having trained at the University of Port Elizabeth as it was known at the time or in Grahamstown at Rhodes University specifically referred to Object Relations, Phenomenology, Person-Centred Therapy, Play Therapy, Cognitive-Behavioural Therapy, Transactional Analysis, Systems Therapy, and an array of theoretical interests potentially beyond their training including Dialectical Behaviour Therapy, Sex Therapy, Gestalt Therapy, Psychodrama, Narrative Therapy, Solution-Focused Therapy, Analytical Psychology (Jungian), Sandtray Therapy, Logotherapy, and Positive Psychology.

Intern psychologists spoke of having the opportunity to be on a theoretical “journey” (A), or “pull from a lot” (C), and yet having their “main kind of likings” (C), finding particular theoretical orientations “appealing” (C) or “attractive” (A) to them and using therapeutic models that personally “made the most sense” (D). Intern
psychologists also expressed that they had not “downplayed” and had been cautious in “not downing any specific approaches” (B), or “taking away from” (C), certain models of therapy eventhough they may not have resonated with them as individuals. Instead they had taken “a little bit of”, “certain bits and pieces”, or have found “advantages”, or made “a mix” (E), from the array of theoretical orientations. Intern psychologists acknowledged that they did not at the time subscribe to a specific theoretical orientation, and that they may not have a “great understanding” of some of the models (B). For example, “I can’t really say that I only use one approach really” (A), “I don’t know if I have a particular approach” (C), and, “I think I’m still going to discover that. At the moment, (...) I think I’m using a bit of an eclectic approach- I mostly look at what the patient or the person, is like” (B), and, “I use the eclectic side, I don’t actually use the same theory every time” (E).

With exposure to many models of therapy intern psychologist, Participant D, limited herself to focusing on two models as she “didn’t want to hop around too much.” In contrast, Participant A found herself “diving into” numerous theories in her postgraduate years “to explore” what she regarded as valuable principles for therapy. Participant A then spoke of a ‘tailor-made portable’ orientation that could be accessible and on-hand when needed, “I developed a suitcase for myself in which I took some of those things that I value and I thought that was valuable in therapy”.

Hess (1987) argued that the second stage of supervision (or training) for beginner therapists namely, skills development, was characterised by the supervisee beginning to take hold of a system of therapy and a philosophy of human nature. However, not all intern participants articulated a preferred therapy model nor a particular view on human
nature that resonated with them. Possibly, exposure to numerous systems of therapy in their particular training context endorsed a sense of open-endedness to therapeutic systems that could be potentially utilised in clinical work. Yet another possibility of not having an in-depth understanding of a particular therapeutic model could potentially have led to having “inadequate conceptual maps” to guide one’s clinical work (Skovholt & Rønnestad, 2003, p. 51).

Orlinsky and Rønnestad (2005) found that psychotherapists, in their international study, predominantly conducted in Germany, United States of America, Norway, Switzerland, Spain, Portugal and South Korea, who showed no commitment to a salient theoretical orientation displayed the least signs of progress or flux in their professional development and the highest indication of felt stasis and regress. Therapists with a Cognitive Behavioral Therapy orientation showed signs of flux and regress as well as less progress. Contrastingly, “broad-spectrum integrative-eclectic” psychotherapists were found to be the “most growing” practitioners displaying more progress and the least stasis. As a result Orlinsky and Rønnestad (2005) argued that theoretical breadth ignited therapist experimentation in practice. In addition, humanist therapists reported the most felt progress was linked to their openness to experience (Orlinsky & Rønnestad, 2005).

Established psychologist participants reflected on their theoretical orientation in light of the context of their training years. For example, Participant I stated:

I’ve got a set of experiences in terms of education which are completely different to yours, but there is also the facts of time like- how old am I? (...). But, I think going to Rhodes University, being educated in Phenomenological was quite big (…). I think that you are getting a totally different setwork and course to what I got, okay? So, obviously, we are going to be different just in terms of that.
Established psychologist, Participant J, stated a general adherence to a particular orientation, that of Object Relations:

I always tried to apply my Object Relations principles wherever I was working because that was the way I thought (...) it would never be Object Relations therapy as you would like it to be but it certainly gave me and the person I was working with a framework. And, that has always been my approach. Always within an Object Relations framework.

In contrast, established psychologists, F, and K, identified themselves as eclectic. Participant F relayed that she conceptualised mainly within a Transactional Analysis framework but had a “mix” with other theoretical orientations. However, she emphasised her main focus was what was occurring in the therapist-client relationship along the lines of a relational approach to therapy. Participant K admitted, “I’m quite eclectic – I know it’s a very like cliché sort of term,” and that with her practical focus she found, “somehow it all seems to gel”. Participant G stated that she generally conducted Cognitive Behavioural Therapy in line with the requirements of the hospital setting in which she worked. However, she personally remained open to Systems Therapy and Narrative Therapy where it became applicable.

However, established psychologist, Participant I, saw herself as a “maverick” who subscribes more towards integrative psychotherapy, even likely as far as an integral psychology (Wilber, 2000) where the person was viewed holistically:

I like the word ‘integrated’ because everything has played a part, you know? If we look at, let’s say truth or knowledge, per se, what we know isn’t just theoretical or empirical. You cannot put it down on a statistic. What you know is a story and it has (...) evolved, set in its contextual life as well. So, you cannot have a theory to understand human beings. You cannot work empirically when you’re dealing with the heart, okay, and you’ve got the spirit. If we look at the human being we are faced with: the person comes in with a set of knowledge, a set of beliefs, a set of thoughts- the cognitive side, and then you’ve also got the other side, which is the heart- the irrational side,
and then you’ve got the subconscious which you can’t even speak about, and then you also got the set of experiences which is completely different to yours and then you’ve got the spiritual side. So, how can one theory cover all those sides?

Intern psychologist, Participant A, also advocated an integrative theoretical approach, however she admitted to choosing a main framework and then incorporating other theories as adjuncts. She also argued that Rogerian therapy was useful for her in terms of understanding herself in terms of the person of the therapist:

different theories address some parts of human function (…) for me to understand an individual I would have to rely on one of them (…) to contextualise this client’s case – if that makes any sense? (...). I need a framework, so I would sort of think, “What is most prominent with this client and this particular problem and which of these can best make me understand the dynamics with this client?” And, then I can always use that as my main approach and my main conceptualisation. But, then as a person, I will be Rogerian- (...). I can’t really take that away from who I am. So, I think in a way I’ve integrated, but with a preference for some theories than others.

Similarly, Millon (2000) rejected continued adherence to a school-orientated or a dogmatic stance to psychotherapy, rather he advocated that therapists must be willing to accept that the array of theoretical perspectives on offer had legitimate claims in assisting people therapeutically. Furthermore, Millon argued against the arbitrary use of therapies as a “grab bag of fascinating techniques” (p. 47). Rather Millon (2000) proposed “the orchestration of diverse, yet synthesised techniques of intervention” (p. 47). This clarion call for synergy in therapeutic intervention is intended to aid fledging therapists from oversimplifying the complexity of the problems of the client and the requirements of the therapeutic process:

Integrative therapies will lead us back to reality by exploring both the natural intricacy and diversity of patients we treat. Despite their frequent brilliance, most schools of therapy have become inbred; more importantly, they persist in narrowing the clinician’s attention to just one or another facet of their
patient’s psychological makeup, thereby wandering ever farther from human reality (Millon, 2000, p. 47).

In a similar vein to Participant I, Millon (2000) found that therapy was a complex endeavour as human beings were inherently complex he therefore resolved that therapists need to construct a “configuration of therapy” that is as “organismically complex as the person” (p. 51).

**Matching the Know-how to the Need**

Participants across career levels illustrated that before one employed a specific theoretical orientation a therapist needed to identify the client’s needs. Following this the therapist would have a theoretical orientation that fitted the client’s expressed needs as well as the client’s resources and limitations:

I am part of a psychoanalytic reading group, we talk about it all the time, it’s just a core underlying thing: I must be able to hold you. But, not all people are needing to be held (...). You will come in and say, “help me with this career decision-making problem”. Now, we’re working on a totally different level. We are working on a counselling level. We’re saying, “you know, I need to change my job”. So, I’m not going to hold you. I am going to understand what it is you’re wanting and then I am going to have to try and orientate you into a different direction. So, now my job is more of a facilitator. (...). I’m giving you the strength to change but I am not just bearing your pain. The difficulty of the job- (...) your first job is to find out what the patient wants (I).

Established psychologist, Participant I, also spoke of being sensitive to the ‘fit’ of the theoretical orientation, of how one is choosing to intervene with the unique individual, “I’ll do interpretations if it’s necessary with the right patient in the right place, you know? (...). If I’ve got my long-term people, I work psychoanalytically with them. It’s the best way”.

Intern psychologist participants also highlighted how they had begun to recognise how central it was for therapists to align their interventions overtly with the client’s needs
and expectations, “a client that I lost in the process made me very aware of- (...) you need to be very attuned to what your client’s needs are” (C); and “comply with the expectations of the client (...) from the beginning set out what the expectations are and then to try and help the person” (D). Intern psychologists also emphasised that choice of theoretical approach hinged upon the client’s needs, “I think the approach that therapists choose, or that I choose, depends a lot on the client, the problem that he’s bringing” (A), and:

I would have always downplayed CBT, but I know that for instance in therapy this year I have used that a lot (...). It doesn’t resonate with me at all. But I find that with many people, like that is what they need (...). There were two people I did CBT with this year (...) I just knew they are very cognitive-this is what is going to work best with them and it also works with their pathology. ‘Let’s do that!’ And it worked (B).

What I do is the first time I meet a client I basically just let them talk and talk and talk, and so I get the feel of what kind of person they are, what their problem is and then I try to think what way of working would function well with this client, whether it’s in terms of a certain framework or what kind of things you would do with them – whether it would be experimental stuff or whether we would just sit and talk or teach them something or just see if they need to maybe empty the house or if they need, you know, like a wall to bounce off (...). I get a feel of the client and the situation they’re in and how they would like to work (E).

Established psychologists, G, J, and K, acknowledged how the current context of managed care had brought Cognitive Behavioural Therapy and Solution-Focused Therapy into prominence, “I’ve only had the opportunity, I would say, to have worked with CBT. My exposure is limited to the hospital setting”, yet despite the official constraints Participant G demonstrated flexibility in her theoretical orientation and placed priority on the client’s needs when determining her theoretical framework:
I wouldn’t say there is any model I wouldn’t work with (…) every case for me gets dictated by the circumstances that surround that case (…) even in the hospital environment I find myself using Systems Therapy [and] I have had an opportunity to use Narrative Therapy and have enjoyed it immensely (G).

I think it’s all been a learning curve (…) if I sit back and think where did I learn this or where did I learn that, most of my learning actually started once I’d left varisty [with] employee wellness providers (K).

**Theoretical Differences**

Intern psychologist, Participant A, highlighted a prevalent dynamic of therapists, namely that despite an openness to adapting their theoretical framework to clients’ needs, therapists do indicate preferred theoretical orientation(s) and ways of working, “I think in a way I’ve integrated, but with a preference for some theories than others” (A).

Participant A confessed that Cognitive Behavioural Therapy held little appeal for her in terms of a theoretical orientation of therapy:

Cognitive Behavioural Therapy (…) is for me almost like Polyfilla (…) you polyfill the wall and, but you don’t really know what cracked the wall. You have this problem – “Oh, shit! the wall is cracked! – polyfill and it looks beautiful, it will go on, but what if?, what makes that wall crack?, you know, what if it cracks again? You know, can we get to that?

Preferences, in terms of the therapy duration of certain theoretical models, were also verbalised by established psychologists. Established psychologist, Participant I, verbalised a challenge to long-term therapy:

I don’t actually like the psychoanalytic person believing that they can solve every problem as long as they’ve got ten years. To me that’s not really good for the patient (…). I also don’t like dependency. I know it’s good for your profit to have patients that end up coming twice a week. But for me, I want them to get better. I suppose that is silly in some cases where some people aren’t just going to get better and I think if you tell someone you want them to get better then it’s my need and not yours but actually overall we should all be wanting our patients to get better actually.
In line with Simon (2006), theoretical orientation also appeared to be deeply entwined with one’s philosophy of human beings and the person of the therapist. Intern psychologists, A, B, C, and E, spoke of the theoretical orientation of the therapist fitting the person of the therapist, “I think a therapist should be aware of what feels comfortable with him or her, um, you know, sort of feeling congruent with the theory” (A). Narrative therapists, Carlson and Erickson, (2001) advocated linking one’s theoretical orientation with one’s personal values to bring about a sense of therapist accountability. Intern psychologist, Participant C, resonated with Carl Rogers’ view of human nature and the strength-based approach of Narrative Therapy:

I suppose I also value the way [Rogers] sees people and the fact that he sees potential in people that for me is very inspiring and that is the way I see people. I feel that anybody can change and make a difference in their lives (…). I just feel like you go through a lot of the theories that we do have are very pathologising and that just doesn’t fit with my worldview on being optimistic and knowing that anybody can heal.

Similar to Arthur (2000), and Buckman and Barker (2009) established psychologist, Participant G, argued for an openness to the diversity of theoretical orientation as it reflected the diversity of therapists in the profession:

I’m all for the different types of therapy that are out there. I am all for options for people because not every therapist is going to go with CBT and not every therapist is going to go with Narrative or Systems (…), and I think that it is good to have those options.

Interestingly, intern psychologists drew a distinction between theoretical orientations that were directive (structured) as opposed to non-directive (unstructured), and from this basis chose a theoretical orientation that fitted their general therapeutic style, “I do use some concepts of CBT, but the homework side of it just doesn’t fit with
me and the directiveness of it - doesn’t fit me as an open person” (C). Similarly, Participant D reflected:

I find it very difficult to identify with CBT because of the structure thing - which I always thought was quite weird because of my personality (...) I thought because I’m very Type A type person (...) I would have liked the structure. But I find it very, um, nerve-wracking to have set plans and exercises (...). I find I am much more comfortable when the patient is leading and just talking about what they need to talk about (...) throwing things in-between but not having a set plan for a session.

Yet, Participant D also verbalised that she found non-directive therapy challenging at first:

[Person-Centred Therapy] was a big challenge for me- trusting the process (...). You can’t push, you can’t really confront too much, so that really challenged me as a person and as a therapist to just let go of the control. So I felt myself throughout the process often not trusting myself, and not trusting the process. And, wondering, ‘Is this working? Should I do something more? Am I on the right track? Are they getting something from it?’ And, that was quite difficult for me, very difficult.

In contrast, intern psychologist participants, B, D, and E, also included directive techniques from CBT, Gestalt and TA into their therapy, “use some TA techniques (...), sometimes it’s just nice to have some structure”, and “experiment with different things (...) quite Gestalt-type things. Make people do things and to interact with people” (B).

Intern psychologists thus appear to have invested time in finding their personal comfort level in terms of the degree of being directive or non-directive in their clinical work and in turn have applied particular theoretical models in a way that fits their preferred level of structuring the therapeutic process for clients.

**Systemic Ways of Thinking: The Butterfly Effect**

The systemic thinking of participants, B, E, G, H, and I, provided evidence of cultural competence being demonstrated by psychotherapists who are taking into account
individuals, groups, and institutions in their decision-making processes with the awareness that systemic forces fundamentally affect people and therefore require psychologists to advocate in social and political arenas to effect change (Sue, 2001). Sue (2001) argued that therapists treating the “identified patient” alone could prove to be ineffective unless the practitioner took into account the individual’s intimate relationship and family system as illustrated by established psychologists in the South African context.

Established psychologists G, and H, highlighted the importance of psychotherapists adopting a systemic way of thinking when addressing a patient’s changeable needs and:

to look at the whole context of the person (...) you can’t only deal with that person, I mean, *people don’t live on islands*. So, you might have Mr, you know, Joe Soap, in front of you but he’s got a wife or a sister or a mother or a brother or whatever it might be. So you’ve got to be aware all the time of when you give guidance and guidelines as to how that’s going to affect that person, but also those with whom he or she comes into contact with (H).

I think that sometimes the identified victims are not the ones that are sitting in front of you having therapy. It’s the wider picture that needs the treatment and it is very important to be inclusive in whatever we do because if you heal this one individual and take them back into a destructive system, whether that being a family or a workplace, you’ve done half the job. You might have empowered them and given them all those skills to carry on forward but it’s more the better if you tackle the other spheres (...). We are trying now to include the family where these people are being discharged. We’re trying to work with the police, the community, the clinics where they are being discharged to (...). It is that kind of a profession now. It’s no longer me and myself in my office seeing just this one person; it doesn’t work like that anymore (G).

Participant H, described a case example of a down-trodden housewife to illustrate how he as a therapist needed to be aware how her personal change as a result of her
therapeutic process impacted upon her intimate relationship and her context, and to adjust the process accordingly:

In adjusting to that person’s changing needs because, this is very simple: (…) I had one woman who came to me. She was sent by her husband. And he said to me he’s got this wife now who doesn’t look after herself. She’s got a moustache and she doesn’t shave under her arms and she wears old clothes and she doesn’t have a nice hairstyle and he can’t- he doesn’t find her attractive or anything. And the whole big story, okay. So, eventually I see this wife and she is a very downtrodden, sort of mousey-looking person (…). I do a lot of therapy with her; get her to change, build up her self-concept, her image, her sensuality, whatever. She ends up six months later with a lovely hairstyle, she’s lost weight, she’s wearing nice dresses. He now comes with the problem, “my wife’s having an affair now”. In other words, there’s a whole change he can’t cope with the new wife. He can’t, she’s not having an affair, but he can’t cope with this pretty woman who can stand up to him, who’s got a self-concept. Who’s not just a “yes, yes…” and mat to walk over. So you had to deal with those problems as well. So, the whole situation remains fluid when you do therapy (…) any one theory doesn’t work throughout a process, and basically I think, to be a good psychologist, you’ve got to understand the needs of that person. You’ve got to really, really care for that person in a very objective way obviously (…) and you’ve got to be able to change your-, the way in which you look at his or her problems even on a weekly basis and to try this and try that and come up with tangible solutions. Not just airy-fairy theory (H).

**Getting a Grip on Theory**

Intern psychologist, Participant A, offered a description of her process of engaging with various theoretical orientations of psychotherapy, which vividly depicts the Piagetean concepts of assimilation (fitting the new ideas into the existing framework) and accommodation (changing the existing framework to make sense of the new ideas) (Basseches, 1997; Piaget, 1972). Brendel, Kolbert, and Foster (2002) also spoke of an assimilation/accommodation disequilibrium in beginner therapists that acted as the impetus for both cognitive and emotional growth. In her initial exposure to new theory, Participant A spoke of being excited about being exposed and immersed in new theories,
“when I just got exposed to all these things, you know, all these theories, I was very excited and, you know, dived into these things and, it makes all sense and I can see this”.

Secondly, Participant A then spoke of having to make sense of all she was exposed to through a process of self-reflection in order to draw generalisations and construct useful tools and sort out which theoretical principles can become applied theory in her clinical work, as such having a toolbox on hand:

as early as my Honours I started to draw commonalities between different theories (…), already integrated and already started building my toolbox and, you know, reflecting and, how do I believe this or how do I see this.

Thirdly, she spoke of a subsequent stage of re-engaging with uncertainty in moving from ‘grasping’ to later having a ‘grip’ on a new theory, and how new theories engendered a process of disruption and prompted an openness to “re-shuffling” theoretical certainties:

when I got introduced to Object Relations (…) it really took me a lot of reading to really grasp what it’s about. You know, I still can’t do - see things regarding Object Relations (…) but, you know, I think as soon as I started feeling like a grip now for most theoretical approaches – now I can, with comfort, choose from any of them because I know I’ve explored them and I’ve felt comfortable with each of them separately (…) or feel ethnically that, “okay, now I can use this because I’m knowledgeable about it”. The uncertainty was when I was exposed to new therapist theories in which I wasn’t exposed to before. So, then that disrupted my little toolbox that I developed for myself a bit, because now I need to open this suitcase and I need to re-shuffle because new things are coming in.

Lastly, Participant A, spoke of currently being at a “stage” of revisiting all the theory she had learnt and engaging in a process of discarding the non-essentials and then integrating the valuable aspects into a unique theoretical kit for herself:

Now, I’m looking into the suitcase and I’m like, “okay, these are all the new stuff (…) what is the important ones here? Is there some that I’m gonna might
have to take out”, and then put those that are left in my suitcase together in a way that makes sense to me.

With this ‘reshuffling’ process in mind, intern psychologists were potentially in a developmental process that fundamentally included theoretical development. In that alongside developing their ‘person’ and their cognitive and relational skills intern psychologists needed to develop personalised ways of using psychological theory to inform their therapeutic work. From Participant A’s description, one’s understanding of theory and accumulation of knowledge can optimistically be in a Piagetean “upward expanding spiral” where one must constantly reconstruct the ideas formed at earlier levels with new, higher order concepts acquired at the next level. However, to benefit from this learning spiral it seems that a certain amount of disruption to one’s established thinking needs to be tolerated. If this is achieved, ‘disruption’, ‘reshuffling’, ‘uncertainty’ can be seen as a necessary impetus for growth. For along the lines of Piagetean thinking established psychologist, Participant H, found that when one remains open-minded one is then capable of doing new things in one’s clinical work and expanding the knowledge of the field.

**Beyond Book Knowledge**

Orenstein (1993) argued that psychologists in practice were confronted with the limitations of learned theory:

even the best theoretical guidelines may not always be good enough. Once we discover this, many of us slowly gain the courage to loosen our bondage to these necessary guidelines. As a result, we begin to test and retest our theories in the crucible of actual patient care. In our daily work we start to monitor their usefulness (p. 193).
Established psychologist, Participant G, reflected that psychology comes to life when one is in the day-to-day profession and confronted with the real experiences of clients and how this went beyond one’s learned theories:

I think in training everything is quite theoretical. It is only when you get to scenarios within the real experience of being in an environment that you realise, um, what you need to be aware of (...) patient’s sexuality, patient’s financial well-being, the treatment of patients by others.

Timm and Blow (1999) and Thorbeck (1992) highlighted the use of self of the therapist in sessions. Intern psychologist, Participant B, identified the need to work within a theoretical framework in order to justify how one is working clinically, yet elaborated on using her self as a woman to overcome a stalemate with a client:

Eventually I just used myself as like a woman. And to give him a different experience (...), when we were terminating, he said that, he didn’t want to come and see me anymore, because I made it difficult for him to hate women (...). That is all he needed, like a different experience, that not all women are going like hurt him (...). It was such a small thing but it was really- It was so profound to me! Just being with him was actually all he needed in the end.

However, intern psychologist Participant D cautioned that use of self is “good if it is warranted” and Participant B conceded only once one has demonstrated clinical competence, can one wisely from this foundation effectively apply the higher order task of use of self in therapeutic work. In her opinion the use of self is best used by experienced clinicians:

But, I think it is very dangerous for young therapists. (...) it’s very important to initially start with having all our theories and to being able to explain everything within a modality. ‘And this is what I am doing, and this is why I’m doing it’. Because, you still very mixed up I think with your own emotions and your own feelings; and you could be doing a lot of things for yourself and not the person. So, initially I think do that stuff, but when you are older and wiser then I think definitely just who you are and bringing that in depending on where the person is and if they will be comfortable with that. Then I think it can be very healing and very helpful (B).
Carlock (2000) cautioned that:

therapists with enough maturity, can use the self as a powerful instrument of change through which healing can occur (...) use of self in the therapeutic relationship requires the most skill, the most self-awareness, and the soundest judgement since the potential for harm is as great as the potential for healing (p. 70).

Along similar lines, established psychologist, Participant G, highlighted that theory can only take a therapist so far in becoming competent:

some things are not going to be taught by the book. Some things are going to come from within yourself, - that if you’ve got the sense of kindness and care, you’ll make a good therapist, if you within that kindness and caring you exercise proper boundaries with your patients and you are able to respect your patients and give the best of your ability at all times.

Skovholt and Jennings (2004) confirmed that master therapists made use “self” in their therapeutic relationships with clients. Established therapists thus recognised that who they are is the powerful “agent of change” in the relationship (p. 64).

Intern psychologist, Participant B, proposed a growth point in relation to a therapist’s theoretical orientation in that therapists learn over time to prioritise the therapeutic relationship over and above any particular theoretical application:

sometimes just being there is all- like I tried all these things and patients weren’t getting better, and I would try this and try that. And, I started realising that I don’t necessarily need to be trying so hard (...) I must just be-with them, with many of them. Just realising the importance of the relationship.

