

**THE TRAINING CRUCIBLE -
EXPERIENCES OF A SYSTEMIC THERAPIST IN THE MAKING**

by

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ABSTRACT

Family Therapy training programmes have recently come to appreciate the importance of addressing the personal growth of the trainee-therapist, in addition to the traditional focus on skill development. Suggestions in the available literature on how this “person-of-the-therapist” issue could best be addressed, represent almost exclusively the ideas of authorities (authors, clinicians and trainers) in the field of systemic therapy. Constructivist thought endorsed by the UNISA training programme, encourages and values different viewpoints. According to this view, students and faculty co-construct the training process.

The aim of this study is therefore to present the voice of the trainee. Several training contexts, the essential qualities of the different supervisory relationships and difficulties encountered, are explored from the trainee’s perspective. It is hoped that this “inside story” about the author’s experiences on her journey toward becoming a psychotherapist, will engender sensitivity for and a deeper understanding of the complexity involved in training the person of the therapist.

TABLE OF CONTENTS

CHAPTER		PAGE
	Acknowledgements	i
	Abstract	ii
1	INTRODUCTION	1
2	THE PROBLEM	3
3	METHOD	6
	Research Design	7
4	RESEARCH DATA	13
	Context A: The Lion's Den	13
	Context B: A Safe Haven	23
	Context C: The Madness Zoo	29
	Context D: The Macabre Circus	35
	Context E: Learning to Fly	46
5	ANALYSIS OF DATA	48
	Essential Features	48
	Comparative Analysis	53
	Table 5.1	54
	Integrative Analysis	55
6	DISCUSSION	58
7	CONCLUSION	61
8	BIBLIOGRAPHY	62

CHAPTER 1

INTRODUCTION

During recent years, training programmes in Family Therapy became increasingly aware of the need to address the person of the therapist in training. There has been a longstanding debate in the field about whether training should focus primarily on skill development or on the personal growth of the emerging professional. The interactive nature of skill development and the personal development of the trainee was soon recognized and the debate over which aspect should take precedence in training became superfluous (Watson, 1993).

The supervisory relationship, traditionally regarded as the vehicle for training the neophyte therapist in therapeutic skill, must now be adapted to include facilitation of the personal growth of the trainee. Despite recognition of the importance of addressing personal concerns of the trainee as it may affect therapeutic effectiveness, training practice and the Family Therapy literature on training in Systemic Therapy sadly lags behind.

The available literature on how the development of the person of the trainee should be addressed presents almost exclusively the point of view of authors and trainers interested in or involved in Family Therapy training and are usually based on the particular theoretical orientation and therapeutic model preferred by the training institute (Aponte & Winter, 1987; Costa, 1991; Getz & Protinsky, 1994; Watson, 1993).

Constructivist thought encourages and values different viewpoints and implies that the student co-constructs the training process. This necessitates that the voice of the Family Therapy trainee be heard. The aim of this study is thus to present the experiences of the trainee in an attempt to expand knowledge, increase awareness and stimulate thought about training in the field of Systemic Therapy.

In Chapter 2 the researcher's experiences during training and the questions raised by these experiences are briefly referred to. The research problem and the questions used as guidelines for this research project are described.

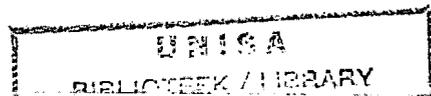
Heuristic Research is described as the preferred approach for this particular study in Chapter 3. An explication of the heuristic process and a list of the data sources used for this study is also offered in this chapter.

Chapter 4 contains the research data. The data is presented in detail and is divided into four sections. This division was determined by the different supervisory contexts the researcher participated in as part of her training. For each context the descriptive "raw" data is presented, followed by reflection on these experiences. A very brief exposition of experiences in Context E is provided, but no reflection is offered as this was a post-training experience.

In Chapter 5 the data of the different training contexts are analyzed, compared, contrasted and distilled in order to identify the essential features of each context.

The implications of the author's training experiences are discussed in the light of existing literature in Chapter 6.

Concluding remarks are presented in the final chapter.



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CHAPTER 2

THE PROBLEM

In 1995, I was selected for the Masters Degree in Clinical and Counselling Psychology, presented at the University of South Africa (UNISA). The UNISA programme is based on Cybernetics and General Systems Theory. As far as psychotherapy is concerned, a Family Therapy approach is therefore favoured. This is evident from the list of prescribed publications which includes the work of Haley (1963), Minuchin (1974), Watzlawick, Weakland & Fisch (1974) and Hoffman (1981).

The didactic part of the programme is aimed at familiarizing students with systemic conceptualization of dysfunctional behaviour. This is done through scheduled seminars and workshops. Theoretical input is complemented by clinical training on a regular basis.

My experience as a student and trainee, prompted a host of serious questions. The reason being that I had a rather torrid time right from the start – especially as far as practical training was concerned. Unfortunate events during therapy sessions, caused tremendous stress and negative feelings toward certain supervisors, fellow trainees, as well as the course in general. Employing the metaphor of a crucible for this experience reflects this, since it signifies a severe test. One which is intended to refine and purify, but which can also cause irreparable damage.

The ensuing years were characterized by fluctuating functioning in all areas of my life. This reached such critical proportions that upon the completion of my training, I was seriously in need of psychological therapy. I had become a casualty myself. This personal experience of impaired functioning, cross-pollution and damage in all spheres of my life, prompted me to launch a self-reflective enquiry into the preceding life events and different training contexts. I thus had a strong personal need to explore the training experience and this problematic phase of my life.

In order to make sense of the ordeal, I asked questions like the following:

- Why did things happen the way they did?
- Why did I struggle so much?
- How did I eventually get to feel so awkward, worthless and vulnerable?
- Was it me that was at fault?
- Did I lack the necessary aptitude or intelligence?
- Why was I not able to ask for help?
- Was the programme beyond reproach?
- Were the faculty members at fault?

In my search for answers to these nagging questions, I scrutinized the relevant literature. I found very little about the trainee's point of view in the available literature, since most publications contained general expositions of current training practices and presented the perspectives of trainers and researchers. An exception was the article by Liddle, Davidson & Barret (1988), which documented the experiences of trainees enrolled in a Family Therapy programme and the typical effects live supervision and other training methods had on trainees. I could identify with their findings, but it nevertheless still failed to address the questions generated by my own training experience. Liddle et al. commented on the fact that Family Therapy (Systemic Therapy) Training Programmes lagged behind, in terms of programme evaluation, in comparison to training and supervision evaluation in counselling and clinical psychology. Exploring my own training experience could therefore possibly be worthwhile and informative in this regard, especially since the constructivist philosophy (subscribed to by UNISA) legitimizes the validity and value of all points of view. It occurred to me that it was imperative that the voice of the trainee be heard. According

to the Systems Approach, collaboration is valued and the student co-determine the educational process in no small way. Hence my decision to make my training experience the focus of this dissertation. Three basic questions guided my efforts, namely

- 1. What was the essence of the experience?
2. What sense could be made of it?
3. What were the implications for training philosophy and practice?

CHAPTER 3

METHOD

In pursuing the stated objectives it was decided to employ a hermeneutic approach and heuristic research methodology. Babbie (1992) writes that *hermeneutics*, originally a theological term referring to the interpretation of Biblical texts, has been secularized to mean the art, science and skill of interpretation. The term ‘hermeneutics’, historically preceded the synonymous term *verstehen* (understanding) coined by Max Weber – in reference to an essential quality of social research. According to him hermeneutics refers to the researcher’s act of interpreting social life “by mentally taking on the circumstances, views and feelings of the participants” (Babbie, 1992, p. 343).

Tyson (1995) states that the “term *heuristic* is from the Greek word *heuriskein*, which means to discover or to find.” (p. xiv). The central idea in the heuristic approach is that all ways of knowing are heuristics, and that no one way of knowing could be said to be inherently superior to any other, in the generation of knowledge (Tyson, 1995).

There has been a longstanding debate about what constitutes the appropriate path to the discovery of ‘truth’ in the human sciences. Hartman (in Tyson, 1995) suggests that the heuristic paradigm offers a route to knowledge that challenges the hegemony of the positivistic epistemology. The heuristic approach to research offers a postpositivist conceptual framework that can be used by behavioural and social researchers and clinicians to generate relevant and meaningful scientific knowledge.

This study has been informed by the heuristic model of Moustakas (1990). Heuristic research, as described by him, entails a process of internal search through which a person discovers the nature and essential meaning of personal, human experience.

"Whatever presents itself in the consciousness of the investigator as perception, sense, intuition, or knowledge represents an invitation for further elucidation" (Moustakas, 1990, p. 10). The primary task of the researcher is to recognize and become aware of whatever exists in consciousness, "to receive and accept it, and then to dwell on its nature and possible meanings." (Moustakas, 1990, p. 11).

Research Design

The Centrality of the Researcher

"The self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge" (Moustakas, 1990, p. 9). The heuristic research process involves an illumination of the self of the researcher.

Frick (1990) comments on the demanding nature of the heuristic research process, since it requires "rigorous definition, careful collection of data, and a thorough and disciplined analysis. It places immense responsibility on the researcher" (p. 79). It demands total honesty, presence, devotion, courage, and a willingness to expose the self.

Heuristic Procedures

Moustakas (1990) explains that heuristic research is characterized by six phases:

1. Initial engagement. The researcher discovers an intense interest or passionate concern, which holds important social and personal meanings and compelling implications. During this process, one elucidates the context from which the question has arisen and encounters one's self, one's autobiography and significant relationships.

2. Immersion. Once the research question and its terms are defined, the researcher comes to be on intimate terms with the question. He 'lives' the question and grows in knowledge and understanding of it. Anything and anybody connected with the question provides material for immersion. Everything in the researcher's life crystallizes around the question.

3. Incubation. The researcher retreats from the intense concentrated focus on the question. During this period of incubation, expansion of knowledge occurs through the workings of the tacit and intuitive dimension, which lies outside immediate awareness. Although the researcher is detached from the question and not attempting to increase understanding of the problem, growth is taking place and new meanings 'incubated'.

4. Illumination. This process occurs naturally when the researcher is receptive to the intuition and tacit knowledge 'incubated' in the previous phase. Illumination entails a breakthrough into conscious awareness of hidden meanings, qualities, themes and new dimensions relevant to the question; as well as corrections of distorted understandings and missed or misunderstood data.

5. Explication. The purpose of this phase is to examine in detail what has been awakened in the researcher and what has transpired in the research process thus far, in order to understand the multiple layers of meaning. The explication process involves focusing, indwelling, self-searching and self-disclosure. The evolved meanings are unique to the experience, since the explication phase draws on the researcher's own thoughts, feelings, beliefs and awareness. Focusing and indwelling are central to explication of an experience: An inward space is deliberately created by the researcher. This space may be used to focus on discovering additional features, textures and nuances of the experience being studied, which may then be elucidated through indwelling. The research process thus incorporates a recursive feedback-loop, thereby rendering the process flexible and dynamic, continually allowing new meanings to

emerge. A comprehensive depiction of the phenomenon is ultimately provided.

