Psychotherapist development of trainee and qualified Psychologists within the South African context: A qualitative study

by

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Healing is not a work of perfection or expertise... We heal with our wholeness, our humanity, all of our life experience, even our wounds. Our own wounds make us gentle with the wounds of others and able to trust the mystery of healing, not as a theory but from lived experience. Our vulnerability connects us to the vulnerability in others in compassionate and loving ways…

- Rachel Naomi Remen

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DECLARATION

I declare that **'Psychotherapist development of trainee and qualified Psychologists within the South African context: A qualitative study'** is my own work and that all the sources that I used or quoted are indicated and acknowledged by means of complete references.

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ABSTRACT

This qualitative study aimed to trace the psychotherapeutic development of clinical and counselling psychologists across the careerspan within the South African context. Through purposive sampling 34 psychologists were recruited according to the inclusion criteria of the study. Five distinct career levels were explored, namely, student (n=10), intern (n=7), early career (n=7), experienced (n=5), and senior (n=5) psychologists in relation to the Society of Psychotherapy Research's international model of psychotherapist development. By means of semi-structured interviews, couched in the social constructionist position, participants' experiences were thematically analysed from over 600 pages of transcription. Additionally, the researcher's personal journey of developing as a psychotherapist was reflected upon. The current study found that a number of aspects fostered the development of psychotherapists. Participants reflected on personal and familial wounding events that influenced them choosing a career as a psychologist; this awareness was gradual over their development. Across theoretical orientations, participants resisted adhering to one way of working in light of the diverse South African context. However, the need to limit the number of theoretical orientations taught within the first months of training was proposed. Professional sources of influence highlighted by participants were personal therapy and peer supervision or reading groups. Qualified professionals to a lesser extent made use of individual supervision which when pursued needed to be a 'felt' collaboration. Participants found as they developed they became more comfortable being a psychotherapist however the complexity of cases still kept them humble. Limitations of the study, potential future research directions as well as recommendations for practicing clinical and counselling psychology were outlined.

Key words: clinical psychologists, counselling psychologists, psychology trainees, psychology training, psychotherapist development, teaching of psychology

CHAPTER ONE: INTRODUCTION

1.1. Introduction

In this chapter I begin with the reasons that make this current study a necessary undertaking within the discipline of psychology, specifically the field of psychotherapy. Following on this, the thesis statement of this specific research undertaking will be stipulated together with the main and secondary research questions that the current study sets out to answer. To contextualise the current study, both the international and South African context in relation to psychotherapist development will be introduced in order to orientate the reader within this richly textured field of the psychotherapist and his or her development. Lastly, within this chapter, the main concepts of the current study will be defined with specific reference to psychotherapist development, namely, psychologist, psychotherapist, development, competency and expertise.

1.2. Research Rationale

Controversially, Calestro (1972, cited in Owen, 1992) declares "psychotherapy is the bastard progeny of a long tradition of neo-religious and magical practices that have risen up in every unit of human culture" (p. 89). Internationally, the profession of psychology is experiencing pressure from a number of systemic influences for psychologists to demonstrate and implement evidence-based therapy with clients (American Psychological Association, 2006; Klein, Bernard, & Schermer, 2011; Spring, 2007; Rønnestad & Ladany, 2006).

With this in mind, the professional development of psychologists who conduct psychotherapy should be a key priority, alongside specific therapeutic procedures, when investigating the efficacy and effectiveness of therapy (Neufeldt, 1999), which in turn will aid in developing optimal training for psychotherapists (Klein, Bernard, & Schermer, 2011).

Despite critique, studies on the efficacy and effectiveness of psychotherapy have been undertaken to inform the profession. Importantly, a distinction needs to be made between efficacy and effectiveness studies of psychotherapy. Hunsley and Lee (2007) note that efficacy studies are implemented to good effect when examining the internal validity of treatments by orchestrating clinical trials which are highly controlled and where participants are recruited to test out treatment methods. Whereas effectiveness studies are conducted in routine practice settings to examine real treatment in action in order to evaluate the external validity of treatment.

For example, within the United Kindom (UK), Stiles, Barkham, Mellor-Clark, and Connell (2008) compared the effectiveness of Cognitive Behavioural Therapy (CBT), Person-

Centred Therapy and Psychodynamic Therapy finding that different therapeutic models tend to have the same level of effectiveness. Cuijpers, van Straten, Andersson, and van Oppen (2008) in their meta-analysis of the efficacy of seven different therapies in relation to mild to moderate depression in adults found no significant differences in the efficacy of the different psychological treatments.

In addressing critics of psychotherapy, Wampold (2014) points out that psychotherapy in the United States of America (USA) is regarded as a legitimate and beneficial treatment for psychological distress. Clinical research indicates that psychotherapy is effective in treating depression, anxiety, marital problems, substance-related problems, smoking, asthma, pain disorders, eating disorders and sexual dysfunctions. In light of these potential benefits of psychotherapy, over 10 million Americans attend psychotherapy annually (Olfson et al., 2002; Wang et al., 2005). The average person in distress who seeks psychotherapy will be better off than 80% of distressed individuals, who do not seek out psychotherapy (Hubble, Duncan, & Miller, 1999; Wampold & Imel, 2015).

1.3. Statement of Purpose

The current study proposes to explore and describe the similarities and differences in psychotherapeutic development of South African clinical and counselling psychologists practicing psychotherapy across the careerspan in comparison to the international model of psychotherapist development of the Society of Psychotherapist Research (SPR) (Orlinsky et al., 1999; Orlinsky & Rønnestad, 2005; Skovholt & Rønnestad, 1995, 2003, 2012). This exploration is to be undertaken by means of interviewing psychologists about their experiences of psychotherapeutic development over their career.

1.4. Research Questions

In light of the thesis statement the following questions have been posed to be answered in the current study:

Primary question:

- How does a South African psychologist as a psychotherapist compare to the five levels of development as outlined by the SPR's international model of psychotherapist development across the careerspan?

Secondary questions:

- What are the key psychotherapeutic developmental experiences of South African trainee psychologists during masters coursework and internship years?

- What are the key psychotherapeutic developmental experiences of South African qualified psychologists after registration? What differences in development, if any, occur in comparison to identified international psychotherapist levels, namely, early career psychotherapists, experienced psychotherapists and senior psychotherapists?
- In what ways are trainee and qualified South African psychologists as psychotherapists similar and different in their self-descriptions of their psychotherapeutic development?
- What do trainee and qualified South African psychologists utilise to enhance their psychotherapeutic development? What are the professional and personal issues that positively or negatively affect psychotherapist development?

