CHAPTER 5

PSYCHOTHERAPY TRAINING

The Chosen

The selection process for acceptance to Unisa’s Master’s course in Clinical Psychology is like the paradox of a paintball war game. Staying quietly behind a rock might keep you safe until the end of the game, but you run the risk of being shot in the back. Running across the open field might get you eliminated too, but unless you do it you will never be victorious. So you take the risk, leave your place of safety and pray you won’t end up with the bruises of failure.

I was still busy with my last two Honours subjects when I applied for acceptance to the Master’s course in Clinical Psychology at Unisa. Even though I knew that this was what I really wanted, I kept reminding myself that the competition would be stiff and that I might not make the selection. I was in a paradoxical situation: If I stayed in my current position I would be financially secure but would feel unfulfilled; and if I was selected I would fulfil my dreams but I did not know how I would survive financially.

I had dropped some hints to my parents that I was unhappy in my work and was considering a career change, and I put out feelers to establish whether they would be prepared to assist me financially in some way, even if all it meant was signing surety for a study loan. I got the cold shoulder and realised that I was on my own. Yet it is when the chances are slim and the situation looks bleak that your passion gives you the courage to take the risk anyway. At this point I reached the final stage of emotional cut-off (Bowen, 1988) and divorced my parents. This was not just a career I was going to follow; it was an expression of who I was. It was too special to me, and nothing was going to threaten or tarnish the experience for me. If my parents could not find it in their hearts to offer any support, they would have no part in this journey. I also broke off contact with my extended family. It is one thing to keep quiet about my studies to my parents, but I was not going to lie to my family or force them to take sides. This was not a family feud; it was a personal quest. My parents managed to triangle some of the members of our extended family into their emotional system and at work I would be called out of meetings for unexpected and
“very urgent” phone calls from distant aunts and cousins to implore me to visit my ailing parents. These contacts, which Bowen (1988) describes as attempts by the family to restore the former togetherness equilibrium would upset me for days, as my parents had managed yet again to paint a very bleak picture to the rest of the family of me as the spoilt, ungrateful, only child who had discarded her frail old parents.

On the last day of the selection we were all lined up on chairs in a semi-circle against the walls of the meeting room. The course leader proceeded to read out the names of the nine students who had been chosen. My name was read last. My first reaction was: “Oh hell, what have I done now!” My fate was sealed. I had taken the first step out onto the high wire without a safety net and there was no turning back. Not that I had second thoughts about my career choice, but it meant that I would have to resign from my management position, give back my company car and somehow cope without an income. I had been assured by everybody that there was no chance that my old jalopy, which had been in storage for eight years, would ever run again. Yet I was elated to have been chosen, despite my misgivings and the “survivor guilt” I felt when I saw the disappointment and sadness on the faces of those who did not make it.

I went home and cleaned my house, which always helps me when my thoughts are chaotic. The result was a clean home and an action plan for my new career. A good friend cajoled her cousin into resurrecting my car and I twisted my boss’s arm to allow me to continue working for three months on a part-time basis. I had no idea what I would do for money after that. The tool shed in my friend’s garden started looking mighty attractive and I was convinced I could live off yoghurt and coffee for two years, give or take a few vitamin pills. At the end of the three months, I just kept going back to work after my classes and quietly got the job done. I reasoned that as long as they continued to pay me at the end of each month, I would just carry on working without asking any questions.

**Hitting the Jackpot**

We had been warned that we had to prepare ourselves to hit the deck running. My Master’s course commenced early 1998 and I still had to write the final exam for one of my Honours papers. If I failed, my career would be down the tubes, as I
would not be allowed to continue. I can truly say that this was one of the most stressful periods of my life and all I knew was that failure was not an option. This was when I made the acquaintance of a fine lady at Unisa. Maryna de Kock, who later became secretary to my supervisor, managed to hunt down my results before I suffered a nervous breakdown. She continued to be extremely helpful and supportive beyond the call of duty during my entire period of study at Unisa and later, when I was completing my dissertation, her assistance was invaluable. This early, positive socialisation experience (Botha et al., 1995) with the Unisa training system encouraged me to work towards forming similar bonds with the rest of the training team.

The supervisors did not believe in giving students a standard recipe of theoretical techniques to be used in therapy like a bag of tricks. As early as the third week we were sent into a therapy room with our first client. My supervisor and other psychology students watched from behind a one-way mirror in a room that is linked via an internal telephone. Everything is videotaped for later scrutiny and discussion. Very soon you realised that the most important tool you took into that therapy room was yourself with your total life experience. You also learnt very quickly that a request from your supervisor to bring your tape to the next supervisory session did not mean you had done something brilliant during the therapy session. It was his way of saying that you had made a mess of it. Being a novice to the supervisor-student training context, I was functioning, in terms of Stoltenberg et al.’s (1998) model, as a level 1 supervisee. I had some background theoretical knowledge, acquired from the Honours degree studies, as well as some life experience of individuals and systems, but very little clinical experience and I therefore relied quite heavily on my supervisor to provide information on how to structure, plan and execute therapeutic interventions within a systemic theoretical model.

I was very happy to be placed with my particular supervisor, Ricky. He was the course leader, very knowledgeable and highly respected. Initially one feeds off the euphoric ego boost of being chosen, but then you have to buckle down to the practicalities and requirements of the course. It’s a bit like being chosen by a nice family, from among a crowd of kids at the orphanage, but then you have to adapt to the family rules and carve out a place for yourself. At the back of your mind is the
fear that if you disappoint them they will send you back to the orphanage for failing to meet their standards. These insecurities experienced by the student could be explained by the view of Botha et al. (1995) that self-esteem is influenced by evaluation of traits by authority figures. According to Stoltenberg et al. (1998), these fears, insecurities and evaluation anxiety are typical of the level 1 trainee due to lack of knowledge and experience, as well as lack of exposure to the more personal nature of the student-supervisor relationship. Bordin (cited in Stoltenberg et al., 1998) rightly emphasises that the unequal power differential between student and supervisor makes it essential to clarify both the supervisory relationship and mutual expectations of both parties, and to build a strong working alliance at an early stage.

I did not see it so clearly at the time, but I had become a member of a “temporary” family once more and the old insecurities about my endearing qualities, or their lack, and about my place in the group, would surface again (Bowen, 1988; Louw et al., 1995).

Initially, students may adhere to a romanticist view of self, as described by Gergen (1991), and of psychology practice. They want to believe that some inherent and unique qualities allowed them to be selected for the course and they feel that their chosen career is a “calling”. Due to their lack of experience they tend to rely on what “feels right”, rather than depend on rational decision-making skills, like anyone who has adopted the romanticist view of life discussed by Gergen. As I see it, this strategy coincides with the cognitive skills of a young baby who has to adapt to rapid changes and relies on instinct in order to survive (Louw & Louw, 1995). As novice students we had to work out what I would call the “logistic family rules” of who unlocked the therapy rooms, who sat where, who did what and who talked when. During these initial stages of training an existential self (as Lewis & Brooks-Gunn, cited in Botha et al., 1995, would put it) was exhibited, which demarcated the student’s physical boundaries in the training system. It was important to build a good relationship with the supervisors and fellow students, as offending someone would not be a good start. It was vital to achieve the “goodness-of-fit” (to which Thomas & Chess, cited in Louw & Louw, 1995, refer in discussing this early stage of development) between the self and the training system because we knew intuitively that if we were not liked, the next two years would be very difficult. At this stage it
seemed prudent to present the mask of the conscious ego self or outer petals of the Lotus of Self (Zohar & Marshall, 2001) to the rest of the training team. To listen carefully, comply with instructions, be pleasant to everybody and not annoy anybody seemed to be the best approach. This approach coincides with Kohlberg’s (cited in Louw et al., 1995) stage of preconventional moral development where behaviour is aimed at avoiding rejection and obtaining rewards. The first few weeks of orientation went by in a haze, and most of us were exhausted and complained of nightmares. We were the “babies” of the training course who could only process a limited amount of information due to the lack of adequate conceptual frameworks (Piaget, cited in Meyer & van Ede, 1995) and we needed a lot of rest to recharge our batteries.

The mood of the supervisory sessions varied from light and chatty to guarded and reserved. At first I was so absorbed by my own emotions that it was difficult to read the cues from Ricky and my fellow students to react appropriately in the particular context (Louw et al., 1995). Initially Toni, a fellow first-year student, and I relied on the experience of the three second-year students in our group and followed their lead. This confirms the view of Louw et al. (1995) that the peer group provides information and assists adherence to rules and regulations. As level 1 trainees our awareness of self and others was limited and Ricky relied on concrete interventions to emphasise his expectations (Stoltenberg et al., 1998). For instance, when Toni and I arrived at the second supervisory session without the notebooks he had requested, he simply stressed that he highly recommended taking notes as it would be useful in future. He did not go into a lengthy discussion of the reasons for our lack of compliance, but made it quite clear that he expected us to have notebooks by the next session.