Rønnestad and Skovholt (1993) found that:

the beginner uses context free concrete and specific techniques that he or she has been taught, whereas the senior practitioner operates out of an embedded and internalised gyroscope [of] “experience-based generalisations” and “accumulated wisdom”. These internalised data may be hard to articulate (p. 399).
In line with Howell’s (1982) unconscious competence level, established psychologist, Participant H, referred to how the distance of years between apparent theoretical application translated to ‘unconscious’ natural application of principles when working therapeutically with people:

when I went into private practice I threw those theories away. And all I determined was that when a person walked through my door, I’ll give that person, first of all, absolute, hundred percent undivided attention (...). I would look at each and every person on a practical, functional, situational level to see (...) what is that person’s problem?, (...) so, I can’t even tell you what theory I used. I obviously knew all the theories and I learnt them and passed them at university and whatever. At the end of the day, I just used to-I’d regard that person as a person. That person who sat there was not a theory, was not a something I’d learnt at university. It was a person. “Now, you just sort that person out basically”. And, I think one had to be very flexible in adjusting to that person’s changing needs (...) although you have theories and you have methods that one uses and that, it still boils down to what does that person feel, what are that persons’ needs (...) how are you going to best adapt to them and how are you going to get the best out of them (...). I think theories I threw them out of the window when I left university.

Encouragingly, Participant H emphasised that despite psychotherapy being undergirded by the academic discipline of psychology, the individual client in the therapeutic space remained the therapist’s focal point. Similarly, intern psychologist, Participant E, reflected:

it’s mostly common sense that I use. And, you know, I could have done that before I started (...). I mean it’s not the fact that you go and sit through hours and hours of classes that makes you a good therapist but you need to do that in order to do it legally, and ethically (...) the fact that you take a genuine interest in other people’s life (...) it’s not something that you can go and learn by reading a book necessarily, it’s something you have to live through and I think for me also the thing I do the best is I think I’m very good at putting myself in somebody else’s shoes.

Millon (2000) underscored how the individual needed to remain the centerpiece in therapy:
It is the person who lies at the heart of the therapeutic experience, the substantive being who gives meaning and coherence to symptoms and traits-be they behaviors, affects, or mechanisms – as well as that being, that singular entity, who gives life and expression to family interactions and social processes (...). Therapists should take cognisance of the person from the start, for the parts and the contexts take on different meanings and call for different interventions in terms of the person to whom they are anchored (p. 49).

Established psychologist, Participant I, found that when called upon in a crisis there was little time to draw upon theory as one was under pressure to intervene:

I have to confess I’m a bit of a “maverick”. I think we are very much on the spot. A lot of the time you do thumb-sucking. You’re in a place like I was, I help out Lifeline sometimes and here is this guy, he is jumping off a bridge (...) I’ll say to them “okay, I’m not there, tell me his body language” and then I will use that (...). You just got nothing. No theory is going to help you - is it? You’ve got like a once-off chance, you’ve got to find something, and then make some kind of a difference to his thinking.

As a result of a sense of urgency often inhabiting therapy, established psychologist, Participant I, highlighted how she placed priority on how useful a particular theory was and with her bent for resourcefulness continued to learn theory with an eye for its immediate applicability. She found the immediate, more covert and fluid role that theoretical orientation and ‘book knowledge’ played in her practice of psychotherapy:

it’s theory-based because I mean if I am working on a story maybe I will think of Narrative Therapy, if I’m working on play, then I think of Play Therapy. And I read a lot so now I’m reading this book on ambivalence and shaping ambivalence. So I am always- even use Bibliotherapy (...). The thing is if I can shift you with a song, I’ll use Music Therapy (...). So ja, I will use anything I can.

From a different standpoint, potentially depicting Howell’s (1982) conscious competence level of development, intern psychologist, Participant A, reflected how she as a client felt in relation to her former therapist’s use of theoretical knowledge:
[With] my previous therapist I felt like that person is trying to be like a book. Like what the book says (…) try to look like a book or come across as what the book says. So they don’t make it their own, they don’t individualise it. [However] being congruent as a therapist, and using that theory and applying it in different ways makes the world of difference for me as a client.

In sum, the client’s needs, resources and suitability to a particular therapy brand took precedence over the therapist’s preferred theoretical stance. Established therapists particularly reported an almost imperceptible use of theory. Arguably, theoretical ways of doing therapy over time become difficult to outline as they have become absorbed to such an extent by practitioners that it becomes difficult to pinpoint each theoretical construct that is being applied in therapy.

**Personal Qualities**

The main thrust of this category highlights the participants’ personal qualities that contribute to their therapeutic work. The three themes identified include the primacy of the therapeutic relationship, a flexible therapeutic style, and concocting a palatable therapist self. Kieley and Piercy (1999) placed value on therapists identifying their personal and relational qualities as well as their preferred way of being in the therapeutic context that they have enhanced or developed during their journey of becoming a therapist.

**Primacy of the Therapeutic Relationship**

Jordan (2009) confirmed the centrality of the therapeutic relationship:

I feel clearer about my stance that we grow through relationships, that it is the relationship that heals people in therapy. I feel more comfortable with the intangibles about that belief- the places of not knowing quite how it all works—and still believing that it works (p. 245).

Intern psychologist, Participant C, held that the therapist-client relationship is the crucible of the therapeutic process, “For me, my relationship with my therapist was very important. A lot of issues were dealt within the- our relationship”. Similarly, established
psychologist, Participant H, illustrated with a case example that a solid therapeutic alliance is imperative above any adherence to any theoretical orientation:

[Doing therapy] was a very uplifting part of my life. I remember I had a little girl- that her mother phoned up one day (...) said, “My daughter wants to come and talk to you”. But she wouldn’t tell me what the problem was. And this little girl walked in, a lovely little girl, she was about seven years old. And, she sat down and she spoke to me. I gave her tea. She showed me her little schoolbook and pictures of her little, whatever, house and whatever it was, things like that. That girl carried on seeing me until the day I left [city]. And I’ve still got the horseshoe hanging up (...). This girl, when she turned about 13 or 14 her parents allowed her to go horse-riding. She became a horserider and she gave me this beautiful golden-painted horseshoe. [She] said to me, “Doctor, you must hang it up the right way around. It mustn’t be upside down because your luck runs out” (...). I mean, that girl used to make her own appointments. I just said to the parents, “right, because she’s underage-”, they said, “no, she will make her own appointments, and we agree with it, and she will phone herself”. And, this girl every now and again, like every (...) six weeks she’d phone up to come and see me and come and sit down, have a chat with me, have tea with me, show me pictures of her horses or her friends at school, where she went camping and she just wanted to talk (...) just wanted to talk to me. But it helped that girl (...) and till this day, you know, every person who walks through that door is an individual.

Participants voiced Rogers’ (1957) facilitative conditions were foundational but not necessarily sufficient, “You have to have a trusting relationship. That is where Carl Rogers will come in, so we will keep Carl Rogers because we need the trusting relationship” (I).

The Chameleon-like Therapeutic Stance

Skovholt and Jennings (2004) found that “therapists who adapt their relationship stance to their client’s relationship needs are more adept in forming stronger therapy relationships” (p. 55). Orlinsky and Rønnestad (2005) differentiated between relational agency, and relational manner (how therapists relate or bond with clients) of psychotherapists. Relational manner falls into four dimensions namely, Affirming,
Accommodating, Dominant and Reserved. Relational agency refers to the therapist’s positioning in the therapeutic relationship as an agent of change. The therapist’s agency included three dimensions namely, Invested (involved, committed, intuitive or not neutral) Efficacious (skilled, organised, effective, subtle, pragmatic or determined) or Baffled (confused or unhelpful).

With the array of stances available to psychotherapists, Carlock (2000) extended Satir’s Parts Party method advocating exploration of the therapist’s many faces and Timm and Blow (1999) proposed self-of-the-therapist groups from an Internal Family Systems approach to expand the parts that therapists could make use of in the therapeutic space. As such, therapists needed to develop a “flexible repertoire of relationship styles” alongside their toolbox or quiver of techniques (Skovholt & Jennings, 2004, p. 56). Orlinsky and Rønnestad (2005) found an engaged, collaborative, empathic and warmly affirming therapeutic style has been linked to positive therapeutic outcomes.

Intern psychologist, Participant A, emphasised that therapists needed a “good interpersonal style” or “having a feel for people,” and intern psychologist, Participant B, spoke of working from “quite an intuitive stance”. Leary’s (1957) Interpersonal Circumplex Model offered a range of interactional styles that have been used to pinpoint differences in interpersonal behaviour (see Figure 1, p. 252) and to conceptualise the range of potential therapeutic styles (Orlinsky & Rønnestad, 2005). Carlson and Erickson (2001) proposed that psychotherapists carefully examine their “relational ethics”, as such, how their qualities and ways of relating assist their caring, and which skills and abilities they needed to develop to be most helpful clients:

The most important thing therapists can do is engage in a very personal exploration of their preferred ways of being with others and the effects that
these ways of being have on others (…), how others experience themselves in their presence; what the new therapist’s hopes are for how the clients experience themselves as persons; what qualities the therapist wants to guide their ways of relating to others (p. 214-215).

Participants confirmed that various styles of interaction were adopted when engaging with a wide range of clients. For example, established psychologist, Participant I, contemplated if there was an ideal therapeutic style or therapeutic role:

you can kind of guide-, you can be a guide in a sort of dark place but in others you’ve got to just stand back. Completely stand back. Sometimes you’re the wolf, you know, and this thing carries on and you’re actually not allowed-, you’ve got to watch the thing. So, I don’t know, I don’t know that, if there’s a way of being as a therapist?

To illustrate her point, Participant I, then used a clinical example of her overpowering energy on a submissive client to emphasise the impact of the psychotherapist upon the therapeutic relationship and the need to continually explore how the self of the therapist or one’s therapeutic style can impact particular clients:

I am okay with the most people, but a really shy mousey person? I’m not so good with them because I’m too strong. So, I think we’ve also got to look at just the idea of energy, you know, that certain people are much more powerful than others. I actually think we all got a certain amount of energy so if you come in and your life is- you are just flickering- and I’m a flippen sunshine, you are going to run a mile, you know.

Participant I further reflected on how a therapist needed to weigh up the value of abstinence within the therapeutic setting, in that the patient may need permission to state:

“if I’m going to talk to you, I’m not going to look at you, I’m gonna turn around.” And, there comes in that, old Freudian thing of stand [sit] behind the patient. And, they tend to think of you in the room, you don’t want to be in the room. I don’t want to judge anybody (…). I never tell them my belief[s] because I don’t want that to impact on them.

Overall, in line with Orlinsky and Rønnestad (2005), established psychologist, Participant I, concluded that psychotherapists need to be flexible and demonstrate
malleability in how they relate to clients and keep in mind the stage of the therapeutic process:

you’ve got to allow the patient to mould you and as a strong person, it’s very difficult I think being a white canvas. I also don’t think that it’s our job to absorb and absorb and absorb and then feel the pain, and feel the pain indefinitely. I think that’s the problem with the psychoanalytic person (…) at some point you’ve got to say, “Stop!”,(…) then you can say, “Go to the other chair. Now be that, be what you’re afraid of” (…). You can hear the words but you can watch the body language and you can then gauge something from it (…) I did quite a bit of drama in groups.

Similarly, to Mahrer (2005) benefiting from “some inspirational teachers” in his training years, intern psychologist, Participant E, highlighted the opportunity during training to be exposed to numerous training psychologists’ therapeutic styles which enabled him to witness a style that resonated with one’s own individuality:

I think meeting different psychologists we had for lectures and guest lecturers and see what their style is like and what they’re like as persons and also like those whose style I found comfortable or considerate (…) trying to emulate some of that or not emulate, but more focusing on the things in me that I think are similar.

Through this process Participant E found that certain qualities of an admired therapist became important for him to reflect in his therapy, such as “those who manage to incorporate humour in the therapy” and how to develop oneself along the passive-active continuum, which is likely reflective of the vertical axis of Leary’s model (1957), to a more or less “degree” to effectively engage with clients. Similarly, intern psychologist, Participant A, reflected on drawing inspiration from her established therapist’s active and engaged therapeutic style:

I thought the last therapist that I was with, Phew!, “I want to be like that!” (…). That therapist was so understandable and in touch with where I’m at, yet being very pro-active or active; and in three sessions I’ve done so much it’s not even funny (…). I think that she was a master therapist (…) she’s got a lot of experience and she knows what she’s talking about and she’s involved,
you know. She’s active. She’s not sitting there stagnating (...), you work – you come there and you speak a lot and [her] just picking up on the facial expression and she goes into that and there’s such a big thing lying behind that (...). So, getting a lot out of a little (...) and being able to challenge a client in a respectful manner.

Established psychologist, Participant H, stated that he used a predominantly pragmatic and directive style with clients:

A person goes to a psychologist, hopefully, to get answers (...) to get a guideline and to come out with some tangible homework to do, as I call it, or something to do that’s going to make a difference before next week or to go on some plan (...). I would make them write things down. I would say to them, “Right, I’m seeing you in a week’s time; I want you to do this before next week”. I would be very directive. Very, very directive. And, some patients would walk out; they wouldn’t like it and whatever, okay. But it seemed to work. It worked very well.

Therapeutic style and preferred therapeutic stances also seemed to be inextricably linked by the participants to the influence of their personality traits. Established psychologist, Participant K, while reflecting on her personal therapist’s style, emphasised a gentle, collaborative, non-expert style with clients, “I would like to see myself as a similar therapist to her – very empathic, very, very gentle (...). I think I’m more directive maybe. You know I like to like give skills (...) you’re kind of in there as a collaborator with them,” and how her personality trait of wanting to please others may have contributed to her caution when confronting clients:

I think sometimes I have a need to please (...) and for me I feel like very stressed and I tend to take it personally if I feel like I’ve offended someone in therapy and I will try and fix it (...). I have this idea that, ‘it must be all good’ (...), but I’ve learnt to accept that you can’t be a good therapist to everybody and some people will not like you and some people will (...). I’ve often got to use like self-talk on myself and say, “you’ve had one disgruntled customer, in however many”. I’ve recently had a case like that and I had to go for supervision. And she said, “you’ve actually done nothing wrong (...) But, why do you think you’ve done something wrong?” (...), which has been great
because it’s had to help me explore why, I actually did feel that. But, it didn’t stop me feeling that sense of failure, maybe? Or, like, I’ve let this person down! (…), it takes a lot of me to be confrontational in therapy (…). I’ll actually challenge only much later, once I’ve felt like I’ve established the rapport and I feel comfortable with it. I won’t do it right upfront whereas I know some therapists do feel comfortable doing that.

Participant K further stated that her style included appropriate self-disclosure to initiate liberation for clients in therapy:

I think with me – what you see is what you get. I think I’m a very talkative person too. In my personal life I am too. And, sometimes I tend to feel myself doing that in therapy too. I bring myself right into that therapy session. And, I think particularly because of the type of clients I have (…) I can jump in there and say, “Yes, I, this is how I felt”. So it ends up being a liberation in therapy and I’m like that at home as well (…). I’ve actually become like more aware of what I can bring to therapy (…) there’s more a collaboration to deal with their problem and to find solutions because not that I’m coming in as the expert.

On reflecting on her therapeutic style, established psychologist, Participant J, relayed that she does not impose upon the patient. Notably, her therapeutic stance or style is informed and deeply embedded in her preferred psychoanalytic theoretical orientation of Object Relations, which finds confirmation in the results of the survey of Arthur (2000), and Buckman and Barker (2009) which linked choice of theoretical orientation with key personality traits of psychotherapists.

Intern psychologist, Participant C, commented that she worked non-directively, “Rogers takes a non-directive approach, um, and I also take a non-directive approach, it fits well with me”, and intern psychologist, Participant D, acknowledged:

I tend to be more nurturing with my clients. I don’t like to be too directive in the way that I approach my clients because I feel like it doesn’t give them the opportunity to just be themselves and to bring whatever they want to bring to therapy.
Yet, she emphasised that her non-directive stance did not necessarily amount to being non-challenging, “not judging them and being open. But also not being so soft that they can, you know, that you don’t challenge patterns recurring in their lives. So I think it is a balance”. Here her reflections easily align with Leary’s model (1957) depicting the need of therapists to be flexible in relating to clients, as such to shift between for example the Accommodating (nurturant) and Affirming dimensions (accepting) as well as being in the Dominant dimension (challenging) in order to be effective with clients. With this in mind, Orlinsky and Rønnestad (2005) spoke of a support-challenge balance being the most effective style or relational manner for clinical work.

Jennings et al. (2008) found that master therapists in Singapore value the alternating follow-lead dance or balancing act between support and challenge with clients. Similarly, established psychologist, Participant G, highlighted how she achieved the support-challenge balance, for despite employing the traditionally directive model of CBT, Participant G conveyed that she was known for her non-directive therapeutic style:

I’ve been told, and I would probably tend to agree, that I’m an approachable person, and that I create an environment where the patient feels, safe to explore themselves, to explore their inner thoughts. Therefore in turn I’m quite receptive as a person. I think I listen very well, I think I’m very attentive with my patients, they tend to feel, that they have got their space and their time when they are with me to be who they want to be. One lady said to me, I bring out the realness in her, that she lets her guard down and she feels comfortable. I do like to sit back and allow people to be themselves when I am in therapy and I do that by basically creating a safe environment (…) the gentle approach is there but it also comes with some expectations and some clear directions.

**Concocting a Palpable Therapist Self**

Intern psychologist, Participant E, pointed out that for him the theoretical perspective of the therapist remains in a subordinate role to the person of the therapist, “I
wouldn’t change myself – I’ll adapt a theory but I won’t change like the way I am as a person”. Established psychologist, Participant J, reported that her training had a fundamental influence on her professional development. For she found that her training went beyond merely dispensing theoretical modalities but also emphasised the growth of the person of the therapist in their own direction:

At Rhodes at the time they had a very unique approach to your Honours year. For them, Honours was not so much about the quality of work that you produced. It was more about how you were growing as a person and more about an absolute requirement of you would go into therapy. And, so you were encouraged to explore, you were exposed to, not a huge number of modalities, you were just exposed to, well, what the staff were good at. So, it was mainly Phenomenology, Object Relations.

Importantly, Blow et al. (2007) pointed out that psychotherapy relied more upon the person of the therapist rather than a theoretical model:

Models work through- and therefore largely as well as- the therapist. Models are words on paper, and are as such not “effective” in and of themselves; rather, models help therapists be effective. Similarly, therapists help models appear effective. Models either come alive or die through the therapist (p. 308).

For participants therapeutic style was closely entwined with identified qualities (ingredients) that they felt constituted a great therapist. Orlinsky and Rønnestad (2005) identified the following key characteristics of therapists: strong interpersonal skills, intellectual strength, curiosity, flexibility, openness to experience, a reflective temperament and freedom from severe psychopathology. Jørgensen (2004) outlined “active ingredients” of psychotherapy and Carlock (2000) proposed therapists engaging in self-examination to pinpoint characteristics or traits that constituted a good therapist. Kahr (2005) identified fifteen key ingredients of what he deemed good psychotherapy. The four ingredients Kahr (2005) elaborated upon include psychotherapy offering the
patient permission and a space to confess pathogenic secrets or a cathartic purging, foundational reliability, curiosity in the minutiae of their life and the warmth of the therapist’s tone of voice. Similarly, Jennings and Skovholt depicted (2004) the three-legged stool of therapeutic expertise constituting of high intellectual ability and rich conceptual structures (cognitive leg), refined emotional maturity and personal stability (emotional leg) and superb interpersonal skills (relational leg). Kahr (2005) highlighted that cognitive and emotional intelligence was essential to the therapist in order to effectively “disentangle the secret unconscious meanings of the patient’s material” (p. 12). For example, Kahr constructed a basic psychoanalytic-imbued recipe of psychotherapy as follows:

    Psychotherapy may be defined as that very special, very private, very confidential professional interaction between an emotionally and cognitively intelligent, well-analysed, well-educated, well-resourced, and mentally zestful clinician, and a reasonably co-operative patient, in which the patient engages in the cathartic process of talking or communicating, assisted by the interest, benevolence, curiosity, and memory of the psychotherapist, who helps the patient verbalise, to confess, to tolerate, to mourn, and to grow, through compassion, understanding, and deciphering of unconsciously coded material (p. 13).

    In terms of painting a portrait of a master therapist (Jennings & Skovholt, 2004) or compiling a list of active ingredients or a recipe for a therapist (Kahr, 2005; Orlinsky & Rønnestad 2005), intern psychologist, Participant A, pointed out the individuality of psychotherapists, “therapists are unique and they’ve got unique backgrounds and different values” and therefore the likelihood of an array of what constitutes a ‘great therapist’. She thus explored the possibility of working from her own composition of how she would like to develop, “If I, for myself, would make a list for myself, you know,
in terms of what would I like to be”. Similarly, intern psychologist, Participant E, devised his own recipe for an ideal therapist:

Intelligence, was the first thing that came to mind and then empathy. I still say humour and then the ability to, number one, to serve another person’s affairs and then, number two, to think outside the box. And, then I also think you need to be able to challenge the person and then you need to know when to push and when to stop pushing and you both need to know when to shut-up, and let the person think for themselves. And, then you could add to that the ability to research and network. And, also tenacity because-, and not giving up, because you can have all your other things but if you give up after two months because the patient hasn’t moved anywhere (...) it’s not going to do much good for the patient.

Participant E verbalised that his depiction of a good therapist was informed by “what I would look for if I was going to see a therapist, if I needed help”. Yet, he recognised that his choice of an ideal psychotherapist might not be a good therapist for every client:

I do think different people they need different things in their therapist (...) we talk about a person-to-person fit (...). I think it depends on the clients, it depends on the kind of problems, or the theory or the framework which is suitable for specific persons and it’s possible that some people will be great for one person and could be lousy for another one.

In a similar vein, intern psychologist, Participant B, found through her personal therapy that for her a person-to-person fit, beyond theoretical orientation, determined therapeutic outcome:

I think it’s more her. I think that’s the thing. That is why I think there is not necessarily a right and wrong because I have been to other therapists before where I just didn’t click with them- and it doesn’t matter what they were doing (...) I just clicked with her. When I met her, I was like- it just felt right (...). So that’s why one therapist can’t necessarily work with everyone, won’t always have success with everyone. It depends who that person feels- that’s where the transference and countertransference is so important. Because if it is there then I think you can work.
The basic essence of therapists

Participants across career levels emphasised basic relational skills and made ample reference to Carl Rogers’ (1957) three facilitative conditions as essential ingredients for a therapist, “for me a therapist needs to have empathy. If you are a person with empathy then obviously it aids your therapy (...). Just really understanding your client’s pain” (C). Intern psychologist, Participant C, spoke of “a core therapist” as kind-hearted and established psychologist, Participant J, prioritised “love-infused respect” being embodied by therapists towards patients.

Intern psychologist, Participant A, spoke of psychotherapy involving the free-associations of the client, which suggested a psychoanalytic-informed therapy, yet she highlighted Rogerian congruence, empathy and unconditional positive regard as essential attributes of a psychotherapist. Furthermore, Participant A emphasised she aimed to exude Rogerian qualities to forge the therapeutic relationship as she attempted to strike a balance between freedom/permissiveness and a challenging stance towards the client:

empathy is big (...). I do a lot of listening, I’m not sure if I want to call it: to let the client free-associate (...). I want my client to tell their story so I’m giving them space to tell their story. So when I’ve got that story and that story will always grow bigger and evolve into other things and certainly other areas (...). (I’ve realised – (...) unconditional positive [regard], the main thing for me first is to establish that solid therapeutic relationship. So, I focus a lot on the relationship (...). [Then] when someone tells me a bit of their life story I ask them a question but with the intention of expanding their awareness to see more alternatives (...). I summarise themes that I hear and give it back to them. They hear it in another perspective. Sometimes it’s challenging. But sometimes you do need to challenge a client. I don’t think it’s a dominant thing in my therapy. When I realise that I have to challenge a client is when I’ve started to feel incongruent in terms of the therapy is not going anywhere and the client is in a comfort zone, stuck somewhere (...). I just get that little inch and then it goes on again from there.
Along such lines intern psychologist, Participant D, encapsulated the near-experience essence of a Rogerian therapist and yet added that insight-orientated therapy held much potential for clients:

for me it is important for the person to have good listening skills, um, to be able to be with the client the whole time throughout the session (…). I think it takes a lot for a person to come see a person they do not know. And, therefore I think it’s important to create an environment that is very safe, secure and to be consistent with the client as well. I think better therapists are-, um, give insight to the client, if they are struggling, that they don’t feel judged, that they can experience their life in a new way. See something that they hadn’t previously seen (…) and still feel that they are able to share with the therapist.