1.5. The International Context

The international model of psychotherapist development (Skovholt & Rønnestad, 1995, 2003; Orlinsky et al., 1999; Orlinsky & Rønnestad, 2005) was conceptualised in the USA and is continually undergoing worldwide research in Norway, Switzerland, Spain, Portugal, and Germany (Lorentzen, Rønnestad, & Orlinsky, 2011; Orlinsky & Rønnestad, 2005), Austria, Germany and Switzerland (Willutzki et al., 2005), Germany and Norway (Lorentzen, Rønnestad & Orlinsky, 2011), and Vietnam, Egypt, and Sweden (Dennhag, 2012; Dennhag & Ybrandt, 2013).

Other studies of individual countries include Germany (Cierpka, Kaechele, Buchheim, & Orlinsky, 1997), South Korea (Bae & Orlinsky, 2004; Joo, 2009), Australia (Schofield, 2008), New Zealand (Kazantzis, et al., 2010), Denmark (Jacobsen, Nielsen, & Orlinsky, 2012), Singapore (Jennings, D'Rozario, Goh, Sovereign, Brogger, & Skovholt, 2008), Japan (Hirai, 2010; Kanazawa & Iwakabe, 2015), India (Bhola, Kumaria, & Orlinsky, 2012), and Turkey (Bilicon & Soygut, 2015) by the Society for Psychotherapy Research Collaborative Research Network (SPR-CRN, www.psychotherapyresearch.org), intiated in 1968 (Orlinsky, 1995).

Internationally, Thomas Skovholt and Michael Rønnestad have, since the early 1990s, set out to track the professional development of psychotherapists. Asking, 'how do psychotherapists develop over their career?' In their seminal work, *The evolving professional self*: *Themes in counselor and therapist development,* Skovholt and Rønnestad (1993, 1995) conceptualised eight stages of psychotherapist development over the lifespan, based on one hundred interviews with

American psychotherapists. Within the eight stages, which may span forty or more years, Skovholt and Rønnestad identified key themes that embodied each stage of psychotherapist development. Subsequently, their eight stage model has been collapsed into a parsimonious six phase model (Skovholt, 2012; Skovholt & Rønnestad, 2003a, 2003b, 2003c, 2012; Trotter-Mathison, Koch, Sanger, & Skovholt, 2010).

Orlinsky and Rønnestad (2005) point out that previous studies on the professional development of psychologists have predominantly been conducted within the USA and have largely focused upon psychologists in training (e.g., Bischoff, 1997; Bischoff & Barton, 2002; Burnley, 2012; Grater, 1987; Hill, Sullivan, Knox, & Schlosser, 2007; House, 1997, 2007; Kannan & Levitt, 2009; Karter, 2002; Kottler, 1986, 2003; Morgan, 2007; Thériault, Gazzola, & Richardson, 2009; Thériault & Gazzola, 2010; Whitmire, 1991; Woodcock, 2005). O'Donovan and Dyck (2011) point out that research indicates that training of clinical and counselling psychology is currently problematic and in need of revision by universities and professional bodies.

Other work has focused upon collating experienced psychotherapists' narratives (Burton, 1972; Dryden & Spurling, 1989; Goldberg, 1986, 1992; Goldfried, 2000; Goodyear, Wertheimer, Cypers, Rosemond, 2003; Kassan, 1996; Marzillier, 2010; Mullan, 1996; Skovholt, 2012; Raymond & Rosbrow-Reich, 1997; Reppen, 1998; White, 1997) or individual psychotherapists' reflecting on their own professional development through their lifespan (Brown, 2005; Casement 2006; Ehrenberg, 2004; Ellis, 2005; Foster, 2014; Jordan, 2009; Kaslow, 2005; Knopp, 1976; Leigh, 2012; Miller, 1981; Manganyi, 2013, 2016; Swartz, 2011; Tomasulo, 2008; Wilmer, 1964; Yalom, 2001, 2017; Zimmermann, 2014), and even the worst failures of those regarded as master psychotherapists (Kottler & Carlson, 2002). International studies on cohorts of experienced psychotherapists outside of the USA across the world, namely, Czechoslovakia, Canada, Portugal, Singapore, Japan, and Korea have been collated recently by Jennings and Skovholt (2016).

Ricks (1974) coined the term *supershrinks* who are defined as psychotherapists who stand head and shoulders above other psychotherapists. Currently, Miller, Hubble, and Duncan (2007, 2014), and Chow (2014) are defining what elements constitute a "supershrink" drawing on Ericsson, Krampe, and Tesch-Römer's (1993) study of experts who were committed to deliberate practice, the amount of time specifically devoted to reaching for objectives just beyond one's

level of proficiency to enhance their professional skills. Miller et al. argue that, "*Who* provides the therapy treatment is a much more important determinant of success than *what* treatment approach is provided" (p. 4) in the sense that the "catalyst" in successful therapy can be attributed to the individual psychotherapist .

In studying trainees, Hill, Sullivan, Knox, and Schlosser (2007) stress the importance of the initial experiences of trainees, as the quality of experiences in the first semester determines the foundation of subsequent development in becoming psychotherapists. The lived experiences of the five trainees revealed their self-criticism and anxiety about implementing helping skills effectively without being perfectionistic (Hill, 2009).

Recently, Kannan and Levitt (2017) set out to understand how 15 American psychotherapists-in-training experience and cope with self-criticism in the context of their clinical training and psychotherapy experiences. Trainees reported that their self-doubt was heightened when clients wanted ready solutions for their problems. Feelings of inadequacy and self-criticism were experienced by trainees when experiencing poor therapeutic alliances or early terminations with clients. Some trainees' self-criticism lessened when they considered the clients' responsibility in psychotherapy. Trainees' self-criticism was mediated for better or worse by interaction with each client, peers, and supervisors. Particularly, supervisors' judgments increased trainees' shame and led to self-protection maneouvres. Yet, trainees also reported reduced self-criticism with having had more experiences with clients and learning in supervision to manage and be self-reflective regarding their self-criticism. In essence, Kannan and Levitt (2017) found that as trainees learnt to be more authentic with clients and supervisors their self-criticism lessened.

Ladany, Walker, Pate-Carolan, and Gray Evans (2008) studied 250 hours of clinical work by four beginner psychotherapists and concluded that effective psychotherapists demonstrate empathy, manage their countertransference, and tolerate ambiguity, as well as elicit consistent client feedback regarding the therapeutic relationship.

Promisingly, professional development beyond training has become a focus in terms of identifying the cognitive, relational and emotional characteristics that epitomise experienced and master psychotherapists (Orlinsky, 1999; Skovholt & Jennings, 2004; Thériault & Gazzola, 2005). Eshel and Kadouch-Kowalsky (2003) investigated the professional satisfaction of Israeli senior psychotherapists in terms of the possible selves of senior psychotherapists. Possible selves

can be defined as the individual's "images of their future of what they hope to become and what they are afraid of becoming" (p. 429). Eshel and Kadouch-Kowalsky (2003) found senior psychotherapists enjoyed increased satisfaction with their work as they accumulated years of experience and that declining fears about their future in the profession contributed to this level of satisfaction. Specifically, Eells et al. (2011) have compared the case conceptualisation skills of American novices and experienced psychotherapists in an effort to clarify characteristics of therapeutic expertise.