A question that was uppermost in my mind was why I had been chosen by my particular supervisor. The other four female students were younger, prettier and more assertive than I, a 41-year-old spinster with glasses and an extra few pounds on my hips. I did not mind that perhaps my previous qualifications had been a deciding factor, but I wanted to be valued for more than that. According to Louw et al. (1995), the ordinal position of a “child” in a family system and the age differences between siblings have an influence on development. I became very sensitive to Ricky’s reactions and often went home mulling over insecurities such as: “Why did he look
at me so strangely?”, “Did I say the wrong thing?”, and “Maybe he does not like me”. These insecurities are typical of the Level 1 trainee who fears a negative evaluation by the supervisor (Stoltenberg et al., 1998). Toni’s view, by contrast, was that irrespective of what the supervisors thought of us, we were there to learn as much as we could and that is what we should focus on doing. Her reaction, which exhibited intellectual goal-directed functioning instead of emotional reactivity, was indicative of a higher level of differentiation (Bowen, 1988). So, we worried and we cried and we learnt.

Despite my insecurities one fact remained; I had been chosen by my supervisor for the course, whatever his reasons might have been. Herein lay my biggest challenge, but also my ultimate healing. Once more I had to try and resolve Erikson’s (cited in Meyer & van Ede, 1995) first developmental crisis of trust versus mistrust to get the courage and hope that I would prevail and succeed. I took the plunge and placed my trust in Ricky’s integrity, experience and wisdom that I had sufficient inherent qualities and abilities that could be harnessed to mould me into a successful psychologist. According to Stoltenberg et al. (1998), trust is the initial building block on which the supervisory relationship is built. This step gave me the skills to deal with the subsequent developmental challenges that would inevitably follow (Erikson, cited in Meyer & van Ede, 1995).

Setting the Stage

Initially when Ricky told us that he highly recommended that we get some experience in choreography and drama, I thought: “Give me a break! I’m having enough trouble with psychology and now the man wants me to be an actress.” I had done ballroom dancing for a while, so I thought I could wing the choreography part, but acting! At high school I was one of two girls who read for the part of Shakespeare’s Juliet in Romeo and Juliet. The other contender won the coveted role and my acting career was dealt an early death blow. So, here I was being trained in the serious business of being a psychologist and I was expected to do role-plays all the time. I was amazed at what good actors my lecturers were and how the roles they chose to enact as clients fitted so closely with their own personalities. I also realised with time how the illusion of hiding the “real self” during a so-called role play could
very rapidly strip away a person’s defences and leave the self exposed and vulnerable. As I had learnt from an early age to be as invisible as possible so that I did not intrude where I was not wanted, this was not an easy task for me and I felt like a fool most of the time. However, I realised that in order to join effectively with a wide variety of clients I had to be versatile enough to enact various roles. I also needed to be a director of the interplay between the actors on the therapy stage to allow the therapy session to flow constructively. So, albeit reluctantly, I packed my bags and joined the road show. Ricky’s recommendations assisted us in adding structure and flow to our therapeutic sessions, which imparted a sense of clinical efficacy and self-confidence that would eventually allow us to become level 2 trainees (Stoltenberg et al., 1998).

It is unnerving and exciting to take part in the live theatre of therapy, and as a novice you tend to stick to the basics. The client’s intake form gave some basic background information, which the therapy team could use to construct a preliminary hypothesis. There were some basic rules for Act I: Ask what the presenting problem was, why the client was seeking therapy at that time, what methods they had used to try and solve the problem, and what their expectations of therapy were. Next, constructing a family genogram would use up the rest of the first session and you were home safe and dry. Stoltenberg et al. (1998) confirm that a focus on basic interpersonal and therapeutic skills is advisable for level 1 trainees due to their lack of clinical experience.

Act II was a slightly different story. Most of the time I was concentrating so much on the finer details offered by the client and on my thumping heart that I remained insensible to the emotional world of the client and underlying themes and processes (Stoltenberg et al., 1998). It was as if I was peering through a little hole in a piece of paper. Applying the metaphor of the Lotus of Self (Zohar & Marshall, 2001), I was functioning at the level of the conscious ego self, where the serial neural tracts of the brain are used for rational thought to achieve strategic goals. At this early “preschool child” stage of development I used my cognitive skills to absorb as much information as possible, tried to apply this knowledge in the therapeutic context, copied the therapeutic behaviour of the supervisor and fellow students and formed basic concepts of the supervisory and therapeutic systems (Botha et al., 1995;
Louw & Louw, 1995; Stoltenberg et al., 1998). This level of cognitive thinking equipped me with the basic therapeutic skills required by a novice psychologist. I also had to acquire additional language skills to incorporate new terms, like “orthogonal”, “isomorphic” and “resonance”, into my repertoire and to adapt my language to suit the particular context, similar to the expansion of language skills in the preschool child in preparation for an academic career (Botha et al., 1995). It was very helpful to view the videotape after a session. It offered a meta-perspective of the therapy process and enabled me to recap on some of the finer details that had been obscured during the session. It also assisted me in the development of metacognition (Botha et al., 1995), which could be applied at a later stage of development to more effectively monitor and regulate information processing during sessions. Sometimes seeing myself on tape left me cringing. One of my fellow students described his posture during sessions as the “stiff corpse syndrome” – a very apt description of the restricted movements of the anxious, rookie student who has not yet achieved sensori-motor integration of new information (Botha et al., 1995).

At this stage of my development as a therapist I viewed Ricky as a “father figure”. I depended on him for guidance, support and recognition and to teach me the skills I required. I also had to rely quite heavily on him to guide me through the ethical tangles of systemic therapy as my knowledge was insufficient at this stage to deal with sticky issues such as disclosure of information to the family members of a client. This coincides with Kohlberg’s (cited in Louw et al., 1995) preconventional level of moral development where a concrete analysis does not allow ethical dilemmas to be viewed from different angles. It was important to form a close bond of mutual trust and to perform adequately as a novice psychologist in order to confirm that he had made the correct decision during selection (Louw & Louw, 1995; Stoltenberg et al., 1998). Like a young child whose religious beliefs in a “higher power” are undifferentiated and concrete, I attempted to follow Ricky’s instructions religiously and verbatim (Fowler, cited in Gerdes & van Ede, 1995). I watched his behaviour closely during therapy sessions and tried to copy some of it (Botha et al., 1995; Stoltenberg et al, 1998). However, as a female I did not possess the dominance and presence of this powerful male figure and had to make some adaptations to suit my personality. At this stage of development I was inclined to
follow the practical approach of modernism (Gergen, 1991), in other words, logical thought, observation, reasoning and application of knowledge during therapy sessions. The goals of this stage were to assimilate a wealth of information and to gain experience in diverse therapeutic contexts to expand my knowledge base and broaden my therapeutic repertoire. We had to learn new concepts and techniques and unlearn “bad habits” such as talking too much or interrupting clients, as in the period of modernism, as described by Gergen (1991), where the focus of “therapy” was to modify troublesome behaviour. It was important to get Ricky’s recognition and approval and to avoid a negative evaluation (Gergen, 1991; Stoltenberg et al, 1998). During the two years in Ricky’s supervision group I saw him become angry with a fellow student only once and I decided to avoid the same misfortune at all costs. However, we all know what happens when you try to avoid driving over something lying in the road!

I had progressed to Kohlberg’s (cited in Louw et al., 1995) preconventional level in my understanding and application of professional ethics, with an emphasis on the consequences of my behaviour, obtaining support and avoiding disapproval. In accordance with the modernist view as conceptualised by Gergen (1991), I had to rely on observed behaviour to conceptualise an authentic view of the self of the supervisors, students and clients. In the supervision group I had to assume that “what you see is what you get” and that the group members would be reliable, sincere and consistent and would adhere to high moral and ethical principles (Gergen, 1991). This mutual trust provided a sense of security within a cohesive group and assisted me in developing an internal “compass” to guide my therapeutic work (Andolfi et al., 1983; Gergen, 1991). Just like a young child, I started becoming more aware of my positive and negative personality traits (Botha et al., 1995) and how I could use them pragmatically during therapy sessions. In order to develop the self-confidence to face therapeutic challenges I had to master Erikson’s (cited in Meyer & van Ede, 1995) second developmental task by acquiring a certain level of autonomy and overcoming shame when I made an error and experienced doubt about my abilities. This second attempt at reconciling these opposing poles was more successful, as the training context was supportive and accommodating, unlike my parental home. Erikson (cited in Meyer & van Ede, 1995) emphasises that authority figures should deal
sympathetically with failures to facilitate self-confidence and a successful synthesis of the shame and doubt versus willpower developmental crisis.