Arguably, Participant A and D’s descriptions of a good therapist fitted the Person-Centred approach and Alexander and French’s (1946) psychoanalytic “emotional corrective experience” as well as Gill’s (1984) “re-experiencing therapy”.

Intern psychologist, Participant C, recalled having had to figure out how to balance therapist self-disclosure with congruence/genuineness:

I was struggling with, you know, whether I open up an issue, whether or not you disclose to a client, um, if that is going to help the therapeutic relationship. So, I suppose I would take it from that, just being genuine about how you feeling. So being congruent about your feelings in therapy (…) I’m pulling here from Rogers a lot.

Participant C went on to add, the need to “be true to yourself and to your clients” and being “very real and genuine”. Intern psychologist, Participant A, also relayed that she admired her established therapist’s ability to “just being congruent but also appropriate”. Intern psychologist, Participant B, admitted, almost abashedly, to going ‘back to basics’ of Rogers’ (1957) conditions:

I’m going to use the word ‘unconditional positive regard’- But I don’t know-it is such a cliché, and so theoretical, but I think it would be that (…). The fact that I don’t really see; that I see everything as sort of relative. And, um, I think people pick up that non-judgmental side. And the fact that I think I am
very comfortable with myself. I think people pick up on that and it makes them more comfortable in the therapeutic setting.

**Other personal variations**

Participants also outlined qualities that potentially go beyond Rogers’ (1957) triad of congruence, empathy and unconditional positive regard. Participants prioritised cognitive or knowledge related traits. However, established psychologist, Participant H, pointed out:

> there are so many factors beyond high IQ and, excellent marks (...). There’s just so many other things that you need to look at, in what you’re doing in life and how you cope with life.

The importance of the presence of the therapist appeared to also have been captured by participants. The need to be a resilient practitioner as highlighted by Skovholt (2001) found support in the current research and the notion of an open-minded therapist was held in high regard. Participants also valued the passion, vitality and flair in therapists as found by Skovholt and Jennings (2004). Yet participants also emphasised the reliability or unchangeableness of the therapist and adherence to an ethical stance was prioritised by participants in terms of being ethical, which was also prioritised by American therapists (Jennings et al., 2005). Another quality, that of networking skills, was seen as imperative in a profession where the therapist was one’s own business and making referrals form part of one’s daily work. A list of ingredients has been compiled in the current study which constituted the participants’ ‘recipe’ for a South African flavoured master therapist (see Appendix E).

**The imperfect therapist**

“I will never be at a fixed place where I feel, “This is it! I’m now the perfect psychologist!” I’ll never get there. You know life is continuous and my development is continuous and I will always challenge myself to learn more.
And I think that’s with life as well and that’s the way I see my clients as well” (A).

“I think resilience is a very important thing. I think being motivated. I think being well-balanced, um, I think being able to accept failure (...) determination and having staying power just to see it through, you know, and to realise that there are mistakes one makes” (H).

Despite pinpointing necessary and ideal characteristics of a psychotherapist, participants held that therapists by definition need to be an “imperfect other” (Maroda, 2010) for the benefit of their patients. Jordan (2009) reflected that despite her decades of experience as a therapist she believed experienced therapists needed to maintain a “beginner’s mind” as such, engaging in:

more appreciation of the intangible, perhaps mysterious aspects of therapy, and an increased attitude of listening, waiting, not doing, there is also an increased sense of making use of “what works” (...) realising that life is all about learning – not knowing, not having the answers, not certain, but growing and learning and finding some graceful ways to continue on the path of being a learner (p. 247).

Alongside Singaporean master therapists (Jennings et al., 2008), both intern psychologist, Participant B, and established psychologists, F, H, and K, highlighted the need for therapists to remain humble. For example:

to be able to admit weaknesses because we all have those and they do affect our therapy. And we must be able to I think acknowledge those weaknesses that we have (...). So, I also would actually say humility – is quite a big one (B).

I think it is to become more humble. Because also maybe that is one of the qualities that we have to have is that we don’t go in there as the expert (...) like ‘I know it all’ which is actually dangerous and I hope I never get like that (K).

Jørgensen (2004) emphasised that each patient needed a unique therapy that addressed their specific problems, needs, and way of being. With this in mind, Jørgensen (2004) argued for “good-enough” psychotherapists that were capable of a high level of
flexibility. Additionally, intern psychologist, Participant B, prioritised flexibility within the resource-constrained South African context where she relayed therapists may need to conduct therapy under a tree. She elaborated:

it’s about being able to adapt, to a person and also your own worldviews and you know, being open. It’s being open to something different (...)I mean we learnt all these techniques and theories but every person is unique. And, also especially when- because I am also interested in many different cultural aspects and different spirituality (...) you must be able to adapt the way you do things to what the person needs (...) and I think that is being able to adapt the whole time. Because sometimes also when we are also young I think we find safety in methods and in this and that, that A leads to B, leads to C (...) the flexibility possibly also leads to unconditional positive regard- being able to accept people.

Curiouser curiouser: Welcomed interloper

Skovholt and Rivers (2004) spoke of therapists being captivated by their patients. Their ocean method was described as intense therapeutic involvement with clients, one of immersion, diving into the client’s world wherein the therapist seeks to demonstrate empathic engagement, open-mindedness, through an almost sensory indwelling, a ‘swimming’, with the client. Furthermore, Levine and Williams (2010) found that the therapeutic process hinged upon therapists igniting the curiosity of clients to reflexively explore their own vulnerable and emotionally-laden internal landscapes for therapy to be regarded as beneficial.

Participants across career levels valued psychotherapists possessing curiosity. Intern psychologist participants spoke of “openness to experience – I think that relates to being curious and self-reflective” (A). Intern psychologist, Participant B, and established psychologist Participant J, both verbalised how one’s curious nature finds expression in the therapeutic session:
I want to understand. I still have this desire and I think it’s unquenchable, hopefully. So, when someone sits down, immediately, I’m like, ‘What are you feeling?’ I won’t say it, but I’m picking up things. And, I’m like, ‘What am I feeling about this person?’, ‘Why am I feeling this?’, and it’s just- It’s like this person is this amazing thing that is in front of me and I’m just like, ‘What are you?’ I want them to open up to me and I want it to work (B).

I want to get into your world and I know that you’re going to resist it maybe, that’s where I want to be, I want to be able to get into your skin. I want to understand where you are. (...) I want to know all about you. I want to understand you, and, it’s not overt. It’s just- I don’t say much. But, I like to think that I convey a sense of, “Gosh, she’s interested in me! She really wants to know about me” (J).

Working from a psychoanalytic framework established psychologist, Participant J, proceeded to outline the unfolding nature of how she saw the therapeutic process. She highlighted the centrality of curiosity in creating the intimacy and connection being weaved between therapist and patient as opposed to an overt focus on the patient’s problems:

I don’t start off taking a history, I think that’s just too- it’s too contrived. So my first session would just be what seems like chit-chat, you know. So, I would say-, I’d start off, “what brings you here?, what are you dealing with?”. So, just get a sense of why they want to come for therapy. And, then I actually just leave it. And, then just say, “so, tell me about yourself, your family, you married?, and children?, where do you live?, where did you grow up?”. So I-, I’m sort of taking a history, but I just want to, “tell me about yourself” (...), and then what happens then is they clearly start relaxing, and then they start talking about their problem. But it’s not-, I don’t like the thought of people feeling they’ve got to come in and start working on the problem. Because they-, I don’t want them to feel that their problem defines them. “You, you’re a person and I’m really interested in finding out about you (...) there’s something about you that you’re wanting to work on” (...). Just by doing that I start picking up the Object Relations. I start seeing how things are happening and so I think curiosity (...). It’s really a very strong need to just let’s be two people together. I’m not telling you anything about me (...) an unbalanced interaction. But it’s, we’re two people together and I really just-, “I’m so interested in who you are and I’m interested in your life”.
From his more directive, pragmatic stance, established psychologist, Participant H, remembered being advised that psychotherapists must hold onto a childlike sense of curiosity throughout their career and adopt an enquiring stance in order to help their clients solve their problems:

You must never stop developing expertise. You must always continue to try to learn more about your profession, your trade (...). There was this thing years ago where our professor, she said, (...) “Einstein was walking along (...) and he was deep in thought that people had to say, “Professor, have you found the answer to your question?” He said, “No, I’m still looking for the question”. And that is, it’s a very important statement because if your car stops on the side of the road, you open the bonnet- You try and, you ask yourself questions. ‘What could be wrong? Is there lack of petrol? Is it oil?’ (...) in order to make progress in whatever you’re dealing with, you have to ask questions. If you don’t show the initiative (...) if you don’t have an enquiring mind and don’t ask yourself questions, you can never solve other people’s questions or problems. You’ve got to actually have an enquiring mind and to forever be asking questions of, ‘Why is it like that? (...) Why did that happen? Why did that happen, not this? How did that develop and not this?’ You’ve got to ask those questions (...). I think I was always a curious person. Ja, I’d always clean engines and parts - I’d always want to find out how they worked (...). I love to develop new things and research things (...). trying to work out things (...). I use myself as a guinea pig very often.

**Having an intuitive feel for people**

Intern psychologist participants, A, B, and E, and established psychologist, Participant K, spoke of possessing the gift of intuition in relation to people and developing intuition within their therapeutic work with clients, “you get that feel and I think then your intuition also develops as a therapist” (A). Intern psychologist, Participant E, relayed that he has had the gift of intuition since he was a small child:

I always had this amazing intuition earlier because as a small child whenever I was reading or watching a movie or seeing a situation with some people (...) I always had this very good feel about what was going to happen. My parents could never understand – I would be this small child (...) and I would
say, “Oh, this or this or that is going to happen now!” in the crime novel or in
the thriller or whatever action movie we were watching (…) and they would
say, “How could you know that?”

Participant E reflected that psychology offered him, “something I could study
where I could use this whatever intuition”, yet he conceded, “I’m thinking that intuition
could be really helpful. But not everybody needs it (…) I use it as a guide to focus”.

Similarly, intern psychologist, Participant A, has found that the profession of
psychology, “calls for intuition because there’s no manual that says a client’s going to
come in, this is what’s going to happen, then you must say this and this- and, you know,
that doesn’t exist”. She found that as a psychotherapist she relied upon her intuition to
know how to apply learned theoretical knowledge to a particular client:

there’s all these files in your brain. This relates to this and this, you know, so
they have to rely, sort of, on your intuition. Which files are you going to grab
out for this person?

Established psychologist, Participant K, reflected on how she developed more
towards a Jungian function of iNtuition away from just Sensing as a therapist by,
“listening with your eyes (...). You know being perceptive, like looking underneath (…) because you do like not always just trust what you hear. You do actually look for an
accompanying thing, you know, like, ‘what am I hearing?’”

Not taking oneself too seriously

Intern psychologists, B, and E, and established psychologists, F, and I, valued
psychotherapists possessing a sense of humour. Participant I relayed her appreciation of
humour, in relation to her interaction with children, and a potentially ‘socially taboo’
incident with an adult client who stated to her:

“I hate you, absolutely hate you because you’re too thin.” So, you’ve got this
fat black person who is able to tell me she hates me because I’m thin and we
are both able to laugh about it. Because I didn’t make myself thin, she didn’t
make herself fat. We both know that and we don’t care. And, she will say to
me, “You, bloody Christian.” And that’s my sense of humour, very important,
it’s very important to be able to laugh (...) with people especially children, I
can cry with some of these children. But, I mean even when I was a teacher, I
was like four years older than them, some of them, and then the boys, one set
of twins, they used to make me laugh and I would just about weep and they
would pick me up and say, “Go out the class and close the door and come
back when you’ve calmed down”. I loved that. But I think just like music and
art and laughter it changes cultural boundaries even spiritual boundaries.
Because it doesn’t matter, I can laugh at myself.

Intern psychologist, Participant A, recommended that psychologists need to
maintain “a positive outlook on our profession and really appreciate the nice moments”
due to the often distressing nature of clinical work.

**Appreciating diversity**

Alongside, Singaporean psychotherapists (Jennings et al., 2008) and Kaslow’s
(2005) personal multicultural experiences, participants in the current research prioritised
demonstrating cultural competence in their work. This focus on cultural competence
appeared to differ from most prior research on therapist development conducted mainly
from a Western standpoint (e.g. Orlinsky & Rønnestad, 2005).

Similarly to Kaslow (2005), intern psychologist Participant B related how as a
child she was exposed to diverse cultures and how it fostered in her an openness to
experiences of difference:

there was also a very big interest- from a young age- in different cultures
because our family goes into southern Africa every year and, uh, my dad
studied anthropology (...). So, he would always speak to us on different
tribes. There was always like this thing, ‘Everything is relative’- (...) the
way that different people see things and to try and understand it from their
point of view (...). He would speak to us, me and my brother about different
ways and people and trying to understand, “And, isn’t this interesting! And
look what they do”. And like, “but wait, wait!” . Like but- I almost want to
say crude-like rites of passage are also fascinating to me and rituals (...) he
would always encourage us to try and to not just judge something (...). My
favourite quote one man once told me, this old pastor, “Wisdom doesn’t
criticise, what it doesn’t understand” (...). I loved that, because whenever-
often we don’t understand, “Oooh! What are they doing? Mmm” And, you just don’t understand it. And, that always says to me, ‘But what is it? But, I want to understand it’. ‘You’re not a monster’. Or, “This isn’t gross, just explain it to me” (…) rather, “explain to me why you are doing this? What are you doing? What are getting from this?” (…) The interest in trying to understand why people do things in a different way.

In a similar vein, established psychologist, Participant H, relayed the importance of psychotherapists being advocates of open-mindedness, diversity, and non-prejudice in South African society:

the range of normality is broad, broad, broad. So if you are a psychologist and you’re very staid or restricted in your own ways. You’re never going to be able to cope (…) when you’re psychologist you deal with lesbians, with homosexuals, (…) different cultures, I mean I was very lucky at UPE, I majored in anthropology. So that gave me also a very good background in dealing with different cultures (…). And the work I did for [corporation] was, of course, multi-cultural. And I’ll never forget, when I first was asked to do the work. I’d never, ever counselled a black person in my life up to that stage. And I had a very good colleague, friend, a medical doctor who was South Africa’s first coloured doctor. And I said to him, “I’ve been asked by --------to go and counsel all their blacks. I’ve never counselled a black, what do I do? He said, “Go and learn from them” (…) they gave me an interpreter, we learnt so much from them and then also taught them afterwards, you know. But it was a case of being totally, you had to be flexible (…). I just wanted it to be fluid and flexible and understanding.

Wolgien and Coady (1997) found that therapists verbalised that their formative experiences as a child inculcated an appreciation of diversity. Lopéz, Pany Grover, Holland, Johnson, Kain, Kanel, Mellins, and Culkin Rhyne (1989) spoke of the developmental stages of a culturally sensitive therapist. Leach, Akhurst, and Basson (2003), Sue (2001) and Swartz (1998) argued for culturally competent mental health professionals to ensure equal access and delivery of relevant treatment to all cultural identities and fulfil the mandate of social justice.

**Ministering to the soul**

Notably, the current research found a future recommendation made by Orlinsky and Rønnestad (2005) namely that the therapist’s spirituality/religious experiences and
background was a viable facet of therapist development and therapeutic work. Similarly, to Singaporean master therapists (Jennings et al., 2008), participants across career levels, B, C, and I, were open to exploring spirituality and meaning of life within their psychotherapeutic work:

I have also always been very interested in forms of expression (...). spirituality, also the search for meaning-our continuous search for meaning (...), high school was very much trying to understand spirituality, and also negative forms of expression like violence and, um, hurting and all these other things. I was just like “Arr. Why do people do it?”, and also very much the occult was very interesting to me. I was very fascinated in, um, Satanism and so forth. Just, ‘Why do people do this?’ and, ‘What are they searching for?’(...) [ In undergraduate years] I became quite interested in stress release. I have a very close friend who had a big influence on my life who went to Thailand when we finished school and he (...) teaches Tai Chi and yoga and he also does body stress release. And, we would often discuss just like the benefits of these different practices. I was involved in a Christian church at that time so it was like we had different spiritual beliefs but just the effects of those on mental health and on stress (...). We all looking for something more. Not all. But many of us are. And many people find that within spirituality (B).

Intern psychologist, Participant C, attached her priority on meaning to new theoretical orientations within the field of psychology:

I think meaning is very important in life. Everybody needs to have meaning and that is another reason I like Narrative or the postmodern approach (...). I just feel like you go through a lot of the theories that we do have (that) are very pathologising and that just doesn’t fit with my worldview on being optimistic and knowing that anybody can heal.

Established psychologist, Participant I, highlighted the potential healing aspects of spirituality within a psychotherapeutic context, however she emphasised that spiritual concerns need to be centred around the beliefs of the client:

I never tell anybody my spiritual background. I never tell them my belief because I don’t want that to impact on them. But at the same time if I can see that you’ve been to a witchdoctor and the witchdoctor has told you that
someone has cast a spell on you and you’ll never come right until you get the 
muti or whatever and the thing starts becoming very kind of odd, you know, 
you can kind of go, “I wonder if what you’re doing now hasn’t got something 
to do that”, and the thing is I’m not criticising a belief you can believe 
whatever you like, I really don’t mind what you believe. I really believe 
everyone is entitled to their own thing, but I think having a strong faith is a 
great advantage, been a great advantage for me (…) it helps me when you are 
so sadly depressed. It helps me to give you strong faith, it helps me to help 
you to endure it because I have some knowledge, you know, twenty years of 
knowledge of the Bible (…) So, at anytime I can always point you to 
something that will comfort you. Or, if I see you don’t believe in the Bible, 
the knowledge is very similar in the Koran and the other, so the principles are 
the same. So I can have theory that the psychologist will give (…) and then I 
can also have some wisdom that comes from a place that’s different. And you 
never know what’s gonna touch somebody. If you can just touch them in a 
way that they can actually go, “Hey, I can bear this.” Then you’ve helped 
them.

Recently, Keeling, Dolbin-MacNab, Ford and Perkins (2010) explored spiritual 
intricacies within the therapeutic context prioritising both the spiritual self-awareness of 
therapists and yet engaging in “respectful explorations” within the frame of the client’s 
spirituality.

**Steering an ethical course**

Intern psychologists, A, B, C, and D, and established psychologists, F, G, and J, 
emphasised upholding an ethical, respectful stance towards patients and in the profession 
as a whole and the need to be cognisant of the potential harm or “damage” one can 
commit through not being adequately self-aware. For example established psychologist, 
Participant G, highlighted the importance of psychologists embodying the ethic of non-
maleficence towards patients:

I think because of my exposure to the United Kingdom Psychiatrist services, I 
have learnt to be very aware of human rights of patients and as a therapist for 
me that now is very prominent and very in the forefront of my mind. You 
know the medical motto or ethos is First Do No Harm- that applies to
anybody who is within the helping professions. It applies to psychologists as well (…) respect for patients is very important - they are human beings (…) treat them like you would like to be treated.

Participants D, H, and J, also expressed concern regarding the need to preserve a respectful, composed approach to patients despite the ‘absurdity’ or ‘craziness’ that may be apparent due the pathological aspects of the patient being displayed. For example intern psychologist, Participant D highlighted that the ethics of confidentiality and human dignity need to be uphold in relation to working with clients:

a lot of people think to patronise their clients or they will, um, not say things behind their back, but they would like laugh at things that had happened or stuff like that (…). I think you have to mindful and respectful of your client at all times whether they are with you in the session or not with you in the session. And you need to be protective of them as well.

**Approach to Therapeutic Process**

**Word Pictures of the Talking Cure**

Witztum, Van der Hart & Friedman (1988) defined a metaphor as “essentially a comparison between or juxtaposition of objects which are literally disparate” (p. 2). Furthermore, this creative act of juxtaposition generated a new profound meaning of the phenomenon being discussed.

Aronov and Brodsky (2009) prioritised a metaphorical understanding of the therapeutic process in their development of The River Model. This training model set out to teach psychotherapists specific tools (Equipment) and enable the identification of key features of the psychotherapy process (Topography). The advantage of this metaphorical training model lay in the explication of the pacing or timing of the therapeutic process, identification of the therapist and client’s resources and roles, and the transcending of theoretical preferences.
Pepper (1942) proposed that each effective model of therapy in psychology is characterised by a root metaphor or image which underlies the assumptions of the theory articulated. For example Carl Rogers’ Person-Centred Therapy (1951) was held by the implicit image of a tree growing on a precipice of the ocean and Sigmund Freud’s Psychoanalysis was put forth by the notion of a closed energy system.

Recently, Levine and Williams (2010) found that eminent psychotherapists facilitate client change in their use of metaphor in the later processes of therapy to enable clients to symbolise their experience of difference which is often held within therapeutic space. As such, metaphor offered greater accessibility and integration of new experience to the extent that clients could continue to rely on their metaphor outside of therapy to understand themselves and carve out expectations for their future.

Intern participants found the healing power of therapy lies in it being a unique experience that can inform and generalise to the client’s life, “giving a different experience” (B), enabling the client to “experience life in a new way,” (D), and:

I think psychotherapy heals (...) because it basically provides the client with a situation where they can express what they need to express or feel what they need to feel in a way that leaves them contained. [Therapy] creates a link for them where they can experience painful or harmful things that happened to them in a positive way (...) which gives them the confidence to go try it outside of the therapy session as well. So you are teaching them, to an extent, skills as well, that they can incorporate (D)

Therapy goes beyond the therapeutic room it goes into your life as well and huge changes happen in your life (C).

Established psychologist, Participant H, saw therapy as “a slower unravelling process” wherein, “we’re going to see what happens and allow the process to unfold but in a more positive way”. Vividly, using a client-made clay sculpture, established psychologist, Participant I, demonstrated the therapeutic process as a space for personal
expression and a safe place for disclosure, to unlock and let out what is internally
terrifying to the individual and to no longer remain silenced – to be given one’s voice
back in therapy:

**INTERVIEWER:** What are you working on when you don’t have your theory?

**PARTICIPANT I:** I look at my situation. So, if you come in here and you won’t to talk to me, I have already cancelled out a lot of theories. This man wouldn’t talk to me, four sessions! I gave him some clay (...). I say, “take it home, make me something and bring it back”. (Participant I hands me the client’s creation. Her client brought back a clay object of an open skull with a hand in it holding a key, with a mouth tied closed with a lock at the back of the skull)

**INTERVIEWER:** (looking at the hand, inside the head, holding an object). Oh, my word, it’s a key.

**PARTICIPANT I:** He just sits and looks, he just waits for me to interpret it.

**INTERVIEWER:** So, what did you say?

**PARTICIPANT I:** What would you say?

**INTERVIEWER:** I’ll say, he has been silenced!

**PARTICIPANT I:** He can’t talk, he’s a lock, he’s terrified. He’s terrified of speaking, he’s locked it, there’s the key, he’s got the key.

**INTERVIEWER:** So, it’s in his head.

**PARTICIPANT I:** In his head, but he’s got his hand in his head, giving it to me.

**INTERVIEWER:** How impressive!

**PARTICIPANT I:** So, I couldn’t find a way to unlock him. But the clay did it on that instance. I mean I might read a story, a narrative. I often will use a story to open up something. I will use the collage (...). I will use any method that I can to make you express yourself, to help you express yourself (...). After that we had a breakthrough.

Skovholt and Jennings (2004) reported on the healing of wounds metaphor of psychotherapy. Established psychologist, Participant I, elaborated:

I’m not going to make your life necessarily easier. So if you think of the hospital, the patient has just flown of the motorbike, I used to ride a motorbike, I flew off my seven fifty on the white line and I landed on the
I didn’t want you to blame the ride over the gravel, I want you to get it out. I don’t want that to fester. So your job is (...) to get the scrubbing brush and take the gravelstones right out of my arm so when the bandage goes on I’ve got a chance of healing. So it’s a painful job (...) I guess the patient has got to cry. That’s for that kind of therapy.