1.6. The South African Context

This research undertaking is deemed relevant to the South African context as to date there has been limited research of South African clinical and counselling psychologists' professional development as psychotherapists (Knight, 2004; Viljoen, Beukes & Louw, 1999), especially in terms of the cultural competence of practitioners in addressing ethnic, racial and economic diversity (Comas-Diaz, 2005; Ellenwood & Snyders, 2006; Ivey, D'Andrea & Bradford-Ivey, 2011; Johnston, 2015; O'Leary, 2011; Ruane, 2010; Stevens, 2001; Sue, 1998, 2001; Sue & Sue, 2007; Swartz, 1999). Internationally, psychotherapist development has been studied across mental health disciplines such as psychology, psychiatry and social work (Orlinsky & Rønnestad, 2005). However, the focus of the current study is upon clinical and counselling psychologists' development as psychotherapists.

Historically, R. W. Wilcocks established the first independent Department of Psychology, within South Africa, in 1917, at the University of Stellenbosch with 30 students, whereas, other universities' psychology courses were still under the auspices of philosophy departments (Louw & Foster, 1991). Hugh Reyburn was appointed as chair of psychology at the University of Cape Town (UCT) by 1920 and Morris Ramsay headed up the department of psychology at RU in 1926 and the first chair of psychology at Rhodes University (RU) was held by Ernst Wild in 1941.

South African statesman Jan Smuts had extensive correspondence with Alfred Adler (Individual psychology), Fritz Perls (especially with regard to the idea of holism, and Gestalt Psychology) and Kurt Koffka (Gestalt psychology). During World War II, Perls with his wife Laura sought refuge in South Africa, and established the South African Institute of Psychoanalysis (1934-1946) (Nicholas, 2013, 2014). Arnold Lazarus (1983) practiced behaviour

therapy in private practice in Johannesburg from 1959 to 1966 and later developed multimodal therapy in the USA (Peltzer, 2000).

The Jewish Russian physician Wulf Sachs, originally from the Psychoneurological Institute of Pavlov and Bekhterev, in Russia, practiced as a psychoanalyst in Johannesburg from 1922 (Peltzer, 2000). In 1934, he published a series of lectures given in the philosophy department at Wits wherein Freud provided suggestions and wrote an introductory note (Cooper & Nicholas, 2012). In 1937, Sachs wrote *Black Hamlet: The mind of an African negro revealed by Psychoanalysis* (Dubow, 1993). The Psychoanalytical Society of South Africa with links to the International Psychoanalytical Association (IPA) was established in May 1949, and Sachs set his sights on establishing a psychoanalytic institute in South Africa, but this was cut short by his untimely death that same year. In 1979, a Psychoanalytic Study Group was founded in Johannesburg and by 1984 in Cape Town (Gillespie, 1992; Hamburger, 1992) where a Kleinian model featured prominently. By 2002, Solms returned from London to re-establish a training institute for psychoanalysts (Solms, 2010). Only in 2016, was Sach's dream realised when nine candidates completed their psychoanalytical training years on South African soil with the afffiliated South African Psychoanalytical Association (SAPA).

To date 17 psychoanalysts practice in Cape Town and Johannesburg under the auspices of the IPA (www.sapsychoanalysis.org). Swartz (2007) notes that psychoanalytic theory and practice has for over 80 years had an "enduring, professional, cultural and academic presence" in South Africa even though at times this presence has been experienced as "thin" and "embattled" (p. 5) due to the socio-political context.

Overall, during colonialism and Apartheid, the discipline of psychology did "little or nothing to challenge the prevailing social order and injustices, tending rather to collude with them" (Pillay, 2016, p. 149). The South African Psychological Association was established in 1948 with 34 members, however it refused to admit black members, due to adherence to policies of the Apartheid regime, until 1962 (Nicholas, 2014; Pillay, 2016) which led to a splinter white-only group the Psychological Institute of the Republic of South Africa (PIRSA). In 1983, the Organisation for Appropriate Social Services in South Africa (OASSA) was formed to address the inequalities of Apartheid (Louw & Van Hoorn, 1997). Senior clinical psychologist Chabani Manganyi (2013, p. 280) recalls how he entered the profession of clinical psychology "through

the back door" as the first black clinical psychologist to secure an internship in 1969 at Baragwanath Hospital, Soweto, Johannesburg, despite strict Apartheid policies.

The first clinical psychologist registered in South African can be traced to 1956 (Pillay & Siyothula, 2008). UCT established the first psychology training programme for professional psychologists in 1974, and subsequently during the 1970's programmes were established nationwide (Pillay, 2016; Rhodes University, 2017). RU traces their first clinical psychology trainee to 1975 under the supervision of Professor Dreyer Kruger (D'Angelo, 2009; Rhodes University, 2017).

Bantjies, Kagee, and Young (2016) trace the history of counselling psychology within South Africa as being introduced in 1974, with a major focus being career counselling. Counselling psychology training programmes were predominantly instituted at then Afrikaans-speaking universities: University of Stellenbosch, University of the Orange Free State (now University of the Free State), Rand Afrikaans Universiteit (now University of Johannesburg), the bilingual University of Port Elizabeth (now Nelson Mandela University (NMU)) and one English-speaking university, the University of Natal in Pietermaritzburg (now University of KwaZulu-Natal).

In terms of homegrown publications, *Psygram* (1959-1969), was replaced in March 1979, when the *South African Journal of Psychology* published its first volume (Cooper, 2014). In addition, *Psychoanalytic Psychotherapy in South Africa* has been published since 1992 (Gillespie, 1992).

All organised psychology societies merged to form the Psychological Society of South Africa (PsySSA) in 1994 when democracy was realised in South Africa (Cooper, 2014; Nicholas, 2014). Since 1974, all psychologists have needed to be registered in accordance with legislation (Cooper & Nicholas, 2012).

At the time of conceptualising the current study to be carried out, the number of psychologists in South Africa registered with the HPCSA as of 31 March 2012 was approximately 7180 registered psychologists, 1261 registered counsellors, 780 intern psychologists, and 963 student psychologists (masters students) (HPCSA, 2012a; 2012b).

McFall (2006), in commenting on diversity in the USA, reported that people of colour constitute approximately 10% of the American psychologist workforce, 15% of the recent graduates, and 22% of the trainees. In terms of diversity within South Africa, Pillay and

Siyothula (2008) noted that in 2006 only 14, 2% of clinical psychologists (325 practitioners) registered with the HPCSA were black African, in terms of redress and diversity. Furthermore, four out of five black African clinical psychologists were trained after 1994.

According to Bezuidenhout (cited in Burke, 2012) psychologists, per ethnic group, that were registered with the HPCSA as of February 2012, can be tabulated as follows in Table 1.

Table 1: South African Psychologists per Ethnic Group.