6. Creative synthesis. Once the researcher has familiarized himself with and mastered knowledge of the material that illuminates the research question, the challenge is to combine core themes and qualities into a creative synthesis. This usually takes the form of a narrative portrayal, which incorporates verbatim material, relevant literature, and examples.

These steps are based on the notion of 'tacit knowledge' (Polanyi & Grene, 1969). *Tacit knowledge* is knowledge that cannot easily be put into words (Polanyi et al, 1969). Polanyi et al. differentiates between *subsidiary* and *focal* elements of tacit knowledge. *Subsidiary factors* are the obvious elements of perception that attract immediate attention when we examine our experience. They are visible outlines or distinct understandings, that according to Polanyi et al. are essential to knowing, but of secondary importance. *Focal factors* are the subliminal, unseen, unspoken, invisible or implicit aspects of an experience. Subsidiary and focal aspects of an experience, if combined, provide a sense of the essence or wholeness of a phenomenon.

When the tacit dimension is excluded from research, the depth and layers of meaning inherent in human experience are reduced. The tacit precedes intuition and leads the researcher to untapped sources of meaning that will contribute to illumination of the problem. Tacit knowing "gives birth to the hunches and vague, formless insights that characterize heuristic discovery" (Douglas & Moustakas, 1985, p. 49).

Polanyi et al. (1969) asserts that tacit knowledge is indispensable in the discovery of knowledge. He further maintains that: "while tacit knowledge can be possessed by itself, explicit knowledge must rely on being tacitly understood and applied. Hence all knowledge is *either tacit or rooted in tacit knowledge*" (p. 144).

During my research project, I was continuously receptive to my thoughts and feelings. I dwelt inside the seen and unseen aspects of my training experiences, and engaged in an inner dialogue, which allowed different and new nuances and meanings

to emerge.

Validity

The present study falls outside the bounds of conventional research methodology, since the trainee is both the researcher as well as the subject of study. The use of qualitative, subjective methodology to arrive at the essence of the experience, renders the question of the validity of a heuristic finding one of meaning. If the depiction of the experience, derived from the rigorous self-searching process; accurately, vividly and comprehensively presents the meanings, core themes and essences of the experience; the research is regarded as valid (Moustakas, 1990). NB

The basis of validation is of necessity subjective, since the judgement of validity is made by the primary researcher. The synthesis of meanings ascribed to any human experience, is a reflection of the researcher's pursuit of knowledge. Polanyi et al. (1969) has emphasized that what is presented as truth and thus included and what is removed as implausible or regarded irrelevant can ultimately be accredited only on the grounds of personal judgement. Bridgman (in Moustakas, 1990, p. 33) acknowledges subjective validation as essential, rather than perceiving it, as most traditional researchers do, as a shortcoming:

The process that I want to call scientific is a process that involves the continual apprehension of meaning, the constant appraisal of significance, accompanied by a running act of checking to be sure that I am doing what I want to do, and of judging correctness or incorrectness. This checking and judging and accepting that together constitute understanding are done by me and can be done for me by no one else. They are as private as my toothache, and without them science is dead.

Research becomes a task of re-examining (re-searching) what one did to construct the particular research reality. Bateson's assertion that "the point of the probe is always in the heart of the explorer" (1979, p. 100), was further explained by Keeney (1983), who states that clinicians and researchers have a responsibility to examine and

explicitly recognize the epistemological assumptions underlying their work.

The heuristic approach gives credence to the observations and careful analysis of thoughtful practitioners, who bring their experience-based knowledge to bear on the understanding and solution of problems in their particular field of interest or study.

According to Hartman (1995), heuristic research is a form of self-reflective enquiry undertaken by participants, that allows regulation and systematic analysis of the inevitable biases that inform the research process. In order to understand any realm of phenomena, be it a training or family system or research project or whatever, it is vital to explicitly state the assumptions, to see how it was constructed and what distinctions underlie its creation. Andreozzi and Levant (1985, p. 41) comment that when research biases, inherent to all research, ~~“are made explicit, they pose fewer ‘threats’ to the validity of the study’s findings”~~.

Sources of Data

The data used for this study was derived from the following sources :

- Process notes on clinical work conducted with client-families and individuals during my formal university-based training period (2 years) and internship (1 year) at two accredited institutions.
- Journal entries documenting the numerous defeats and triumphs in my struggle for personal and professional growth.
- Written assignments as per programme requirements.
- Personal correspondence with one of my clinical supervisors, which took the form of a dialogue about relevant training issues.
- Reflections on relevant literature.

- My own experiences as a client in therapy.
- Notes containing the fruit of 'associative reading' (Duhl, 1983) done in preparation for this thesis.
- A short autobiography of my early life.

CHAPTER 4

RESEARCH DATA

Context A: The Lion's Den

The masters programme in Clinical Psychology consists of three major components, namely theoretical input, clinical training and research. Clinical training is considered of great importance and students are required to attend therapy clinics on a weekly basis for the full duration of the programme. Clinics are manned by small groups of students under the supervision of experienced staff. The trainers follow a "hands on" approach – it is believed that students learn best by *doing*. Students take turns in attending to clients. The remaining team members, under leadership of their supervisor, observe the proceedings from an adjacent room, through a one-way mirror. Team members may make comments and suggestions regarding the therapeutic process, but the supervisor has the final responsibility for case management. Therapist and team can communicate via an intercom system. Additional individual and/or group sessions are provided on a weekly basis, for purposes of enhancing the learning experience. Reading material and clinic cases are discussed during group supervision. Individual supervision sessions center around case management and planning for future sessions.

My particular supervisor endorsed a directive, strategic approach to therapy. This refers to a way of working in which the therapist controls the sessions, makes hypotheses regarding the nature of the problem, and determines an appropriate strategy or therapeutic intervention to bring about change. The premise underlying this approach is that if a client, under the guidance of the therapist, is able to exhibit the desired behaviour within the therapy room, this behaviour was likely to extend to other contexts. The emphasis during clinic sessions was on the interactional process between the trainee-therapist and client on the one hand, and between the therapist-client-subsystem and the therapeutic team on the other. In laymen's terms this approach could

be described as a no-nonsense, problem-focused approach, that centers on changing behaviour, rather than dealing with feelings.

I personally found the approach confusing and rather upsetting to say the least. Relating the following critical events should illustrate this.

The case of Mrs. A: This lady was in her early twenties and she had a six year old son and a daughter of eight. She and her kids were living with her parents at the time. She had been separated from her husband for 2 years and was advised by her boyfriend to enter therapy, due to her "lack of commitment". He broke off with her the week before the intake session. She presented at the clinic ~~with~~ the complaint of not being able to maintain stable relationships and related that she often left her husband for the first man that came along. She reportedly soon became disillusioned and always returned to her husband. Mrs. A was the middle child and had an older brother and younger sister. She mentioned wryly that she was her father's favourite and that he had sexually touched her, with the onset of pubescence. In the second session, she related that she worked at an escort agency, and that her sister and mother was aware of this. She met the above-mentioned boyfriend, when he required the services of the agency. Mrs. A's mother took her for the interview at the escort agency, as she was unable to financially support Mrs. A and her children.

Subsequent sessions revealed a clear pattern of "triangulation" in all her ~~relationships~~. This means that she was repeatedly participating in dysfunctional relationships involving three people (triads). For example, Mrs. A was drawn into the parental subsystem, through the incest that occurred over a period of time. The client was seen for 8 sessions, and she then withdrew from therapy. Her ex-boyfriend attended the fourth and fifth sessions. Significant events that occurred during the course of therapy included: (1) the revelation of the escort agency 'secret' to Mrs. A's father, (2) the demand by her mother that she and

her kids leave the parental home, and (3) the client's divorce from her husband.

I found several suggestions proposed by the therapeutic team, inconsistent with the process and content of my sessions and often felt confused. The prescriptions given to the client at the conclusion of sessions were not discussed with me. For example, the supervisor suggested at the end of my first session that the client be presented with the choice of either coming to therapy alone, if she entered therapy on her ex-boyfriend's request; or bringing her ex-boyfriend along, if entering therapy was her own idea. My assumptions regarding the rationale of the prescription was documented in my first process note: "Issues of responsibility and commitment has to be addressed, if the patient presents on her own; but a relational description of the problem may be obtained, if the ex-boyfriend comes along." The supervisor wrote in the margin: "No, paradoxical prescription. Conceptual frame?". I did not know at the time what paradoxical intervention meant, nor was I familiar with any other conceptual frame besides the psychodynamic.

I found the clinical training process disruptive, rather than facilitative, as is evident from the following process notes:

"The supervisor's questions (about patterns and why change occurred now) were based on the idea of triangulation (as I only learned afterwards, and a concept I was unfamiliar with at the time), and how revealing the so-called secret affected the relationships of those concerned. I was, however, under the impression that I should discuss the existing pattern of triangulation; so as to predict and normalize the fact that she would want to 'return to her previous relationship with the ex-boyfriend'. With regards to the second question, I was under the impression that I am exploring her present belief system/worldview. ←The discrepancy between the supervisor's thinking and mine was obvious and the effect was devastatingly confusing.

...in general I am very unhappy about the session. I am not as unhappy about the way I handled it (although I pursued several unfruitful paths of enquiry), as I am unhappy about the communication-gap between myself and the team. The misunderstanding of their train of thought and the way it influenced my work, caused total confusion. I did what the team suggested but had to make my own conclusions about the rationale for the interventions. We were therefore not working towards a common goal."

The general therapeutic plan at this stage was to (1) address the triangulation, through creating functional boundaries around dyads; and to (2) induce closeness in Mrs. A's relationships, which would facilitate meaningful interaction. In the sixth session, the therapeutic team requested that the lights be switched off and that the client be asked to relate details about the incest. The reason for switching off the lights was not known to me. I assumed that the supervisor associated darkness with emotional intensity, and that the intervention was aimed at promoting closeness between client and therapist.

I was not comfortable with this intervention, but trusted that the therapeutic team knew best, especially since this was my first client and first insecure attempt at conducting therapy. My concerns were explained as arising from my own need for protection (which seemed a plausible hypothesis), and were subsequently dismissed, instead of dealt with. To this day, I regret the intervention that I perceived as abusive.

On 17 May 1995, I wrote in my process notes:

"Although I could not see Mrs. A's face in the darkness; I could hear her breathing quicken and she coughed ... I gathered that the situation was difficult and painful for her. I switched the light on and was shocked to see how pale she was. The harshness of the intervention concerned me. What is more, the team impatiently kept buzzing me, and I found it difficult to locate the phone in the

pitch-darkness. After the session, I felt angry and humiliated."