Similarly, intern psychologist, Participant C, viewed therapy as a process of heartache and loss. In terms of loss, established psychologist, Participant K, outlined an extensive, versatile metaphor that portrayed her own collaborative, pragmatic therapeutic style and therapy process. Here she described an evocative metaphor of a client surviving a shipwreck which lends itself easily to communicating empathy, employing self-disclosure, asking questions in a non-threatening manner and activating client agency and self-reflection. It further communicated how therapy was a process and adaptive to different time frames and therapeutic aims for example journeying, crisis/disaster management, reconstruction, maintenance or a meaning-making effort. She also linked other therapeutic tools to her metaphor of the shipwreck and explored principles of theoretical orientations, namely the externalisation of the problem in Narrative Therapy and the meaning-making process of Existential Therapy in relation to her central metaphor (see Appendix F).

Intern psychologists spoke of the initially frustrating picture of therapy as creating a reflective space which involves the seemingly more passive stance of a process of holding, waiting with or sitting with clients and their problems. Intern psychologist, Participant B, referred to “just being with” clients and the idea of the therapist fulfilling the role of providing a personal space for the client’s distress, “you are just like their little room,” with the reassurance of the therapist’s presence, “I will sit with you, through all the shit with you”, and:
Just giving the client more room to actually just experience their problem (...). I think a lot of the time the need to rescue and the need to make things okay becomes so overwhelming that you don’t let the client sit long enough with the problem to be in (...) a position of discomfort which would allow them to move in the process. You want to save so much and you want to take away the hurt so quickly that they don’t get an opportunity to save themselves (D).

In terms of therapy being a process of uncovering, participants saw therapy as “just unwrap[ping] what they are struggling with” (D), and as such therapy often can be likened to “detective work”, “sifting through information” (I), or “a cupboard has been opened that’s been locked for so long and it’s okay” (J).

Intern psychologist, Participant E, spoke of clients needing to “empty the house”, as such an opportunity for disclosure or a catharsis, or to rearrange how they viewed themselves. Similarly, established psychologist, Participant J, regarded therapy as a process of opening up, and understanding which involved metaphorically:

opening that cupboard and taking your stuff out; things that you just shoved in there. Sure there’s some psychological word for it, you know, getting, you getting into the repressed material (...) but for me it’s about understanding and that’s where I’m coming from as a therapist, “I want to understand you, but we’re doing it together (...). So, you’re going to be empowered. The bits you don’t understand are dragging you down.”

From this process of understanding, Participant J stated that the therapist witnesses less constriction within the patient:

almost like an easing inside, it’s almost like an- you’ll find your patients will take a deep breath and sigh and you can just see, ‘Oh, it’s eased up inside’. Something is making sense now. It’s not so tight and constricting anymore. It’s opening up the space.

Therapy was also pictured as a reflective space and a space for holding and containment of pain:
I think a lot of it is mirroring (laughs), so, it’s really very difficult. When someone comes in I think I am very tuned to them and I naturally start adapting to what I think they need or want (B).

Similarly, intern psychologist, Participant E, spoke of clients needing “a wall to bounce off” and, established psychologist, Participant I, relayed, “I just get reflected on, (...) you’re a wall, you’re a mirror, you know, you’re different things. But as a reflective mirror you’re going, “And this is what you’re saying…”

Established psychologist, Participant J, provided a case example of working with an adult patient who was neglected as a child and how the therapeutic process can be seen as a process of reparenting, containing or holding, and reconfiguring or recolouring the internal world of the patient, which are key metaphors employed from an Object Relations theoretical framework:

at the moment I’m working with a woman. She’s 66, um, and she’s what you would call a simple soul. Never married, teeny little thing, that worked as a nursing sister forever, devoted to her job but she’s falling to pieces (...) she came in and she had gold takkies on, gold running shoes (...) and all the rest of her was prim and proper. So, the gold shoes and turquoise glasses, ‘oh, there’s something interesting happening here’ (...). Within the first session, I, we, looked at the fact that she was one of seven children, mother completely unavailable and how, um, what brought her to therapy was her Tai Chi teacher referred her to me because she was inappropriate, she always wanted to hug her. And the teacher felt that this is crossing a boundary and then she broke her wrist, so the Tai Chi teacher said, “maybe, you need to just go, talk about things” (...). In an instant we could see, we could see where it was coming from. “You’re a little girl looking for a mommy,” and the tears just-and then her making connections. “Yes, I do that and I love to hug people and, you know, mother never hugged me. She just stood there”. So, for me, it’s the then taking it further. And, they start bringing in all the connections. And the tears (... ) that sadness that comes out, that’s been locked away for so long (...). she was talking about not having nice clothes, hand-me-downs. And I said, “oh, they must have been horrible colours” (...). “I can just sort of see you with brown clothes gym slips;” and, I said, “oh, and the gold shoes”. She said, “Yes, now I can, now I can put colour into my life” (...). It was
again getting into her world, getting into the colourless world that she came from.

Along a similar vein, intern psychologist, Participant B, spoke about therapy involving an encounter with human brokenness and fragility and by implication resulting in recognition and authenticity of humanness:

I remember thinking about it when I was in [another country] and I still thought like, ‘Wow, this is what it is!’ And, it is just - I saw it, it as a very fine glass, porcelain glass, or porcelain bowl that someone is like handing to you. But it’s so fragile – it’s almost like an eggshell (...) eggshell bowl! (...). It’s such a fragile thing. And, it’s like a little bit cracked and you must just like hold it so perfectly or it might break. And that is what I see therapy as. It’s this thing that this person, like, hands over and you hold it with them. Um, but you must just hold it right because otherwise it could crack. And, um, eventually you give it back to them. And, it doesn’t necessarily become whole, but you’ve held it with them for awhile. And, they have showed it to someone and it is real. You’ve acknowledged it as real (...). I like that whole fragileness of this thing that they take out and like show you, and, “Hold it with me”. And, you take it, maybe for a while. But you give it back to them. And, it is not always fixed and it doesn’t have to be.

Established psychologist, Participant K, and intern psychologists, A, B, and C, also emphasised that therapy is not necessarily a process of fixing, repairing or renovating. Established psychologists, H, I, and J, relayed utilising metaphors of maintaining or repairing cars and reconfiguring the default position on a computer with clients. Participant C found she more actively regarded therapy as a process of challenges, learning, continual development and growth. Intern psychologist, Participant E, saw therapy as a process of personal transformation and empowerment of the underdog as depicted in fairytales such as in Hans Christian Andersen’s “Ugly Duckling” becoming the swan and:

the little puppy or the little fighting dog that is running around the bigger one or the master and is always following and doing everything the master does
without having a free will of its own, and having that animal become independent and proud and strong through a series of challenges.

Three participants, C, E, and J, saw therapy as involving plant growth or cultivation which depicted the personal growth involved in therapy. Within the idea of gardening established psychologist, Participant J, spoke of her favourite metaphor entailing:

an overgrown garden. It was a beautiful garden once and you discovered this place and, but we’ve got to start cleaning up. We’ll pull up the weeds, we’ve got to scrape away the dirt, and, “oh, we’re seeing beautiful things emerging” (...) and, ja, we need to prune things.

Intern psychologist, Participant E, saw therapy as a process of strengthening oneself to effectively thrive and individuate in one’s environment:

if you look at the plant kingdom and you have that thing either to give you an invasive plant and you have this other plant that has grown close to it, doesn’t get any sun, or doesn’t get the proper nutrients, it’s all sucked up by the other one. How you can draw this plant out and away and find a place that is fine and good for this one? And, now slowly it will grow up and become big and strong and beautiful because it’s in its own (...) proper space with the nutrients it needs.

Similarly, intern psychologist, Participant C, described her gardening metaphor of the therapeutic process, elaborating on the therapist’s role as the gardener being entrusted to cultivate the potential residing within the husk of the seed, which has a Rogerian feel to it:

I see a seed and a gardener and I see the elements like the sun and rain and soil and I see the gardener-I see myself as the gardener and the seed as the client. And sometimes the elements have just been too harsh. And for me the gardener tends to this potential to help it grow.

Compellingly, gardening as a metaphor may capture both the enriching, strength-focused stream of therapy (planting, watering), and the more pathogenic aspects of therapeutic work (uprooting, pruning, revitalising).
Intern psychologist, Participant C, saw the therapy process as one of “gaining insight,” and closely aligned, established psychologist, Participant G, portrayed her Africanised Jungian metaphor of illumination, enlightenment, using the dawning and setting of the sun, for she elaborated:

Therapy is like a sunrise (…) over Table Mountain. Sometimes you can’t see Table Mountain. The sun is under the clouds and it can become fuzzy and non-directive and you don’t know if the sun is ever going to shine and sometimes you kind of follow whatever you’re doing in that haze, in that cloud, because you really want to get there and within no time the clouds disappear and the sun breaks through and you see sunshine and that kind of like is the high moment where you’ve hit the nail on the head and you’ve come to the essence of the problem and the sun is shining and it’s nice and warm. And, somehow the sun goes down again and it mellows and you, as the person, you are Table Mountain. You are still remaining there as the patient sitting there with you and (…) to take all that heat that you’ve absorbed throughout the day and use it and take that information and move forward with it and heal yourself.

Alongside nature, art also offered compelling metaphors to describe the creative and expressive elements of the therapeutic process. Established psychologist, Participant I, stated:

I come from a place of being didactic (…). The teacher with answers, but because I was an art teacher there’s no answers, so it’s very similar. There’s no answers in psychology - there’s no answers in art. So for me, a person comes in like a painting, they’re a white canvas. I know nothing, I know nothing about them. And then as I piece together the thing, I see this harmony, I see the irrationality, I see the problem bigger, you know. It becomes- it’s more obvious.

Similarly, intern psychologist, Participant D, drew upon art to describe the creative and illuminating aspects of the therapeutic process:

a client basically comes to you with a canvas if you had to look at it in terms of a painting which they are busy painting. And there are aspects of it which they cannot see; or that they are not aware of and your job as the psychologist
is to help make them aware of the things so that they can see the complete picture.

Furthermore, therapy included the idea of completion or integration, “when you put the pieces of the puzzle or help put the pieces of the puzzle together” (C), and a process of quilt-making (F). Established psychologist, Participant H, saw therapy as an opportunity for wholeness, “the advantage of being a therapist is you get to help people to be more well-rounded”.

Participants across career levels also saw themselves in an active role within the therapeutic process in terms of being, “an agent of change (A), and “the facilitator of change (...) a positive model in a person’s life- that to me is very important (...). I like to see progress and I like to see people being able to be actively involved in their life” (D).

Established psychologist, Participant H, employed a sporting metaphor from his personal history, which depicted his directive, encouraging coaching-style in therapy:

it still boils down to what does that person feel (...) what do they need, how are you going to best adapt to them and how are you going to get the best out of them. It’s similar to being a captain of a team (...) you must know each and every one of the guys playing for you, and one guy will respond to a pat on his back, the other guy you’ll shout at him (...) but another guy you will encourage him in a certain way (...). Therapy is just encouraging people to do the right thing (...) it’s getting the best out of those people.

Diplomatically, intern psychologist, Participant D, conceptualised the therapeutic process as a fine balance between being a “safety net” containing (soft) and the challenging (hard) process of reconfiguring patterns:

I think it is important to create an environment that is very safe, secure and to be consistent with the client (...) to facilitate an environment or atmosphere where they can bring about change (...) that safety net for the client, that environment that they feel that they can share anything, it doesn’t matter how traumatic, how horrible it is and you would be okay with that, it won’t break you and being able to contain them as well. And
not judging them and being open. But also not being so soft that they can, you know, that you don’t challenge patterns recurring in their lives. So I think it is a balance but to just to have that environment where they feel safe. And, to be present the whole time.

Intern psychologist, Participant A, described the therapeutic process as a journey which involved a process of repair and of encountering historical and new places within oneself:

I’m in this car or you’re in this car with this client and you’re driving and things happen. Sometimes the wheel falls off, or the petrol runs out or whatever and we get that fixed in some way and learn from it but life goes on, you know, and we go on with it. So what can we learn from the things on this journey? Um, where can we get petrol, where can we get energy? Um, what is the destination through one to visit? What is the places we want to go re-visit in which we don’t feel or sort of unfinished business-type of places? You know, so it’s an ongoing journey. For me I don’t think there’s really a definite end. I personally believe that human beings can develop themselves throughout.

Furthermore, Participant A, emphasised the excitement, challenging and risk-taking elements around the adventurous journey into the unknown. She held that such a riveting experience has the potential for the therapist to work at the supracompetence level characterised by flow (Howell, 1982) and as such the therapist employing their own positive excitement-seeking self in their clinical work (Wilson & Luther Wilson, 1997):

you want to explore (...). I’m in this 4 x 4 and I’m driving here in this 4-wheeler - I’m just like, “this is so exciting! (laughs)” (...). I don’t look at what I’m wearing or like, you know, what’s going to happen now. Let’s go! (...). Like flow, you know. You’re like so into what’s happening around you don’t even see, other things are not even in your awareness (...). I think I’ve been like that throughout my studies. I dive into things, hey, and sometimes it can become not good, but being aware of that sort of protects you from going too deep into that (...) you can’t predict, so you’re thinking, ‘Okay, I’m going to step into this. It’s a risk. I’m going to do this. If there’s consequences that are bad then I’ll deal with them when I get there. But, for now I need to have and take this step.’ Because there might be coming something good or the intent is for the good to come out of it. But if it’s bad, you know, that’s life (...). Sometimes you need, you feel that, ‘I need to challenge this client now and he might not like it – he or she might not
like it – but, you know, I’m a therapist and we need to move somewhere and (…) I need to work”.

In terms of therapy, being a process of learning, notably, four of the six established psychologists, F, H, I, and J, interviewed were originally teaching in an educational context prior to practicing psychology and as such were familiar with imparting skills and knowledge to others. Using a car metaphor differently, established psychologist, Participant G, employed the metaphor of teaching an individual to drive as depicting therapy as a process of learning a practical skill for moving somewhere in life:

Sometimes I actually see it as two people in a car, a passenger and a driver and sometimes I’m the driver and I am holding on to the wheel and I am getting into the direction and I’m telling this client well, where to go, or the client is telling me where to go and at some point I would park the car on the side and just swap seats and the patient needs to drive and I’m going to be the passenger watching this process unfold in front of me.

In discussing metaphors of therapy, established psychologist, Participant J, referred to encouraging her clients to develop their own metaphors of their therapeutic process, “what I do is I pick up metaphors from them (…), I click into their world, world space and their being in the world and use my metaphors from them”. Similarly, Witztum, Van der Hart and Friedman (1988) referred to the power of client-generated metaphors and metaphor-informed rituals in facilitating change in clients. In terms of therapy being a reparative, maintenance, and cleansing process in terms of psychoanalytic therapy, Participant J, relayed:

if I’m working with a motor mechanic, you know, then [with], my limited knowledge I will say, “you know if you’re stripping down an engine. You’re taking all the bits apart and you’re cleaning them and, and because the car is not working, you’re cleaning them and you’re putting them all together. And, now it goes beautifully (…), that’s pretty much what therapy is about. We’re going to take all the dirty bits out.
Intern psychologist, Participant E, spoke of the imprecise timed process of deconstructing and reconstructing within therapy leading to healing for the client over an inexact amount of time:

you break something down or you get to pull it out and get it out of your system (…) and then you look at the way (…) you contained it. You need to build something up again (…). And, whether that takes one week or 100 weeks?

Intern psychologists B, and C, and established psychologist, Participant F, highlighted the intimacy that featured in the therapeutic relationship. Ehrenberg (1992) confirmed the unique “intimate edge” of the therapeutic relationship as: “the point of maximum and acknowledged contact at any given moment in a relationship without fusion, without violation of the separateness and integrity of each participant” (p. 33).

Somewhat contrastingly, intern psychologist, Participant B, spoke of how therapy could be seen as a kind of contrived intimacy or an intimacy transaction, ‘emotional affair’ for she referred to how her mentor proposed that therapy could also be seen as a form of “emotional prostitution”.

Intern psychologist, Participant A, saw the therapy process as being a context where the client’s story is told and the therapist carefully probes with questions in order to encourage the client to flesh out their story. Furthermore, participants, C, G, I, and K, saw therapy as involving the client’s narrative as understood in narrative therapy.

Additionally, participants, I, and J, both have had an interest in media and journalism which revolves around the disclosure, witnessing and making sense of people’s stories.

**Complexity of the Therapeutic Process**

no one arrives. No one actually arrives (…) the moment you think you’ve arrived, you’ve got big problems (H).

Established psychologists, H, and K, found that the therapeutic process became
more complex over time. Participant K found, due to the complexity of the therapeutic process, it has become essential that psychotherapists place priority on establishing the therapeutic relationship to propel the therapeutic process. Participant H attributed the increased complexity of the therapeutic process to one’s increased knowledge spurring on higher expectations of one’s clinical work:

as you learn more and more, you expect so much more of yourself in terms of your knowledge. You expect so much more of that person. You have such a broader concept of the complexities of life and situations (…), you never stop learning (…) what happens is, you build up in your hard disc drive all those experiences (…) although it becomes more complex, you’ve got a massive base on store (…). It doesn’t make it less complicated there. But I’m able to draw upon my experiences and how to deal with it, you see (…) there’s a whole-, there’s an expanding knowledge all the time.

Participant H also found that as one gained experience one embraced the complexity in an attempt to take psychotherapy as a whole further:

you also create your own knowledge as well (…). Never be afraid to create your own knowledge. Never be afraid to take a chance. I know, in therapy, people say, “you can’t take a chance and you can’t use new therapies, you’ve got to be careful”. I know you have to be careful, but, you also have to move beyond the box sometimes (…). If you’re going to always only work on what the existing knowledge tells you, then you’re not actually trying and breaking boundaries or barriers (…). I broke boundaries when I did a lot of sexual therapy all those years ago. I broke boundaries when I helped people who had incontinence problems (…). I worked out new methods (…) I did develop my own theories. [We] would not have been successful if we’d gone according to rules and regulations and previous therapies.

Participant H provided support for a psychotherapist to become a “reflective practitioner” (Schön, 1983) as such developing critical, self-reflecting practice:

The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him, and on the prior understandings which have been implicit in his behaviour. He carries out an experiment which serves to
generate both a new understanding of the phenomenon and a change in the situation (p. 68).

Established psychologist, Participant F, from her theoretical vantage point maintained that the complexity of therapy lies in the transferences (“That there are two people and not just two but all the other people you bring into therapy with you”) and yet with the self-awareness of the therapist the complexity can be held, which in turn enabled the therapeutic process to remain simply effective:

I know this sounds like a copout, but I think it’s both [simple and complex]. I don’t see it as difficult-, so, in many ways it is simple because it is about listening- getting the other person- with them wherever they want to go. The complexity comes in - what is mine and what is yours and what is neither of ours (...). I think the whole transference kind of thing that is where the complexity comes in (...). There are complexities like in every human relationship. So it’s just ‘be aware’, and then it’s quite simple.

Established psychologist, Participant K, found with her particularly active therapeutic style therapy needed to continue to be complex in order for her to be seen as doing effective and worthwhile work:

I think it’s become more complex. I don’t think it’s become simple (...) for me, if it’s like simple I’m not doing the job well enough (...). One therapist said to me that, “if you’re actually analysing every case, after the case, you’re working too hard. You’ve got to really take it as it is”. But, that’s not the kind of person I am (...). Sometimes, I have to actually say, “But it worked and it was simple!” But for me, I think like it can’t always be simple. I’m not comfortable with the like simplicity of it. You know, if I’m sitting in the playroom and watching someone drawing in the sand and just reflecting on it, for me it’s like too easy (...). I don’t trust my own like power in the simplicity. You know for me it’s got to be- I’ve got to be doing something, I’ve got to be seen to be doing something. I’ve got to be like human bonding, I’ve got to have a recipe to do something and I can’t just sit there and reflect and it seems to work but-, Ja, I’ve got to get more comfortable with that still. That’s an area maybe I could develop in (...). I’m still grappling with the fact that it’s simple.
Whereas established psychologist, Participant J, saw the therapeutic process becoming more simple as one’s confidence increased and one became ‘therapy fit’ as a busy clinician:

You know, if I think of how hard I worked in the beginning (…) and how tired I was at the end of the day. It’s become more simple. And, maybe the two went together. As I became more confident, I could just put the theory out there and just be with the person and then, being reinforced by the fact this works.

Yet, alongside Participant K who concerned herself with an isolated incident of a “disgruntled customer”, Participant J also acknowledged that she still experienced performance anxiety and questions whether she had done ‘good-enough’ clinical work in terms of client satisfaction with the psychological services she had provided:

But having said that, (…) particularly when I start a new case, I’m a wreck. I’m an absolute wreck (…) my stomach is churning (…) it’s pure performance anxiety but within minutes it’s over (…), it’s always been like that (…). I’ve always been anxious. Even, if the person’s been coming for a few times I still have those butterflies before the session. And, I’ve learnt to accept it as ‘well, that’s good! I’m glad you still get nervous. Don’t think you know everything’ (…). It’s good and bad because, you know, I told you when I was a shy person. So, I do have difficulties meeting new people. And, the feeling of am I going to be good enough. That’s what the anxiety is about. Am I going to be good enough?, are they going to leaving thinking, ‘that was an utter waste of time’? Or, am I going to be able to give them something that’s going to make them want to come back again? That’s my anxiety (…) and then when I meet the person and we sit down and we start talking, it goes.

Similarly, to the self-talk of established psychologist, Participant K, established psychologist, Participant J, reframed her anxiety as anticipation or excitement and as potentially keeping her on her toes to ensure she did a good job and as evidence of humility, and genuine care for patients as people rather than adopting a stance of indifference or overconfidence:

I’ve learnt to just say, ‘well, that’s good’. I’d rather be that, than just arrogantly, just people come in, work with them, let them go. They’re not just numbers, they’re not just entries in the diary (…) there’s usually a sense of excitement seeing people.
From a systemic stance, established psychologist, Participant G, reflected on the complexity of the therapeutic context in relation to the history of psychology and her reabsorption back into the South African context after years abroad working for the National Health System in the United Kingdom. Yet Participant G found one’s therapeutic experience and new therapeutic aids/resources made the actual therapeutic process easier:

I wouldn’t say therapy has become more complex. I think that we’re privileged to have a lot of information now. Therefore therapy should be becoming easier. I wouldn’t see therapy as becoming more difficult. I think that we’ve got a lot more issues to address. I think that therapy now is more than just the individual that you see (...). So, there are a lot of issues that get addressed in therapy nowadays that probably weren’t there, many-a few years back. I think that a lot of people are accessing therapy more than they had before (...). I think, for me, I’ve got more material to work with and I see all sorts of different people (...) a lot of books now have come up with step-by-step things -12 steps for this and eight steps for that - and, yes, you do use a lot of it but you also are very careful not to be constrained and, stereotyped into it (...). Probably, the problems are complex (...) but, I think that we’re not short of, the skills and the tools to deal with these problems (...). I certainly haven’t been finding it to be getting difficult. I think that with more experience I think it gets easier. I think you get into the role and you move with it.

Evaluation of One’s Therapeutic Work

Gauging the success of therapeutic work overall involves therapists engaging in a process of self-monitoring due to the general solitary nature of therapeutic work. All participants across career levels spoke of the “difficulty” of gauging successful psychotherapy. Karter (2002) saw the therapeutic process as almost indefinable and as possessing an ephemeral feel. Schröder and Davis (2004) outlined how gauging success in therapeutic work was not easily accomplished as difficulties in a therapeutic process could stem from three sources, namely, current skills deficits of the therapist, enduring personality dynamics of the therapist and problems inherent in the situation that the
therapist was confronted with. Keeping in mind the complexity of therapeutic work and ill-defined measures of success, Smith (2006) proposed that evaluation practices needed to stay close to the Latin root of the word “evaluate” which is “to strengthen” or “to empower”. With this in mind he argued that evaluation needed to involve both being a connoisseur and a critic.

A therapist’s process can be likened to an educator’s process as outlined by Smith (2006). Therapeutic development could involve an ‘ability to think on our feet’ where improvisation and new ways of perceiving were valued in a realm where there were little room for habitual methods and predictability. The following key steps could be identified as being followed by the psychotherapist in consultation namely: to assess what may be going on in the therapeutic encounter and what one’s role was as a therapist. Secondly, for the therapist to actively engage in conversation or a similar equivalent with the patient thereby, thirdly, provoking questions for the therapist which in turn one considered in relation to, fourthly, what therapists discern made for best treatment outcomes. Fifthly, from this enabling stance, the therapist then can develop an appropriate therapeutic response. The key, argued Smith (2006), lay in combining knowledge and techniques in an original way to meet the needs of a particular situation which amounted to therapeutic artistry.