Soon after our training started, a dark cloud appeared on the horizon that would remain there for the entire two years of our training. Some changes were taking place in the corridors of Unisa’s psychology department, and we did not know whether Ricky would be able to continue as our supervisor. It was like being a young child and having a parent diagnosed with a serious illness, and not knowing when the end would come. For me, this constant fear of abandonment was one of the most difficult issues to handle during the training period. It made a knot in my stomach that never really went away and added a sense of urgency to the supervision sessions. I might have appeared overbearing and demanding as I tried to extract as much from Ricky as I could, because I did not know when my access to the well of his knowledge would be cut off. This was separation anxiety revisited (Botha et al., 1995).

The Agony and the Ecstasy

Once you find your sea legs in therapy it is time to set sail and head for uncharted waters. This is when you find out that even though you have gained a wealth of knowledge, you understand nothing. Stoltenberg et al. (1998) ascribe this to a cognitive shift away from self-preoccupation to the life circumstances of the client, which adds complexity to the previous, simplistic view of the client’s problem. When the student is ready to learn, the teacher will arrive.

At this stage it was necessary to resolve the third of Erikson’s (cited in Meyer & van Ede, 1995) developmental crises, of taking initiative during academic and therapeutic sessions and dealing with the resultant guilt if the acceptable rules of conduct were breached, in order to develop the confidence to strive towards academic and therapeutic success. Ricky’s role now changed from that of “parent” to “teacher” and I felt comfortable with his authoritative style of teaching, which was in stark contrast to my parents’ unique blend of authoritarianism (Baumrind, cited in Louw et al., 1995) and uninvolvement (Maccoby & Martin, cited in Louw et al., 1995). Similar to Fowler’s stage of mystic-literal religious belief (cited in Gerdes & van Ede, 1995), a trainee-supervisor relationship had been established and I viewed
Ricky as a person who was knowledgeable, powerful and ethical. He provided enough structure and guidance to act as a safety net, but at the same time gave us a lot of breathing space whilst being encouraging, patient and supportive, similar to an authoritative parent (Baumrind, cited in Louw et al., 1995) or in accordance with effective supervision, as described by Stoltenberg et al. (1998). As predicted by Louw et al. (1995) and Stoltenberg et al. (1998), this promoted academic performance, independence, self-confidence, empathy and high ethical standards. As I was used to a parental style that fluctuated between demands for compliance and obedience contrasted with disinterest and rejection, I welcomed the involvement and dedication of my supervisor, but often felt very exposed in the supervisory context (Louw et al., 1995; Stoltenberg et al., 1998). In addition, I mirrored my parental dichotomy in my own behaviour by either withdrawing or dominating the conversation in an effort to establish boundaries and achieve an acceptable comfort level. Stoltenberg et al. (1998) explain that the level 1 trainee is usually not accustomed to the more informal nature of the supervisory context and is unsure what to expect from the relationship. According to these authors, the level 1 trainee is also concerned about a negative evaluation and may be reluctant to reveal too much personal information.

During the two years at Unisa, each student was assigned to a specific supervisor for practical tutoring. Each of the four supervisors had four or five Master’s students during each academic year, some first-year and some second-year students. The small groups allowed the supervisor to pay more attention to individual training needs according to the level of development across domains (Piaget, cited in Louw et al., 1995; Stoltenberg et al., 1998). The supervision group became the nuclear training family of origin, which acted as a home base and provided a sense of security (Bowen, 1988; Louw et al., 1995). The other supervisors and lecturers involved with the Master’s course, together with our fellow students, all formed part of our extended family and contributed to our knowledge and development (Louw et al., 1995). This group was composed of people from different academic, language, cultural and religious backgrounds whose ideas and values embraced a variety of theoretical paradigms. This made for a very interesting and challenging training crucible. It was also a source of conflict, heated arguments, a few emotional
outbursts and prolonged sulking. However, as time progressed a decrease in egocentrism occurred and we gained an understanding of our varying perspectives on the same issue, and conformity with the established rules of the student group and supervisory system as well as interpersonal cooperation during group projects increased (Piaget, cited in Louw et al., 1995). The student peer group provided warmth, friendship, support, information and confirmation of self (Louw et al., 1995). It allowed us to experiment with various roles, express conflicting opinions, receive valuable feedback and generally take risks without the consequences intrinsic to the student-supervisor relationship (Louw et al., 1995). However, alliances between students belonging to the same supervision group, which required mutual loyalty and support during teaching sessions with the entire student group, led to disputes and feelings of betrayal. Students were also curious as to how other supervision groups were run and compared their “nuclear families” with those of other students with resultant feelings or pride in their own group or disappointment in its perceived inadequacies (Louw et al., 1995).

In the diversity of our lecturers lay our ultimate strength and vision. Ricky (like any parent) could not be expected to be the perfect role model for all aspects of clinical practice and he and the other supervisors, as well as the other students, contributed considerably to my differentiation (Bowen, 1988; Louw et al., 1995).

Dian, our only female supervisor, was the steel in a velvet glove. She was well versed in narrative therapy, the art of showing respect and allowing clients to tell their stories. Her classes had a softness and kindness about them that resonated with my own gentle side. They provided an altogether softer place to fall. Then I hit the steel. I decided to choose the topic of ethics for a workshop in her class. My decision was based on a general interest in the minefield that ethical standards present, spurred on by some ethical dilemmas in my part-time research work. My intention was to stir the pot in order to make people sit up and think, but I did not expect to be shot at dawn. Dian and my fellow students were perturbed by the ethical question I posed and made their displeasure known. I should have known that amateurs should never open a bees’ nest and not expect to be stung. As I was not used to open conflict, I was ill-equipped to handle their criticism and took a considerable blow to my pride and self-esteem (Louw et al., 1995). I felt
misunderstood, betrayed, angry and discriminated against. Stoltenberg et al. (1998) warn that the therapist-supervisor relationship can be marred by significant conflict due to the troubled nature of therapists’ development at level 2. However, I did manage to illustrate the dilemma of ethics in new paradigm research; you have an ethical responsibility to people if you are going to expose them to issues of a sensitive nature. It was a case of a successful operation, but the patient died.

Debriefing with Dian and a discussion of events with fellow students provided some sense of resolution and brought me some support during a difficult period. This confirms the view of Belsky (cited in Louw et al., 1995) that social support could offset some of the negative effects during periods of stress. I had become acutely aware of the individual differences, perceptions and beliefs of this diverse group of students and supervisors (Stoltenberg et al., 1998). I was accustomed to working in accordance with strict international ethical guidelines for conducting clinical research and had developed my own personal code of conduct, but I still had a long way to go to grasp the subtle ethical nuances of psychology practice (Stoltenberg et al., 1998). Even though I had achieved a certain level of emotional awareness and maturity, the partially resolved developmental crises of Erikson (cited in Meyer & van Ede, 1995) and the resultant underlying feelings of mistrust, shame, guilt and inferiority, were a stumbling block in handling criticism in emotionally laden contexts. At this stage of my development a negative evaluation and the impact on academic achievement were additional fears (Turner & Helms, cited in Louw et al., 1995; Stoltenberg et al., 1998). I could not understand why other students were treated with kid gloves when they came unstuck during a workshop, but nobody would throw me a life preserver when I was drowning. In retrospect, my knowledge about the morals and ethics of clinical practice was probably not sufficiently developed at that stage to manage such an intricate issue (Kohlberg, cited in Louw et al., 1995). In addition, I had only partially mastered Erikson’s (cited in Meyer & van Ede, 1995) third developmental task; I could take the initiative on a cognitive level to face challenging issues, but had not resolved the resultant guilt on an emotional level. As Kohlberg (cited in Louw et al., 1995) would put it, cognitively, I had a “law and order” orientation, but emotionally I was functioning at the “good girl” level of moral or professional ethics development. The result was that
cognitively I wanted to illustrate the need for ethical standards, especially when moral dilemmas arise. However, on an emotional level I still wanted to be accepted and was trying to avoid rejection. The old childhood schism between my cognitive and emotional development surfaced once more and I wondered how I had managed to construct yet another context where my feelings did not seem to matter (Bateson, 1980; Gergen, 1991).