I was pleasantly surprised by Mrs. A's arrival the following week, since I feared and expected that she may not return after our previous session, which I experienced as emotionally intense and disrespectful of her pain. A structural intervention was used in this session: In response to the therapeutic team's request, the client and I moved our chairs to opposite ends of the room, to spatially depict the distance between us and this was experienced as meaningful. The team then requested that we switch our therapist-client roles, which I experienced as confusing and unfruitful. The rationale was once again not explained by the team. This role-reversal also caused undue stress for the patient. Closeness was only brought about between me and the client, when the team behind the one-way mirror challenged "us" to convince "them" that we have a good relationship. This intervention proved effective in accomplishing closeness within the therapist-client dyad, since it effected a collaborative atmosphere and supportive relationship between myself and Mrs. A.

In planning for our next session, I wrote the following in my process notes:

"I am fairly happy with the way in which I conducted this session, since I felt like extending it, instead of experiencing the usual urge to escape ... I feel that I am getting closer and reaching her ... the following few sessions are going to be crucial for continuation or termination of therapy ... we are only now beginning to really "connect". This proved to be a difficult phase of relationships for Mrs. A-in-the past ... In the following session (session 9), I would like to move the focus away from problems to the positive aspects of her living. I believe that non-abusiveness and tender loving care, coupled with gentle challenging are now called for ... I want to empower her and provide her with some hope."

There never was a next session.

I have often wondered whether I could have been more useful to this client, if I had done things differently. I knew all along that she needed to hear a different language - one of caring, nurturance, protection, respect, acceptance and trust. Instead I ~~gave her~~ more cruelty and harshness. I should have been less submissive toward my supervisor and the team. Compliance has its limits and too much of it implied cowardice on my part. When I realized that she needed love, it was too late.

The experience with Mrs. A was a critical event, which increased the discontinuity between my beliefs and my supervisor's behaviour. Our opposing assumptions about human beings reinforced my withdrawal from my supervision group. I lost all interest in the literature on systemic therapy. I regarded the approach as pathetic and inhuman. Naturally, indifference to systemic thought would never be tolerated by the powers that be. I focused on becoming intellectually adept in order to protect myself: I could give theoretically intelligent and critical expositions of the similarities, differences and discrepancies inherent in the work of several authorities on the subject of family therapy. This temporarily bought me peace, by distracting others' ~~focus~~ from my personal characteristics to my intellectual capabilities. My heart was not in my work. I was asocial and anti-theoretical, but wore the desired mask of "Keen Systems Theory Adherent".

Despite the mismatch between supervisor and student and the very unfortunate experience I had with my first client, I must acknowledge that my supervisor was highly ~~intelligent~~. I admired her excellent clinical observation skills and impressive conceptual abilities. She sincerely encouraged and genuinely appreciated my efforts at ~~systemic/relational~~ conceptualization. She taught me how to accurately observe and describe processes and patterns of interaction at different levels of system. She always took the trouble of giving written feedback and comments on my process notes. The comments often implicitly referred to the assumptions/epistemology of the therapist and suggested tentatively that the self of the therapist could be utilized in a different, more fruitful manner. Clearly, there was a discrepancy between my descriptive and practical

skills. However, putting theory into practice posed a dilemma for me. I could use the jargon, but I never learnt the moves. My theory-as-espoused (adherence to systemic thought) and my theory-in-use (my own assumptions about people and the way to deal with them) were hardly reconcilable (Argyris, Putnam, & Smith, 1985). The way in which this gap between theory and practice could be bridged, was however never discussed, not even during individual supervision.

The case of Mrs. B: The client, a middle-aged, divorced school principal, presented with the complaint of being preoccupied with her problems. The latter related to two general difficulties, namely (1) accusations regarding the misappropriation of school funds, made by members of her staff, and (2) her teenaged daughter, who repeatedly ran away from home. The girl was often found in informal settlements far away from her mother's house. Mrs. B felt that ~~the~~ daughter's unhappiness could be related to her divorce. She had been unsuccessful in her attempts at getting closer to the child, as had several members of the community. Mrs. B believed that God was the only person who could help her child and she therefore prayed almost day-and-night. At the time of Mrs. B's decision to enter therapy, she was in poor health and grieving the latest disappearance of her daughter. Mrs. B was seen for four sessions.

During the intake session, I allowed the patient to talk. The supervisor felt that I failed to "get" the information, failed to co-create the necessary therapeutic parameters. ✓ The diagnosis was that the patient's incessant talking about the problem with her child, actually constituted and maintained the problem. The therapeutic strategy was thus to curb Mrs. B's verbal activity. I attempted this in the second session, but the supervisor felt that this needed "to be done right at the outset of the process" (Process notes, 7 July 1995).

During the second session, my supervisor painfully indiscreet and very sarcastically criticized my sensitive, passive and empathic stance toward Mrs. B, whilst

I was conducting therapy. Not only did I take exception at being called dull and unimaginative, but I also experienced the criticism as tactless, since it was delivered at a moment of intense sadness for this particular client. Muffled laughter of team members was audible from behind the mirror and the client looked bewildered at me, searching my face for rejection and ridicule and meekly asking what the team's message was. I felt awkward, humiliated and angry at the fact that the team members were making fun of her misery and my genuine empathy. I remember struggling to withhold my tears. Their indiscretion and profanity shocked me. For the first time since the beginning of my training, I showed my utter displeasure with the situation. After the session, I ignored the team (including my supervisor), despite their efforts to engage me in discussion. For the next two weeks I attended supervision without talking or being talked to. I was disappointed, sad and angry about the team's inexcusable behaviour. My supervisor briefly apologized to me (in the absence of my colleagues). I accepted the delayed apology, but remained wary of her and the others, whom I now perceived as persecutory and dangerous.

~~The~~ unfortunate experience, however, confirmed my conviction that the only way for me to travel through life and training uneventfully, was to withdraw, to protect my empathic, sensitive self, thereby perpetuating the pattern my supervisor was so intent on altering!

Driven by my caring and the belief in human potentiality, I silently persevered, refusing to accept that my mistake of being overly empathic with this patient would lead to failure. During the third session, I made use of imagery, which proved to be fruitful. Mrs. B's appearance and health improved drastically within weeks. She reported significant improvement in her psychological well-being and felt that termination was appropriate after four sessions. In my process notes of 2 August 1995 I wrote:

✓ *"This therapeutic relationship allowed me to make my own mistakes, which was quite a learning experience. I came to be more creative and flexible and closer*

to being true to myself."

After the sad event described above, I silently questioned my supervisor's expertise, doubted her intentions, ignored her opinions, and shamelessly disposed of her advice, as I recoiled from hurting those who came to our clinic in good faith and in need of help. I, however, remained civil, since she still possessed the power of evaluation.

✓ ~~My~~-supervisor unfortunately never did realize that I only moved when inspired to do so and not when pushed, pulled, forced, coached, taught or punished. She tried to "get" me to do the right thing. She tried threatening me into a new way of being with her so-called "jump-or-be-pushed" approach, but to no avail. What I needed instead was for her to understand my mixed feelings and my reluctance to accept her approach ~~to~~-therapy. I needed her to be available for me, precisely because I was struggling. I needed her to be present, which is more than just being there. Ironically though, my struggle was intensified by the obvious discrepancy between what she was preaching ~~did~~actically (the constructivist idea of all world views being equally valid) and practicing clinically (do your own thing, but always do as the supervisor says).

Reflections

I entered the Family Therapy training programme presented by UNISA, armed with a psycho-dynamic background. I was entirely unfamiliar with systemic thought and theory, endorsed by UNISA and my vulnerability soon settled into an inherent ~~sense~~ of not knowing what everybody else seemed to know.

I soon realized in training that I am like a butterfly - my lacewings vulnerable to be ripped to shreds by some angry or powerful person, cunning enough to get beyond the barricade of reticence that guards my vulnerable core. You see, I am easily wounded by criticism. My core encapsulates a feverish fear of being found barren as a therapist

and a person - not good enough - a failure. Criticism has always been and still is indigestible to my system - it is like a burning fire, consuming my dignity, which (if acceptance by the other is important enough) may lead to a despicable parade of my virtues or withdrawal.

I was not assimilated into my clinical training group (which consisted of two senior students, a male and female, and a junior female peer), probably due to my tendency to isolate myself, which is reportedly interpreted as haughtiness by others. My hardship and struggle during the training process was exhausting, but very quiet, characterized by what may have been perceived as stubborn inactivity, due to my natural stance of reluctance to engage with others, in this case lecturers and fellow-students. I was pushed and pulled by my supervisor, in her attempts to bring about a "shift", to challenge me into risking new behaviour, but with very little success. I often wished that she would just tell me what to do or how to be or where to shift to.

I started feeling excluded and "different" in the bad sense of the word. I complied half-heartedly with the expectation of interacting, by stating the obvious during discussions, thereby hiding behind my mask of inauthenticity. I frequently felt like an imposter when I shared an idea which seemed to me worthwhile sharing. This was met with surprise by others, which sometimes made me feel "out of place", like someone talking aloud in church; and at other times made me feel proud of my unconventional, "superior", creative thoughts and my ability to shock others.

On one occasion, I was reduced to tears of anger, shame, exasperation and helplessness, when I was told during group supervision : "If you don't jump in, I will push you in". The tears, as all other negative or uncomfortable emotions were, however, delayed. I realized that the supervisor must have thought of me as a "tough one", because I took great pains not to allow her near my emotional self. I had no idea at the time what this threat was about, but knew that I was bad, sinful, wrong, stupid, a failure.

The increased forcefulness of my supervisor's attempts to extract my creative potential, led me to perceive her as dangerous and malignant. She came to be associated in my mind with other authority figures, who misused their power to mould others' thoughts and behaviours into exact replicas of their own. This association, coupled with my sense of allowing others to engulf me, intensified my tendency to withdraw. I felt traumatized and desperately resisted change, since my marginalized position, which had served me well in the past, was now seen as a defect or injury. I needed her to respect the degree of courage that was required from me to let go of the familiar patterns that has worked for me, in order to risk the uncertainties of change.

Context B: A Safe Haven

I vividly remember the first morning when the three of us (two senior students and one junior student, all female) filed into our new supervisor's office, like Grade 1 children on their first day of school: We were slightly anxious, despite our foregoing big-mouthed pact to not let him drown us in more work. His "advanced" age, stern eyebrow-frown, the fact that he belonged to the opposite (superior) sex and the pleasurable, pensive manner in which he puffed his cigar, like a man of great wisdom, immediately put us at an unspoken disadvantage. We were so overcome with astonishment at being asked what we wanted to do with our supervision space (instead of instructed), that we were rendered unintelligible, and subsequently allowed to reflect upon this in our own time, at our own pace. I suspected that he had some devious plan of getting us to bring our weaknesses to supervision, so that he could use it to bludgeon us into submission. I stood in mortal fear of this supervisor, based on the distant memory of a clever phenomenological assertion that "the past comes to meet you from the future" (or something similar), and the more basic learning principle of only bumping your head once, which has been around for donkey's years.