Schön (1983) argued that artistry was an active intelligence or a kind of knowing. Through engaging with their experiences with clients therapists would be in a position to develop axioms to guide their subsequent therapeutic work. Therapists as such learn to appreciate - to be aware and to understand, to in essence ‘know’ their therapeutic encounters with patients. From a learning point of view, Eisner (1998) argued for
connoisseurship, the art of appreciation which could be displayed where the value of therapists’ ‘performances’ in the clinical encounter could be regarded as distributed and varied. However, “if connoisseurship is the art of appreciation, criticism is the art of disclosure” (Eisner 1985, p. 92). Criticism, according to Eisner (1998), “functions as the midwife to perception. It helps it come into being, then later refines it and helps it to become more acute” (p. 6). He held that “connoisseurship provides criticism with its subject matter. Connoisseurship is private, but criticism is public. Connoisseurs simply need to appreciate what they encounter. Critics, however, must render these qualities vivid by the artful use of critical disclosure” (Eisner, 1985, pp. 92-93).

Established psychologist, Participant J, depicted a successful therapy as almost a sense of relief expressed by the patient’s body which becomes evident to the perceptive observer as:

almost like an easing inside (...) you’ll find your patients will take a deep breath and sigh and you can just see, ‘Oh, it’s eased up inside’. Something is making sense now. It’s not so tight and constricting anymore. It’s opening up the space.

Intern psychologist, Participant E, weighed up the obvious signs of successful therapy and the more subtle indicators of therapeutic success. He found that he relied on his intuition to gauge whether therapy benefited the client rather the concrete rating scale appraisals of his performance as a clinician:

I mean the most obvious one is what the client says, him or herself (...). There’s also just an intuitive feeling (...) you can feel if you sat with a person (...) I mean you can tell by a person’s body language (...) what they radiate. You can tell if you’ve moved something in them or if they’ve developed from the first day they started a two-week counselling programme to the 14th day (...). I don’t monitor myself in terms of any success rates.

Established psychologist, Participant I, explored how successful therapy hinged upon meeting the specific aim of the therapy undertaken. For wounds she advocated
surgery to lance out the pain and the attendant catharsis of tears and yet for an entrenched habit she pictured a victorious conquering and dissolution of the troubling overt behaviour:

I don’t really know how I know I’ve done good work. I actually don’t always want to do good work, I sometimes want to be- I’m playing a role, so if I’m facilitating a change, I may say that I’m their advocate (…) like if I get a teenager who’s resisting their mother’s marriage because the father died, I’m not going to support her indefinitely (…). I’m not there to hold your hand and to make you okay, and feel okay and reflect everything you want me to hear (…). I’m not going to make your life necessarily easier.

the whole time [Obsessive Compulsive Disorder is] a battle, it’s not a therapy. It’s a battle and a struggle and a failure, a loss of everything. But then, how do you know it’s successful? Well, when they get over it, when they no longer have it. They no longer collecting condoms or seeing blood on the table.

Intern psychologists C, D, and E, valued movement in therapy, becoming “unstuck”, their own feelings of fulfillment, and the therapist-client shared experience of success and feedback regarding the process from the client:

it’s not so much your success also as it is the client’s success (…). I think it depends greatly also on your expectations as a therapist. If your expectation as a therapist is to rescue people then I think, um, you would measure it by whether they have bettered themselves or reached their potential (D).

we all have crap sessions and then we have very good sessions. For me I would say that success is monitored on the feeling of fulfillment. When you have those really good sessions and that you moving somewhere, you not remaining stuck (…). For example if the client has post-traumatic symptoms and if you talk about certain issues, feelings- then he opens up; if relationships are healed or clients come to accept that a relationship can’t be healed. [Success] also comes from the client’s perspective (…). Clients will often say to me, “That really meant a lot to me in my life” or, “I went home and I thought about this at home and spoke to whoever about it and that was really important for us”. So, I think you could measure your success on both your feelings of fulfillment – when you put the pieces of the puzzle or help put the pieces of the puzzle together- and also on the client’s verbal feedback
is also quite important. “We spoke about this in therapy and I went home and
I noticed that is exactly it” (C).

Similarly, intern psychologist, Participant B, found that there were various ways
to measure therapeutic success. She outlined the need to track the fulfillment of goals,
however she realised that therapeutic process did not necessarily fulfil all the facets of the
pre-determined treatment plan, and nor did the client’s needs necessarily remain in
tandem with the set-out obvious goals:

Success is obviously with your goals. If you come in- even if consciously or
subconsciously you have got goals: This is where we want to move towards
or the person wants to move towards. And, maybe you have got different ones
in yourself, but that is where they want to go to. And, if for instance it was
quite a directive approach you would write your goals and when you meet
them, ‘Great’- “Goodbye!” (…). But it need not always be as simple as
meeting of those goals.

In an attempt to pin down what qualified as good psychotherapy participants
B, C, H, I, and J, drew on work with specific clients to illustrate how they assessed
whether they had accomplished good clinical work. For example, intern
psychologist, Participant B, reflected how she had to revise how she evaluated her
level of accomplishment with clients in light of her work with a particularly
traumatised client:

I had a PTSD client, who- we wrote all these goals. We had wonderful things
we were going to do, and in the end all we got to do was for him to
understand that thinking something is gonna happen, doesn’t mean it’s gonna
happen. And I was like, ‘Oh my word, that is one of the ten goals!’ But,
actually that was success (…). I think it is easier to see when therapy is not
successful (…). It is also very subjective, because at the moment I am also
seeing someone who is totally regressing now, bedwetting (…) that is
success, like we’re working. Stuff is happening, but she’s getting much
worse, but something is happening here. Therapy is not successful when um,-
when the person doesn’t come (laughs). Ja, it shows you resistance and all
these other things but if they are not coming, they are not ready. But, also I
don’t always see it as a personal thing if it’s not successful (…). ‘They are not
ready’. ‘Maybe, I am not just the right person for them’ (…). If they buy into the idea and into me and therapy and then it is like, ‘Okay, now, we can go!’ And, ‘We can work!’ And, something will happen (B).

Intern psychologist, Participant A, suggested that she regarded a successful therapy as one that was focused on the client’s specific concerns and then broadly enhanced the client’s self-awareness, integration and a healthy ambivalence towards life:

in the modern world, the client has a specific problem coming for work – that’s your goal – you work at that. And, in the real world it doesn’t happen that a client can be in therapy forever, you know, so maybe trying to broaden that client’s awareness to the fact that, you know, ‘tragedy happens in life and we’re working through this’ (…) if you want to look at in an Object Relations way, the good and bad comes together – that’s life! (…) a mature way of seeing things.

Participant A identified markers of self-monitoring as including checking one’s theoretical formulation of one’s clinical work, the client’s feedback regarding the therapy and reviewing process notes of the therapeutic process to pinpoint which goals had been achieved. Established psychologist, Participant H, also favoured use of notes to provide feedback in the therapeutic dyad:

we could tangibly from session to session, from month to month, we could look back and say, “we’ve achieved this”; look[ing] at their note. “Look, what you were, look what happened there” (…) So, there was always that tangible feedback in terms of whether they changed their image, their clothing, their posture, that their relationship is now working.

Participant A also reported having derived her life meaning and feelings of accomplishment in her work and as far as she was responsible for the therapeutic outcome:

I’m pretty happy with the outcomes of every client I’ve approached (…). It makes me feel good (…). I mean I can’t really say that these are the factors that led, to success with this person’s whatever because yet again it remains the client whether he’s going to choose to learn from this or grow.

In relation to monitoring therapeutic success, participants learnt to conceptualise their therapeutic role as one of empowering the client:
I think it is as psychologists, or in the helping profession a lot of people see it as their responsibility to fix, all the time. And then that leads them to try take over the process instead of just letting the client run with the process (...) the biggest lesson that you can learn is knowing when to distance yourself from the client, not to get personally involved and also then knowing when to back off so you don’t control everything (D).

I want to be an agent for change – that’s my aim. I don’t like being directive in sort of making choices for a client. For me it’s to empower the individual that’s with me so that they don’t develop a dependency. Um, so my hope or my ideal way I would want therapy to work is to use my knowledge and training and experience in helping that individual, [yet] the responsibility at the end of the day still lies with the client (...). I think that’s also a level of maturity regarding a psychologist, um, because I think accepting that- it will make it a lot more easier for a therapist because you can’t choose for another person (A).

as a therapist the only thing you can do is basically provide the environment for change to happen. And then you’ve got to know that you’ve done everything in your ability to facilitate an environment or atmosphere where they can bring about change. Um, whether they take the responsibility or not to bring about that change is not really your responsibility (D).

if they want to change. If you there for them and they want to change and you are reflecting or doing whatever, then stuff is gonna happen. If they don’t want to it’s not go happen (B).

there is more to people than you think, I don’t know; they are so capable. Maybe part of your job is to just to know nothing. Because if your patient has the tools to fix himself or herself- They have the tools (but they have just been so dominated by something, fear or shame or guilt or what bad deed, that they can’t do it, they can’t).- So, you’ve [only] got to like realign them, a lot like a computer operation, you tune it up, default-changing (I).

Jennings et al. (2007) found master therapists placed value upon the ethic of the patient’s right to autonomy, to determine the course of their own lives. Clients also needed to be able to dictate the pace and direction of the therapeutic process. With autonomy as central, master therapists placed more priority on helping the client to become empowered to find their own answers than merely dispensing an answer. Established psychologist,
Participant I, also found that she managed the extent of her responsibility for the outcome of the client’s therapy:

if there isn’t success I don’t take it personally, I mean if someone falls off their motorbike and you’ve cleaned them up and then they go jump of a cliff, what am I supposed to do about that? I expect that it is not permanent. I don’t expect to permanently fix anybody.

She conceded that:

I don’t mind how much you grow when you come see me, but I would like to see some growth (…). If it’s a mindshift, if it’s an environmental thing or a job change, I don’t care, a boyfriend change. You’ve come to me and you’re stuck, something you can’t shift and I’m going to help you do it. And then the other thing, I’m a realist. You know people only have medical aid for about five sessions. So let’s try and get something going, you know. Get to the cause, the problem as soon as possible.

Established psychologist, Participant K, advocated that, ideally, therapy goes beyond symptom relief and equips clients for self-development and self-awareness in their future:

it is a nice feeling when somebody says, “I feel so much better!” Um, yes, but they must take that feeling of actually feeling better to actually grow with the future and say, “How did I feel better?” (…) it’s like a tool for the future to make you feel better”. Fixing is-, like for me, is more on a like linear level. Okay, if there’s a problem you fix it – it’s done. Whereas empowerment is more the growth, I think. Through the experience (…) to be aware that it could happen again (…) “at, least I’ll know how to handle it in the future”. I like to think that people come out of therapy not just feeling better, but feeling richer (…) like even if I wasn’t there, they’d be able to do some stuff for themselves. Because then they wouldn’t become dependent on the therapist just to always fix it.

Established psychologist, Participant H, emphasised success as being defined by taking hold of all experiences as learning opportunities:

the successful person learns from those mistakes, has good error utilisation, doesn’t make the same mistake again, (…) is able to then put aside the past and say, look, that was a hell of a flop (…). But they don’t do it again.
Whereas other people will have the same mistake recurring (...) they just cannot learn from their mistakes or build upon those mistakes.

Established psychologist, Participant K, also proposed the signs of successful therapeutic work being possibly linked to one’s professional reputation and the size of one’s current client base:

if you’re in private practice I think you monitor your success, if you can call it that, in terms of your, like, word-of-mouth referrals (...) also you get a gut-feel as well, I think, whether you are working or whether you’re not (...) you’ll be the flavour of the month for a big period of time and then next thing you’re out of favour because there’s a new psychologist in town.

Established psychologist, Participant G, emphasised the importance of self-affirming one’s successes in a systemic context of a multi-disciplinary team and therapist-patient dyad and a profession that does not always easily lend itself to clear-cut performance appraisal:

I do measure progress with my patient sometimes as to how I see them develop. Um, because of the structure of the hospital, sometimes it’s very difficult to take credit to yourself because we are so many of us – there are social workers, there are psychiatrists, there’s nurses, but you have to bask sometimes in that glory and say, “Well, maybe something I did or said has made that person better!” And, that’s the kind of re-affirmation that you need to go to give yourself because psychology is not a clear-cut, easily measured, successful profession. You can’t really sometimes see- sometimes in therapy whether you’re getting better; or whether this patient is getting better or getting worse. So the positive strokes don’t come so quickly and so easily (...). You need to be able to say to yourself, “I’m not doing any damage here and I’m not making things any worse, and I’m doing this to the best of my ability, to the best of my competence!

Thériault, and Gazzola, (2005) have found that feelings of inadequacy, insecurity, and incompetence do occur among experienced therapists, yet along a ‘continuum of intensity’. Admittedly, established psychologist, Participant K, explored how she still,
after years of being in practice, experienced self-doubt regarding the quality of her clinical work, despite her successes far outweighing perceived ‘failures’:

I think, there’s still bits about me. You know, why am I still so hung up on about-? (…) Is it like something in me that says, ”you have to always like make everyone happy for you to be doing the right thing?” (…). I’ve got to look at the, like, facts, then I’ve got to actually keep on telling myself that I did nothing wrong here (…). It is a constant thing for me. It’s not something I can just put away.

Despite ambivalence around her self-examination of her work Participant K regarded self-questioning as a protective factor against complacency and overconfidence in her work:

I don’t think I’ll ever become too complacent. I don’t think it’s just in my nature to say, “I’m okay – I’m doing fine.” I will always question myself (…) I think I have become more comfortable but I’m not completely comfortable, you know, with just going with the flow or just accepting everything- and maybe it’s a good thing.

**Shifts in Felt Competency**

Orlinsky and Rønnestad (2005) found that psychotherapists at different career levels reported experiencing “different degrees of therapeutic maturity” (p. 147). Over time therapists reported increased therapeutic skills, a decrease in anxiety and professional self-doubt, and a more affirming and less reserved therapeutic manner. Similarly, Skovholt and Jennings (2005) have indicated that the main task of the established therapist lies in creating a comfortable style of doing therapeutic work.

In their quantitative study of family therapists at different career levels Kral and Hines (1999) found significant differences between trainees and experienced therapists. At the inexperienced beginner level, therapists reported high levels of anxiety prior to sessions, fear of communicating incorrectly to clients and thereby instigating a crisis situation, self-doubt regarding whether they personally have what it takes to be a
psychotherapist and feelings of not being calm and confident during therapeutic work. In contrast, experienced therapists viewed themselves as effective when working with clients, experienced lower levels of anxiety prior to sessions, felt more trusted in the profession, more confident in their competency and in managing crises, less self-doubt regarding whether they personally have what it takes to be a psychotherapist, more comfortable with their professional identity and importantly therapist’s experience level was not correlated with choosing one theoretical orientation to work from. In light of two proposed models for psychotherapist development from trainees’ first therapy case to many years after qualification (Friedman & Kaslow, 1986; Skovholt and Rønnestad, 1995) and the results of their study Kral and Hines (1999) found that the gap between a beginner therapist and an experienced therapist was approximately five to six years after graduation. This lends weight to Carl Whitaker surmising that, “Technique is what you do until the real therapist arrives (…) in my experience, it appears to take five years” (cited in Kral & Hines, 1999, p. 102).

Recently, Folkes-Skinner, Elliot, and Wheeler (2010) explored initial shifts in a beginner therapist. A loss of certainty and anxiety around personal competency to be an effective therapist became evident and as such:

from the very beginning of practice, trainee therapists are likely to experience dramatic change particularly in relation to self-confidence, and they are prone to damaging levels of stress because of their lack of prior experience and their embryonic therapeutic self (p. 91).

Kottler and Jones (2003) summarised a host of fears that plague psychotherapists namely fears of rejection, failure, ineptitude, mediocrity, power, limitations, shattered illusions, losing control, harming others and annihilation. Other struggles included issues around permission, competence, competitiveness, doubting one’s impact, temptations,
boredom and being overwhelmed by clinical work. Similarly, Skovholt and Rønnestad (2003) noted that beginner therapists have a “fragile and incomplete practitionerself” (p. 50) that ricochets between feelings of enthusiasm, insecurity, elation, fear, relief, frustration, confidence, bewilderment, anxiety or shame in relation to their therapeutic work.

**Bursting Bubbles: Naivety to Groundedness**

Skovholt and Rønnestad (2003) found beginner therapists report a “loss of professional innocence” (p. 46). Similarly, intern psychologist, Participant B, reported that her “sandcastles coming crashing down” when faced with the reality of clinical work. Here, Kottler and Jones (2003) spoke of the beginner therapist within the stage of disillusionment where the therapist was faced with existential questions of whether their work with clients was influential and made a difference in their clients’ lives and the world. Skovholt and Rønnestad (2003) and Szymanska (2001) spoke of the glamorised or unrealistic expectations of beginner therapists. Intern psychologists, B, C, and D, spoke of having had to confront the unlikelihood of their glorified expectations of the profession being fulfilled and going through a process of, “letting go of some of the naivety I had” (D). Intern psychologists found that having been trained as a psychologist was not a panacea to solving all human distress one was confronted with in one’s consultations and as such having to confront their potential Saviour complex:

When you idealise psychology and the therapist’s role you kind of think that when you are finished with internship-. You know, you start realising in terms of the therapeutic process that you, you know, in the beginning feel that if you get trained you are going to know how to solve people’s problems. And, you know that was my opinion. And, you realise that when you get into therapy you might not be able to do that for a person (C).
I applied for my Masters and I wasn’t accepted and (...) during those interviews I remember, I was very-I still am naive- but I was very naive. And, I remember telling everyone how everyone is getting better and how-. They focused very much on my isolation, the fact that I was very isolated in Mozambique. But, I remember telling them that, “I don’t- I know it’s wrong to say it-, but I don’t think I need people”, which I know is totally warped. But- I realise that now (...). I built sandcastles in the sky and I think they all just crashed that year! (...) it is not always fixed and it doesn’t have to be. I have become more cynical (laughs) (...). I think that we all have our sandcastles crashed sometimes and I think it’s very good when that happens because it’s I think we are very idealistic sometimes, and that is not life (...) that is where we have a difference or where I have a difference is . B-! B! B! is- lives in fairytales and dreams and I have got a B-bubble and everything is happy (...). But, I know a lot of it’s fantasy and I’m fine with that, but, I like my dreamworld. But, when I become B-therapist then- I sound a bit like I have multiple personalities- but, when I’m therapist I know what reality is. I have seen stuff and felt stuff and I think that is very important and that comes with experience. I still think I am- I still don’t know what type of therapist I will be. I’m still very young to be a therapist (B).

Intern psychologist, Participant D, acknowledged being generally non-confrontational with clients. Wilson and Luther Wilson (1997) offered an understanding of growth points in therapists as a shifting of multiple selves, as outlined by Apter’s reversal theory (1994). The initial non-confrontational approach towards clients of Participant D may at times, according to reversal theory, be seen as operating from a negative conformist self. However, Participant D verbalised that she found her voice during her training which suggests a growth leap into being autonomous within a group context, suggesting that she was able to inhabit her positive negativistic self (autonomous) when necessary both with colleagues, and clients:

not judging them and being open. But also not being so soft that they can, you know, that you don’t challenge patterns recurring in their lives. So I think it is a balance.
She went on to reflect that her self-confidence had increased, and that, “I think I have changed a lot as a therapist and as a person. I think I have become a lot more like independent, um, as a therapist specifically”.

Participant E found that with more experience, “I’ve become now-, I feel comfortable basically in my ability and just wait to see whatever it is a client is going to bring to the table”. Yet, Participant C argued that despite her increased ability her fear still remained when faced with the complexity of the therapeutic process:

It becomes easier in the sense that you become more comfortable in your ability but at the same time it is difficult because you realise how complex the process is. And there is always fear, for me. There is always fear there.

Established psychologist, Participant J, admitted to still feeling apprehensive when beginning with a new patient, this is confirmed by Kottler and Jones (2003) who conceded that it was rare that therapeutic work became simple or automatic, rather they argued that master therapists still had “continuing butterflies” for “what we do, when all is said and done, is a science-based art. Great art is never routine, and great artists seldom, if ever, approach a new work with feeling of total confidence” (p. 17).

Thrown in the Deep End to Swimmingly Well: Trepidation to Anticipation

Intern psychologist, Participant D, gave voice to the dissonance that beginner therapists feel, “I think a lot of beginning psychologists are quite fearful and feel quite like they are thrown in the deep end”. This sense of flailing in a pool of uncertainty is documented in Sawatzky, Jevne and Clark’s (1994) model of becoming empowered, which was similar to the developmental process outlined by Loganbill, Hardy and Delworth’s (1982) supervision model. Sawatzky, Jevne and Clark (1994) proposed that psychotherapists undergo a cyclical process of experiencing dissonance or confusion in relation to their therapeutic work which propelled them to respond to this discomfort by
seeking out assistance through supervision or knowledge generating activities (reading) to inform subsequent therapeutic consultations and thereby experienced increased competency and integration of a new conceptual understanding which led to a feeling of having shifted to being empowered.

Morgan (2007) documented that beginner therapists need to become acclimatised to a profession “where uncertainty reigns” (p. 40). Negative capability, a theory of the Romantic poet John Keats, described the capacity for accepting uncertainty and the unresolved. Keats stated, “I mean negative capability, that is when man is capable of being in uncertainties, mysteries, doubts without any irritable reaching after fact and reason” (1817, cited in Bion, 1978). Psychoanalysts argued that:

True learning and growing is a painful experience and involves a lot of anxiety. For learning to take place, a certain amount of frustration is inevitable – the frustration of not knowing something, or of being confused and anxious about being ignorant. The capacity to bear these feelings determines the capacity to learn. This pain is essentially the “uncertainty cloud” or the ability to tolerate uncertainty (Emanuel, 2000, pp. 61-62).

Recently, Skovholt and Sparkey (2010) found that:

this search for certainty shares the stage with a reluctant accepting of uncertainty. Over time, practitioners begin to realise that the circle of not knowing grows as fast as the circle of knowing (…). The work is confusing, the ambiguity at times frightening. This paradoxical quest, the intense search for answers while accepting the swampy reality of human complexity is a life long journey (p. 125).

Skovholt and Rønnestad (1993) found that beginner therapists were overly focused on having structure in the therapy process and mastering techniques whereas there should be more attention to developing reflective practices. Skovholt and Rønnestad (2003) argued that the task set for beginner therapists was one of “searching through uncertainty via reflection” (p. 55) in order to effectively assist clients with their
problems. Similarly, Skovholt and Jennings (2004) found that master therapists embraced ambiguity in their therapeutic work. Kottler and Jones (2003) believed that as therapists developed they no longer hankered after the right answer to solve presenting problems of clients but become adept at discerning the “best of available choices”, and as such out of the complexity generated plausible options for the client to make use of. This tension between offering guidelines and likely outcomes, ticking off goals (A, B, and H), and doing something (K) with the client as opposed to just being with the client with no answers (B and I), was voiced as an ongoing dilemma that participants across career levels experienced in their therapeutic work.

For example, intern psychologist, Participant B, highlighted her developing the skill of formulating and sharing the prognosis of the patient or anticipating possible outcomes for the client. However, she added that this predictive capability needs to be balanced with a willingness to stay with the client where they are at and hold the current chaos or ‘mess’ that they were experiencing, “You doing this and that is why this is happening, (…) I will be there with you. I will sit with you through all the shit with you. But this is probably gonna happen”.

**Handing Over the Reins: Empowering the Client**

“as one goes through life one learns that if you don’t paddle your own canoe you don’t move” – Katherine Hepburn

Skovholt and McCarthy (1988) highlighted a growth point for psychotherapists involving “letting go of overresponsibility” (p. 71) in relation to clients. In their development, intern psychologist participants, B and D, acknowledged the potential negative impact that beginner therapists’ overeagerness to rescue or cure can have upon the client’s therapeutic process:
I think a lot of the time the need to rescue and the need to make things okay becomes so overwhelming that you don’t let the client sit long enough with the problem to be in (…) a position of discomfort which would allow them to move in the process. You want to save so much and you want to take away the hurt so quickly that they don’t get an opportunity to save themselves (D).