I had never realised what a negative view the general public had of pharmaceutical research, and decided that the world of psychology and the world of pharmacy were not good bed partners. From the beginning of my studies I had been questioned about the effect of my pharmaceutical background, which was based on a medical model, on my functioning as a therapist whose training was based on systems theory. I viewed the body as just another system and some of the same rules for healing applied. In my mind they merged into a seamless fabric with different aspects accentuated by the relevant context. My research work had grounded me in the scientific practicalities of daily life and my psychology studies fed my heart and my soul. This provided a comfortable balance and although the long hours of work and study were gruelling, I had never been happier. However, my colleagues at work and at university seemed to view me as two different people, and I started leading a double life. My self-concept at this stage resembled that of the middle childhood years; it had become more complex and differentiated due to increased cognitive abilities, mastering important skills and interaction with supervisors and peers (Louw et al., 1995).

We learnt hypnosis from a gentle craftsman. David reminded me of a mountain that seemed inhospitable from a distance but whose slopes, when you got closer, were filled with an abundance of life and whose cliffs gave shade in which to rest. He led his scared charges with great care into the dark caves of therapeutic hypnosis. I had been looking forward to the experience for a long time, but with some trepidation. As hypnosis represented a new domain of knowledge for most of us, it was to be expected that we would function at a lower developmental level than in domains where we had acquired some sense of mastery (Stoltenberg et al., 1998). David therefore needed considerable flexibility in order to deal with the variety of developmental levels of each individual student in a group supervision session.
(Stoltenberg et al., 1998). He was sensitive to our hesitancy, and I was impressed with the way he slowly led us into the mouth of the cave by casually dropping a few hints. We were each armed with a light to find our way and with the help of some interesting anecdotes from his practice the bats were soon chased away and the adventure began. When someone’s foot slipped or they feared that they had lost their way, his calm demeanour and confidence kept us safe and allowed us to find our way out. Stoltenberg et al. (1998) emphasise that good supervisors self-disclose, have good theoretical knowledge and are experienced therapists. Some of us found a different reflection of ourselves against the shiny walls of the cave, and others managed to climb through narrow crevices and mastered old fears. The time with him was too short to explore all the wonders and treasures that lay hidden in those depths, and I vowed that I would return for another look. David’s warmth, sensitivity, understanding and support, characteristic of an authoritative style (Baumrind, cited in Louw et al., 1995) of teaching, gave us the courage and self-confidence to experiment with hypnosis on our own and provided us with another valuable therapeutic skill.

When the name of a new client appeared in our appointment book Ricky usually selected a suitable therapist, but did not mind if someone volunteered. Depending on one’s courage on the particular day and sense of achievement during previous therapy sessions, you would either put in an eager offer or pray to let this cup pass you by (Stoltenberg et al., 1998). However, we realised that the only way to learn was by doing, as emphasised by Piaget (cited in Louw et al., 1995) with regard to the “middle childhood stage”, and we often enjoyed the challenge of new and interesting clients. The small training group provided teaching that was tailor made to the developmental level of a particular trainee, but it offered few places to hide (Piaget, cited in Louw et al., 1995; Stoltenberg et al., 1998).

This was when two sensitive issues popped out of Pandora’s box. I was a forty-something, unmarried, childless woman who had grown up as an only child. Ricky must have had some doubts about my abilities to work with children, and I was a bit hesitant myself. I was aware that the perceptions and resultant conclusions of my supervisor and fellow students regarding my single status could differ from my own views, much as in middle childhood we become aware of discrepant
perspectives (Louw et al., 1995). The second was an issue that the textbooks skirt around very delicately (Stoltenberg & Delworth, 1987; Stoltenberg et al., 1998). Ricky casually made some vague comments about my sexual orientation. Initially I laughed it off and decided just to let it go. I did not feel that I owed anybody an explanation or that I needed to defend my decision not to get married. One of my fellow students was gay and it had never been an issue. It might have been easier if Ricky had just called me aside and asked if I was a lesbian, instead of throwing down the gauntlet and waiting for me to pick it up. Stoltenberg et al. (1998) believe that due to the power differential of the supervisory context, supervisees may be reluctant to express their feelings in connection with individual characteristics such as gender and sexual orientation. I did not know if Ricky had concerns or whether it was just my fertile imagination, but the comments made me doubt my own femininity and I felt a bit offended. Then I felt guilty about being offended, because lesbians are not lesser women than heterosexual women. Nevertheless, this fed into my deepest insecurities about my female identity, my attractiveness to the opposite sex and my fear of men, inherited from childhood (Thom, 1995). My mother had always teased me about the shape of my body and had not validated me as a woman. In my father’s presence I was always uncomfortable about displaying typically feminine behaviour, and stuck to an intellectual expression of self. I expect I did the same during supervision, but this time it was out of habit and not out of fear. At about the same time, my gynaecologist added insult to injury by referring to me as a perimenopausal woman. The only conclusion I could draw from the male perspective was that I looked old and butch. I started taking extra vitamins and told Ricky that I was “not that way inclined”. I was heterosexual and did not think that I needed a husband and children to prove it.

Convincing Ricky that I had the ability to work with children was an easier task. He casually sent me into a session to do co-therapy with a child. I was quite surprised at how my tone of voice and body posture changed to meet those of the child, and it gave me the confidence to attempt working alone with children. Stoltenberg et al. (1998) emphasise that the supervisor must assess supervisee competence and development across domains and supervise accordingly. I was then thrown into the deep end with a family consisting of a mother and three children. The
sessions were lively, noisy and the kids were all over the place – and I loved it. My medical knowledge was a useful adjunct in treating the presenting diagnosis of enuresis and encopresis, as it required intervention on both medical and psychological levels. I received positive feedback about my integrated treatment plan, and this provided important validation that my pharmacy and psychology personas could live in peaceful coexistence (Erikson, cited in Thom, 1995; Stoltenberg et al., 1998). The systemic processes that maintained this child’s symptoms were revealing, and I had my first exposure, as a therapist, to lack of differentiation within a family (Bowen, 1988). Cognitively I was functioning on Piaget’s (cited in Louw et al., 1995) concrete operational level, and was now able to utilise information more effectively for problem solving. I could reason on a logical level regarding the medical, psychological and social factors that were maintaining the symptoms and could consider the influence of these contributing factors simultaneously. I could also adapt my language skills according to the therapeutic context, for instance when talking to the mother or having a session alone with the children. My processing speed increased and I could handle a larger amount of information at a time, for instance listening to the mother whilst observing the children’s behaviour out of the corner of my eye. I was gradually progressing to a level 2 trainee in this new domain, as illustrated by a more complex view of the client’s problem, utilising relevant schemata during the session and having empathy with the client, which assisted in case conceptualisation and increased intervention skills competence (Stoltenberg et al., 1998).

After a number of therapy sessions with this family, my pale, withdrawn and shy little bird came back from her summer holidays. She was tanned, had grown two centimetres, put on some weight and was chatting away like a sparrow at dawn. It gave me a sense of deep satisfaction to release her from the bonds of humiliation, and watch her soar.

I came to the realisation that the developmental model for training psychologists also offers a useful framework for therapy (Stoltenberg & Delworth, 1987, 1988; Stoltenberg et al., 1987, 1998). In the initial stages it was advisable to assist the family in creating a functional systemic structure and thereafter to expand their knowledge base regarding the various contributing factors and treatment
options for their problem. An integrated therapeutic approach was followed with the family, including re-socialisation of the “identified patient” and integrating differentiated aspects of the self into her identity (Bowen, 1988; Erikson, cited in Louw et al., 1995; Stoltenberg & Delworth, 1987, 1988; Stoltenberg et al., 1987, 1998). My client’s differentiation as a unique individual within her family system was isomorphic to my own process of differentiation within my training family of origin (Andolfi, 1980; Bowen, 1988).

I was humbled by the thought that if I had not been selected for the Master’s course, I would have missed all of this. I could not bear the thought, and was afraid that I might wake up to find that it was just a dream.