Ethnicity of psychologist	Number	% of registered psychologists
African	685	9.70
Chinese	1	0.01
Coloured	240	3.40
Indian	412	5.83
White	4062	57.51
No information	1663	23.55
TOTAL	**7063**	**100**

By 2014, black psychologists had increased to 25% of HPCSA registered psychologists within South Africa and black African masters student numbers (26.4%) increased dramatically as well as increases in "Coloured" (9%) and Indian (7.9%) masters student enrollments (Cooper, 2014).

The qualification framework for psychologists who are registered as clinical, counselling and educational psychologists with the HPCSA links therapeutic expertise with three academic qualifications. Firstly, registered counsellors have an honours degree in psychology with six-month internship. Secondly, qualified psychologists who conduct psychotherapy are registered either in the clinical, counselling or educational category (masters degree in psychology including twelve month internship in designated category). Thirdly, psychologists who have a doctorate degree of a minimum duration of two years involving research in a specialist interest/area of psychology (HPCSA, 2005).

Educational psychologists have a master's degree in psychology like that of clinical and counselling psychologists. However, despite many similarities in training and development, there are key differences which would benefit from a study that could accommodate these differences

more accurately. For example, though scope of practice within South Africa is currently under review, historically in terms of development and training, educational psychologists work with children or students within learning or educational settings which involves unique competencies and intervention strategies which extend beyond the scope of the current study. The decision to study both clinical and counselling psychologists was considered viable as some universities train them together within the first year of masters, especially in terms of psychotherapeutic competencies for adults and children.

The Department of Health links job positions and remuneration to the years of experience of the clinical psychologist. The following levels are stipulated: Community Service Psychologist (graduate clinical psychologist), Grade 1 psychologist (clinical psychologist having completed one year of Community Service), Grade 2 (clinical psychologist with eight years of relevant experience after Community Service year), and Grade 3 (clinical psychologist with 16 years of relevant experience after Community Service year) (Department of Health, 2012). Thus expertise has been linked to tertiary academic qualifications and years of relevant experience. Yet, expertise beyond recognising qualifications and accumulated years in the field has yet to be defined and understood within South Africa.

Specifically, insight into the therapeutic expertise of South African psychologists who practice psychotherapy needs to be elaborated upon. With a more detailed understanding of therapeutic expertise through the career span, Continuing Professional Development (CPD) activities and post-qualification training can be developed that is pitched accurately to the developmental needs and tasks of psychologists as psychotherapists at their specific stage of career.

1.7. The Conceptual Framework

The current study will be conceptualised in terms of and based on the following conceptual understandings:

Psychologist: An expert or specialist in psychology. The word *psychology* originates from two Latin words, *psyche*, meaning “soul, mind, and spirit” and *logia*, meaning “the study of”. Therefore psychologists study “the human mind and human emotions and behaviour, and how different situations have an effect on people” (www.cambridgedictionary.org). According to MedicineNet a clinical psychologist is “a professional specializing in diagnosing and treating

diseases of the brain, emotional disturbance, and behavior problems" (www.medicinenet.com). In terms of counselling psychology, the APA (1952, p. 175) states,

> counseling psychologists will spend the bulk of their time with individuals within the normal range of functioning, but their training should qualify them to work to some degree with individuals at any level of psychological adjustment.

Valued characteristics of counselling psychology emphasise preventative interventions, positive mental health, strengths-based adjustment and coping, empowerment of individuals, advocacy, and direct teaching of skills. Promotion of mental health interventions is encouraged at individual, group and systems levels (Rude, Weissberg, & Gazda, 1988).

Unlike a psychiatrist, a psychologist does not have a degree in medicine, and therefore is not qualified to prescribe medication. Clinical, counselling and educational psychologists, amongst having other competencies such as assessment and diagnosis, conduct psychotherapy. Within South Africa all psychologists (including research and industrial psychologists) have as a minimum requirement a masters degree in psychology.

Psychotherapist: A psychotherapist can be understood as a person skilled in the treatment of mental disorders by psychological rather than medical means. According to Frank (1961) psychotherapy can be understood as a healing relationship. Frank identified four common features shared by any model of psychotherapy that makes psychotherapy effective: An emotionally charged relationship, a healing 'set aside' setting, a rationale or myth providing a plausible explanation for the problems and an intervention to resolve the symptoms, dilemmas or problems. Norcross offered the following definition to the APA:

> Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviours, cognitions, emotions, and/or personal characteristics in directions that the participants deem desirable (cited in APA, 2012, p. 218).

Within South Africa, the term *psychotherapist i*s used informally and is not protected by any legislation. However, particularly clinical, counselling and educational psychologists are regarded as skilled at practicing psychotherapy as one of their core competencies.

Counsellor: Within South Africa the term *counsellor i*s used informally and is not protected by legislation or recognised accredited bodies, which by implication means that there is

little recourse for the public regarding the quality of services rendered. Thus, individuals can refer to themselves as counsellors with little or limited training which is not necessarily conducted under the auspices of universities. Lay counselling services are often conducted within non-profit organisations or religious organisations (Ahmed & Pillay, 2004).

An exception is the designation of an HPCSA registered counsellor which refers to individuals who have completed four years of tertiary studies in psychology and a six-month supervised psychology internship within South Africa (Elkonin & Sandison, 2006). Since 2004, 3023 HPCSA registered counsellors have been trained and legally permitted to conduct first-line psychology services and are equipped to then to refer complex or severe cases on to psychologists (Rouillard, Wilson, & Weideman, 2016).

In contrast, in the USA and the UK, a counsellor may include counsellors who have a masters degree and are registered with legislative bodies. For example in the USA, Licensed Professional Counsellors (LPC) focus on counselling and do not have psychological testing and research as major training foci (Cohen-Filipic, 2015).

Development: Within the discipline of psychology which focuses on human beings, Reber and Reber (2001) define *development* as an irreversible sequence of changes or a process of maturation over a lifespan of an individual. Generally, development involves a positive, "progressive change leading to higher levels of differentiation and organisation, with increases in effectiveness of function, maturity, sophistication, richness and complexity" (Reber & Reber, 2001, p. 195). Salkind (1985, p. 59) adds that this progressive series of changes occurs in a predictable pattern or pre-determined "sequential patterning" due to interactions between various factors. Developmental factors include intrapsychic, interpersonal and environmental/contextual factors. Importantly, " development has direction", yet this process over time involves alternating states of disequilibrium/imbalance and then equilibrium/balance (Salkind, 1985, p. 59).

In essence, the current study traced self-identified markers of clinical and counselling psychologists. The pathway involves a gradual, predictable unfolding of the advancement of their developmental pathways in being psychotherapists within a real-world or uncontrived setting.