I think we can do a lot of harm when we are young and when we are very naïve (…). Our desire for someone to be better will make them pretend to be better because they are picking up all these things, and they’re like, “I’m fine”, but sometimes they are fine for you and not for themselves. And, I think older, more experienced people are more able to sit with pain or with hurt and not to change it or challenge it or anything like that; but to just be with it. I think we, myself included, still want to make things better and that is not necessarily what it is about (B).

Intern psychologist, Participant C, added how an experienced psychologist quelled her fears about taking inappropriate responsibility for clients’ healing:

with that narrative course, the psychologist who took it said something about, “you can never expect something out of a session or even a client”, um, and she doesn’t put pressure on herself to always have growth in a session. And for me that was very powerful (…) that allowed my fear to subside a little bit, ja. I think as beginning therapists you put so much pressure on yourself to perform and to help your clients and you know. And when you look back you laugh at that. But, ja, it’s normal among beginning therapists (…) there was this expectation that I had to help to the best of my ability. Sometimes my expectation was sometimes more than what the client was capable of. And so, now I realise that even the slightest bit of change is important. Ja, I think that has been a big learning curve for me.

Similarly, intern psychologists, B, and D, reported having come to the realisation that the ability to make a client better does not sit with them solely, but rather lies within the self-healing capabilities of the client:

in terms of my personal life I’m very much a people-pleaser, you know, wanting to make everything okay (…). I had to learn as a therapist it is not my job to make everything okay (D).
you can’t actually heal another person. And, um, another book that influenced my, me alot is: If you meet the Buddha on the road, kill him. It’s all about how one man can’t be another man’s disciple, another man’s Buddha, and you can’t be like- you must let the person just realise from within (…) it just influenced me a lot in the sense of- because I think I had this glorified idea of like I’m going to make people better. And I don’t. I just create the awareness (B).

I am a very Type A type of person so I like structure and stuff so that is probably the biggest lesson I have learnt throughout the whole Masters journey is to trust your instincts and, um, to trust the client as well and to not try and control the process. So also having introspection but knowing when to step back and to let the client lead (D).

Closely aligned to intern psychologists surrendering inappropriate responsibility for clients’ well-being, were intern psychologists handing over the reins of the therapeutic process to the client as such letting go of anxiety-driven need to control or please, and overly structure the process of psychotherapy.

Wilson and Luther Wilson (1997) depicted this shift in therapists as moving from operating from one’s negative arousal avoidant self (non-confrontational/people-pleasing) to exhibiting positive arousal-avoidant tendencies (caution in giving client feedback) and in a growth leap working from a positive negativistic self (able to give difficult feedback to client as an independent individual).

As a beginner therapist, established psychologist, Participant H, found that he learnt to leave the onus on the client to decide about pursuing a therapeutic process:

I decided that people should not come and see me because I told them to come and see me. They should come and see me the next time because they wanted to. So, I’d use to say to them, “Mr Smith, I would like to see you in two weeks’ time (…). But go back and think about it (…) you’ve got to make the phonecall”. They have to buy in, and they only buy in if they feel they’ve been helped (…). I won’t go back and buy bread if I get stale bread.
Hess (1987) illustrated that beginner therapists learned through experience with clients and supervisory input that client change largely lay with the client actively participating in the therapeutic process.

**Loosening Up: Rigidity to Flexibility**

I think it was more mechanical initially. I was kind of afraid of just being with the person comfortably you know. [Yet] even now, if it has been a very deep session I need to go outside and clear my head. But, um, you get used to it as well. Fitting yourself into it (...). I think I am more, maybe, patient. I am more kind of ‘Let’s see where it goes’ Maybe all we can do is see where it comes from (F).

Another developmental shift in therapeutic work involved moving from anxiety-generated rigidity in order to feel secure, to a sense of freedom in flexibility in doing therapy. Participants reported initially being “mechanical”, overly prepared (F) and “uber-structured” (D) to allowing more space for the client to bring their material to sessions, (D, E, F, and J), and to engage in “random things” (B), creativity, experimentation within the therapeutic process. As such a key growth point for psychotherapists was to “step out the box” (B) or feel that they could throw irrelevant aspects “out the window” (H). Intern psychologist, Participant D, verbalised her shift from being overly structured to becoming more flexible within the therapeutic process:

because I was so uncomfortable and I didn’t feel like I had the confidence or the skills I would put a lot of structures in place so that there was very little room for the client to actually, just um, you know, be themselves and talk about what the problem was. I think throughout the process I have gotten a lot more confident in my ability to just, um you know, lead the process in a way that they can gain insight. So where it has gone from being uber-structured and I would have like a plan for every session, it is now much more up to the client whatever they bring, we will deal with. (...) that is the most (...) - the biggest thing that has changed in the therapy.
Karter (2002) proposed that rigid interventions in therapy were a result of therapist’s perfectionism, fears of incompetency and holding the unrealistic expectation of ‘having to get it right’ which was especially evident in beginner therapists. Recently, Levine and Williams (2010) found that therapists who overstructured therapy with clients compromised therapeutic alliances. According to Wilson and Luther Wilson (1997) therapists who were overly structured (in a “structural comfort zone”) could be seen as constrained by their negative telic self (lost in details) until they shifted to being in their positive telic self (realistic planning) and moreso in a growth leap allowed their positive paratelic self (spontaneity) which would parallel the playfulness of the therapist advocated by Winnicott (1958) to foster depth and exploration in therapeutic work.

Intern psychologist, Participant B, depicted her shift when her mentor encouraged her to make use of her creativity as such a positive paratelic self in therapy. Contrastingly, established therapists valued the therapeutic space to be a maverick (I), play (J), or see where things go (F), and the freedom to create new ways of doing interventions (H), and as such embraced the higher order Piagetean notion of possessing the capability to do new things.

In a paradigm shift towards a social constructionist standpoint, Carlson and Erickson (2001) proposed that trainee therapists inherently had personal knowledge which in of its self was expert knowledge that needed to be reverenced. However, current practices in training contexts failed to privilege such assets. This disavowing process occurred to such an extent that Carlson and Erickson (2001) argued that a trainee’s “freedom and creativity decreased as professional outside knowledge was used to describe their desires, skills, motivations” (p. 205).
Influences on Professional Growth

Recently, Skovholt and Starkey (2010) visualised the practitioner’s stool being made of three foundational legs of best sources of knowledge to practice namely, experience with clients, academic research and personal life experiences. Steiner (1985) outlined three key aspects that constitute effective psychoanalytic training namely, a personal analysis (personal therapy), extensive opportunities for clinical experience with supervision, and theoretical input. Yet, Orlinsky and Rønnestad (2005) found three key sources of professional growth in their international sample of 4 923 psychotherapists namely, experience with patients was the leading source of professional growth (84%), followed by personal therapy/analysis (80%) and seeking supervision/consultation (79%). Personal life experiences (66%) were endorsed by two-thirds of psychotherapists as influential in their professional development. Orlinsky, Botermans, and Rønnestad (2001) regarded experience with clients, personal therapy and supervision as the major triad of professional growth for psychotherapists.

Learning From Direct Experience with Patients

Recently, Folkes-Skinner, Elliot, and Wheeler (2010) argued that the “presence of real clients [is] the main driver for change” and a necessary “baptism of fire” for the beginner therapist (p. 89). Skovholt and Rønnestad (2003) found that clients served as the therapist’s “primary teachers”. Wolgien and Coady (1997) confirmed that experienced therapists emphasised learning from clients when reflecting upon the development of their helping ability.

Intern psychologists, D, and E, highlighted how learning from clients had primarily developed them as beginner therapists, “I learned from working with the
patients” (E), and, “every client that I have seen has contributed to the way that I do my therapy. Because you bring a lot of your self into it but you also experience a lot of the client” (D).

Participant D voiced that she hoped patients would remain influential in her development throughout her career and that she would never be removed from this essence of therapeutic work nor patients’ work being a source for personal growth:

just never losing touch with your clients, never not seeing it as a learning experience for you as well. I would like to still be able to draw insights from my patients, from my clients as well.

Established psychologist, Participant F, reflected on how critical direct contact with clients had impacted her in terms of both her personal and professional development,

You cannot grow as a therapist if you don’t grow as a person. And, you learn from your clients –a lot! I’m often- Yoh!- I meet people who have gone through so many things and I’m humbled by it because I think, you know, they are here in therapy but actually they’re just amazing because they are so optimist[ic], (...) to watch people go through a process of loss- for example, a child’s death or a partner’s death or- and, to see their growth definitely impacts on me, because you kinda – you then take a little from them and you learn from them.

Participants across career levels relayed specific experiences with clients that influenced their development as therapists or that holds the essence of psychotherapy for them. For example, a child client dying redirecting one’s interest away from working with children (B), a threatening client inculcating a determined dedication to clients (C), a young horse-rider gifting the therapist with a horseshoe at termination of the therapy as exemplifying the importance of the therapeutic relationship (H), the locked mouth sculpture of a client breaking through his fear of disclosure illustrating the importance of


choosing a suitable disarming medium of expression (I), a ‘simple soul’ woman with gold shoes embodying the profound yet subtle change process of therapy (J).

Compellingly, this suggested that psychotherapists collect ‘cases’ or memorable encounters that define a key feature of their therapeutic development or their therapeutic work as in the footsteps of Sigmund Freud’s ‘Dora’ (1905), Virginia Axline’s ‘Dibs’ (1964), Carl Rogers’ Gloria, (1965), or Irvin Yalom’s ‘Ginny’ (1974). As such some clients continued to live inside their therapists (Davies, 2005), and even so as far as the canon of the profession.

**Therapists’ Use of Personal Therapy: “I would be in that chair”**

“But where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession? The answer is, in an analysis of himself, with which his preparation for his future activity begins” (Freud, 1937, p. 248).

Intern psychologists, A, B, and C, and established psychologists, F, I, J, and K, spoke of the benefits of their own personal therapy. Steiner (1985) argued that a personal analysis was the most important single element in the training of a psychotherapist” (p. 56). He outlined that psychotherapists were their own tool, which was voiced by intern psychologist, Participant C. With in mind, Participant C verbalised psychotherapists need to able to use themselves to understand what is happening within the therapeutic encounter. Steiner (1985) added that personal analysis (therapy) holds numerous benefits for the the psychotherapist, namely, the potential to improve one’s own mental health, provide insight into one’s own personality dynamics which can inform one’s clinical work, demonstrate how the therapeutic process works, potentially provide an opportunity to take hold of a role-model, and as a way to know what it means to be a patient with distress. Cross and Glass (2001), Szymanskya (2001), and Wolgien and Coady (1997)
proposed that personal therapy had been found to benefit some therapists in their professional development.

Recently, Oteiza (2010, p. 4) found that therapists verbalised the following advantages of engaging in their own personal therapy experience namely: becoming more conscious and aware of their own issues, abandoning the fantasy of seeing themselves as the ‘healthy ones’, coming to the realisation that they were fallible humans too, learning to respect an individual’s personal rhythm or pace, allowing themselves to be directed and accompanied, to expect to be challenged themselves and to enhance their own affective development. In terms of how personal therapy contributes to professional development Oteiza (2010) found that therapists reported a better capacity to hold a client and their distress in the therapeutic space until the client was ready to work through their issues. Other professional benefits included an acquired skill of how self-exploration works and an ability to identify blind spots and one’s own unresolved issues and to use personal therapy to maintain one’s well-being in order to remain effective in clinical work and as a source of professional support.

Intern psychologist, Participant C, pointed out how pursuing one’s own personal therapy provided one with an inside view of the therapeutic process, which fostered a critical understanding of the therapeutic process not found in the academic component of training:

you kinda of go into therapy not sure of how the process is going, eventhough you have studied it for how many years. And when you do start, that empathic relationship with or that trusting relationship (…) builds for me only after a couple of sessions and you only really start opening up and that was true for me as well- you test the therapist in that way. So, that beginning part that Rogers always speaks about is very true- It’s a process.
Furthermore, Participant C saw her personal therapy as an opportunity for “gaining insight into my own issues and in therapy you are able to separate your issues from your client’s issues, so your countertransference (…) and you also just go through that growth process yourself”. She went on to reflect how:

you become vulnerable. And, you kinda realise what your clients are going through in that process. So, for me that was very powerful (…). I suppose my own therapy has taught me that it is quite humbling to go through that process. To know the impact that it has on a person. That in my therapeutic process you start thinking about, ‘I wonder, you know, what she is diagnosing me with?’ (…). I even looked up the codes. You see the ICD-10 codes there and it’s very, ja, - grounding to go through that process (…). I don’t think you can actually be a therapist without going through your own therapy, at some or other stage. I think you need to experience the therapeutic process. I have gained so much, you know, to work on with myself. And, being empowered (…). It is a process of continual evolution.

Established psychologist, Participant I, relayed that she pursued personal therapy for an extensive period and found it enabled her to identify more profoundly with clients’ struggles and to sift through potential countertransference concerns, “I would be in that chair. So, I could understand that (…) everybody has got fears, they’ve got angry stings, they’ve got stored emotions, they’ve got experiences”. Participants across career levels, A, B, C, F, I, and K, reflected how important it was for psychologists to differentiate between their own issues as opposed to their client’s concerns, “I might be bringing my stuff into the room. So I need to know what’s my stuff and what’s your stuff” (A), and:

when a person has their own ideas in their head and you don’t allow anything to infiltrate you, [you] sort of get stuck. And also openness is in terms of your own being as well because sometimes I will be working with a client (…) but then stuckness is with me. So openness also I think to go to therapy to deal with your own stuff (F).
Intern psychologist, Participant A, found her therapist to be “a pretty good role model” and found that her therapist gave her hope. Established psychologist, Participant J, added that over the years of her personal therapy she internalised her therapist:

I have, obviously, been with the same therapist for fifteen years, but she has the most love-infused respect that I have ever experienced, it is so holding and so safe. And, for me, my therapist is my role model. If I can convey a fraction of what she conveys in therapy then I feel good (…) you are just so held in her presence. And nothing shocks. Nothing is bad. ‘All is’, well, Phenomenologically-speaking, ‘just is’. And that, ja, I think that Phenomenological part of my training, it probably also contributes to the sense of respect.

[Without her] I would be a different therapist because I sometimes think, “oh, what would M do in a case like this? What, how would she respond?” And, usually I would just think she would just gently listen, you know. And, that’s sometimes the crutch for me (…), when I really feel, ‘oh, I’m out of my depth here, what would she do?’ And, then that picture comes into my mind (…). She would just have that gentle, holding smile. That’s what I would do (…). I have internalised her (…) she’s a mother, she’s a friend, she’s a co-therapist (…). I think mentoring would encompass all that.

Established psychologist, Participant K, found that her own therapeutic process served as inspiration to become a psychologist: “I think it was a good experience for me (…) the experience was actually good enough for me to think I would like to do this. I did gain some direction”. Oteiza (2010) highlighted how one’s therapist can become a professional reference point in that one’s therapist became a role model in terms of the impact of their style, attitude or manner and how this can become a way of being in one’s own work with patients.

**A Bird’s Eye-view: Supervision of Psychotherapists**

Brammer and Wassmer (1977) delineated three tasks of supervision namely, firstly, facilitating supervisee’s growth, personality dynamics and interpersonal style (self
awareness), secondly, teaching the supervisee practical therapeutic skills and behaviours (tasks), and thirdly, to assist the supervisee in formulating conceptualisations of clients and mastering the necessary cognitive knowledge to enhance therapeutic practice (content). Hess (1987) argued that supervision was defined by the quality of the relationship established between the supervisor and supervisee. Furthermore, Hess (1986) argued that supervision should hinge upon the changing needs of the supervisee. He identified four needs of supervisees namely, supervisors assisting unanchored supervisees in becoming familiar in the therapist role, teaching skills and assisting the supervisee with limited autonomy in developing a personalised theoretical framework, assisting the self-defined supervisee with consolidating, integrating and refining skills in a confident manner and finally, mutually sharing as autonomous professionals insights in relation to clinical work.

In line with Cross and Glass (2001), Folkes-Skinner, Elliot, and Wheeler (2010) Szymanskya (2001), and Yogev (1982) intern psychologists highlighted the purpose of supervision for beginner therapists in providing them with feedback, guidance, direction, encouragement, support and assuming responsibility for the clients’ welfare until one has the necessary skills to be autonomous as a therapist:

I think it has helped a lot just in terms of checking yourself. Because I think a lot of beginning psychologists are quite fearful and feel quite like they are thrown in the deep end. And having that support and having that someone say, “You’re on the right track”, “Try this”, or “Read that” type of thing is very comforting, so that’s helpful (…). I think individual supervision is very important, so that you know where you’re going and you know where you are at, and also, um, just to have that support as well because it is quite daunting and hectic and just to know that someone has your back and knows what is going on is quite comforting, for me specifically (D).
Similarly, intern psychologist, Participant A, reflected that supervision provided “practical direction” and a shared reflective space between supervisor and supervisee of the supervisee’s clinical work:

What to look at – “did you consider this or this or that?”, “Maybe, you can do this or this or that?”. Like, “this is my client, this is his problem, this is what’s happening”. Phew!’ she reflects it back to me, and I also sometimes gain a different perspective (...) our high moment there.

Jordan (2009) reflected that she feared that her supervisors had X-ray vision and would discover her to be fraudulent when she was a beginner therapist under their scrutiny doubting her competency, yet she went onto benefit from mentorship in an ongoing group of therapists. Skovholt and Rønnestad (2003) also documented that beginner therapists speak of the illuminated scrutiny of the profession’s gatekeepers.

Orlinsky and Rønnestad (2005) highlighted that:

supervisors must recognise the inherent structural ambivalence of the supervisory relationship when evaluation is required. On the one hand, the supervisor represents potential guidance and support to the supervisee on the other hand, the supervisor represents scrutiny and potential reprimand (...) a major challenge that supervisors confront is how to optimise the supportive aspect of supervision in relation to its evaluative aspect (p. 192).

Intern psychologist, Participant C, highlighted the influence of supervision on her professional growth stemming from feedback on her clinical work and the influential ‘person’ of the therapist:

working dynamics in my last placement and (...) from the supervisor in terms of feedback of how I interacted in the group (...) she worked with me in my everyday working environment which was hard for me to take. But it really it opened me up to I suppose my vulnerabilities at the end of the day. So that would definitely be a turning point.
In line with Rodenhauser (1994) referring to supervision as often being a “compression chamber” (p. 10) for the supervisee, intern psychologist, Participant A, explored the initial trepidation she felt in relation to supervision of her clinical work:

I felt very scared (…) if I knew what I know now I would have made more use of supervision then. You know, I didn’t share a lot, I was like very academic, you know, “this is the thing and this is it – Okay, thank you, bye!” Supervision was like ten, fifteen minutes and then out of there (…). Then I asked myself, ‘why, do I do it this way?’ – again I was self-reflective, you know, ‘Why am I scared?’ You know, ‘what does this mean – should I change something, should I be aware of something, should I be able to risk more,’ and saying, ‘that it’s okay’.

Furthermore, Participant A, emphasised the ethics and power dynamics that surround supervision of beginner psychologists. She found that if the power difference was not managed well then supervision could prove to be harmful to beginner psychotherapists:

I’m very strict with boundaries regards to personal; professional (…). I had experience, a huge experience with this supervisor which became very personal. And, at the end of the day it harms me (…). I think students are vulnerable in terms of how they look up to supervisors and lecturers – ‘you know, you’re the experienced one’ (…). I think sometimes they’re not really aware of that power (…) and then misusing, you know, the role of supervisor.

Notably, Participant E relayed that he did not hold formal supervision as a key influence in his development as a therapist. Rather, Participant E, found inspiration and confirmation for his unique therapeutic style from rather actively, and often informally, observing elders in the profession and peers in training in terms of their way of being:

I don’t really know how I arrived at my style. I’ve also learnt a lot just from seeing and being with people who I think are creative (…) there might be one or two things in what they do – ‘that’s what I would like to do’ (…). Three persons stand out for me (…). There’s something about like the warmth with which they greet people – how confident they are – there’s something initially, or immediately that make people comfortable in their company (…), I like that. I want to give that to my patients also. And, then I think of P the
way (…) she manages to work with the group and at all times there’s still individual attention for everyone. But, in a way I kind of think that I was like that already (…). So, I don’t know if I’m just focusing or paying attention to that because that’s just like how I would do it, or if I just paid attention to it because that’s how I want to do that. I’m not really sure what came first.

Intern psychologists, D, and E, valued the opportunity to observe peer and established therapists doing therapy through, for example, time-limited group therapy and role plays. In agreement, Akamatsu (1980), and Folkes-Skinner, Elliot, and Wheeler (2010) highlighted the potential of observing various role models in action to enrich the beginner therapist’s future repertoire of therapeutic skills and therapeutic styles. Kolb, Boyatzis, and Mainemelis (2001) highlighted that experiential learning involved trainees engaging in the four key facets of concrete experience, reflective observation, abstract conceptualisation, and active experimentation in order to learn new skills. From a social cognitive perspective, learning takes place through observing others who act as role models (Bandura, 2001). Such experiential learning included role play exercises with peers and tutor modeling of ways of working with clients.

Despite her alluding to a harmful experience of supervision intern psychologist, Participant A, regarded supervision as crucial throughout her career as a psychologist especially, if one worked from a psychoanalytic framework:

you need to have full consistent supervision (…) you would always need supervision. Not only in training (…) I would always see myself as a person developing and I will never reach a fixed point- that ‘this is it’(…) you need to be ethical and sometimes you can be just so subjective or not see things. I think really supervision is (…) a very helpful thing to remain ethical to ensure that you provide the best service for your client.

Briggs and Miller (2005) proposed constructing a model of supervision inspired by Solution-Focused Therapy as such “success-enhancing supervision” where feedback is sought from varied sources in contact with the supervisee, and evaluation is framed in
terms of goal-setting. Steiner (1985) argued that the most critical advantage of supervision lay in the provision of a second point of view, in that the supervisor was not immersed in the therapist-client dyad and therefore from an observing stance the supervisor could potentially see the blind spots of the psychotherapist. Yet Steiner (1985) advocated the productivity of the second point of view lay in the supervisor adopting the stance of a collaborative partner rather than an authority figure or educator.

Established psychologists, F, G, I, J, and K, also emphasised the ongoing importance of supervision in their development:

Supervision is very important. It doesn’t matter what stage of your development and the stage of your processes as a therapist is. It is very important to be able to reflect with somebody else about how you are doing, how you think you are doing. Um, it’s very supportive to have supervision. It also re-affirms whatever direction you are trying to take with a patient or are taking with a patient. It is also quite safeguarding because you monitor yourself through the eyes of somebody else and you are open to criticism, you are open to constructive criticism as to where you need to go with a patient (G).

Established psychologist, Participant J, expressed her joy when supervising other therapists:

it’s lovely because it sharpens my thinking and, it’s a fantastic position to be in, you’re not emotionally involved with the material and you can stand apart, and it’s really very useful, and there is a debate that goes on between you and the person you’re supervising.

Specifically, established psychologist, Participant K, outlined the post-training benefits of individual supervision in addressing countertransference concerns in relation to patients:

I’ve become more comfortable in therapy like since I have more regular supervision (…). I have group supervision but I have individual supervision as well. I’ve grown so much in individual supervision and my first few years I never did it, but for the last four years (…). [My supervisor] seems to be
able to tap in if it’s related to a personal issue. You know, my own personal stuff that is actually blocking me (...) there’s always a link, you know, between, ‘Why am I finding this difficult? What is it about me that is making this difficult?’

Established psychologist, Participant I, commented that she benefitted from the supportive context of co-supervision with a trusted colleague, which would indicate the stage of *mutuality* outlined by Hess (1987):

we get together and we supervise each other (...). We’ve got a very trusting relationship and we help each other. (...) she sometimes she gets out of it and sometimes I do. You know, it depends, like say, my daughter is in hospital, then she will be holding me. But, if she’s got a court case or something, I will be holding her.

From a different angle, Participant K, found that group supervision “is like sharing of ideas and comparing notes almost”, which offered a sense of collegial support that counteracted the lack of companionship often inherent in private practice, and also served as a forum to discuss any matters related to the profession, such as council matters. In a similar light, Carlson and Erickson (2001) promoted communities of therapists of concern for therapists across career levels with the express purpose of honourably witnessing each other’s personal/professional development, in an effort to amplify and celebrate self-knowledge and counteract burnout and compassion fatigue, or a sense of ‘stuckness’ in one’s clinical work.