During our two years of training with Ricky, he went on overseas trips twice and left us with the responsibility of conducting some of the sessions on our own. During our first year this gave the second-year students an excellent opportunity to act as supervisors, and gave us more freedom to flex our muscles of independence (Louw et al., 1995; Stoltenberg et al., 1998). However, we were acutely aware that he might be forced to delegate his supervisory duties to someone else, depending on what would happen during the next few months. After an extended visit to a first world country, most people experience a culture shock on their return to Africa and we were concerned that Ricky might decide to leave South Africa altogether. Added to the insecurities was the fact that Ricky did not take on any new students in our second year, and Toni and I missed out on the chance to be “big sisters” to the newcomers. A second-year student from one of the other supervision groups joined us for live supervision, but we still felt somewhat orphaned. We reacted like children whose parents were considering a divorce, who thought their behaviour could influence the final decision (Louw et al., 1995) and thought that if we were really outstandingly superb students it might make it worth his while to stay, despite a heavy workload. Toni and I were also aware that we were his last students before he took over as head of the department and we wanted to make his experience with us memorable.

This fear of abandonment illustrates one of the double binds of establishing a bond with the supervisor that is based on trust, liking and caring, but that can be terminated at any time (Bordin, cited in Stoltenberg et al., 1998).
We had a saying in our training group: “You always get the clients you deserve.” As I was entering the adolescent phase of my psychology training, a teenage girl was assigned to me for therapy. Her story would shock me cold and awaken my creative spirit. She had been sexually abused by a family member for years and was suffering from Post Traumatic Stress Disorder. In addition, she had to resolve Erikson’s (cited in Thom, 1995) identity versus role confusion developmental crisis to prepare her for an autonomous adulthood. She was having difficulty integrating her previous identifications of “child abuse victim”, “abandoned child”, “adopted child”, and “parentified child” into a stable identity that would provide a sense of wholeness and continuity. At the same time I was attempting to consolidate my own previous identifications of “unwelcome child”, “invisible child”, “academic child” and “pharmacist” into my new self-concept as trainee psychologist. I was also acquiring some of the skills associated with Piaget’s (cited in Thom, 1995) formal cognitive operations, which allowed an exploration of the relationship between the various individual, family and societal factors that had contributed to my client’s problem. I was also able to formulate hypotheses of why she was experiencing an exacerbation of symptoms and could consider a number of possible treatment options. I handled discussions around the abuse, her fears about its possible recurrence and the effect it had on her daily life, with a fair amount of ease.

Then she brought me her diary. It was written in the form of a narrative in the present tense. As I read it, I became the proverbial “fly on the wall” who was witnessing the events. The sheer brutality of her abuser was revealed in all its horror as this child was injured and humiliated. I was filled with disgust and the notion that human beings are advanced life forms began to seem questionable. What was even more heart wrenching was her account of the few occasions when her family had treated her with a bit of kindness. She held them in her heart the way one would keep a few prized possessions in an old shoebox at the back of the cupboard. It was as if there were just enough crumbs falling off the table to keep her from starving. I resonated with her issues of neglect, abuse and fear and spent the first few sessions with the disconcerting sensation of being dissociated from my body. It was as if I was watching this unfolding drama from the stalls.
At level 2 of my development as a supervisee the focus was on the emotional experience of the client, which provided a more in-depth understanding of emotional and cognitive factors and assisted in case conceptualisation (Stoltenberg et al., 1998). The increased involvement with the client’s emotional experience also carried the risk of enmeshment with her emotional world (Stoltenberg et al., 1998). An exploration of personal issues, transference and counter-transference and an increased level of self-awareness were required to maintain therapeutic efficacy and prepare me for Stoltenberg et al.’s level 3 of my development as a therapist. I had to deal with a number of difficult ethical issues, such as child abuse and sex-role confusion, as well as the inadequacies of the criminal justice system and the limitations of the child welfare system. At the same time I was being challenged by my supervisor regarding my own sexual orientation and resonating with my client’s emotional world due to my own childhood experiences.

Characteristic of a level 2 trainee, I needed guidance from my supervisor regarding professional ethics, as I did not yet have the experience to balance the needs of all the relevant role players in this systemic therapeutic context (Stoltenberg et al., 1998). My client had reached Kohlberg’s (cited in Louw et al., 1995) conventional level of moral development, and followed the “good girl” approach in her belief that rules serve to maintain “law and order” in society. However, in terms of Kohlberg’s theory, my own post-conventional level of moral development highlighted the importance of protecting the individual rights of my client within the “common good” orientation of her “surrogate parent” family. As Hoffmann (cited in Thom, 1995) would have pointed out, it was important to assist her with the development of an individual value system to replace her heteronomous respect for adults in order to prepare her for adult life.

Our sessions together were as much for my healing as for hers. I had acquired an awareness of the complexity of human nature and the wide repertoire of therapeutic interventions required in clinical practice to deal with this diversity (Stoltenberg et al., 1998). My self-confidence had increased with experience and I could take the initiative to devise an intervention independently and take responsibility for the outcome (Erikson, cited in Meyer & van Ede, 1995). Ricky’s authoritative supervisory style struck a fine balance between granting conditional
independence and providing support (Baumrind, cited in Louw et al., 1995; Stoltenberg et al., 1998).

Towards the end of the therapeutic relationship with my client I involved the whole supervisory group in a ritual to welcome her to the planet and confirm her “coming of age” as a full member of the community. She did not have to feel like an “alien” anymore and was entrusted with the responsibility to take charge of her life. She taught me about courage and the extraordinary resilience of the human spirit. The ritual was very meaningful to me. I had the opportunity to go beyond theory and techniques and could infuse my self into the therapeutic context to assist in another person’s healing. At this stage my knowledge base and experience were sufficiently advanced to utilise the collective unconscious or parallel neural networks in the brain during therapy (Zohar & Marshall, 2001). In accordance with Piaget’s (cited in Thom, 1995) formal operational thinking, sequences of events and patterns of connection emerged and I was able to use symbolism and ritual creatively for therapeutic purposes. Ricky’s supervisory skills were displayed in his trust, acceptance and support of my “experimentation” with a new, idiosyncratic treatment approach (Stoltenberg et al., 1998). As I was progressing to level 3 of trainee development, the ability for self-reflection and integrating various sources of information allowed me to create an innovative treatment plan and utilise aspects of the self in therapy (Stoltenberg et al., 1998). I became more comfortable in coping with a strong emotional climate during psychotherapy sessions, and was motivated to meet the academic standards I had set for myself. At this stage I had been exposed to multiple voices and contexts, and was reaching the state of social saturation described by Gergen (1991). I could express a variety of selves within different therapeutic contexts and therefore the self expressed in therapy became, in Gergen’s terms, a function of the relationship.
Colouring Inside the Lines

Ricky and I never crossed swords over autonomy issues (Stoltenberg et al., 1995; Thom, 1995) or the choice of therapeutic interventions, but he had one serious bone to pick with me. He confronted me with the fact that I had problems with my interpersonal boundaries. This meant that while it was not difficult for me to display warmth and kindness to clients, they were running rings around me. Often I could not exercise control over the flow and direction of the therapy session, and I was always going over my time limit as I did not have the heart to end a session when a client was very upset. This led to a few irritated phone calls from Ricky from behind the one-way mirror after some futile knocking against the window, and I became worried about the negative effect it might have on my marks (Stoltenberg et al., 1998). The value of Ricky’s clear communication regarding an area of weakness is highlighted by Stoltenberg et al. (1998), who warn that a supervisor’s avoidance of negative feedback due to the potential academic implications for the trainee may eventually result in a pseudo level 3 therapist. Furthermore, I often worked with children whose boundaries had been severely violated due to emotional or physical abuse and neglect. If I could not model how to set appropriate interpersonal boundaries, I was not doing good therapy. I hit a crisis point when a child refused to help me pack up the toys that lay strewn all over the floor and was physically hanging on to me so that I could not leave the room at the end of a session. It might be good for the ego that a child is enjoying your company so much that she will create such a scene at the end of a session, but I was not doing this child a favour. I understood her hunger only too well and felt very torn inside, but I was her therapist, and could not fulfil the need she had for a mother. If I made her dependent on me I would be violating my most basic rule as a therapist – first do no harm.

Not following Ricky’s instructions was not an act of defiance, but rather a reflection of my inability to carry them out during the session. I could model some of the appropriate behaviour on him, but I needed the help of a strong, assertive woman (Erikson, cited in Thom, 1995). Toni had a strategy for expanding one’s behavioural repertoire: “Act as if” you have already mastered the skill and the rest will follow. I
did not have a suitable role model available in real life, so I decided to include a fictional character from a television series as “co-therapist”. Actors infuse the character they portray with parts of their own self, until the boundaries between them become blurred and reciprocal synergy results from the socially constructed persona. Accordingly I decided to “borrow” some of the skills that I lacked from this character and try them on for size, thereby, incidentally, confirming Gergen’s (1991) contention that celebrities have become our frame of reference in this technological age.