Despite my intense fear, I noticed that his office seemed to hold a story about real life between the four walls and the ambience was inviting and alive, unlike all the other rooms I have entered, which seemed to be clinical and had a Lilliputian effect on me, like the dwarfs of Lilliput in *Gulliver's Travels* by Swift (1940). My fear and cynicism was gradually replaced by serenity and hope in the ensuing few months. I soon came to respect and admire him as the most significant mentor in my professional career. I made the following brief entry in my journal : "Prof. Gert seems to understand ~~that I cry without weeping, plead without speaking and shout without raising my voice~~" (10 June 1996).

I was lucky to encounter this professor with the self-acclaimed "Atlas-syndrome", who acted like a kind uncle, saving me from my destructive disbelief in my own capacity to be useful to others. Every institute has a few kind, caring and ~~competent~~ people and a few who are less so. Luckily, he was one of those kind ones who made a conscious decision to deal with unsympathetic, unscrupulous colleagues, rather than to flee and leave trainees to fend for themselves.

~~He~~ seemed to believe that talent is to be found in everyone – dormant talent, waiting to be expressed, waiting to find its voice, potential that will become manifest if only it is nurtured a little. He validated my writing talent and my natural tendency to accurately observe and reflect upon my observations. These intellectual skills of observation and reflection were previously seen as weaknesses, that had to be corrected, fixed and eliminated within the supervisory context. Accepting and building upon my ~~leitmotiv~~ or now so-called "natural strengths", initially developed in my interaction with family members, provided me with a safe atmosphere. The latter allowed me to experiment with setting goals and acting on them, thereby expanding my therapeutic ~~repertoire~~. He made me realize that my achilles heel also potentially constituted my greatest strength.

Why was I able to allow this person so close to my inner self? Let us inspect more closely the qualities and characteristics of this supervisory context, that seemed to have been more conducive to my growth as a person and as a professional psychologist, than the contexts I had previously moved through:

The supervisor's stance was that of respectful curiosity toward the uniqueness of each of his students. The ingenuity with which he structured supervisory contexts, allowed varied experiences; and the liveliness of the metaphors he employed, facilitated looking at myself in a non-threatening and even enjoyable manner. All personal issues were openly discussed, with the greatest care taken by him to ensure that this was done in a manner which preserved the dignity and privacy of the student. In languaging about trainees' difficulties experienced in the clinical setting, the experience gained over many years of being involved in the field of psychology, and idiosyncratic ideas and theories were shared by the supervisor. He was able to be simply human with us and his willingness to make himself vulnerable, by sharing some of his most painful experiences of loss, engendered respect, hope and courage in me. This created a context of trust and mutual respect and made it safe enough for me to reveal myself, protected by the knowledge that my vulnerability will not be used against me.

I clearly recall the day on which the supervisory group explored the inner experience of each of our lived realities, by evoking pictures in the mind's eye. The professor used to say that a picture says more than a thousand words. I would like to add that a picture conveys that which cannot be captured in words, and grasps the essence of that which is inaccessible to the conscious mind. The professor's collaborative spirit, as evidenced by his active participation in all the activities, fueled our enthusiasm. The following, simple exercise proved to be one of my most valuable training experiences:

X ✓ We were asked to "see" ourselves at that particular stage in training (August 1996) and I depicted a little house, hidden in the thick brush and overgrowth of

climbers, tucked away in a dense forest. There were notions of decay, neglect and isolation. I felt criticized and worthless as a therapist. I was discouraged and wanted to hide myself to avoid further scrutiny, criticism, pain and sadness. I tried to keep a low profile, but felt rejected and excluded.

—The professor then asked us to portray the ideal picture and my fictional self was represented by a neat house, decorated with flowers. It was simply a rearrangement of the elements of the first picture. It had stepping stones, so that it could be reached by others, thus allowing and even inviting others to come closer to me. There was a sense of exposing myself, though in a hesitant, cautious manner (only a clearing in the forest).
 —When asked what needed to happen in order to allow me to move from the real to the ideal picture in training, I imagined the presence of a respectful visitor to my house, who would approach with caution and believe in my potential. My supervisor became this mysterious visitor, a witness to my existence and potential. At the conclusion of my training, I received a laminated copy of these two pictures from him - a thoughtful, —special gift that captures hope and dedication to continuous growth.

On occasion, I was quite taken aback when this supervisor pointed out my ✓ —tendency to "corner" him. I felt he needed to be called to task, in order to protect the interests of my fellow-supervisees. I realized that he created a supervisory context wherein I felt safe and secure enough to oppose him. This safety allowed for the dynamics implicit in my relationship with my father (in my family-of-origin) to be made explicit. I could tell the supervisor how I felt, without feeling rejected by him or —fearing that I would create displeasure in him. I knew that he would not evaluate me negatively, or penalize me for thinking differently or being different to him. I was even able to laugh about this dynamic he reflected upon! This was my first step toward individuation and I felt somewhat scared; yet very proud at the same time.

This person has lived through sorrow, joy, indignity and contentedness and he —understood that a person needs to be nurtured in order to grow. I believe that he has

—devoted his life to ‘growing’ people – investing time, love and energy; empowering them by believing in their potential and respectfully encouraging them to become what they choose for themselves.

Reflections

The mentor-student relationship was characterized by mutual respect, empathy, curiosity, "warts and all" acceptance, flexibility, creativity, forgiveness, expressiveness, —latitude to simply be oneself, encouragement to try on new hats as a therapist, deep —understanding and humour. The clever reframing of my weaknesses as strengths, coupled with the Rogerian principles which have stood the test of time, did the trick for —me! My observation and reflection skills, valued by this mentor, later proved to be most useful in formulating clinical impressions of patients encountered during my internship. His trust in my ability to simply "be" with patients, allowed me to risk "becoming" therapeutic and more active, without being pushed, pulled or cajoled into anything. His vote of confidence and belief in human potentialities, provided the impetus for beginning the discovery of my talents and the crystallization of potential. This discovery of an acceptable "me" marked an epoch in my personal history and professional career. It was however not an event, but a gradual process, which is still continuing to unfold.

✓ —Believing in myself, is the greatest gift I received from him, but lost and found again along the way. I will always treasure it, since it has become intrinsically part of me, no matter where I go or who I meet. This was the secret passage to escape, that seemed so elusive in the erstwhile schizophrenic supervisory context - if you find yourself in a checkmate position, simply change the rules of the game, believe in yourself and follow your instinct. It should be noted that I faltered repeatedly, since I —still—had the same need for acceptance: I often got stuck, while moving through the passage to becoming a real therapist, to look back to see if he was still present, to —encourage me. He was always there, right where he said he would be and I eventually

only needed to glance back occasionally.

He implicitly legitimized my belief in the fantasy world of my childhood, through his accepting attitude. He walked with me, as I entered that other real world, which I never quite belonged to.

I suspect that this relationship was also meaningful due to a completely different reason to those stated above: I believe that this supervisor identified with my emotional torment, interactional struggles and sense of being different and marginalized, since it seemed to me that he was also an outsider in relation to colleagues, due to his creative and unconventional ideas. It seemed, at times, as if others perceived him as a trouble-maker, which is analogous to the process which occurred in my family-of-origin where I refused to accept the status quo, and was subsequently dubbed a "stirrer" and often saw others smile and say "that child is crazy". The process of developing a sense of connectedness to this supervisor occurred surreptitiously. I, however deem it necessary to share this with the reader, since my sense of connectedness and even belonging in this mentoring-relationship, acted as a significant motivational force in producing this work.

I would like to share with the reader at random, some of the seeds of wisdom sown by this supervisor during my training, which enabled me to reap positive results in therapy :

- Assume that you cannot understand.
Assume that you never will understand.
- ✓ • Therapy is all about attitude, since that is the only thing you have absolute control over!
- Heal sometimes
Relieve often
Comfort always.

- Plan as much as you like, the interactional forces will determine what you do and where you go.
- ✓ • Therapy is like religion, it is all about belief.
- Purity of heart is to will one thing (from the Danish philosopher Kierkegaard).
Similarly, a therapist should have a basic/general idea for each session.
- There is NO set of principles that can save the day, if there is a poor "fit" between the value-systems of the therapist and client. No matter how pristine your approach or how good your intention, you will sometimes be "killed".
- Clients who make therapy their career (I call it shrink-shopping), will trump you.
- ✓ • Act yourself into a new way of thinking (following Constantin Stanislavski).
- There is no such thing as incremental learning or a growth-curve in the training of psychotherapists.

The mentorship was not so much about the supervisor communicating what he ~~—~~knows, but rather imparting what he is. I thus paid attention to his knowledge and ideas, ~~—~~but only after I knew how much he cared.

Context C: The Madness Zoo

I was accepted to complete my one year clinical internship in 1997 in the Department of Psychiatry, University of Witwatersrand, training circuit. I was subsequently employed by the Health Department of the Gauteng Provincial Government and my internship included placement at the Johannesburg General Hospital and the Tara H. Moross Centre.

I completed my first six-month rotation at the Tara Children's Clinic. My work included among other things, child psychological assessments; report-writing; networking, consultation and liaison with other systems, such as the school-, social work-, and medical systems; case management; presentations on current research and journal articles; participation in ward rounds as a member of the professional, multi-

disciplinary team; play therapy; individual therapy and parental counselling. These psychological services were also provided to the Alexandra township community, as part of the Health Department's Community Services section.

The children's clinic did not have a psychologist as a permanent member of staff, and the intern psychologists therefore worked under a psychiatrist. This was an unfortunate situation, since psychology was, probably inadvertently, subsumed under the practice of child psychiatry. The psychiatrist's medical expertise was unparalleled, ~~but she~~ seemed to demand that psychology be practised as a science. This meant that the children's needs were often regarded as secondary to the clinic's research statistics: she insisted that all children be subjected to a full psychological assessment procedure, of three hour duration, irrespective of the reason for referral. I, along with all members of permanent staff, as well as intern psychometrist and ~~psychologist~~ colleagues, found this rigidity unacceptable and I objected to it on numerous occasions, only to find myself entangled in bureaucratic red tape, with the frustrating realization of being back to square one, facing a little 6 year old, traumatized and broken child and (from my test booklet) asking in my most neutral tone of voice : "What does 'conviviality' mean ?", "No, no, don't cry. I want you to look carefully at this picture ... now see if you can ... no, we will talk about that horrible thing when we have finished all twelve subtests ... see? ...now look here ... ".

I was not allowed to give my little customers what they wanted and what I thought they needed. Psychologists, in this context, did not provide services to patients, ~~but~~ mechanically produced statistical data for the clinic's records. I strongly disliked the almost exclusive focus on psychometric evaluation, diagnosis and medication, since it left insufficient time and space for treatment of the assessed and diagnosed problems. Is it not clear that a child who presents with acute anxiety, shock and distress, after a recent traumatic experience, needs immediate trauma intervention and debriefing? Could a thorough assessment, in exceptional cases, not be postponed for a week, thereby risking re-scheduling of an appointment and shuffling of the psychiatrist's pre-

planned cognitive chart and taking the child's concerns to heart? My duties were the direct opposite of what I envisioned it to be, namely providing children with a safe space, in which to explore their feelings, guiding parents in how to meet their child's emotional and disciplinary needs and actively assisting those children with learning disabilities and developmental delays, through appropriate referral.