In light of her chosen orientation of an Object Relations framework, established psychologist, Participant J, found eclectic-orientated peer supervision was not the ideal supervision for her professional growth:

It’s always been a problem for me, peer supervision, because there aren’t people who work the same way that I do. And, that, it’s not a bad thing, you know (...). I’ve been with the same group ever since I started. In fact, there are only two of us that remain from the original group. And, it started off with, there were five of us and we were all Rhodes graduates, and that worked so well. But only two of us
remained. (…) in the beginning, that was wonderful because we were all on the
same page. We all thought the same. The group that I’m with, we - they
acknowledge where I come from and they appreciate my input but there’s no one
to challenge me in my group. There’s no one to run with my ideas. So, I am
inclined to be on my own (…). One of the unique problems I’ve experienced in PE
is the fact that there is so little academic input (…). There’s never anything in my
field [of Object Relations]. That has always been my sadness that I felt that I’ve
lacked opportunity to grow in my field.

**Mentoring of Psychotherapists**

Participants across career levels referred to benefiting from mentors (B, G, H, and
J), yet one intern psychologist participant explicitly stated she had never had a specific
mentor (C). Importantly, various sources of mentorship existed namely, lecturers (B, G,
and J), school principal/institutional supervisor (H), psychiatrists as colleagues in a multi-
disciplinary hospital team (G), and one’s personal therapist (J).

Intern psychologist, Participant B, reflected on how her mentor (a previous
lecturer) during her experiences as a substance abuse counsellor became “a great source
of encouragement” and gave her a “real experience”. In that “he still had that fascination
in people - ja, he’s cynical and all that stuff- But I mean just- he inspired me (…). He
grounded me a lot in therapy,” and:

I think he shaped me a lot as a therapist. He is very postmodern, very much
just being, very much, quite non-directive, and about being with someone and
about your own insight and just about being real with yourself and creating
this environment. And it’s more about- just the environment that heals.

Established psychologist, Participant H, also reflected how his mentor, a school
principal, when he was in the earlier stages of his career as a psychologist in a school
setting, fostered in him a questioning nature and reflective stance:

we used to talk to each other every single week and, and we always came out as a
constructive pair (…). We argued a great deal (…) and he was an extremely
intelligent person. So I’d have to work out, probably two or three days before- try
to work out what, I’m- how I’m going to argue with him. What questions I must ask him, what he’s going to ask (…). So, he taught me to think and plan out ahead.

Established psychologist, Participant J, reflected that her choice of theoretical orientation, where Melanie Klein was her “taproot”, was influenced by one of her lecturers, during her Masters’ training, who had a passion for Klein’s work and thus, “Object Relations became what I always wanted to do”, and her current personal therapist fulfilling in part a mentoring function.

Established psychologist, Participant G, noted how she as a qualified professional had benefited from two psychiatrists that acted as mentors in a multi-disciplinary team context in a hospital setting, who provided affirmation of her therapeutic contribution to patients’ well-being and personal support. Participant G also relayed how as a beginner therapist she benefited from the supportive context of mentorship from a lecturer:

[With] your first therapy case you’re kind of like a child learning to walk. You don’t know where to hold on to. You don’t know whether you’re going back to the floor to touch the floor so that you can stand up, or to find an object on the side that might support you. It’s exactly like that. And, somewhere along the line you just see yourself standing (…) - you doubt yourself, ‘Do I hold on? Do I go back to the ground?’ I mean many kids would never walk if they never took a chance.

Skovholt and Rønnestad (2001) found that senior therapists (with 25 years of practice or more) reported that they continued to benefit from their internalised mentor’s wisdom imparted to them years earlier, to enhance their current therapeutic work.

Hungry to Grow: Ongoing Professional Development

Szymanskya (2001) commented that “training is the first important rung in the ladder of professional development” (p. 120). Rønnestad and Skovholt (2001) emphasised that optimal functioning as a psychotherapist had been linked to therapists
displaying openness to learning. In a similar light, intern psychologist, Participant D, expressed her desire to continue to develop beyond the completion of her Masters:

I would like to still in terms of knowing what is available out there in terms of therapeutic models, theories that type of thing – stay on top of things that way, and in terms of my own life, my own experience to be able to draw that and uh, use that in my therapy as well.

Importantly, lifelong learning was also strongly advocated by established psychologists. Participant H explicated the following rationale that informed ongoing professional development:

you can always learn from others. You can always learn from exposure to training, circumstances, situations (...). That’s why you’ve got to have continuing development. I mean, that’s why it’s so important to always carry on learning and understanding and reading - and experiencing.

Eagerly, established psychologist, Participant K, supported continued professional development (CPD) in order to equip herself and enhance therapeutic services to clients:

*I’m hungry to grow (...). I’ve still got so much to learn and I’ve still got so much that I want to learn. I wonder if I-, you know, how much of my clients are not benefiting now from me not learning. So, ja, they can only learn as much as I can actually learn. Or they can only benefit as fast as I can learn. But, I think what I’ve got now is enough (...) to maintain me for now. But, I’m always looking for something else (...). We all bitch and moan about CPD points but I think it is important (...), it’s actually forcing us to, actually, to deliver a good service and, not just not have to work and just think of this as easy- It’s not easy.*

**Constructing a Professional Identity**

**Drawing the Line: Negotiating the Personal and Professional**

Wilkins (1997) and Paris, Linville and Rosen (2006) found that the personal and professional spheres of psychotherapists were intertwining and mutually dependent, and arguably that the boundary between the two is ever-shifting and hazy. Jensen (2007) argued that the psychotherapist learning to manage their personal life in relation to their
professional life is “part of building competence” (p. 376). The personal life of the psychotherapist is a space of reflection and that personal experiences can be an important framework for therapeutic work, as such a hothouse for personal knowledge.

Skovholt and Rønnestad (2003) found that beginner therapists often start out their clinical work with “porous or rigid emotional boundaries” (p. 48), that could hamper the therapeutic process of clients, and which over time need to become more flexible in order to effectively conduct therapy. Intern psychologists appeared to be negotiating their personal identity with the professional identity of being a psychotherapist. Participant C felt there was no clear-cut separation between the two identities, whereas Participant B felt she had two differentiated selves. Participant D cautioned that a rigid distinction between personal self and professional self could be deleterious for clinical work. Diplomatically, Participant A felt there was an “overlap” between her personal and professional identity:

You can’t separate yourself from being a therapist because you are your own tool. So as much as we try and say, “You need to be professional and separate your personal life from your professional life” - for me they are the same (C).

if you are closed off to yourself- and if you- separate yourself too much from what you do in psychology I think it becomes a bit of a disaster (…) to an extent if you’re are not aware of your own stuff and if you’re not in touch with it and doing something about it, if you have issues, then it could hold someone back (D).

I see myself as having a therapeutic self and a B (…). I think it’s very important to differentiate between the two. I think therapy influences who we are but it’s also something we do. And, that’s my personal opinion. I know many people see it as who you are and you are a therapist. And, ja, to a certain extent I have always been a therapist (…). But it’s also something I do (…). So, I take parts of my real self into therapy but I also change when I’m in therapy (B).
There’s overlap, I’m an empathetic person whether I’m in a therapeutic room or whether I’m with my friends, for example. But I will not give my cellphone number to each and every client that I see, but I give it to all my friends. So, there are certain things that overlap, but there are certain things that stay in your personal life and certain things that stay in your therapy life. So, if you have to draw two circles like that (...) they might be something [demonstrates an overlap]. I think you can’t separate yourself, who you are, as being a person totally from who you are in the therapy room and in your safer life (A).

Participants explored managing therapeutic boundaries in terms of the level of appropriate self-disclosure and involvement in their therapeutic work with clients and how psychotherapy was best-suited to an asymmetrical relationship.

Established psychologist, Participant G, reflected how her therapeutic style depicted the fine line between professionalism and intimacy:

I am, I would say, quite ethical because I think that with that style of therapy where you are found to be receptive, approachable, attentive, listening, there is the danger of patients becoming over-familiar with the therapist and mistaking being friendly as friendship (…). I would say that for me, my style of therapy is not threatening, but at the same time I don’t necessarily escape, or allow patients to escape the reality of the problem (…). You know, it’s not a social call (…) and I also allow uncomfortable situations to exist in therapy where a patient can say to me, “You’re pushing me too much!” (…). I’ve heard that before. “I’m not ready to talk about this and you want me to!” (…), it does get uncomfortable sometimes and it does get tense but that’s therapy. It’s not always going to be smooth-going.

Intern psychologist, Participant D, verbalised, “I think I am able to give enough of me but still be able to maintain a boundary, that there is no confusion in between”. She further recommended judicious self-disclosure and use of self in therapy:

if someone lacks a lot of boundaries I don’t think it’s good to bring a lot of yourself into the therapy because it might create a confusing situation for them. But I think if you’re able to help someone come to a better insight by relating an experience that you had that was similar it could be quite effective.
Intern psychologist, Participant B, also emphasised how the therapeutic relationship was, inherently, a uniquely asymmetrical relationship:

Boundaries are a huge one (…). In therapy, the client has all the control (…). They can do and say whatever they want. And you must be able to deal with it (…). Where in normal life, we’ve-, I have the control, or I feel like I often do. And then it’s also more- obviously it is more balanced relationships. I give and take.

Participant B also admitted that she had to delineate where she could and could not effectively be therapeutically involved:

I get emotionally involved with kids, so I don’t want to work with kids. Because I struggle to keep those boundaries. Because I start thinking, ‘No! no! But I want to save you, I wanna help you’, and I can’t.

The Never-ending Revolving Door: Increased Self-awareness

“The path through training demands self-knowledge and exposes the soul” (Bowden, 2001, p. 180).

Self-awareness was deemed essential in order to grow as a psychotherapist and it was found to be clearly evident in recognised master therapists (Skovholt & Jennings, 2004). Intern psychologists voiced that through their training as psychotherapists their level of self-awareness had increased and how it had impacted on how they conduct their lives in general and personal relationships:

it’s like this little world. And, um, it is also ja, like it gets in the way-. No one really understands what happens in therapy and we have this little world that us therapists go into. Sometimes the therapist’s self-awareness develops to point of where it becomes a source of distress and ignorance of one’s personal conflicts is pined for, in that therapists becomes psychologised to a point of no return. At one stage I was, “I’m so tired of analysing myself”. And he [my mentor] was like, “I’m sorry, didn’t you realise when you stepped in-, stepped into-”, he said something like, “the never-ending revolving door” (B).

a therapist is also a person with a personal background and being aware of that and being aware of his stuff and being okay with it and not let it bias or influence your therapy with a client (A)
One of the biggest things as therapists [is] we need to be aware of all our own stuff-and I want to say all our shit [laughs] so much shit (...). There is so much stuff that comes up in therapy. And, we need to be constantly, constantly, um, analysing ourselves (B).

Participant C acknowledged the ‘double-edge sword’ nature of psychological mindedness. She, during her training, had been learning to negotiate her level of psychological mindedness as a psychotherapist in that it could strain intimate relationships that demanded a kind of relating without analysis:

I try not to take that home- that is a very difficult- the line- analysis (...) especially during your M1 year and you’re learning all these new theories and you’re applying them and it’s so great because you can analyse anybody and everybody’s life, and you do it and you just think you are so cool. And you realise though, that the person hasn’t asked for the therapy or for the analysis and hasn’t asked to be helped (...), it’s very difficult to separate your psychological- How can I put it?- your psychology from yourself. For it becomes a part of you, it becomes a part of the way, the way you think. But you just need to be very aware (...) of the fact that you might be interpreting or analysing and that is what I have become aware of. But also it’s very positive. In the sense that you become more of an understanding fiancée, or more of an understanding daughter, so it’s got its positives and its negatives (...). Being a psychologist is hard; and it is hard on your relationships as well, because of the insight that you gain into human behaviour. And, at a stage I was even wondering if it was really the profession for me because it was so hard.

**Switching Off…and Going Home: Therapist’s Own Life**

Skovholt and Rønnestad (2003) found that beginner therapists “can be very preoccupied with the emotional pain of the client and experience an off-duty penetration of one’s own emotional boundaries” (p. 49), and therefore need to learn to find “the thin line between underinvolvement and overinvolvement” (p. 49). During her training intern psychologist, Participant C, realised how psychotherapeutic work required emotional
energy on the part of the therapist and thus how critical self-care was for her own well-being to obviate burnout:

Emotional energy is a huge factor in therapy. I have learnt that if I’m not feeling okay then my therapy won’t be good. Um, you need to have emotional energy if you are feeling burnt out I would rather cancel with a client and take off (…). So, you need to conserve your energy (…) you get burnout especially this year with everything and thesis (…) it does make an impact on therapy with clients (…) you get led to a point that you feel you don’t care anymore and for me that is worrying (…). I think the advantages would be you stop actually working for a little bit (…), if you continually thinking and, you know, introspecting (…) you get tired. (…). I am just being when I am not a therapist or in that therapeutic mode (…). I don’t have answer to it- Can you cut it off?, or, Turn it off? (…). I am conflicted with regards to that in any case. Ja, I think it will always be a part of you, but you gotta switch it off every once in awhile (…) like let it settle for awhile.

Established psychologists, F, I, J, and K, reflected that they actively separated their professional life from their personal life. However, they admitted that sometimes clinical work did infiltrate into their minds. Similarly to Celenza (2010), established psychologist, Participant K, found through experience and self-reflection in supervision, that she had to learn to vary her work, as intense emotional work alone became all-consuming to the point of fatigue:

the content of what I’m doing is actually quite hard (…) a few years ago I was really drained at one stage. It was like halfway through the year and I was extremely drained and I went to see my supervisor and she says to me: “But, you know, why are you so tired? Let’s explore that” (…) I had done so much griefwork and I think there it’s not very rewarding side because obviously there’s actually a loss (…) So I just had to, like, take a step back (…) and just like space out my clients and I didn’t do only griefwork because that was consuming me.

Established psychologist, Participant, I reflected that as she developed as a therapist she learnt the hard way about balancing her personal and professional commitments and about the need to cutback on some of her clinical work and to take up family life and recreational activities in order to secure her longevity:
I switch off at that time. I get on with my own family and my own life (…)
I’ve always had my art, I can paint, so I’ve got that advantage. But I also use
exercise, I’ve always used that, and I’ve taken up golf and I do a lot of hiking
(…). I plan it in. I plan holidays, I go away every long weekend if I can. I go
away every school holiday (…). I have rainbows that I work towards. I don’t
just sit in a room and go into a black hole.

Similarly to Guy’s (1987) research into the personal lives of psychotherapists

Participant K also relayed how critical support systems were for psychotherapists:

having a supportive husband and a supportive family, you know. Where at the
end of the day I am lucky, even though I actually work from home, I close that
study door and that’s it for the night (…). I’ve been very fortunate in that I
have been able to switch off (…). There is the odd occasion (…) that I
actually lie awake and think, ‘Ooh, shame – I wonder what’s happening with
that?’

Participant J, related, “It’s like I can put them in compartments inside of me. And
just shut of those compartments and open them when I need to”. She relayed the
importance of not being immersed in the patient’s material beyond their designated hour
and the necessary ability to appropriately “cut off”:

[When] I shut the door behind that person, that person’s gone out of my life
(…). I think its something you learn to do (…). Because the next person
probably comes within the next ten minutes so you’ve got to clear your head.
And you can’t, there can’t be remnants of the previous case. I struggled with
that in the beginning and couldn’t sleep at night I was rerunning therapies.
Every now and again it still happens (…) feeling a side that’s sort of carrying
the feelings (…) but, it’s definitely become simpler and easier.

Along these lines of the need for the therapist to have a private life, Kahr (2005)
argued for the anonymity of the therapist in protecting a fulfilling, “rich private life”
which would in turn allow one to practice in an “unembittered fashion” (p. 12).
The Never-not Changing Therapist

Intern psychologist, Participant C, reflected, “I think a lot of the growth for me has taken place this year so that’s obviously closest in my mind”. For she acknowledged her newness in the professional community of therapists:

I have come straight out of school into varsity so I haven’t had a period where I’ve worked or anything like that. So you come out of all this academics into your internship and you actually now working. And for me I have come to believe in it – and in the profession.

Similarly, intern psychologist, Participant D, found that her professional training contributed to her “growing up” and notably she added that, “I found my voice”. Wilmer (1964) depicted the development of the psychotherapist as an odyssey and Goldberg (1988) regarded psychotherapy training as a journey of learning, this found resonance in Participant D having depicted her professional training to be a therapist as occurring alongside her personal developmental trajectory in her life:

in terms of my process it has been my personal progress I’ve made, my personal journey that I’ve walked. Just discovering myself in a new way that I didn’t see myself before. Specifically, because the [Masters] programme is so challenging all the time you really get to see yourself in a different way (...).

I think I have changed a lot as a therapist and as a person. I think I have become a lot more like independent, um, as a therapist specifically. Um, ja, more confident as well. I don’t think you can go through the process without changing. And also I don’t think you ever reach a stage where you not gonna change, not gonna gain new insights, or new perspectives as a person.

Established psychologist, Participant H, emphasised a “well-rounded” therapist and this was confirmed by Wilkins (1997) highlighting that “personal and professional development is about becoming a more complete practitioner and a fuller, more rounded person” (p. 23) for both the therapist and clients’ benefit.
Challenges to Practice

Psychology as a Business: Constrained by Managed Care

In reflecting on their professional development, established psychologists acknowledged that their career interests and development had been influenced by the economic realities that were inherent in being a psychologist in practice, having to earn a viable income in a particular context. Experienced psychologist, Participant I, noted that due to the size of the city where she practiced she could not be too limited in her client base, theoretical orientation, clinical interests or specialisation:

this is also a business. You have to know what it is to earn money and how much, like if you are going to start something, you must start something with a low risk. You don’t want to spend a fortune that you don’t have on equipment and you want to keep your hand in that one job before you start another. So I was always doing two things at once (…). Now, because I’m also a businessman, you know, I can’t allow myself the privilege of a limited number of clients. If I’m going to close my door on all other kinds of theory, problems and people, then I’m going to go bankrupt, I’m the main breadwinner, let’s face it, I’m a realist. I love my job but I’m not gonna limit myself in that way. Look, I think in some cases, like in Cape Town and Johannesburg they have a different set of context. You can limit yourself to just anorexics and you can probably make a better living specialising in anorexics. Not in PE, there’s just not enough of them.

Similarly, established psychologist, Participant J, reflected that despite Object Relations being her chosen theoretical orientation she had adapted to the short-term demands of her context which favoured short-term theoretical orientations that were covered by medical insurance:

I don’t lay claim to be an Object Relations therapist (…) I can’t work in that way in the therapeutic milieu in PE (…) we are so restricted to short therapy sessions, but it is my starting point (…), I carry right through my therapy, even if it’s just for two sessions (…) that is the key that unlocks and I’ve got to bring it in somehow (…). If I can just get some insight into, “you know, what?, all this stuff makes sense because of things that have happened to you”
We are constrained by our environment and the current economic and current political, and people’s understanding and the psychological status of society.

A “Psychologised” Society and the Stigma of Psychology

Established psychologist, Participant J, further reflected that a psychologist needed to be cognisant of how psychologised the community that they practiced in was and the level of stigma attached to going to see a psychotherapist for it would impact how as a therapist one was able to work:

I think coming into private practice was a rude awakening. It was, um, it was so different because especially working in PE which, at that time, you know, I’m talking the late 1980’s, PE was not very psychologised, I think. There were probably about, oh, at most about ten of us working. And, um, so coming to see a therapist was not okay. And when doctors referred people, they would say, “look, go and see this person (…) get your head right.”

Established psychologist, Participant H, also spoke of the continued stigma in society attached to the profession of psychology:

it’s so difficult to walk through the door of a psychologist. It’s much easier to go to a dentist and an optometrist but a psychologist- “there’s something wrong with me”, so it has a helluva stigma attached to it. So when they walked in and you made them feel comfortable and they walked out again and they wanted to come back again, that was very important. Because they were getting something, they were getting something for their money. They were getting something for their effort and for the courage they showed in walking through that door, and in essence, I don’t want anybody to walk out that room without thinking that they’ve gained something from being here (…) something positive or they’ve learnt something.

From a personal stance, intern psychologist, Participant C, spoke of how she herself had gone through a process of becoming familiar with the stigma of being a psychologist in terms of integrating her personal identity with her professional identity:

I was kind of wearing or carrying the psychology bag around with me- if I can say it that way, and now I have become integrated into psychology. So, for me I am comfortable with being a psychologist.
My Personal Journey

The Researcher in the Mirror: My Self-reflexivity in the Research

“The researcher and the research are intertwined” (Byrne-Armstrong, Higgs, & Horsfall, 2001, p. 5).

“constructionists have by and large chosen to view language not simply as a mirror or map of the world, but rather as the very instrument that is itself the basis for our methods of simultaneously understanding the world and constructing it” (Korobov, 2000, p. 367).

Litvin and Betters-Reed (2005) developed the self-reflexivity tool of The Personal Map to facilitate students in reflecting upon their personal lives in relation to creating their own sense of self. The Personal Map brings forth the individual’s values, commitments and choices in relation to their personal life experiences. Furthermore, Litvin and Betters-Reed (2005) argued that self-reflexivity is increased as one commits to seeing “others as complex individuals rather than simply members of demographic categories” (p. 200). With this in mind, I can be described demographically as a white, South African, single, female, with mild cerebral palsy, in her early thirties journeying to become a psychotherapist by virtue of pursuing the qualification of psychologist. However, such ‘identification facts’ tell you very little about me or my experience of being a psychotherapist, which is likely why I hope that the richness of the data in this research lies not in the objective facts or quick comparisons between the intern and established psychologists but rather in the uniqueness of each description given by each of the participants.

During the research I found myself wondering if I was like the participants of this research to select the significant events that influenced my professional development, what ‘places’ I would recall of (cf. Wilmer, 1964). I think my map would include my
parents’ inculcating values of compassion in me from a young age, managing family struggles, my experiences with my disability, my love of engaging with others and yet my solitary obsession with reading. An excerpt from a Wizard of Oz-inspired reflection (in April 2010) offered an opportunity to reflect upon my development as a therapist (see Appendix G).

My self-reflexivity, my “internal conservation” (Pagis, 2009, p. 265), or “a critical perspective (…) posture”, as such “questioning one’s own position” (Korobov, 2000, p. 367) during this research has been particularly meaningful. Self-reflexivity has been understood as:

the conscious turning of the individual toward himself, simultaneously being the observing subject and the observed object, a process that includes both self-knowledge and self-monitoring (Pagis, 2009, p. 266).

I found my research topic of psychotherapist development compelling as I often found myself feeling like I was doing a self-study with all its angst, biases and hopes, despite the fact that during the interviews I sat before eleven unique wonders.

At certain points I felt as if I was straddling two territories, that of ‘not knowing’ what it means to be a therapist and ‘knowing’ what it entails due to my previous forays of being a trainee therapist. An indicator of being in limbo between two positions became felt in relation to the language indices employed by the participants, which is particularly found in discursive self-reflexivity which regards language as the symbolic medium through which we relate to our self(ves) and others. Through language we can speak about oneself to an audience, as such construct a narrative (Pagis, 2009). For example, the filler “you know” became a little red herring in qualitative research, for can I ever really know if I understood the way in which participants were using the “you know”. I often found myself reflecting whether the participant’s “you know” was an invitation to
“come and begin to understand me”, to forge a bridge of rapport to allow me to “you
know, come over to my landscape of understanding”, or was it rather a moment of
recognition “you know, because you, yourself, have been there, so, I do not need to make
you understand”. For example, established psychologists, H, and J, relayed:

Unless you’ve gone through a bit of hardship, unless you know what
discrimination is like, I think, you know, you just, I mean, you know yourself,
you just have so many more experiences. And you see it from a different
degree, I mean we all remain vulnerable. When one is disabled, more
than other people, I suppose. (…) I think you become toughened to life. And,
you understand more readily what other people also may or may not go
through (H).

you know that feeling of desperation. You know that feeling of, “I don’t know
where to go”. I know, you know, that feeling of waking up at 3 o’clock in the
morning and your life just seems pointless. If you’ve been there (…) you’re
going to have empathy, you’re going to have understanding. Um, you would
have gone to those dark places. You’re going to be afraid of those dark
places, you’ve been there. So, you know, age for me is crucial. (…) it
wouldn’t mean that, you know, a thirty-three year old is going to have all
those things in place but there’s a better chance that they will and then, by
virtue of their own woundedness (J).