My “gentle” side was far more developed than my “assertive” side and I was inclined to fluctuate between the two due to insecurity, rather than blending them into a harmonious symphony. I realised that I had learnt to take an avoiding or apologetic stance, especially in threatening situations. I would often humiliate myself in the face of conflict as a protective device. This meant that my kindness and warmth might take on a kind of ingratiating or pathetic nature and my assertive side was often exhibited as anger or impatience, which could appear disrespectful or even abusive. This duality in my identity and the problems I experienced in integrating these characteristics into my self-concept reflected the two opposite poles of “strength” and “softness” that my two parents had represented (Bateson, 1980). As I was progressing to a level 3 trainee, my self-awareness increased and I was ready to explore the effect of personal dynamics on my clinical work (Stoltenberg et al., 1998).

I had spent a large proportion of my life trying to be “invisible” to others. However, I could not remain so if I wanted to be a good therapist. In therapy it is not so much what you say or do that brings about change for people, but rather who you are in your relationship with them (Andolfi & Menghi, 1980). I needed to have a presence, an air of confidence and command when I entered the therapy room – not to control my clients, but so that they could have trust in my ability to help them. I also needed to be firmly in control in order to maintain my therapeutic manoeuvrability. If I allowed the client to dominate or manipulate me, I would be dead in the water. To quote Ricky’s wisdom on the matter: “‘Rude or polite’ becomes meaningless in the face of ‘coherence’ and ‘effectiveness’” (F.J.A. Snyders, personal communication, May 27, 1998). This realisation was a watershed for me,
but the pragmatic application of the concept was still problematic. I tried to find out from Ricky whether he operated from a central pivotal point to integrate these various sides of his personality, but he was either ducking the question or did not understand what I meant. I reverted to my fictional character for assistance and developed a sense of the core of dignity, grace and nobility from which she operated. Authority was utilised to establish a context of confidence, respect, trust and security instead of being abusive, and gentleness created a caring atmosphere of kinship, warmth, kindness and protectiveness instead of weakness.

I “borrowed” the sense of dignified command that the character exuded, but had to find a way to mask my interpersonal power so that I could join effectively with the client’s world. I walked into the therapy room with the clingy little girl firmly resolved that I would set some new rules for our sessions. We started our usual play therapy, but the opportunity to raise the issue did not arise. When I announced that we had to finish because the time was nearly up, she put her hand in mine and left the room without a fuss. I was astounded as I had been my usual friendly self and had not said a word about my decision not to allow her to take advantage of my kindness any more. The mere fact that I was allowing myself to “act as if” I was the “captain of the ship” must have been evident in my body language, and as children are very perceptive she must have picked up the message. Sometimes you have to borrow a dress from someone for a special occasion, and with a few alterations, you too can be the belle of the ball! Characteristic of level 3 of trainee development, my increased self-knowledge allowed me to use the self in therapy more effectively in an effort to personalise my clinical practice (Stoltenberg et al., 1998).

Then the significance of drama in the world of psychology became clear. Both crafts involve science and art, require passion, have an influence on the lives of others and require that you immerse yourself fully in the context (Andolfi & Menghi, 1980; Andolfi et al., 1983). Both professions are an expression of who you are and in the process of enacting your various roles you are developing and growing (Jervis, cited in Andolfi, 1980). Being a therapist means that you must be able to help a child tell her story with hand puppets, counsel a woman who has been raped, help a couple with their marriage problems, and talk to a teenager about raves and the latest “cool”
music and fashions, all in one afternoon. It requires flexibility and a broad interpersonal repertoire to be able to enact all these roles and still be congruent (Gergen, 1991). The journey of psychology would take me to drama theatres that I never dreamt of visiting.

The Shaman

A strange and mysterious class appeared on our timetable. It was referred to as “Stan’s class” and nobody was entirely sure what was to transpire during the two hours allocated to it. After three weeks, we were as befuddled as ever and Stan seemed to become impatient. I opened my big mouth, and that was where the trouble began. A sequence of events followed that I perceived as a series of put-downs and rebuffs at every attempt of mine to get clarification about his expectations. With retrospective wisdom, he was probably annoyed with my intellectual analysis of a process that required a more metaphysical approach. I was repeating the behavioural pattern learnt during childhood to intellectualise emotional issues such as feelings of insecurity, shame and inferiority to mask my pseudo-differentiation (Bateson, 1980; Erikson, cited in Meyer & van Ede, 1995). Even though I had reached developmental level 3 in other therapeutic domains, I had regressed to level 1 in a context where the focus was on emotional and spiritual domains of development (Stoltenberg et al., 1998). Then one day I ventured a question regarding integration of self that was quite important to me and which I thought was pertinent to the discussion. The core of our misunderstanding reached critical mass, and he lashed out at me with “don’t you try and play therapist here”. The crack in the wall that contained the core of my emotions for so many years ripped open. It hurt so much it took my breath away and the tears came too quickly for my defences to shield the pain. For the first time in my life I, the good kid, got up and walked out of a classroom. I struggled to find the words to describe the wound. I felt disrespected, disconfirmed and invalidated – my contributions had no value and consequently I had no value as a person. I felt ashamed, humiliated and isolated. All the feelings I had suppressed during childhood came rushing through the floodgates and I found some relief in finally being able to give voice to them. However, my experience with open conflict had been that a discussion of the problem usually led to an escalation of conflict and division, and I therefore avoided further exploration of the issue with Stan. Stoltenberg et al. (1998)
also warn that conflict can create tension in the supervisory relationship and due to the power differential the trainee may be hesitant to disclose personal feelings to the supervisor. This was the second time I had been confronted with all the previous developmental crises postulated by Erikson (cited in Thom, 1995). I had to deal with feelings of mistrust, shame, guilt, inferiority, identity confusion and isolation all at once. My pseudo-differentiation was a continuous stumbling block, I had problems establishing interpersonal boundaries and I was unable to achieve integration of self. These three shadows would stay with me even after the training period had ended and would become the proverbial ball and chain in my developmental process. I withdrew emotionally to mull things over and come to terms with the developmental challenges, but intellectually I remained connected, as I believed that I could learn a great deal from Stan’s class.

I should have understood that a good surgeon is recognised by the sharpness of his blade and the swiftness of his hand. This skilful procedure left me with a scar, but also with precious gifts. Confirming and validating a client’s experience before trying to effect change became my most valuable therapeutic tool. I sought the assistance of a more senior student to try and make sense of the incident. She was tough enough not to let me wallow in my pain, kind enough to understand my confusion and wise enough to let me make my own decisions. She became the one that I could turn to when I came at a crossroads, and later on when I had to make a decision about my internship she was there for me again. The importance of a supportive and accepting peer group was once more highlighted by this experience (Thom, 1995). My fellow student was an important source of information, which normalised my experience, defused the situation and provided a safe context in which I could express my anger, fear and disappointment without the risk of retribution (Thom, 1995). She was also an important role model of an integrated self, with a harmonious blend of warmth, kindness and assertiveness, accompanied by firm interpersonal boundaries. Her ability to make a skilful assessment of the problem from a meta-perspective whilst showing an appropriate level of empathy is characteristic of a level 3 therapist (Stoltenberg et al., 1998). Stan’s intervention allowed me to step outside the bounds of intellectuality and work towards emotional and spiritual differentiation. During the storm I also experienced an extraordinarily
kind and gentle side of Ricky, which provided a brief glimpse into his extensive diversification of self. This illustrates the conviction of Stoltenberg et al. (1998) that a high level of differentiation in the supervisor is necessary to deal with the diverse needs of trainees. At this point of my training it was not how much I knew that was important, but rather how well I understood.

Alone in the Jungle

The end of my two years of training at Unisa came sooner than I expected, and I had to choose an internship. My first choice was 1 Military Hospital but alas, this was not to be. I took being one of the “unchosen” harder than I expected, but Ricky’s comment of “they don’t know what they’re missing” helped to put it in perspective. Shortly afterwards an opening at Helen Joseph and Coronation Hospitals was on offer. The rest of the students would be going to Sterkfontein Hospital and I had to consider the negative aspects of Helen Joseph, such as a long drive in heavy traffic and being separated from my fellow students. I would have to resign my part-time employment as well, and losing two sets of social support systems in one go was not a prospect that I relished. Social support systems act as a buffer against emotional stress (Thom, 1995) and as Gerdes and van Ede (1995) point out, loss of these relationships are traumatic for the adult. However, I was under pressure to make a decision before the Sterkfontein interviews took place, and after consultation with my senior student mentor and careful deliberation, I decided to take a chance. Thom (1995) confirms that the peer group acts as a source of information, facilitates emancipation from the “parental home” and offers a safe environment to discuss fears and goals. I realised that I was the first student from Unisa to be offered an internship at this hospital and knew that I had a responsibility to prove myself. I was blissfully unaware of the controversy that surrounded this placement.