I must admit that I was disappointed and somewhat disillusioned by the whole idea of therapy and psychology. The clinic employed several psychology supervisors, who rendered services on a part-time or sessional basis. Their physical absence from the clinic most of the time and the limited contact with them, precluded the possibility of approaching them with personal concerns that impacted on my therapies. The majority of the supervisors were proponents of psychodynamic theory, and they differed in degree of capability to create safe contexts for their students.

Reflections

I learned how to integrate psychodynamic and systemic thought, through fruitful discussions with my play therapy supervisor. She provided me with valuable reading material, relevant to my cases, and with thought-provoking interactional feedback (she, however, talked about defense mechanisms, transference and counter-transference). She was sensitive, caring, understanding, reliable, natural, unpretentious, accepting, exacting and wise. She had great respect for people and a deep understanding of human pain. She allowed me to work with both psychodynamic and systemic orientations at the same time - we agreed that these theories were merely different means of languaging about a created reality. Our supervisory relationship came close to being collaborative, and I found it sufficient in terms of case management and establishing therapeutic goals. It was also effective as a vehicle for improving my therapeutic performance, since I was able to integrate the results of our discussions into my practical work.

From my assessment supervisor, I learned how to competently utilize emotional, intellectual and developmental assessment tools. She also honed my professional report writing skills and appreciated my clinical observation skills, adeptness at clearly and cohesively describing the child and the family dynamics, as well as my sincere efforts at connecting with my child-patients. This supervisory relationship was very structured and task-oriented, thereby excluding the personal growth factors of the trainee, but definitely furthered my understanding of the emotional worlds of children and my ability to communicate with, assist, appropriately refer to and/or consult other health professionals, such as speech therapists, audiologists, optometrists, occupational therapists, remedial therapists, general practitioners, psychiatrists, neurologists and support groups. This relationship thus helped prepare me for all the professional responsibilities, besides obviously providing therapy to clients, psychologists are faced with when practicing independently. I found the supervisor's guidance very useful and in retrospect, even indispensable, since these practical issues were de-emphasized during my training at UNISA. Assessment of the difficulty experienced by the patient, allows for accurate diagnosis (systemic or otherwise) and allows the clinician to make informed decisions about his capability of competently managing the case and/or about the appropriateness of referring to another professional for treatment. These functions are essential to successful practice by the psychologist who is just starting out on a new career path and ensures accountability and professionalism.

My experiences at the children's clinic culminated in an increased ability to balance, accept and embrace the polar opposites that constitute life, such as love and hate, cruelty and kindness, justice and injustice, young and old, reality and fantasy, black and white, life and death. These and other polarities were evident in my play therapies with numerous children - all of whom seemed to struggle to find a balance between the contrasting parts of themselves, like the good self and the bad self; the strong man and the vulnerable boy; the cute, little lady and the furious wild child. These children were labeled as mad or bad (so-called little conduct disorders and

hyperactives) by people like us (the professional mental health workers), who have not lived their lives, who have not moved through their contexts. As I considered the presenting "problems" within context, systemic thought with its emphasis on contextual meaning and process, proved to be a very useful framework for conceptualizing cases. These children's unacceptable behaviour almost invariably constituted an adaptive function under precarious circumstances, within unfortunate surroundings, perilous to the emotional well-being of a defenseless child. I often wondered about the concepts of "mental illness" and "psychiatric disorder":

A 6 year old boy, who was diagnosed as "a conduct disorder" for pulling an earthworm apart, entered play therapy with me. He once took a pair of plastic eyes, with long eyelashes, and held it in front of his eyes. He said (to me) in a high-pitched, stern voice: "I will smack you !", and lifted his hand in a threatening gesture, "I will tell your father". He applied make-up and "accidentally" dropped objects, that the therapist was ordered to pick up. He often prepared food for baby-dolls, and demanded that the therapist not tell anybody that he removed the doll's pants. The therapist was also asked to close her eyes when he kissed a doll. One week, he furiously bombarded the therapist with dolls and threw objects at her, and she set firm limits. The following week he drew a "fairy god lady, whose name is the same as yours". He wrote "Marinda Foushe" next to his drawing of a female figure, surrounded by yellow light, and added that she talks to him about things that hurt him and that she never-leaves him. He tested the limits, to see whether he would be rejected. Most people, including the school teacher and -principal, felt that he was plain naughty, even hinting that he might be a hopeless case! His life certainly must have seemed hopeless to him - abandoned by his mother; sent away to stay with his maternal grandparents who had a brothel, where he was sexually abused and witnessed violence; again abandoned by the grandparents who felt that he was in the way; and sent at the age of 5 years to his father, whom he had not seen in 4 years and where he was subjected to and bossed around by a very

✓ *intolerant, critical and demanding stepmother. Was he guilty of misconduct or did he learn to protect himself from aggression by becoming aggressive? Was he not being torn apart, like the earthworm?*

There were many others: victims of divorce, rape, sodomy, cruelty, neglect, criticism, abuse; witnesses to domestic violence, murder and suicide – they were never afforded the luxury of my childhood, the dear belief that fairies live in purple iris-flowers, that gnomes paint the leaves in Autumn and the rainbow across the skies.

These children are brought to the clinic, since the parents cannot understand why they act strangely, why they cry and have temper tantrums, how come their school performance, eating and sleeping patterns are poor, why they become a bit crazy, naughty, spiteful, enuretic, encopretic, depressed, withdrawn, aggressive, over-responsible or infantile and sometimes simply wild.

✓ ~~I~~ was repeatedly struck by the adaptive quality of these children's behaviour under the particular circumstances and still am inclined to believe that there is no such thing as a problem child. The question thus remains : "Who is who in the madness zoo?".

Tanya

The positive experiences within my play therapy supervision, were however somewhat tainted by the required quarterly progress reports: Despite receiving mostly positive ratings, the evaluative sword of Damocles that hung above my head, seemed to threaten to slit open my wholeness, to expose my fragile identity as beginning therapist, to render me fragmented and feeling incomplete ... afraid that I will be weighed and found too light ... afraid that "they" will expose of me like a fruit that is halved and still green.

I could not live with an ever-increasingly imperfect self. I expected improvement, coming closer to being the best; to being perfect.

As the end of my rotation was rapidly drawing to a close, I was panic-stricken ~~by~~ words, such as "needs more exposure", "can improve". I needed reassurance that ~~even~~ though I was imperfect, I was simply "okay" as a person and a therapist. I would ~~also~~ have preferred and appreciated more personal feedback (discussion about the person/self of the therapist in the therapeutic system), which I felt could have facilitated my personal- and professional growth.

Upon asking colleagues toward the end of my rotation to choose a metaphor for me, as part of my ongoing need to be aware of how I am evaluated by others, the following emerged: I was seen as a deer - gentle, sensitive and harmless - by a psychiatric sister who had only occasional contact with me. Another intern psychologist chose the metaphor of a cuckoo-clock: ornate, precise, likeable, perhaps not working in some ways (my vulnerability, weakness), and with an element of surprise that only shows itself at the exact right time. I immediately connected with this metaphor, since I was acutely aware of being able to "just be" in her presence. I also felt safe enough to be creative and spontaneous, without being concerned about the consequences.

It should be clear from the above that I was still struggling in my attempts to ~~show~~ myself to others, despite the knowledge that what was hidden, could potentially ~~be~~ useful in my work with patients. I believed that I had something valuable to ~~contribute~~, but a safe context once again seemed to be prerequisite for being authentic, congruent and willing to share. The children's vulnerability and forced dependence on adults, sensitized me to consider the emotional safety aspects of the therapeutic relationship and respect for human dignity even more carefully.

Context D: The Macabre Circus

In June 1997, it was time to move on to my new placement at the Johannesburg General Hospital. I was stationed in the adult psychiatric ward, where patients with

acute psychiatric disorders were admitted. My duties included the provision of brief psychotherapy to inpatients for the duration of their hospitalization and occasional continuation of therapy on an outpatient basis. Most of my patients were referred from the Psychiatric Outpatient Department and -clinic, but I also received referrals from all the other hospital departments. I was often consulted by various medical professionals to provide a psychological opinion on ward patients, in order to assist the attendant physician in deciding on the preferred method of treatment for the patient.

I was supervised by a remarkable, eccentric Jewish lady, who has had many years' experience in the field of psychology, especially as practiced within the hospital setting. On my first day at the hospital, a psychiatrist requested counselling for a young street-child who tried to commit suicide, after realizing that she was pregnant - I was a bit shocked when my supervisor sent me off, with an eyewink, a caring smile and the words: "Just talk to her about her sadness, discuss realistic alternatives and give her hope ... find something in her life that she can hold onto. You will be fine, you can do it." This patient showed up in my office four months after this consultation, proudly announcing that she decided not to kill herself or the baby, but to give the child up for adoption by a loving couple. She was living in a shelter for single mothers, which I arranged through the social worker, and she came to say familiar words that took on a new meaning that day - she simply said : "Thank you".

To the embarrassment of my colleague and I, our supervisor once seemed to have fallen asleep during a joint supervision session - we assumed that our case presentations must have been boring, but when this recurred several times, we realized that she was pensively present, but deliberately chose not to interfere with our preferred ways of working. She was flexible and gave us free reign to use any and all reasonable treatment modalities, trusting that we would be ethically and professionally responsible ---which incidentally prompted us to be very accountable and reliable. She provided structure, when needed and was willing to support and guide me, at times of insecurity, confusion, doubt and cynicism.

The latter cynicism escalated as time went by. I saw mostly so-called "antisocials, depressives, suicidals, phobics and psychotics". I felt that I had to make the antisocials want to follow rules; make the depressed gather energy; make the suicidal want to live; make the psychotic aware of reality and make the phobic overcome their fear to participate in life. I still wanted to change the world. I was soon swallowed by the vortex of vicious sadness, anger and pain. I was spat out a few months later - a spiritless pusher-and-puller, who failed in the futile attempt to change others. My dark mood grew increasingly black, as I was faced with others' severe sorrow, as I witnessed people suffer mental torture, others being tormented by voices without faces, some suffering excruciating pain caused by harrowing memories.

Single-session counselling for patients, with failed suicide-attempts, was a common occurrence, but difficult part of my work - I visited them in the wards, where they were stabilized and sent home, often on the very same day. The absence of closure plagued me.

I dreaded the visits to the Oncology wards, where the smell of death always seemed to hang in the air and I will never forget the "call-outs" to the Pediatric Intensive Care Unit. The emaciated, grey cancer patients; the yellow, dehydrated babies and the purple-black premature babies with sunken tummies reduced life to an illusion between a sleep and a sleep.

I wanted to stay, to help them hold onto life; but always found myself running after leaving these wards - with the knowledge that I am trying to escape the inescapable. I could not say that I understood, I did not even want to know. I was often jolted from my fitful sleep in the middle of the night, wanting to rush back to them and ~~also~~ not wanting to, but I always went back the following morning... and sometimes, some of them were not there anymore.