Which spurred me to think can I really know what it means to journey in each
participant’s Land of Therapeutics, and to what extent have I been able to give a
trustworthy account of what they shared from their travels. From a social constructionist
perspective, I do know that as we all have a different mental photograph of the USA,
(whether one has been there or not) in our mind; so do we all construct a different picture
of psychotherapy.

In relation to the subject under exploration I found myself becoming more aware
of how I saw myself as a therapist, how I see the therapeutic process and how I
understand therapist development. For example, personally, I have found the easiest way
for me to establish any blindspots of theoretical preferences/biases that I may have is to
ask a colleague, “theoretically-speaking from where do I work from?” They assured me I am what they would call an “open-minded psychoanalytic thinker”. My colleagues I feel have read me well. I find that despite my love of contemporary psychoanalytic thinking I spend considerable time in other theoretical territories, always looking out for a new theoretical insight/site. Furthermore, potentially due to my own exposure and love of the humanities and arts I focused on metaphorical understandings of the therapeutic process and therefore it is possible that the science of psychotherapy has not been drawn out adequately in this study.

In light of my own preferences I found myself balancing the idea of helpful prompts with not purposefully eliciting a more ‘favoured’ response with a leading question. Yet despite my attempts to be as exploratory and open as possible, inherently this research remains subjective, for even in explorations we make choices- after all we choose as to whether to go left or right in the jungle and thereby leave many areas unexplored.

With this in mind I trust that the map I have sketched of beginner and established psychotherapists’ journeys of professional development is held in a light that knows it’s but one explorer’s map into what my one client refers to as inhabiting terra incognita.
Chapter 5:

Conclusion

Introduction

The current study included a sample of five intern psychologists all having been educated at the same university in the same year. However, the sample of six established psychologists did not share the same training context as four participants received their qualification from the one university and two participants had graduated at another university. Furthermore, five established psychologists worked in private practice settings whereas one established psychologist worked in a government hospital setting.

Overall Findings

In exploring the professional psychotherapeutic development of intern psychologists and established psychologists the starting point was the life experiences of the participants. Prominently, the notion of the wounded healer and helper role featured as formative early life experiences for the participants. For three established psychologists, chronological age was linked with life experience and by implication readiness to benefit from training, whereas three established psychologists linked only life experience to readiness for training. In contrast, regardless of age, all intern psychologists verbalised drawing on their life experiences as children and young adults to inform their professional role of therapist and therapeutic work.

The theoretical orientation chosen by participants was either eclectic or one of holding openness to various theoretical orientations. A key emphasis in the current study was not the theoretical preference of the therapist but rather that therapists were willing to tailor-make interventions to individual clients’ needs and resources. Furthermore, seven
participants emphasised that therapists needed to take into consideration any influential systemic factors of the client’s world during the therapeutic process. When describing their theoretical orientation both intern and established psychologists drew upon their training exposure and training context. In light of the current study it is worth noting that the theoretical frameworks in which psychotherapist were trained had an influence on how they worked psychotherapeutically.

Participants across career levels emphasised the ability of psychotherapists to form strong therapeutic relationships with clients as this was regarded as the centrepiece of psychotherapy regardless of theoretical orientation. Additionally, despite their preferred interpersonal style, participants spoke of displaying adaptability in relating to clients. As such, psychotherapists needed to be able to be both nurturing (soft) and challenging (firm) towards clients in the therapeutic process. Overall, the ideal South African therapist portrayed by the current sample of participants, primarily had strong relational skills in terms of demonstrating empathy, making others comfortable, displaying comfort with oneself, and being congruent, nurturing, and non-judgemental towards others. Other ideal personal qualities included: a strong knowledge base, intuition, engaging in reading, self-awareness, a willingness to learn, listening skills, curiosity, energy, humour, humility, working from an ethical stance, and exercising good boundary management. Importantly, the current study found that participants emphasised the appreciation of cultural diversity in clinical work. Furthermore, the current study found that therapists in South Africa were open to utilising their spirituality in their therapeutic work to explore the unique spirituality of the client which lends weight to
Orlinsky and Rønnestad’s (2005) recommendation that therapists’ religious backgrounds and spirituality is worth further investigation.

In their approach to practice, the process of therapy was extensively depicted by all participants through a range of metaphors and focal points. Metaphors included a car journey, a fragile cracked artefact, gardening, creating a masterpiece, an unlocking, underdog transformation, quilt-making, phases of the sun, coaching, ministering to wounds, finding one’s voice and surviving a shipwreck. No key differences in use of metaphors emerged between intern and established psychologists.

Participants acknowledged that evaluating psychotherapeutic work or their performance as a therapist was not a clear-cut process. Despite the identified inherent difficulty in evaluating psychotherapy, participants’ evaluation of therapeutic work relied predominantly upon receiving clients’ verbal feedback or conducting a review of progress with clients. Indicators of success for intern psychologists included client attendance, achievement of set-out goals, and positive verbal feedback from clients. Established psychologists spoke of symptom relief, achievement of set goals, witnessing an easing in the client, and admitting to ‘not knowing’ at times.

Catalysts for professional growth that were highlighted by all participants included personal therapy, therapy-defining encounters with specific clients, ‘unforgettable cases’, and group supervision. Established psychologists also added ongoing accruement of continuing professional development points through workshops.

Intern psychologists spoke of their growing pains involving having their naivety and unrealistic expectations being replaced with the realities of working with clients. Intern psychologists also spoke of their initial anxiety working with clients and their
anxiety in relation to their work being evaluated. A shift from being overly structured to becoming more flexible and process-orientated in their clinical work was also highlighted by intern participants. This confidence in the process was linked to their shifting to empowering the client, as opposed to attempting to be in control or responsible for clients and their therapeutic process. In reflecting on their development, established psychologists spoke of having gained more confidence in their competency through their years of practice. However, they acknowledged possessing an acute sense that they had not ‘arrived’ and therefore prized humility. Furthermore, established psychologists verbalised not being completely exempt from the emotional hazards of practice. As such, established psychologists voiced experiencing moments of initial anxiety when beginning with a new client, occasional preoccupation with a client’s difficulties or clients in crisis, and feelings of self-doubt when encountering a rare disgruntled client.

From a systemic view, established psychologists in exploring their development as psychotherapists raised concerns about the profession on a broader scale and how it influenced their therapeutic work. Established psychologists also referred to the stigma of consulting a psychologist in South Africa and voiced concern that the pressure of managed care (limited medical aid funds) compelled therapists into utilising brief therapeutic models despite theoretical preferences.

**Limitations of the Current Research**

The diverse sample of participants in this qualitative study does not lend itself to describing a prototype of South African psychotherapist. Rather, the current study provides a portrait of a sample of psychotherapists within the Eastern Cape Province in South Africa whereas future studies may uncover commonalities and differences in other
regions of South Africa in light of the different emphases of South African universities’ training contexts and therapeutic milieus. Furthermore, this exploratory study did not limit the maximum range of years of practice of the established psychologist participants. A future study may wish to stipulate the number of years of practice after qualification to pinpoint potentially unique themes at different post-qualification levels of development.

Though the current study found an emphasis on the cultural competence of psychotherapists, regardless of the demographics of the participants, the sample of the current study, with one black participant and ten white participants, did not reflect the population demographics of South Africa. Future studies could offer further exploration of cultural aspects by accessing samples from different cultures or employing a sample that adequately represents the entire South African population.

**Recommendations for Future Research Directions**

The current study of psychotherapists’ professional development in South Africa lends itself to further expansion in line with the various undertakings of the Society for Psychotherapy Collaborative Research Network (Orlinsky & Rønnestad, 2005) which has placed psychotherapists’ development on an international platform.

The current study provided rich descriptions of therapists’ early life and family experiences which could be elaborated upon in future studies as recommended by Orlinsky and Rønnestad (2005). In addition, the findings of this qualitative exploratory study potentially could be compared with the pending results of the quantitative study carried out by Michalopoulos and Solheim (cited in Orlinsky & Rønnestad, 2005) in the South African context as part of the Collaborative Research Network, to establish any similarities or differences in psychotherapist development.
In light of the current study within a South African context, themes were found that support Orlinsky and Rønnestad’s (2005) hypothesis that cultural differences in psychotherapy could play a role in therapeutic work. Further studies into the intricacies of cultural competency beyond the current finding of appreciating diversity and demonstrating open-mindedness and non-prejudice towards clients, appear strongly warranted.

One of the main categories of the current study, the negotiation of the personal and professional lives of psychotherapists, highlights the need for further research that could potentially inform the training contexts of psychotherapists as to how they could assist psychotherapists to better manage the overlap between the personal and therapist selves explored in the current study.

Due to the current exploratory study unearthing a broad range of findings in relation to psychotherapist development, the field may benefit from subsequent studies choosing a key area of psychotherapist development to deepen the knowledge of local psychotherapists and their therapeutic work. For example, comparing the supervision experiences of intern and established psychologists, or comparing intern and established psychologists’ development who work within the same theoretical orientation. Other possible research directions include comparing the professional psychotherapeutic development of psychologists from different training institutions or programmes in South Africa, or comparing psychotherapists who work with the same client population for example the professional psychotherapeutic development of psychologists working with children.
The current study also can be seen as a starting point for an ambitious research
dead of sequential individual development of psychotherapists which involves
tracking the same participants over their career lifespan. By collecting data at meaningful
intervals, the course of psychotherapist development in South Africa can be further
delineated or understood in greater depth.
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Knight, Z. (2004). The training of psychologists, and by implication, the majority of practitioners of psychotherapy in South Africa. Keynote address at the 2nd *International Congress of the Asian Federation for Psychotherapy*, Tehran, Iran, 29 September - 1st October.


Wilson, B., & Luther Wilson, L. (1997). The multiple selves of the therapist Journal of Family Psychotherapy, 8(2), 73 – 82


Appendix A: Interview Guide

The Grand-tour Question:

1. Tell me about the main aspects that have led you to become the therapist you are at present (cf. Orlinsky & Rønnestad, 2005).

Prompts:

2. Out of analytic-psychodynamic, cognitive-behavioural, humanistic, systemic, narrative or other, which theoretical orientations greatly influence your current therapeutic work? (Orlinsky & Rønnessstad, 2005). How do you describe the theoretical orientation you work from? (Hersh & Poey, 1987). What theoretical perspectives do you find useful or interesting? (Mullan, 1996).

3. Are you or have you ever been strongly invested in a particular model of therapy? Have you ever been disenchanted with that model? How did you come to that conclusion and what did you do as a result? (Skovholt & Rønnessad, 1995).


5. How would you describe yourself as a therapist, that is, your actual style or manner with clients? (Hersh & Poey, 1987; Orlinsky & Rønnestad, 2005). What would you say is particularly “therapeutic” about you? How does the person you are impact the therapy you do? (Jennings & Skovholt, 2004). What are your core values about therapy and being a therapist? (Johns, 1996; Jennings, Sovereign, Bottonff, & Mussel, 2005).
6. What qualities do you feel are necessary for a therapist to possess? What do you think are the necessary skills a therapist should learn? (Mullan, 1996). What kinds of people make the best therapists? (Skovholt & Rønnestad, 1995). What distinguishes a good therapist from a great therapist? If there were a recipe for making a master therapist, what ingredients would you include? (Jennings & Skovholt, 2004).

7. What have been major sources of influence for you and how has this changed over time? For example: theories, experience with clients, mentors, groups, personal life experiences? (Skovholt & Rønnestad, 1995). How do you see the relationship between the personal and professional development of therapists? (Johns, 1996).

8. What do you regard as critical incidents or turning points that significantly contributed to your professional growth? (Cormier, 1988; Howard, Inman & Altman, 2006; Roehlke, 1988; Skovholt & McCarthy, 1988; Mullenbach & Skovholt, cited in Jennings & Skovholt, 2004).

9. Do you see therapy becoming complex or simple for you as you have gained experience? Can you explain? (Skovholt & Rønnestad, 1995).

Dear Potential Participant

I am currently completing my treatise in fulfilment of my master’s degree in clinical psychology at Nelson Mandela Metropolitan University. This research aims to describe the professional development of psychologists from their perspective, by contrasting two distinct career phases namely during master’s training and seven years post-qualification client contact.

All volunteering participants in the study will remain anonymous, in that, while their words will be made known, their identities will remain confidential. The interviewing process will take place for approximately an hour. Interviewees may refuse to answer any question and may withdraw at any point that they wish. Non-participation or withdrawal in the study will not have any negative consequences for you in any way.

Each interview will be audio-recorded and later transcribed. The transcriptions will be included in the appendix of the final work with all identifying remarks and names.
changed. Feedback regarding the study's outcomes will be made available to all those interested.

You are in no way required to participate in this study. If you have any queries do not hesitate to ask me. It is necessary for me to obtain your informed consent before I can begin the study.

Your support is greatly appreciated.

Yours sincerely,

...............................                                                                  ............................

Christine Laidlaw
Researcher
Cell no: [Redacted]
Email: s209096015@nmmu.ac.za

...............................
Prof. Christopher Hoelson
Supervisor

...............................
Prof. Mark Watson
Head of Department
### INFORMATION AND INFORMED CONSENT FORM

<table>
<thead>
<tr>
<th>Title of the research project</th>
<th>Therapist metamorphosis: Beginner and experienced psychotherapists’ journeys of professional development</th>
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<tr>
<td>Reference number</td>
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<tr>
<td>Principal investigator</td>
<td>Christine Laidlaw</td>
</tr>
<tr>
<td>Address</td>
<td>NMMU Department of Psychology</td>
</tr>
<tr>
<td>Postal Code</td>
<td>PO Box 77000 Port Elizabeth 6031</td>
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<td>Contact telephone number</td>
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## A. DECLARATION BY OR ON BEHALF OF PARTICIPANT
(Person legally competent to give consent on behalf of the participant)

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I, the participant and the undersigned

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Address (of participant):

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### A.1 I HEREBY CONFIRM AS FOLLOWS:

1. I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by

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<th>Christine Laidlaw</th>
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of the Department of

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In the Faculty of

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of the Nelson Mandela Metropolitan University.

2. **The following aspects have been explained to me, the participant:**

2.1 **Aim:** The researcher is studying the professional development of beginner and experienced psychotherapists tracing their development along their career paths by means of their narratives.

The information will be used to gain an understanding of the professional development of psychotherapists within the profession of psychology.
2.2 **Procedures:** I understand that the interviewing process will take place for approximately an hour. I may refuse to answer any question and may withdraw at any point I wish. The interview will be audio-recorded and later transcribed. The transcription will be included in the appendix of the final work with all identifying remarks and my name absent. Once the transcription is complete the recordings will be deleted. Generalised feedback regarding the study's outcomes will be made available should I be interested.

2.3 **Risks:** I will not remain anonymous to the researcher and supervisor.

2.4 **Possible benefits:** As a result of my participation in this study the research findings are intended to contribute to the knowledge of the profession of psychology and specifically the professional development of psychotherapists.

2.5 **Confidentiality:** My identity will not be revealed in any discussion, description or scientific publications by the researcher and supervisor.

2.6 **Access to findings:** A copy of the research will be placed in the library of the Nelson Mandela Metropolitan University. An article may be published in a journal aligned to the profession of psychology. Generalised feedback regarding the findings of the study will be provided to me and other interested participants.

2.7 **Voluntary participation/refusal/discontinuation:**

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My participation is voluntary

My decision whether or not to participate will in no way affect my present or future employment/lifestyle.
3. The information above was explained to me by

Christine Laidlaw

in English and I am in command of this language.

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

5. Participation in this study will not result in any additional cost to myself.

---

**A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT**

Signed/confirmed at

20

Signature or right thumb print of participant

Signature of witness

Full name of witness
### B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR

I, Christine Laidlaw declare that

- I have explained the information given in this document to
  
  (name of participant)

- he/she was encouraged and given ample time to ask me any questions;

- this conversation was conducted in English

I have detached Section D and handed it to the participant

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Full name of witness
D. IMPORTANT MESSAGE PUBLICATIONSTO PARTICIPANT

Dear participant

Thank you for your participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(Indicate any circumstances which should be reported to the investigator)

Kindly contact Christine Laidlaw at telephone number

[Redacted]
### Appendix D: Thematic Analysis: Categories, Main Themes and Subthemes Based on Mindmaps

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<tr>
<th>Category</th>
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<th>Subthemes</th>
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<td>Positive</td>
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<td>• Formative experiences</td>
<td>Negative</td>
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<td>• Painful experiences leading to ‘wounded healer’</td>
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<tr>
<td>Theoretical orientation</td>
<td>• Personal theoretical framework</td>
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<td>• Advances in theoretical understanding</td>
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<td>• Beyond theory</td>
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<td>• Other</td>
<td>Ethics</td>
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<td>• Rigidity to flexibility</td>
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| Constructing professional identity | • Personal-professional boundaries  
• Increased self-awareness  
• Self-care/personal life  
• Always evolving identity |
| Challenges to practice | • Managed care constraints  
• Stigma in society |
Appendix E: Ingredient List of the Participants’ ‘Recipe’ for a Master Therapist

<table>
<thead>
<tr>
<th>Ingredients</th>
<th>Intern Psychologists</th>
<th>Established Psychologists</th>
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<tbody>
<tr>
<td><strong>Basic relational characteristics</strong></td>
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<td>A, B, C, D, E</td>
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<tr>
<td>making people feel comfortable</td>
<td>A, B, E</td>
<td>F, G, K</td>
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<tr>
<td>being comfortable with oneself</td>
<td>A, B, E</td>
<td>F, K</td>
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<tr>
<td>congruence</td>
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<tr>
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<td>J, K</td>
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<tr>
<td>gentleness</td>
<td>G</td>
<td>J, K</td>
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<tr>
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<td>C</td>
<td>F</td>
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<td>realness</td>
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<tr>
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<tr>
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**Presence characteristics**

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<td>G</td>
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<td>approachability</td>
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<td>receptivity</td>
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<td>G</td>
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<td>genuine interest</td>
<td>E</td>
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<tr>
<td>perceptiveness</td>
<td>K</td>
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**Resiliency characteristics**

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<tr>
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<th>A</th>
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<tr>
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<tr>
<td>determination</td>
<td>H</td>
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<tr>
<td>dedication</td>
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<td>H</td>
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<tr>
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<td>non-rigid</td>
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**Vitality characteristics**

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<td>confidence</td>
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<td>H</td>
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<td>excitement</td>
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<td>a love for what you do</td>
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**Reliability characteristics**

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**Ethical-related characteristics**

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<th>C</th>
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<td>F, G, J</td>
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<td>vigilant regarding competence</td>
<td>A</td>
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<td></td>
<td>G</td>
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<td>protective</td>
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**Other characteristics**

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<thead>
<tr>
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<tr>
<td>networking skills</td>
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</table>
Appendix F: Established Psychologist Participant K’s Metaphor:

Surviving a Personal Shipwreck

INTERVIEWER: Using a metaphor or image how would you describe the therapeutic process?

PARTICIPANT K: I use a metaphor about an old-fashioned ship that’s been hit by a storm, (or) maybe just their ship sailing and going through stormy waters every now and then – how to balance the ship? how to plug the holes?, what do I do to plug the holes?, what do I do to keep their ship in good shape?(…) I use it differently.
I would use it like with an old-fashioned ship that’s going through the sea and you don’t know that there’s a tsunami underneath and it crashes and it destroys the ship. And what do you have to do, what do you need in order to rebuild the ship? Do you want to rebuild the ship? (...) It could take some time (...). It’s devastating” (...). Then some people say, “Ja, it does feel like I’ve just been hit by a shipwreck or I’ve just been shipwrecked. And I go and say, “How does that feel? How does it feel if you know that your whole ship has been destroyed, the moment you’re actually holding onto a piece of wood in the sea and you’re just trying to hold- like, tread water now. What do you need right now?”(...) “You know when you’re right at the bottom and you’re clinging to wood, you know, like you need a support structure – do you have a support structure? And then can we mobilise that support structure?” Um, then, I also talk about it holistically – like you need nutrition, you need to look after yourself. How are you going to manage your stress? What do you normally do to manage stress? So you’ve got to rebuild this ship – you’ve got to get strong again (...) what’s also nice is then I do a change curve with them, “That’s where the like ship got destroyed- you cannot just accept it! You’ve got to go the whole way around and in going the whole way around- what do you need?, and if your spouse is on board the ship with you he may be at a different like level”. So, you actually show them graphically and I use a lot of graphics (...). I don’t just sit and talk which is probably a bit of a relief for them! (...) “you’re not just denying that it’s happening and jumping from one end – you have to rebuild, you have to explore life as a result of the
storm. What are we going to do now?” They need to find Meaning in
the shipwreck. Um, and we can’t always find meaning in this
lifetime in the shipwreck, but then they say, “What do you mean?”
And, then I will probably self-disclose and say, “Well for me, like
my meaning was if I never went through infertility I wouldn’t have
been able to rebuild my ship (…). The meaning for me in my storm
was that I became a psychologist because of it”. Just about for every
loss experience I will talk about the ship (…) I think that is quite an
empowering for them (…). They can see that you need to rebuild
the ship. I think it’s really powerful – because it just puts that
distance between like the problem and you- externalising (…). Like
almost using the Narrative.
Appendix G: A Narrative Reflection on My Personal Development as a Therapist:

on the 14th April 2010

The Wonderful Wizardry of Oz: Clicking My Own Silver Slippers

“(…) Like Dorothy, I am familiar with cyclones hitting my family home and I think with this emotional chaos and woundedness came the gift of the silver slippers. These precious slippers were bestowed upon me as a young child and as such it is difficult for me to operationalise the magical mystery of the silver slippers – but let me try. My silver slippers allow me to intuitively go into internal worlds. By clicking them like Dorothy I discovered the array of characterological aspects within and embraced the opportunity to follow the yellow brick road of self-discovery. These shiny slippers can be seen as psychological mindedness if you will, but that’s just a grown-up term for one’s willingness to embark upon the personal adventure within (…).

Recollections of my clarity-giving slippers clicking include: clicking once when I was small where I am watching this movie and all I can now remember is this surgeon having to adjust to being a patient and how he in the process learns empathy. The other clicking moment is when my twin sister and I rushed to set up a butterfly hospital in our garden to save broken-winged butterflies from being smashed to pieces by overenthusiastic boys with tennis racquets.

To be authentically vulnerable, I think my slippers of empathy may have much to do with my disAbility. In that when I had started my first Masters I remember reading this book about therapeutic metaphors wherein it was relayed that Milton Eriksson who had polio felt at an incredible advantage as it put him much closer to human suffering and therefore the capacity for empathy was so much easier.

I find too that in my professional therapeutic journey I have benefited from many buckets of clarity both in my own personal therapy and the pools of knowledge that I have lapped up. Certain wizards’ comforting potions and enlightening spellbooks have helped me along the yellowbrick road and I’m hugely indebted to them. Also, along this rite of passage to the Emerald City, like Dorothy I have encountered a lot of witches and wizards and I have benefited immensely from their Wizardry (…). I have found out how important it is to look behind the screen of the professional façade and professional trappings or at best the professional stance to know that: true wizardry fundamentally requires a set of empathic shoes.

As I journey along my life and therapeutic development I find it’s hard to pin down what is it about me that can be potentially therapeutic for others, for I continue to outgrow my slippers – just when I think I finally feel comfortable with my pair of green glasses of reflectivity the magic shoes start to pinch and without meaning to the journey sometimes causes me to blister and bleed. Yet, as I encounter further challenges along my
yellowbrick road I realise I need to revisit what I know about myself and expand my view (...).

Like all others that set out on the journey to the Emerald City I often-sometimes wish for the wisdom of the Wizard of Oz, and find myself wondering what the Wizard would say or do? But, like Dorothy, I remind myself behind the idealistic makeshift screen is just another human being struggling along in their own hot-air balloon not sure where the wind is going to blow them next. It’s in some ways a lonely journey for regardless of other magicians’ helpful therapeutic potions and protective kisses- indeed they are needed to give one’s Tin Man access to the emotional mind and for Scarecrow the reasonable mind- at the end of the day you have to take yourself back to your inner relational home. *The Wizard can’t click your shoes of inner wisdom for you to arrive and be at home with yourself (...)*”
Figure 1: Leary’s Interpersonal Circumplex Model (Orlinsky & Rønnestad, 2005, p. 44)