My last few months at Unisa were extremely busy. I had to prepare for my final examinations, whilst training new personnel at my place of employment to take over the responsibilities in my absence. I was coping adequately, but then disaster struck late one night on my way home from work. One of the notorious “highway robbers” decided to smash my window when I stopped at a red traffic light and liberated my handbag for redistribution amongst the poor. Not an uncommon or
particularly traumatic event in the South African context, until it happens to you. I went through all the symptoms of acute stress disorder – the nightmares, the flashbacks, the paranoia and the hypervigilance. I should have tried to talk to someone about it, but I had too little money and too little time to seek counselling. Instead I tried to push it to the back of my mind and carried on with the task at hand. However, the ghosts of fear and distrust went into hiding at the back of my cupboard and one stormy night they would sneak out again. I had had to handle a number of losses, such as loss of student and work friends, loss of employment, a reduced income, loss of personal belongings and personal safety within a short space of time. These sudden changes in my life had an important impact on my self-concept as a self-sufficient individual and initiated an extended period of vulnerability and disconnection, which confirms the view of Gerdes and van Ede (1995) that the self-concept could be affected by life situations.

It was true what everybody had said, that it is only during your internship year that you really find your feet as a therapist. My internship consisted of three rotations of four months each on the psychiatric ward and at outpatients at Helen Joseph Hospital, and in the paediatric section at Coronation Hospital. It provided an interesting mixture of environments, which I believed would give me a good all-round training. My first rotation was Ward 2, the psychiatric ward, which most believed was also the toughest rotation. I had two supervisors at Helen Joseph Hospital and one at Coronation Hospital. I was a bit taken back when the person who had pushed very hard for me to take the internship and with whom I was looking forward to working, promptly resigned. With her departure I also lost my last direct link to Unisa. It transpired that the internship had been offered to Unisa before all the parties involved had been consulted, and by the time they realised what was happening it was too late. I was placed in the unenviable position of having accepted the internship in good faith, only to find out that my presence was surrounded by controversy. I had an open discussion with the other RAU interns about their loss of a placement and then decided to put it behind me and concentrate on my clients. I felt more obligated than ever to put in a good performance to at least ensure that the remaining staff members at the hospitals did not regret having me on board. I also felt that I had a responsibility towards Ricky, as he had been involved in the
negotiations to obtain the placement. Post-formal operational thinking, as well as a higher level of differentiation achieved during the previous two years assisted me in problem solving via metaformal schemata (Gerdes & van Ede, 1995). These cognitive abilities allowed me to review the situation logically, evaluate the factors that had led to this dilemma, explore the available resources, analyse interactional patterns in the department and assess the broader context of the hospital.

Ward 2 was a very interesting place indeed. It was an acute intake ward from which patients were either shipped off to other hospitals such as Tara or Sterkfontein, or where they stayed for a maximum of about two weeks. On the positive side, one saw a large variety of patients within a short period of time, but the downside was that you did not have any long-term clients.

If I had to single out clients who made an important impression on me, the first would be a very young girl who seemed to be in the prodromal phase of schizophrenia. She was extremely confused and would pace up and down the corridors all day crying for her family. I ended up walking the corridors with her almost every day while she clung to me like someone who was drowning. She was like a child and I had to explain in very simple language that her family could only come over during weekends and that she needed to make a list of things she needed so that she could tell them when they came. For her just to understand what day of the week it was and when her family would come was a major accomplishment that helped to anchor her in the here and now and alleviated some of her anxiety. I resonated with her feelings of anxiety and discomfort at being “dropped off” at a strange place without her consent. Eventually she improved and was released into her aunt’s care.

Some time later her aunt approached me while I was working at outpatients because she was concerned about this girl’s drinking habits. I spoke to the girl very quietly and asked her if she drank alcohol to make the voices go away. She had never admitted to anyone that she experienced hallucinations and she collapsed in tears into my arms. I felt such compassion for this young girl who had nursed her dying mother as a teenager and now faced the horrors of schizophrenia. I knew that we needed her back in the ward to change her medication and stabilise her condition, but this time I left the choice to her. She confirmed that the alcohol only helped to a
certain extent and I explained that later on it would not help at all anymore and that the correct medication would be far more beneficial. Previously she had been admitted to the ward against her will, but this time I told her to go home and think about what I had said. Shortly afterwards she agreed to be re-admitted and her progress from there on was quite remarkable. She started smiling again and could carry on a normal conversation with me.

Initially the psychiatric ward was an unfamiliar context and schizophrenia represented a new domain of knowledge, but sufficient experience once more allowed me to progress to level 3 of therapist development, at which stage I could utilise the self in therapy, follow a personalised approach and develop an idiosyncratic therapeutic style with this client (Stoltenberg et al., 1998). When she brought her sister to the ward a few months later, suffering from the same symptoms, I saw with pride how she could comfort and care for someone who felt as frightened and lost as she had once been. I thought this was the kind of work that nourishes your soul - it gives you an inner satisfaction that energises and sustains you.

Assisting clients in re-mastering Erikson’s (cited in Meyer & van Ede, 1995) developmental crises became an important therapeutic goal in this context. Clients who are brought to a psychiatric ward against their will are entering the therapeutic context with feelings of mistrust regarding staff members, shame about their hospitalisation, guilt about their possible role in causing the problem, inferiority due to their dysfunction, identity confusion due to labelling as a “psychiatric case” and isolation from family and friends.

Another of my clients had a bipolar disorder and was admitted after a suicide attempt. She was suffering the worst depression I had ever seen. She stared at me with glassy, watery eyes and spoke to me disinterestedly. Something about the expression in her eyes was very scary – it was empty. Later on I came to know this expression well; it usually meant that the client was hallucinating, which I did not realise at that time. Eventually she would not move from her bed to wash and stopped eating and drinking fluids. This client experienced serious side-effects on antidepressants and eventually the psychiatrists decided that ECT was the only option. They had recently acquired an ECT machine and seemed eager to try it out. As a psychologist I have an inherent aversion to procedures such as ECT and
psychosurgery, perhaps due to my own bias and ignorance, but I could not argue with them. If this woman did not eat, she would die and long-term intravenous feeding was not an option. I got hold of some information on ECT to bring me up to speed and the psychiatrists did not mind educating me. I promised my client that I would go to theatre with her.

I remember the procedure as a strange ritual of stripping away defences to the bare minimum, literally and figuratively. I went to the dressing rooms with one of the women psychiatrists where we had to strip down to our underwear and put on theatre gowns, shoes and caps. On the theatre bed lay my client - naked but for her backless theatre gown. Her position of vulnerability, helplessness and dependency resonated with my childhood experiences and was preparing me for future events that would occur in my own life at the end of the internship. She had “difficult veins” and was poked like a pincushion before they got the needle in. They hooked up the electrodes to her head and starting running in the anaesthetic agent. It reminded me of those horrible scenes from American movies about people on death row being executed. I was told that the patient had to have a seizure for about 30-40 seconds for the treatment to be effective and I was given a stopwatch and told to watch the feet to double-check the seizure time. They placed the mouth guard and started ventilating her. Then they flipped the switch. I have heard on numerous occasions that the modern version of ECT is very mild compared to the bad old days, and that one sees no more than a twitching of the fingers and toes during a seizure. This is not true. Even though it is not as severe as a grand mal seizure, almost all the voluntary muscles contract and there is quite a bit of shaking. I watched the feet as ordered, and the image that has stayed fixed in my mind is of this poor pair of calloused feet contracting inwards during the seizure and the EEG machine’s frantic wail to warn that a seizure was taking place. The wailing stopped abruptly, but her muscles continued twitching for a while afterwards. They ran in the drug to reverse the effects of the muscle relaxant, and I watched as she slowly started breathing on her own again. And that was it.

We put on our own clothes again and with them our daily professional masks. It felt odd walking down the corridors and I wondered whether people could see in our faces what we had just done. I was worried that my client would have memory...
loss or other side effects. I wondered whether she would be angry with us when she
got her senses back. It remained a very brutal thing to do to another human being.
This woman taught me the true meaning of courage. Her life was in chaos and she
had been hurt and humiliated for a long time. It wasn’t just doing therapy - I had to
help her rebuild her life. She had never spoken to a therapist before and was very
wary of me. She continued to be my client during the entire internship and I watched
this woman, who had always kept a stiff upper lip, becoming a kind, compassionate
and strong woman. This was differentiation on a grand scale. I remember her with
great fondness and respect. Her mother gave me a beautiful gift - a fresh sunflower in
an old wine bottle and a poem she wrote especially for me. These are gifts of the
heart and their value is immeasurable.