These overwhelming experiences resulted in a sense of helplessness and prompted me to engage in agonizing self-examination. On 28 August 1997, reflecting on my seemingly futile attempts to make things better for others and on my difficulty to start writing my thesis, I wrote about my avoidance and disillusion :

"What if I map my 'growth' as a trainee-therapist and I find only decay and stagnancy? What am I trying to escape? The answer must be myself and especially myself as a therapist. Initially I was inauthentic as a therapist, by the way, I do not deserve to be called that - I am just a person; a sponge to absorb others' misery and splurt weak-digested words back to those, who hoped that I could cure them. Disillusion - the ultimate shared experience of a so-called therapist and equally pathetic patient.

Somehow I envy my patients. Psychosis seems to be an inviting proposition ... But I cannot even comprehend the accompanying pain. I am too much of a coward to enter the world of psychosis - I am afraid that I would not be content to live in the maze of never-ending life-questions, with answers elusive and mocking in every cul-de-sac.

Then again, after having seen so much sorrow, I have no answers and so are trapped in a maze, but it is not psychosis, it is called psychology. At first I was inauthentic. Now that I am aspiring to be authentic, I have no idea what being a therapist means. All I have left is my body and my searching soul. Just me. Still trying desperately to connect and hide at the same time, from myself and others.

This is why I want to write my thesis, but cannot. Facing myself and writing my thesis would mean finding my real- and pretend self in an open, honest and truthful meeting. Remaining authentic would mean loving and accepting all of me. This includes seeing myself as a miserable, unhappy, angry, fallible,

imperfect and ungrateful being at the core, as that self which is everything that significant others do not want me to be, that self that is supposed to be, but is not just a kind, wonderful, perfect achiever."

This self-examination, coupled with witnessing others' pain; and the guilt of having had such a wonderful childhood filled with caring, loving and nurturing parents, when others have lived lives that was unknown and incomprehensible to me culminated in very real fantasies about falling into a twilight sleep. How could I believe in me, when I knew nothing? I desperately wanted to escape from "their" world that now appeared to be a thousand times more cruel and unforgiving than I had always suspected as a young child. This was a time when I longed to soothe human pain and to opiate all suffering.

✓ I had a meeting with my UNISA supervisor, to discuss my helplessness-dilemma, but found him quite unsympathetic. He said what had remained unsaid in my mind for a long time, namely that psychology was not for me. The harsh reality of this jerked me out of my comforting fantasy-world. I was devastated. The implications were too painful to consider - it meant acknowledging that I wasted seven years of my life to become ... nothing.

✗ I made the following journal entry on 3 September 1997:

"Those words really hurt me. My face is aflame of embarrassment, anger and shame. I feel like crying. My hands burn with pain ... again. I wonder if I will ever, ever be good enough. I hate disappointing others and myself. I know that I am far too dependent on other's approval and encouragement. I suppose psychology was a quest to escape from having to be just me (a weak, non-integrated, little girl), in the hope of establishing a new (acceptable, achieving, knowledgeable, adult, respectable) therapeutic self. This obviously did not work - for in the end all I really have in therapy is 'me'. I have to search for what I am missing in that which I have. I know that I can be a successful therapist. It is

✓ ~~all~~ about faith. I have to start believing in myself today and if I fail, I need to start again - and again."

A few days later, my colleague and I attended an exhibition of The Traditional Health Organization, which was held at the WITS Medical School. I came across a beautiful, elegant sangoma, who sowed some intriguing thoughts that seemed to be relevant to the personal struggles (as described above) experienced by me at the time:

She held that traditional and modern medicine are derived from the same natural sources and that they contain the same herbs. She however claimed that the methods employed to produce the medicine, are what really make a difference. Natural methods ensure that the healing power of traditional medicine is retained, whereas western, laboratory methods remove the essential goodness.

✓ ~~For~~ me, this meant integrating my natural, simple self with my trained therapist ~~persona~~. The real knot for me, lay in summoning up the courage to make myself visible to others - to encounter others as a person, first and foremost: I had to find a way in which to regain or access my natural potency, that I knew could never be completely destroyed by anyone.

I subsequently took responsibility for my own learning at the hospital. I was ✓ ~~motivated~~ to work on myself as a therapist and person. I threw the "safety first" principle overboard, since the chief danger in my life is and has always been that I take ~~too many~~ precautions. It took courage to make myself visible to others and myself, although I have always had a strong need to encounter others as just me. I have known ✓ ~~for a long time~~ that one cannot as a therapist wrap your patients, nor yourself, in cotton wool and if you do, it means stagnancy and even silent death. Sometimes a wound needs to be scraped raw before it can heal. If frankness and provocation does not kill my patients or myself - it will at the very least move us.

I found myself telling people that they have a poppy-seed stuck between their front-teeth, that they missed a button on their shirts, that their mannerisms are irritating, that their assumptions are questionable, that their behaviour is self-defeating. My work entailed telling people things they needed to hear, but would never be told by others. I was paid to speak the truth as I perceived it; to say things no one else had the courage to say (just as I had done in my family-of-origin). I remembered how to be presumptuous.

✓ ~~And~~ that is precisely why therapy is not easy - it is about facing your imperfections, but in the presence of a therapist that is a caring, loving, accepting person.

~~I~~ became more congruent and authentic in my therapies. I learnt how to risk within this safe supervisory context, how to doubt my fear of not being liked by others and the result was amazing: Sometimes patients really seemed to despise me, temporarily, but I started liking myself, knowing that even if I am not good enough yet, I am okay!

I still longed for affirmation and encouragement from significant, caring others (a safety-net in case of failure), but at least I was walking the tightrope now, not just looking at and wishing to walk it! I gained a sense of mastery through journalling about all these changes, including my perplexing difficulties and the subsequent illumination.

On 8 October 1997, the following entry was documented in my personal diary:

✗ ~~"My weakness and strength is the same thing! I really should be a psychotherapist. I am a good one, if I allow my 'self' to be!"~~

✓ ~~I~~ learnt how to balance the old and the new, my imperfection and competence, the spontaneous and the learnt, aesthetics and pragmatics. My most fruitful and memorable therapies were those in which I dressed and undressed (my skills and

persona); but were also willing to be naked (authentic/real, human, emotional, less than perfect). I felt less stuck in therapy and became more free, creative, spontaneous and artistic in my therapeutic style.

My colleague noticed the difference in my therapeutic style during family therapy sessions. My co-therapist was able to exchange his usual active, powerful stance for a more relaxed, laid-back position, as I became more creative and confident. I was not so aware of and overly concerned about being scrutinized by others and of making mistakes.

My Jewish supervisor encouraged me to be all of who I am (both vulnerable and strong). Her inspiration, belief and trust in my abilities gave me the security to move out of my comfort zone, knowing that there is room for failure and acknowledging that it takes courage to be imperfect. 

I came to feel that it was acceptable to be vulnerable, thereby accepting the insecure child-parts of me as part of my adult persona, and by extension, of my therapeutic persona. I was doing, instead of talking - my therapies became experiential, rather than intellectual endeavours. I trusted my gut-feeling, forgot about rigid boundaries and unreasonably strict ethical considerations. I became increasingly congruent, visible and real in therapies, which improved my ability to track patients, to establish rapport and to create a trusting, nurturing, facilitative therapeutic context, conducive to mutual growth. I was human. This was real. I gave a patient a little flower for her birthday, which she appreciated very much. Another was overwhelmed by the simple gesture of touching his hand, a gesture that was not as insignificant as it may seem. Symbolically these small actions were gigantically meaningful.

The numerous therapeutic experiences of mystery mixed with fear that ensued, engendered religion, a belief in therapy and in myself. I became aware of the existence of "something" in therapy, which I could not capture or penetrate - a mysterious

experience that stood at the cradle of true art and true science. The gap between the real and ideal were bridged. I felt content.

~~I~~ started enjoying my work and found it extremely fulfilling.

○ ~~I~~ was so deeply affected by all the people that needed someone to authenticate their existence, that I was irrevocably touched, changed. My veil of denial that I was changed wore thin. It became impossible to remain peripheral to my "self". My supervisor in turn authenticated the existence of both my inner and outer selves - she ~~saw~~ what was imperceptible to most - the vulnerability of innocence as the shadow of my adult competence.

Reflections

This supervisory relationship was incredibly valuable as a tool for facilitating my personal- and professional growth. This relationship, as with others that I hold in ~~reverence~~, was characterized by mutual empathy, affection, respect, congruence, acceptance, positive regard, trust, true understanding, encouragement, hope, spirituality, equality and "love".

The absolute mutuality (in all respects) of this supervisory relationship distinguished it from all the other supervisory relationships I have been involved in, ~~during~~ my training. My supervisor believed in my "healing" abilities and implicitly encouraged me to allow my real/hidden self to emerge. I felt that it was *my* ~~responsibility~~ to do what I believed to be in the best interest of my patients - I never felt that I was "risking" new behaviour - the context of emotional safety simply allowed new behaviours to occur spontaneously.

~~She~~ believed in me, which made it possible for me to believe in others' capabilities, potential and inner strength. I learnt not to be so grandiose as to believe

✓ ~~that~~ I can cure everybody. I saw that I sometimes had to fail in order to succeed as a therapist. I could always give hope, faith and love; I could always comfort - and in this sense I was/am a believer in therapy. I became more flexible in my therapies, which allowed for intensity. I was not only a trainee-therapist, but also a mother, child, companion, granddaughter, disciplinarian, peer, motivational speaker and human being to different clients. I was a witness to people's life stories; a priest to whom some confessed their mistakes and a person who was asked to legitimize others' emotional world and to share in their desperate sadness and lonely happiness.

~~This~~ was also a journey of finding myself and exposing my vulnerable side. My UNISA mentor had told me subtly, that I had to face being a failure. Accepting my limitations, vulnerabilities and imperfections proved to be very hard, as has been the case throughout my life. His words plunged me into darkness. This was a critical ~~experience~~ during my training process. I later realized that this was my darkest hour, ~~but~~ also my greatest asset. Accepting or at least acknowledging my stuckness in training (stability), led to dynamic growth and movement (change). This was an example of a ✓ ~~basic~~, but universal truth: Accepting reality, changes reality. It was a question of balancing my good- and bad self. This was a quantum leap.

I decided to allow myself to be a pixie and a giant; a serpent and a dove; a ~~plaguer~~ and healer and above all, to be human on my journey. I became a versi-coloured therapist, who believed in unlocking inner potential to allow emotional- and spiritual ~~growth~~. My patients were companions on my journey toward self-acceptance; each and ~~every~~ one special, because of the unique way in which every one of them touched my heart, my soul, my spirit, my entire being.

~~I~~ am indebted to every person who walked through my door, who trusted me enough to have shared their journey through life with me, who all touched and enriched me in different and unspoken ways. The only thing I did for these people is that I ~~spiritually~~ held their hands. I got close to them - with some - perhaps closer than

anybody had ever been.