Competency: is the ability to do tasks or practices successfully or efficiently. Competencies are a combination of observable and measurable knowledge, skills, abilities,

personal attributes, and attitudes or values that contribute to enhance performance and ultimately result in success (Rodolfa et al., 2014). Kaslow, Celano, and Stanton (2005) indicate that competency within the profession of psychology is defined as "the ability to apply knowledge and skills in the real world and (using) performance outcomes as criteria for evaluating learners and training programs" (p. 338).

From 2002, internationally, eight core competencies have been identified within the profession of psychology as essential: application of scientific knowledge to practice, psychological assessment, psychological intervention, consultation and interprofessional collaboration, supervision, professional development, ethics and legislation, and individual and cultural diversity. The British Psychological Society (BPS) states "clinical psychologists are trained to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and research" (2014, p. 5). Kaslow et al. point out level of competency in each facet needs to be determined according to the professional stage of development of the practitioner. Hence, the need for a clear understanding of the stages of development of practitioners in order to accurately begin to assess competency levels is required.

Expertise: The word *expertise* is derived from the Latin *experiri* which is understood as "experienced in" or "having experience of". As such, expertise is associated with an accumulated set of relevant experiences and knowledge of a particular field which can be meaningfully drawn upon when required, and is regarded as wisdom and intuition (Skovholt & Jennings, 2004). Allied health professions outline four major aspects that constitute clinical expertise: knowledge, technical procedural skills, interpersonal skills and attitudes, and clinical philosophies (Kamhi, 1995).

Expertise forms the basis of credibility for an individual being perceived to be knowledgeable or possessing special skill regarding a specific subject area or domain as a result of their extensive effort, study, training or experience in relation to the subject matter. Expertise also implies the ability of the individual to demonstrate their exceptional performance to others in order to be endorsed as an expert (Bourne Jr, Kole, & Healy, 2014). Norcross and Karpiak (2017) acknowledge that researching the expertise of psychotherapists can be described as a Herculean task.

1.8. The Significance of the Study

Provocatively, Orlinsky (2014) in essence, asks, 'What would happen if qualified psychologists as psychotherapists were rated in a star-system, as Michelin rates restaurants?' He poses this tongue-in-cheek question as therapeutic effectiveness needs to be investigated from two vantage points: firstly, effectiveness as innate 'therapeutic talent' and, secondly, the level of development to which this therapeutic talent has been harnessed. With quality of service being prioritised across professions, Orlinsky and Rønnestad (2005) highlight that insufficient attention has been given to investigating how psychotherapists themselves impact psychotherapy; "these works stand out like little islands in a relatively empty sea when compared with a relatively settled ocean of studies on therapeutic processes and outcomes" (p. 5).

To begin to understand psychotherapists' impact on psychotherapy, Skovholt and Rønnestad (1995, 2003a), and Orlinsky and Rønnestad (2005) at an international level have prioritised researching the development of psychotherapists across their career life through self-reported methods utilising their lifespan model of initially eight stages of psychotherapist development which was revised to five stages within the last decade (Skovholt & Rønnestad, 2012). Such projects, for example, include Chang's focus (2011) on trainee psychotherapists in seeking to answer the question, 'How do counsellors in training develop and how do they make sense of what they are doing/what is happening to them?'

Similarly, Pillay, Ahmed, and Bawa (2013, p. 53) indicate that there is "a relative paucity of critical research" into the training of psychologists within South Africa. Pillay and Johnston (2011) emphasise that nationwide studies into training for example internship is "long overdue, especially considering the need for the profession to monitor training and effectiveness continually, as a way of quality assurance and improvement" (p. 75).

Furthermore, internationally, Rousmaniere, Goodyear, Miller, and Wampold (2017) point out that the field of psychotherapy is in need of a model to inform psychotherapist skill advancement after qualification. Chang (2011) highlights that the middle stages of psychotherapist development remain notably under-researched due to accessibility problems as middle-stage psychotherapists are often overloaded with client work. A similar sentiment in relation to studying qualified practitioners is expressed by Viljoen et al. (1999):

> The evaluation of the professional training of psychologists cannot occur in isolation from practice. If trainers want to equip their students better for the

> demands of practice, it is necessary that they pay attention to the opinions and feedback of practicing psychologists (p. 208).

As such there is a long-awaited clarion call to conduct regular nationwide studies with qualified psychologists who practice psychotherapy on what is needed in a psychotherapist's skill-set in order to meet the needs of clients in contemporary society. The current study aims to investigate all stages of psychotherapist development of clinical and counselling psychologists including the middle stages of early career psychotherapists (two to nine years seeing clients) and experienced psychotherapists (ten to 20 years seeing clients).

The starting point for the current study is the work of Skovholt and Rønnestad (1993, 1995) who conducted interviews in the early 1990s on a sample of psychotherapists across mental health disciplines (e.g. psychologists, social workers, psychiatrists and masters-level counsellors) in Minnesota, USA, which is notably contextually different from South Africa. On this foundation, Orlinsky and Rønnestad defined the essential features of therapeutic work that change over time by tapping American psychotherapists' tacit, practice-based knowledge leading to the international model of psychotherapist development being built and then the Development of Psychotherapists Common Core Questionnaire (DPCCQ) (Orlinsky & Rønnestad, 2005, Orlinsky, 2014). Subsequently, the international model of psychotherapist development has birthed extensive quantitative and qualitative research projects across the globe, however only one study has been conducted in Africa to date, namely, Egypt (Dennhag, 2012).

In essence, the current study aims to investigate the applicability of the international model in psychotherapeutic practice today within South Africa in specific relation to the psychotherapeutic practices of clinical and counselling psychologists who were trained at South African universities. The design of the current qualitative study is deemed cross-sectional research in that it involves comparing cohorts composed of different individuals (34) at different career phases (5). Importantly, in asking clinical and counselling psychologists to report on their overall development from the start of their clinical work to date reflects cumulative career development from the psychotherapist's own perspective, which by implication prioritises psychotherapists' subjective experience as valuable to inform the field of psychotherapy (Orlinsky, 2014) and the professions of clinical and counselling psychology.

Eighty studies or commentaries (Appendix A) in relation to psychotherapy or psychotherapeutic development of clinical or counselling psychologists have been undertaken

within South Africa since 1979, with the inception, notably, of the *South African Journal of Psychology*. Evidently, the majority of studies that have been conducted has limited reach as often only a specific level of development was explored, for example, applicants, trainees.

In relation to Community Service clinical psychologists, one nationwide study (Pillay & Harvey, 2006) and two published personal accounts in the Western Cape region (Padfield, 2013; Rohleder, Miller, & Smith, 2006) focused upon how newly graduated clinical psychologists were challenged by the resource-strapped context of working psychotherapeutically within South Africa when faced with the teething problems of the Community Service year (introduced in 2003 with the Department of Health and 2005 with the Department of Correctional Services) for clinical psychologists. However, no nationwide research regarding the experiences of Community Service psychologists has been conducted to date in order to assess the national impact of the Community Service year for clinical psychologists which has now been instituted by the government for over a decade.