Individual therapy with this client illustrated the difficulty of assisting the
“identified patient” in differentiating whilst the family attempts to maintain
dysfunctional familial transactional patterns (Andolfi, 1980). However, this period of
emotional crisis in the family and my client’s courage to attempt differentiation
whilst remaining in contact with her family brought about important changes in the
family system (Bowen, 1988). She also acquired cognitive, emotional and
psychosocial skills that proved to be very valuable in her personal and professional
life (Bowen, 1988).

It was strange and wonderful to me how one could sometimes, during the
therapeutic process, experience a moment of true magic. I had a very thin client who
grew up in an icy country and was always cold. Everything about her life and her
body was cold and impoverished. She felt completely empty inside and was unable
to experience any joy. She said that the sun did not warm her and that flowers did not
smell like anything to her. One spring day I took her outside and we stood against
one of the flaking hospital walls where the sun was baking down. I told her to close
her eyes and feel the sun on her skin and on her eyes, and to feel it slowly sinking
into her and warming her up from inside. Next to us was a jasmine bush and I picked
a piece and placed it in her hands. I asked her to smell the sweetness of the flowers,
which signal the beginning of summer and a new beginning. I will never forget the
slow wonder creeping across her face, and for the first time since I had met her the
shivering stopped.
At this level of my development I could utilise a combination of my intellectual, emotional, psychosocial and spiritual qualities in the therapeutic context to effect change in a client (Gerdes & van Ede; 1995; Stoltenberg et al., 1998). I was tapping into the central bud of the Lotus of Self or the synchronous 40 Hz neural oscillations of the brain (Zohar & Marshall, 2001), which sharpened my intuition and allowed me to integrate elements in a client’s life with his or her psychological problems. For instance, I developed a “third ear” for clients who were hallucinating long before they admitted it to the psychiatric staff. I could also apply the duality of an African culture with an American upbringing to a client’s bipolar disorder by using symbolic artefacts such as jewellery in an attempt to integrate these apparently irreconcilable definitions of self. At this stage I was starting to touch on some of the level 3i developmental skills, such as fluidity of movement across domains in the conceptualisation of a client’s problem and the implementation of interventions (Stoltenberg et al., 1998). I had achieved integration of knowledge and skills, but integration of self was still a mirage on the horizon.

A Bad Hair Day

I also had some trying times during my internship. As if travelling from Pretoria every day was not bad enough, we had major floods during the first three months. One Monday morning it took me three hours to get to work and I vowed that if it should ever happen that by lunchtime I was still trying to get to the hospital, I would just give up and go home.

About three months into the internship I had an accident. It started with a tree outside my bedroom with a branch scratching at my window when the wind blew, which was very spooky. One night at about 23h30 I had had enough and dragged a ladder outside to cut it off. The paving outside was uneven and halfway up the ladder it tilted to one side and I came tumbling down, hitting the corner of the wall with the back of my head. At first I just thought it was a bit of a bump and felt annoyed at my clumsiness. Even when my hair felt damp and I realised that it was blood, I was not all that concerned. I knew that even small head wounds bleed quite profusely and usually scare everyone to death for nothing. However, when the blood started forming a little pool at my feet I knew without a doubt that I was in trouble.
It was late at night and my neighbours and friends were all asleep. I decided that I had not lost consciousness and seemed to have my wits about me. I grabbed the bit of cash I had at home, got into my car, opened the window and slowly made my way to the nearest hospital. I had to explain at casualty that I had no medical aid and only a little money and that I wanted them to help me. The trail of blood drops that followed me in must have impressed them, or perhaps they didn’t like the mess on their floor. They ushered me onto a bed. I was worried about the intactness of my skull and even more about my brain. In the end they had to cut quite a bit of my hair at the back and it took 11 stitches to sew up the 6 cm cut. After insisting on and undergoing a skull X-ray, and receiving a mug of very sweet tea from the cleaning lady, I made my way home. I looked like a World War I hero with a big bandage around my head and a little tower of bloody hair on top, and I got some very strange stares. This experience left me feeling utterly vulnerable and it brought home to me that I did not feel comfortable about phoning anyone I knew at that hour of the night to help me. For me the truth then really hit home – that when I’m really in trouble I have no reliable support system.

For the next few months I sported a hairstyle reminiscent of “the last of the Mohicans” and had some pretty bad headaches due to whiplash. I was facing Erikson’s (cited in Meyer & van Ede, 1995) sixth developmental crisis in terms of close personal relationships versus isolation in both my personal and my professional life.

Gangland

My work at Coronation Hospital was tough but satisfying. Children are very demanding and the kids at Coronation had no concept of boundaries. They would crawl under your skin if they could. My office was the dirtiest I had ever seen and nothing could get it clean. The windows did not close properly and during the night everything would become covered in dust. My view was of a taxi rank, Mr. Lee’s cafe on the corner and the row of houses where all the wild parties took place at night. I could see attempted hijackings on a daily basis on the street corner. It was an exciting place indeed, but very bad for the nerves. In the corridor outside my office was a row of chairs constantly occupied by waiting mothers with screaming babies,
whilst the bigger children kicked balls against the door or tried to swing on my door handle. Outside, taxis would often stop and hoot at regular intervals for an hour at a time. I realised that this place would most certainly teach me to develop firm interpersonal boundaries if I was going to survive.

I had a young boy as a client who lived in a very chaotic house with a bunch of aunts and uncles. Adults would often have sex in front of the children. This child was described as a real troublemaker. During therapy he preferred to draw a lot and talk very little. One of his drawings had high, snow-capped mountains, covered with flowers and trees, and the footprints of small animals. It was very calm and serene for such a troubled boy. He called his picture “happiness valley” and it had a special place on my wall. Such a beautiful spirit in such a troubled boy! These children made me feel humble. I knew that for all my knowledge and life experience, I did not possess the courage to survive, as they did, in such dire circumstances and yet retain a part of their true selves – the dreamer.

These children also taught me about dignity. They would come in to be tested because of poor school performance, dressed in dirty clothes full of holes. They walked into my office with their heads held high and called me “ma’am”. They would sit there and cry when they told me how they were beaten at home, and would beam from ear to ear when they came back with half a loaf of bread and a coke they had bought with the money I had given them. They had had their last meal the previous day and their thin bodies confirmed that adequate nutrition was a rare luxury. Even though they were poor, hungry and abused they still possessed a quiet dignity, which was poignant and made me feel humble. Some of their revelations were shocking: One of them, for example, had seen a local dog eating a newborn baby in the veldt. Sometimes they would express their hurt and fear via a song that was so beautiful and haunting it gave me goose bumps. These children were preparing me for the difficult period that would follow my internship. The most important lesson I learnt was that every person has intrinsic value and that dignity was the most enduring quality in the face of disaster. In this context I experienced the essence of humanity when all material trimmings are stripped away. I was moving to a level of spiritual intelligence where intellectual and emotional
characteristics were being transcended in favour of personhood and an understanding
of the power and frailty of the human condition (Zohar & Marshall, 2001).

You need courage and compassion to work in a brutal and violent society
such as ours, where the severity and extent of the trauma you have to deal with
sometimes send you reeling. What do you say to a teenager with permanent brain
damage from a gunshot wound or to a child whose entire family was murdered in
front of him? Where in your mind do you put the explicit pictures of sexually abused
children who were brutalised by adults whom they trusted? The impact of this degree
of devastation leaves you speechless, and you often do not even know where to start
with the healing process. You know that you have to learn to conserve yourself
mentally and physically, because if you allow yourself to become bitter and cynical it
will destroy you. Often you are surprised at how well you deal with these situations.
Then one day when you drive to work, negotiating the road works past the squatter
camps and dodging taxis and goats in the road, you think about the abandoned boy
who drew a picture of thunderclouds and rain falling in a green field. On the other
side of the picture was a barren landscape where he planted a single black seed that
unfolded into a huge sunflower reaching for the rays of the rising sun. In the middle
he drew a house with a skylight facing east, and he whispered in your ear: “This
house is for you” (I will allow you into my world). Then, in the middle of this
bustling day, you are caught quite by surprise when the tears come, and you thank
God for sending a child to teach you about love, trust and hope. Such was the agony
and the beauty of this place.

And then, suddenly, it was over! The internship had ended and it was time to
go.