✓ —The-experiences of joy, pain, awe and respect for the way people overcome and
 ✓ ~~rise-above~~ incomprehensible hardship and adversity, represent turning points in my
 training as a psychologist. It taught me humility and gave me new hope, courage,
 strength and belief in human potential, including my own. Instead of pushing and
 ✓ ~~pulling~~, and trying to change others and myself, I started walking *with* my patients,
 sharing their moments of horror and elatedness, their dramas and comedies. I
 ✓ ~~exchanged~~ hunting for answers, for a pilgrimage through life.

✓ —I-was healing myself by not withholding myself anymore. I had a new interest in
 helping and in my profession.

On a sunny day in December 1997, I wrote in my notebook:

*"The therapist's suit is a tight-fit, still somewhat uncomfortable, and at times
 slightly shoddy; but the day when it becomes my favourite, most comfortable,
 best-loved, perfectly tailored garment; is the day when I will not need to be a
 psychotherapist anymore. That will be the dawning of the day when I will be
 healed; a whole person. This is hopefully unattainable, because it will be a sad,
 sad day when one has found what one was looking for. Unlocking the secret
 meaning of life, would signify a readiness to enter death. But hey, I am still
~~travelling~~ hopefully, still alive and kicking!"*

Toward the end of my internship and for the first time in my life, I felt the need
 ✓ ~~to enter~~ therapy, which I did in January 1998. I needed to put aside my mask. I wanted
 to face those imperfections, I have always denied and hidden from myself and others,
 within a safe context. I had already started doing this in my supervisory relationship,
 ✓ ~~but the~~ inevitability of being evaluated by this person, made it impossible to share my
 most private, imperfect parts.

Context E : Learning to Fly

I found a wonderful therapist, who incidentally also obtained his Master of Arts degree at UNISA. He proved to be a communication genius, in that he was able to be ~~totally honest~~ and totally kind at the same time. He was human, empathetic, real, accepting, trustworthy, down-to-earth and congruent. He laughed and cried with me. He understood and was able to connect with some of my struggles during training, as certain issues resonated within him and evoked memories of bygone training days and ~~injuries~~. He taught me how to look at myself, how to accept myself, how to love myself and even how to laugh at myself.

Therapy has been immeasurable in worth - I learnt the importance of self-reverence, self-regard, self-reliance and personal responsibility - in becoming fully ~~human~~. Being a patient was a humbling experience - it taught me respect and greater understanding for those whom I expect to share their private lives with me when I am in the therapist role.

o Sometimes, I found myself highly ambivalent towards therapy: wanting to stay away, to run away, hide away, avoid wounds, to avoid feedback; yet wanting to know, wanting to explore, wanting to grow, to connect, to heal, to live, to be happier. I shifted ~~from being~~ overly dependent at times, and totally isolated at other times, to accepting interdependence as the healthier alternative.

He motivated me to get busy living, because I was busy dying. He told me that ~~"better is not the enemy of the best"~~; that if "you sow a thought, you reap an action, you sow an action, you reap a habit and you sow a habit, you reap a lifestyle".

✓ ~~He made~~ me aware of my tendency to encapsulate myself, to detach and withdraw from others, to live in my own world, especially when I feel threatened. He

helped me to trade my capsule for a cocoon and during therapy I bashed against the sides of the cocoon, I strengthened my wings. I often wanted the therapist to help me, to just give me advice, to provide the answers, to solve the puzzle, but he told me that a botanist once helped a moth, by cutting open the cocoon, and that the moth could never fly. I knew that it was *my* struggle, *my* responsibility, *my* life, *my* choices. And I knew that it was possible to fly.

I greatly appreciated being provided with a safe space, where I could express a wide variety of emotions (including the societally-unacceptable and repressed, but long-overdue bitterness, hate, fury, envy, jealousy); where I could shed tears for others' concealed woundedness, mourn my own losses, where I could say the unsayable, speak what should have remained unspoken, remember what was supposed to have been forgotten, think the illegitimate, listen to inner voices that pretended to have been silenced, believe what I previously preferred to doubt, a space where I could laugh the belly-laughs of my childhood, appreciate my family, sense love, smell contentedness, feel acceptable, taste life ... a space where I could just be.

CHAPTER 5

ANALYSIS OF DATA

Essential Features

Context A

Within this context, my training was experienced as disruptive, confusing, upsetting, harsh, indiscreet, disrespectful, abusive and hurtful. I felt pushed and pulled ~~by~~ the directive training approach of this supervisor. I was criticized and humiliated in a ~~tactless~~, cruel manner. There was no room for failure and very little tolerance for insecurity. I was admonished for innocent mistakes with an "I told you so" attitude. I was made to feel that I "messed up" with patients and that the damage done was irreparable – and I was devastated at the thought of having damaged another. I was bullied into submission in this hierarchical relationship, yet unable to be submissive, as the expectations (rules of what constituted submission) were unclear. I knew I was not satisfying the supervisor, but did not know how to perform differently. I was left in the dark, excluded from the privileged knowledge the powerful supervisor possessed. Her ~~sense of~~ superiority made me feel like an imposter during training. There was not even ~~a~~ grain of respect for my beliefs. The training approach went against everything I held ~~dear~~: *my natural tendency was to protect and respect client's honest attempts at dealing with their problems. My sensitivity was seen as a weakness, since it did not fit with the particular therapeutic style being taught.*

I ~~felt~~ angry, shocked, sad, vulnerable, hurt, disappointed, bewildered, sinful, stupid, embarrassed, inadequate and a failure. *My self-esteem was bruised, my dignity robbed, my pride trampled on.*

✓ ~~I~~ *have always valued achievement and feared failure. I desperately avoided ~~being~~ hurt emotionally or hurting others. My experiences within this supervision*

context made me feel ashamed of myself. I felt sadly “different” and tried to hide my ~~incredible~~ “defects”. I kept a low profile in order to hide my unacceptable self. I became ~~inauthentic~~ in a pathetic attempt to please my supervisor. I wore a mask, pretending to be what I thought she wanted. I desperately tried to protect myself from further pain by ~~participating~~ on an intellectual level in the training process. I moved away from others emotionally. I felt disempowered and exploited in this unsafe environment. The supervisor was seen as punitive, restrictive and directive and I felt helpless to change the situation.

I thus resisted all attempts by the supervisor to further tamper with my already fragile, traumatized and broken self. I have always strongly valued love, sensitivity, respect, regard, nurturance, hope, trust and gentleness in relationships. *The stark ~~absence~~ of these qualities in my relationship with this supervisor, entrenched my concern with being protective of self and others.*

Context B

Based on the preceding unfortunate experiences, I was initially cautious, fearful, anxious, cynical and suspicious of my new supervisor. These inclinations were soon replaced by a sense of hope and a renewed interest in training. My situation had changed drastically.

~~From~~ the outset, this supervisory relationship was characterized by respect, understanding, acceptance, caring, competence, support and encouragement. The serenity I found in this context contained my shattered sense of self.

~~During~~ supervision the atmosphere was inviting, alive, exciting and challenging in a non-directive way. This supervisor employed a totally different approach to the ~~previous~~ one: *He believed in me, had respect for my differentness, nurtured my potential and validated my talent.* He provided a safe context for learning. I admired

him for his wisdom, his willingness to be human, for his deep understanding of others' struggles, for his interest and involvement with students and the support, encouragement and love he extended. He valued different ideas and encouraged dialogue about training issues. The latter was approached with frankness, but in a dignified, confidential and respectful manner. He created a comfortable space for addressing the difficulties I experienced during training.

He was enthusiastic about my personal and professional growth; and the true collaboration that existed in this relationship greatly facilitated my development. Little emphasis was placed on formal evaluation, instead the focus was on empowering every trainee to develop his/her dormant talent. His creativity, flexibility and forgiving, good-natured, humouristic manner allowed me to accept my "flaws" and to believe in myself. *Supervision was used to confirm my natural style and to build on it. I gained a sense of belonging, of connectedness, of being confirmed in this atmosphere.*

Context C

During my internship year, my placement at the Children's Clinic presented me with new experiences and accompanying challenges: I worked within a medical context, where psychiatric diagnosis, evaluation (psychometric assessment) and treatment planning were the order of the day. This proved to be both instructive as well as frustrating. *This matter-of-fact approach, wherein facts seemed more important than people, militated against my natural tendency to protect, nurture and care.*

I found the medical-scientific approach rigid, inhuman and even damaging. As far as I was concerned, my young patients were not abnormal: I believed that their different behaviours (labelled abnormal) merely represented attempts at adapting to unbearable circumstances. I identified with their plight and even tried to change the intake procedures to which they were indiscriminately subjected. I was somewhat disappointed with the discrepancy between the real and the ideal: I became carefully

oppositional in an attempt to change the training to suit my needs. My attempts were futile, since the entrenched way of doing things at the clinic nullified my onslaught.

The limited contact with supervisors, made it difficult to discuss these personal concerns and training needs. Supervision was almost exclusively task-oriented and practically excluded personal growth issues. My female supervisor was sensitive, caring, reliable, understanding, unpretentious, accepting, wise, respectful and exacting. She implicitly understood me, but the relationship was not quite safe enough to address more personal concerns. This near-but-not-quite-collaborative relationship most certainly contributed to my apprehension about being evaluated by her at the end of the term.

I learnt a lot from my child-patients. I was able to identify with their struggles due to my natural tendency for caring and protecting. *The scientific approach followed at the clinic further sensitized me to the crucial importance of providing patients with emotional safety during therapy.*

Context D

I was faced with severe pathology at the Adult Psychiatric Ward of the Johannesburg General Hospital. Contending with extreme disability, dysfunctionality, illness and the incredible pain of other's lives presented me with what seemed an insurmountable challenge. After a period of intense involvement, I started feeling ~~totally~~ incapable of making any difference to the lives of those patients. I became overwhelmed by a pronounced sense of helplessness, cynicism, futility, disillusionment and failure, in the face of the immense sadness I witnessed. I was shocked by the "real" world and experienced guilt about my naïve innocence and my protected life. I did not share this with my supervisor, since I feared being found an unsuitable candidate for this kind of work. During that time, I shared my desperation with my thesis supervisor. Apart from having a difficult time at the hospital, I was also not making any progress

regarding my research project. Being aware of the fact that I had been fighting an uphill battle right from the time I started the training course at UNISA, *he mooted the possibility that I was not cut out to be a psychologist. In retrospect, this event marked the start of a significant change within me, as well as in my therapeutic work.*

▷ I gained a renewed sense of purpose over the ensuing weeks. I shared my insecurity with my Jewish supervisor. To my surprise, she understood this and saw failure as an inevitable part of our work. The fact that she was experienced, caring, trusting, non-demanding and permissive, provided me with the safety I needed to be creative. She continued to believe in my abilities, despite the fact that I doubted myself. ◁ She appreciated humanness and was respectful of my vulnerability.