Furthermore, only six research studies were found that looked at different aspects related to qualified psychologists practicing psychotherapy within South Africa (Bassa & Schlebusch, 1984; De Lange, 2010; Haumann, 2005; Laidlaw, 2010; Viljoen et al., 1999; Viljoen, 2004). However, these studies did not have samples that extended beyond an isolated region for example, the Free State, the Eastern Cape, the Western Cape or Gauteng within South Africa. Therefore the findings of these six studies have not allowed for easy comparison of psychologists working within different provinces nor an understanding of what constitutes the prototypical South African psychologist practicing as a psychotherapist. The full decription of each study is available in the Appendices (See Appendix A).

Thus, despite the collated commentaries (7), national report (1), clinical case studies (1), careerspan memoirs (2), unpublished dissertations of trainees' personal accounts (9), unpublished dissertations with more than one participant (24), and published studies (35) over four decades in South Africa, a comprehensive model of professional development spanning the entire career of clinical and counselling psychologists as psychotherapists which reflects the South African context nationwide is yet to be explored. Less than 80 investigations of worthwhile, but isolated and fragmented aspects of psychologists as psychotherapists has been undertaken to date. As such the field of psychotherapist development is under-researched and has yet to be investigated holistically within the country.

1.9. Structure of the Thesis

This thesis is presented in five chapters. The first chapter has defined key concepts that inform the research question and the need for the current study has been highlighted. Both the international and South African context of psychotherapist development drawing on previous research studies has been introduced, which will be elaborated upon in the next chapter. Chapter Two sets out the theoretical framework utilised in the current study to conceptualise and understand the psychotherapist development of clinical and counselling psychologists. The research design and methodology utilised as well as the ethical considerations adhered to throughout the current study is outlined in Chapter Three. The findings of the current study in comparison to other international and South African research endeavours will be discussed in Chapter Four. Finally, Chapter Five offers a conclusion to the study by highlighting the overall findings of the current study together with recommendations to inform both clinical practice and research within the field of psychotherapy. The value and limitations of the current study, and further directions for future research will be addressed.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter outlines the focus of the current study, that of the professional psychotherapeutic development of clinical and counselling psychologists across the career span in South Africa. Firstly, two models have been drawn upon to conceptualise the professional development of psychotherapists which will be explicated, namely, Skovholt and Rønnestad's (1995, 2003a, 2003b, 2003c, 2012) international developmental model of psychotherapists and, briefly, Klein, Bernard, and Schermer's (2011) five-phase theoretical model of psychotherapist development. Secondly, facets of professional development of psychotherapists as identified by Skovholt and Jennings (2004), and Orlinsky and Rønnestad (2005) were employed as key deductive aspects for the current study. These include participants' personal motivations for choosing to become a psychologist who practices psychotherapy, and their personal and professional sources of influence of psychotherapists during their training and post-qualification.

The developmental models and facets of psychotherapeutic work outlined in this chapter provide the necessary framework to conceptualise psychotherapist development of psychologists within the South African context. Both international and local studies are explored in this chapter to provide a solid foundation to the current study.

2.2. Models to Navigate Development of Psychotherapists

2.2.1. Skovholt and Rønnestad's Developmental Model of Psychotherapists.

Notably, Skovholt and Rønnestad's (2003a, 2003b, 2003c) professional psychotherapist development model delineates the following six phases for psychotherapists across the career lifespan namely: the lay helper, beginning student, advanced student, novice professional, experienced professional, and senior professional.

However, since 2012, Skovholt and Rønnestad have dissolved the lay helper phase as part of their developmental model of psychotherapists. The *lay helper phase* is regarded as the pre-training period where an unqualified person offers help to others by utilising their natural relational skills. Generally, the lay helper quickly pinpoints problems and provides support and advice to the individual in distress based upon his/her own experience. Difficulties encountered may include over-involvement and a lack of investigation and reflection on the part of the helper.

The *beginning student phase* starts when one enters the exciting yet challenging training context to become a psychotherapist. Generally, the beginning student is vulnerable and dependent on support of elders in the profession as the student wrestles with self-doubt as to whether they are suited to the profession. In consultation with clients the beginning student may feel anxious and heavily reliant upon imitating models and techniques in their therapeutic work. Imperatively, the beginning student needs to retain an attitude of openness to learning in order to acclimatise to the complexities of psychotherapy to enhance their professional growth.

The *advanced student phase* is characterised by an internship placement under formal supervision, where one is expected to perform at a basic professional level. Advanced students tend to have internalised high standards for their work performance which is seen in their careful and thorough approach to therapeutic work. Furthermore, advanced students typically have an increased internal focus on evaluating their therapeutic work and yet continue to prioritise supervision which at times may need to hold the independent-dependency tensions experienced by the advanced student.

Kaslow and Rice (1985) depict the internship year as a "professional adolescence" which is seen as a fluid and dynamic process. Lipovsky (1998) defines the internship year as a transition from being a student to professional autonomy where the trainee is expected to emerge as a professional psychotherapist who is able to function independently as a practitioner. When reflecting on her experience as an intern, Lipovsky confesses to feeling internal pressure already in her internhip to present as possessing an integrated professional identity and as a result felt very self-conscious and uneasy in an unfamiliar context: "I was overly concerned with presenting myself as competent and confident in my skills"(p. 139). As such, Lipovsky identified with the words of Erik Erikson's description of adolescence, "I ain't what I ought to be, I ain't what I'm going to be, but I ain't what I was" (Lipovsky, 1998, p. 139).

After qualifying as a professional, three phases of development were identified by Skovholt and Rønnestad (2003). The *novice professional phase* has been delineated as the first five years after having qualified as a psychotherapist. Novice professionals are depicted as being in a "process of shedding and adding" (Skovholt & Rønnestad, 2003, p. 17) to their conceptual and behavioural repertoire as psychotherapists. Novice professionals, free of formalised evaluation processes, experience a sense of freedom and initially set out to confirm their training as psychotherapists. However, when the novice professional is confronted with unexpected

professional challenges a period of inadequacy and disillusionment may follow which engenders deeper self-exploration and matching of oneself to a suitable professional environment. Novice professionals also move towards expressing their personality in their work, integrating the personal and the professional aspects of self more comfortably, as well as appreciating the importance of the therapeutic relationship in managing the complexity of the therapeutic process.

The *experienced professional phase* has been estimated to stretch between at least five years and twenty/twenty five years of practice, post-qualification. Experienced professionals generally have had a range of clients in different work settings. Furthermore, the experienced professionals verbalise enjoying a congruent therapeutic role and a theoretical system that comfortably fits with their personhood. The therapeutic relationship is regarded as the centrepiece of the therapeutic process and is actively drawn upon to bring about therapeutic change whereas techniques, when utilised, are more flexibly applied. Experienced professionals have developed "boundaried generosity" (Skovholt & Rønnestad, 2003c, p. 22) where they demonstrate a fine-tuned level of involvement, and enjoy an effective support-challenge style with their clients. Though experienced professionals speak of trusting their clinical judgment, this is balanced with a sense of 'not-knowing' and therefore remaining open to new learning. In this phase psychotherapists speak of sharing their learning by mentoring and supervising the younger generation in the field. Interestingly, experienced professionals turn to related fields, such as literature, theatre or religion for inspiration in their therapeutic work and make use of their internalised mentors, from earlier years, to self-reflect. Importantly, to be effective in their work, experienced professionals access their accumulated experience to inform new work and as such tailor their interventions using prior knowledge actively with contextual information.

The *senior professional phase* is delineated as the psychotherapist being in practice for at least two decades. Senior professionals, in light of losses, experience a keen sense of the limitations of what can be achieved in a therapeutic process and in turn come across as more modest. Additionally, a greater sense of self-acceptance is experienced by senior psychotherapists. In the late stages of development, reflection on therapeutic work through the years becomes a norm and leaving a legacy becomes a priority and to ward off boredom (Skovholt & Rønnestad, 2003c). Rogers (1980) became bored by safety, as a result he was willing to take risks in order to learn; "it is necessary to my life to try something new" (1977, cited in 1995, p. 77). Inspired by Rogers, Andersen elaborates:

> I find that uncertainty opens doors for learning and it fits with my idea of learning as a lifelong process. And, when you are genuinely curious about another person, walking alongside them mutually determining the direction and destination there is no room for boredom (2001, p. 353).

Importantly, Goldberg (1992), and Orlinsky (2014) offer a more fine-grained model identifying seasoned psychotherapists having at least 15 years of practice and senior psychotherapists at least 25 years of practice. With this line of thinking, a seasoned psychotherapist would be at least 40 years old and a senior psychotherapist would be 50 years old or older in terms of the personal development trajectory.

However what has become apparent in my review of the literature of psychotherapist development across the world, for the current study, is whether there is another clear phase for psychotherapists who are 65 years and older and possibly have already been practicing for 35 years or more. This needs to be investigated as, for example, Carl Rogers had an active career as a clinical psychologist-psychotherapist from 1927 to 1987 (over 60 years of practice). Compellingly, Rogers wrote *Client-centred therapy* in 1951, already 24 years into the profession and spent the next three decades creating an international wave of thought, known as Person-Centred Therapy (Rogers, 1981/1995). Irvin Yalom, too, has had an active career as a psychiatrist-psychotherapist from 1960 to date (57 years) contributing notably to Existential Therapy in 1980, and providing a seminal text on Group Psychotherapy from 1970 (Yalom, 2017). Aaron Beck, a medical doctor, started making his mark in psychotherapy in 1952 and continues to define the field especially with regards to his CBT model (starting in 1970), as such his involvement in the field of psychotherapy spans over 65 years to date (www.beckinstitute.org). Hence, a model that adequately explains what happens after the first 25 years of practice is yet to be articulated.

Intrapsychically, Brott and Myers (1999) outlined a three phase cycle of autonomy and dependence during professional development of masters-level school counsellors which psychotherapists (Moss, Gibson, Dollarhide, & Colette, 2010) have regarded as also being descriptive of psychotherapist development.

In the first phase of the cycle, novice psychotherapists look to qualified psychotherapists as external authority figures to assist with cognitive and experiential learning as well as to

provide external evaluation during their coursework year(s). Additionally, novice psychotherapists also compare their performance to peer novice psychotherapists.

In the second phase, interns encounter supervisors as authorities in the profession and elicit feedback from them regarding their skills acquired during their university training and their subsequent skill application during internship. This feedback helps interns to start relying on their internal locus of evaluation more.

The final phase, which is often most clearly seen in experienced psychotherapists, is the ability to self-evaluate one's therapeutic work by integrating experiences with their clients with theoretical understandings which results in a comfortable merger between personal and professional identities. Brott and Myers (1999) emphasise that professional identity becomes solidified when the psychotherapist's locus of evaluation is predominantly internal in nature.

2.2.2. Klein, Bernard, and Schermer's Model of Psychotherapist Development.

In response to the following question, "Is there a common path that psychotherapists follow in their development?" Klein et al. (2011, p. 3) propose a five phase-specific model of psychotherapist development.

The *pre-professional phase* involves acquiring the basic relational skills of empathy, listening, attunement to feeling, communicating understanding, altruism, the ability to be trusting and trustworthy. In addition, aspiring psychotherapists need to demonstrate psychological mindedness or emotional intelligence, interest in storytelling, a passion for new learning, and curiosity. Furthermore to succeed at such an emotionally taxing career as psychotherapy, aspiring psychotherapists need to possess determination, tolerance for ambiguity, capacity for delayed and partial gratification and emotional resilience (Klein et al., 2011).

The *second developmental phase* is of one of mastering the basics (Klein et al., 2011). Alsop (2000) emphasises that the student role that is assumed needs to promote self-directed learning of trainees to equip them with the necessary skills to continue to augment their learning across their career. Here the psychotherapist trainee accumulates professional knowledge through a comprehensive education of the key subdisciplines of psychology which constitute and intersect within the applied branch of psychotherapy. The trainee also needs to acquire the necessary relational skills (e.g., Brems, 2001; Egan, 2013; Hatcher, 2015; Hill, 2014), and interview skills (Fernández-Liria, Rodríguez-Vega, Ortiz-Sánchez, Baldor Tubet, & González-

Juárez, 2010) that can be utilised therapeutically to connect emotionally with clients and establish a workable therapeutic relationship.

Klein et al. (2011), and Fall and Sutton (2004) believe supervision plays a critical role in assisting the trainee in developing relational skills, becoming acquainted with and start utilising countertransference and the use of self (e.g., Dewane, 2006; Cheon & Murphy, 2007; Satir, 1987; Wosket, 2009) with clients, as well as inculcating values and ways of conceptualising the process of psychotherapy. Within the second phase, the trainee becomes acquainted with the change process that is encased in psychotherapy as well as becoming initiated into the professional identity and role responsibilities of being a psychotherapist. The trainee starts to develop an awareness of the boundaries and limitations of the therapeutic role together with developing an ethical compass and value system in order to practice effectively. By means of personal psychotherapy, supervision and mentoring an internalisation process is initiated that slowly but nevertheless effectively develops fledging psychotherapists in the ways of the profession. Modelling and identification with psychotherapist elders is deemed as essential to develop into a psychotherapist. Personal psychotherapy, overtly divorced from evaluation of therapeutic competence, remains critical for the novice psychotherapist as it assists in ensuring that the person of the psychotherapist is not being lost but rather utilised within the consultations.