✓ *I was able to give up the pretense and the masks. I confronted my fear of failure by accepting and acknowledging my failure. I became congruent and authentic in therapies. I was healing myself by not withholding myself anymore. I made my imperfect self visible to others, which in turn gave them hope and courage. Instead of avoiding others' pain, I engaged with it, drawing strength from people's resilience in overcoming their adversity and hardship. I slowly regained my faith, hope and courage, my trust in human potential, and this acceptance of being simply human myself taught me humility. My therapies became human: I started being with patients, instead of doing something to them.*

Context E

My therapist provided me with the safest relationship I have ever experienced in my life. *His ability to combine honesty and caring greatly facilitated my development as a person and trainee, since it allowed looking at myself in a truthful, yet non-threatening manner. I came to accept my failures as a necessary part of success. I never feared being evaluated, since he never pretended to be totally competent himself. ◁ Rather, I came to value myself, to accept my strengths and weaknesses, to recognize my*

self-worth and to trust my own opinions, instead of relying on those of authority figures who often misuse their positions of power.

This relationship was characterized by incredible warmth, kindness, honesty, empathy, congruence, understanding and deep mutual respect. He was completely stripped of pretense and therefore able to be more human and real than any of my other supervisors. *This therapeutic relationship thus provided me with the psychological safety conditions, that proved to be optimal for my personal and professional growth.*

Comparative Analysis

Having described the essential features of the various training contexts in which I had participated, I proceeded with a comparative analysis of the same (cf. Table 1).

✓ The following major themes emerged as a result:

1. Throughout my training I identified myself with the plight of my clients. I felt compassion for those in need and wanted to provide them with care and protection to the best of my ability.
2. I needed my supervisors to treat me accordingly. Whenever they obliged, I felt confirmed and enabled (cf. Contexts B and D). Conversely, being required to operate in ways which militated against my natural protective tendencies, created unimaginable levels of stress (cf. Contexts A and C).
- ✓ 3. Much of the unhappiness which characterized my training experience could be attributed to my fear of being evaluated and found wanting. This also precluded the possibility of me voicing my disagreement with those in charge.

4. Strangely enough, my situation took a turn for the better when I was forced to consider the possibility that Psychology was not for me. Acknowledging failure somehow freed me from its bondage.

Table 5.1
Comparison of Training Contexts in terms of Therapeutic Approach,
Supervisory Style and Trainee Response

Context	Therapeutic Approach	Supervisor Style	Trainee Response
A	Problem focused Task-oriented Directive Matter-of-fact Rational	Instructive Critical Impatient Controlling Manipulative Confusing	Discomfort Fear Pretense Hurt Anger Resistance
B	Structured Respectful Empathic Humane Emancipatory	Collaborative -Appreciative -Respectful Creative -Tolerant	Confidence Motivation Risk-taking Enthusiasm Frankness
C	Diagnostic Directive Interpretive Supportive Analytic	Instructive Providing assistance Fostering awareness Giving advice	Compliance Opposition Ambivalence Performance
D	Empathic Humane Realistic Eclectic	Facilitative Nurturant Innovative Permissive	Competence Responsibility Dignity Professional identity

Integrative Analysis

Two things struck me about these themes. Not only did they represent the essence of my training experience, but they were also intimately related! More specifically, the fear of failure implied a need for acceptance, which in turn explained my tendency to identify with the plight of others. This insight helped me to appreciate the critical importance of the crisis which I experienced during the latter part of my internship. Being forced to admit failure instead of avoiding it struck at the root of my struggle. I realized that as long as the need for acceptance was fueled by fear of failure, I would be caught up in a "game without end". Supportive supervisors could obviously cushion the unsettling impact of the training process, but that in itself could never be sufficient to prepare me for my professional responsibilities as a systemic therapist.

The crisis marked a turning point in my professional development. It served to shift the emphasis from doing something for clients, to simply being with them. This did not mean that my core values had changed. Rather, what happened was that I was able to care for my clients in a new way and with a different motivation. True empathy, rather than sympathy, became the "name of the game". Stated differently: I was moving toward a more mature expression of my core values.

Despite the significance of this watershed event, I kept asking myself whether the intense pain and unhappiness which preceded it was a necessary condition for its occurrence. Frankly, I was not convinced.

From an early stage I realized that coming to terms with the unique demands of the therapeutic relationship would not be easy. As a novice I was bound to stumble and fall frequently. However, I never expected to experience the total disqualification of myself at any stage during the process. Admittedly, my ingrained fear of failure

predisposed me to being vulnerable and at risk. Yet, it is my considered opinion that the culture and climate of Context A exacerbated my vulnerability to such a degree that an abortive learning experience resulted. I believe that this outcome could have been avoided – as is evidenced by the fact that Context B allowed me to regain a sense of composure. I often wondered how things would have turned out had I been given the opportunity to start my training with Supervisor B. Surely that would have provided me with a more secure foundation on which to build?

Reviewing the information summarized in Table 5.1, clearly shows that I reacted positively to certain training contexts (namely B and D) and negatively to others (namely A and C).

Given my tendency to care and protect, it came as no surprise that I had felt enabled by those contexts which reflected a humane approach. On the basis of my own experiences I would therefore be inclined to offer the following hypothesis: The learning of psychotherapy is facilitated when a positive correlation exists between the style of the trainee and the style of the training context.

When I embarked on this research project, I tended to put the blame for my ordeal at the door of the training programme. I also often wondered whether I myself had been at fault. Granted, lack of intelligence and/or aptitude could very well have played an important role in the difficulties experienced during training. By contrast, the above mentioned hypothesis suggests a totally different explanation. It moves beyond deficit thinking, since cause is not attributed to either of the parties involved. In addition, focusing on the relationship between trainer and trainee, reflects the Systems Approach for which the UNISA programme is well known.

This line of thinking seriously raises the question as to how a lack of fit between trainer and trainee should be handled. In my particular case its devastating effects compelled me to resort to defensive manoeuvres (cf. Context A). This in turn merely

aggravated an already untenable situation. For lack of trust and safety I did not feel free to confide in my supervisor, or in any other member of staff for that matter. I also felt that admitting to training difficulties would jeopardize my chances of successfully completing the programme. In short: I felt trapped. Incidentally, this feeling persisted throughout my training – albeit with different degrees of intensity. It was only afterwards, when I entered treatment, that I was freed from it.

Assuming that (1) training casualties are bound to occur in even the best of training programmes, and (2) trainers cannot deny wielding the power of evaluation, I would suggest that an independent professional support system be made available to trainees.

CHAPTER 6

DISCUSSION

At the start of this research project I indicated that my research efforts would be guided by three basic questions, namely (1) What was the essence of my training experience?, (2) What sense could be made of it?, and (3) What were the implications for training philosophy and practice? Given the heuristic nature of the investigation I was aware of the fact that my experience of the training process was unique. This ~~precluded me from either generalizing my findings or making firm claims regarding its implications.~~ However, entering into a dialogue with the academic community on issues that concerned me was certainly possible and called for.

In order to do so, it was necessary to scan available publications on the training of family therapists. This revealed an interesting and very definitive trend. During the past two decades authors have increasingly emphasized *the way in which the personhood of the trainee impacts on the training process*. Evidently, the “skills” approach to training has been found wanting (Watson, 1993). The fact of the matter is that trainees tend to get bogged down when confronted with certain types of client. Andreozzi and Levant (1985) aptly describe this phenomenon.

The therapist tends to behave in characteristic ways ... when encountering those client characteristics that most resemble ... key foundation experiences ... from (his/her) own past. A specific set of internalisations or critical identity images ... account for the majority of such tendencies to ... act in predictable ways within specific contexts. (p. 38)

Accordingly, supervisors have been forced to attend to such “emotional triggers” (Watson, 1993) in order to facilitate the learning process. Initially there was little agreement on the most effective way of achieving this (Aponte, 1994; Aponte & Winter, 1987). The question was whether and to what extent it required personal

therapy on the part of the trainee.

In response to this dilemma procedures such as “genogramme analysis” and “family of origin work” were devised (Protinsky & Keller, 1984). Developments such as these literally opened a “Pandora’s Box” and all kinds of related issues surfaced. It became clear that matters relating to values (Atkinson & Heath, 1990), learning styles (Perlesz, Stolk & Firestone, 1990), gender (Wheeler, 1985) and ethnicity, culture and religion (Watson, 1993; Falicov, 1988) needed to be taken into account during training.

Of particular interest to me was the article by Heatherington (1987). This author found that the personality traits of trainees significantly influenced their choice of therapy model! Naturally, being wedded to one model would be restrictive and counterproductive. However, acquiring additional skills was best achieved under conditions which favoured personal growth, rather than a forced display of such skills! I felt encouraged by this point of view, since it neatly corresponded with my “hypothesis of fit”.

Of equal importance was Heatherington’s statement that personal style is often influenced by gender stereotypes. This very issue has been specifically addressed by authors like Kaiser (1992) and Watson (1993). For instance, it can reasonably be expected that women from authoritarian cultures would be comfortable in taking supportive or nurturant roles. Such women are bound to experience difficulties when required to take a leadership role – as is demanded by strategic and structural approaches to therapy. Needless to say, my own struggle in the beginning could easily be regarded as a case in point.

Reflecting on the issues outlined above, I cannot but conclude that there is more to the business of clinical training than meets the eye. I am thus in agreement with Watson (1993) who holds that:

The focus of marriage and family therapy supervision on the person of the therapist, coupled with ... emerging trends in the field such as gender sensitivity (and) cultural

NB

diversity ... has precipitated the need to redefine ... person of the therapist issues. (p. 24)

It stands to reason that the task of the clinical supervisor is becoming more and more demanding. *In fact, attending to the personhood of the supervisor is inevitable!* (Watson, 1993). This may pose a dilemma for supervisors because “it will require them to step down from their expert position and become vulnerable” (Watson, 1993, p. 26). Clearly, it cannot be assumed that supervisors are in a position to discharge their brief effectively simply because of their clinical expertise. Hess (1986) has rightly pointed out that, as in the case of trainees, supervisors also have to negotiate distinct developmental stages whilst learning their trade. It thus seems fair to assume that the more mature supervisor is better able to manage the vulnerabilities of the immature trainee (Kadushin, 1968). To this I can attest on the basis of personal experience.

CHAPTER 7

CONCLUSION

Writing this document has not been easy. Apart from the fact that I had to relive much of the unhappiness that had characterized my initiation into the therapeutic fraternity, it took courage to reveal my innermost feelings to colleagues and teachers alike. However, that in itself proved to be a therapeutic endeavour. I have gained a more balanced view of the training situation and its complexity. I also know that things could have turned out differently if the importance of issues related to the personhood of the trainee, as well as that of the supervisor, had been fully appreciated right from the start.

The value of my investigation is not to be found in a list of earth-shattering conclusions, but in providing a window on the trials and tribulations of a psychotherapist in the making.

I can only hope that it will contribute to a continual search for improvement on the part of those who carry the burden of educating tomorrow's professionals.

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