Klein et al. (2011) argue that at this stage of professional development a tentative theoretical orientation and working style of the budding psychotherapist becomes apparent. Novices also begin to be exposed to the general challenges of practice such as un-predetermined termination, strong countertransference reactions and fluctuations in session scheduling. Within this turmoil it is imperative for psychotherapy trainers to equip trainees with a conceptual framework to understand such dynamics in order to manage the therapeutic relationship more effectively and also remain resilient as a psychotherapist.

Phase three is one of consolidation for psychotherapists, across mental health disciplines (Klein et al., 2011). Use of self by the psychotherapist during sessions begins to take centre stage and an authentic professional self emerges beyond the role of being a psychotherapist (Billow, 2010a, 2010b; Satir, 1987). A psychotherapist needs to interpret how they are going to express themselves in their work beyond their acquired generic learning and skills. Klein et al. (2011), and Billow and Mendelsohn (1987) highlight that ongoing direct experience with clients and regular review of case material within supervision and peer groups provide ample opportunity

for growth trajectories for psychotherapists. Self-awareness becomes essential and exposure to the world of rich experiences; in essence to open oneself up to fully embrace the profession. How a newly qualified psychotherapist decides to employ their use of self within their therapeutic work is a key developmental feature as a psychotherapist's originality and creativity can now emerge effectively in their unique style of working. Within this phase, psychotherapists have a keen awareness of their limitations and can harness their key assets in choosing the client populations that they can work most effectively with.

Furthermore, psychotherapists are tasked with working with more challenging presenting problems of clients. Supervisors and mentors continue to play an important role in refining the psychotherapist's skills in addition to drawing from one's accumulated life experiences and difficulties.

Development in the third phase relies heavily upon the now qualified psychotherapist's commitment to lifelong learning and maintaining openness to different theoretical approaches and new advances and trends in therapeutic work (Klein et al., 2011). Learning at this time often occurs within supervision as a supervisee or a supervisor, presenting papers at conferences, through teaching others, and reading or attending case conferences (Alsop, 2000). Balancing one's professional commitments with one's personal life remains imperative as psychotherapists are not immune to stress, especially as over their lifetime needs, priorities, capabilities and opportunities change (Nissen-Lie & Orlinsky, 2014). With this in mind, Austin et al. (2013), Mullenbach and Skovholt (2004), Skovholt (2001), and Wicks (2008, 2012) emphasise that psychotherapists need to establish and maintain their support systems and find regular ways to rejuvenate from the inherent stress of clinical work in order to remain resilient. Within the context of managed care, professionals internalise ethics and personal values to guide their interventions with a flexibility that takes into account ethical dilemmas/conflicts, and relevant outcomes and recommendations from research that can be applied to practice (Hansen, 1997; Klein et al., 2011). In this phase, psychotherapists report having achieved an established professional identity and personalised view of their work and the therapeutic process.

In *phase four*, finding one's unique voice in the profession becomes central (Gabbard & Ogden, 2004, 2009; Vinton, 2008). At this milestone, integration of one's personal self and professional self needs to achieve a comfortable fit for the psychotherapist. Here the processes of differentiation and deeper integration take place. Individuated psychotherapists exude high levels

of authenticity, integrity as well as individuation in their therapeutic work and other areas of their lives. One's professional identity becomes clarified and the peak of professional experiences is enjoyed. Opportunities to assume a leadership role in the profession are often afforded and taken up. Visibility within the profession may increase with assuming leadership, supervising or teaching roles in assisting the younger professionals (Alsop, 2000). Clinical work becomes in essence 'polished' and 'distinctive' (Klein et al., 2011).

Phase five of psychotherapist development involves slowing down one's development and enjoying the fruits of decades of labour in the field. For many professionals it is a time of reassessment. Decisions of how to end one's official career and enter retirement are foregrounded (Hamerman Robbins, 2006; Walcott, 2011). Questions of legacy are reflected upon in the spirit of generativity and ways of dealing with loss are developed (Klein et al., 2011). As seasoned sages (Londono-McConnell & Matthews, 2013) psychotherapists in this phase focus on handing down their knowledge to upcoming psychotherapists in the field through writing books or establishing mentoring relationships as well as reflecting on meaningful therapeutic relationships that have been experienced during one's professional career.

Along their developmental path, psychotherapists need to develop and enhance additional competencies (Klein et al., 2011) which include cultural competency, the ability to work with more than one individual and organisational systems and to offer psychological services with other professionals. Cultural competence when working with diverse populations is deemed essential in terms of being sensitive to cultural factors and how such factors impact the course of treatment from assessment to termination (Cary & Marques, 2007; Gibson, Sandenbergh, & Swartz, 2001; Ruane, 2010). Additionally, psychotherapists are called upon to understand and work across different treatment modalities (individuals, couples, families, groups, or organisations) and to collaborate effectively within and between multidisciplinary teams (MDTs) of mental health professionals. Klein et al. (2011) highlight that often psychotherapists, within a MDT, are tasked with integrating the various treatments of a patient and providing the patient a forum to discuss their treatment and provide psychoeducation regarding the patient's presenting problems.

2.3. Psychology as a Profession

Situated within the USA, Granville Stanley Hall earned the first American doctorate in psychology in 1878. In 1892, Hall established the APA to represent what was then the

developing field of psychology (Lichtenberg, Goodyear, Hutman, & Overland, 2016). Specifically, Lightner Witmer is responsible for coining the term "clinical psychology" and setting in motion the building blocks of the profession of clinical psychology internationally. In 1896, he founded the first psychological clinic at the University of Pennyslyvania, USA and by 1908 the first clinical internship was offered at the Vineland Training School in New Jersey, USA (www.psych.upen.edu). However, psychotherapeutic treatment interventions beyond Psychoanalysis, conducted by clinical psychologists, became widespread only by the mid-1940s in the USA (Humphreys, 1996). Clinical psychology became a division of the APA in 1944 and clinical psychology training programmes became accredited by the APA in 1949 (McFall, 2006)

In the 1940s, during World War Two, the USA military had a need for vocational placement and training which led to the Veterans Administration (VA) starting the speciality of counselling psychology which became a division of the APA in 1946. The VA and university counselling centres formed strong ties to meet the needs of returning American soldiers; in tandem Roger's Client-centred Therapy gained popularity to address mental health concerns. In 1951 at the APA-sponsered Evanston conference held at North Western University in Illinois, USA the term "counselling psychology" was first used and the first counselling psychology programmes across the USA became accredited between 1951-1953 (Lichtenberg et al., 2016; Whiteley, 1984). The philosophy of counselling psychology includes the scientific-practitioner model to enhance research, an orientation towards a strengths/assets perspective of clients' mental health, the domain of career guidance, and a focus upon diversity (Goodyear et al., 2016).

Using the Oxford Dictionary as their starting point, Cruess, Johnston, and Cruess (2004, p. 75) comprehensively define a 'profession' as follows:

> An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to

considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.

Therefore, in light of the enormity of the responsibilities vested in psychologists towards the general public the profession of psychology within South Africa constitutes licensure/registration with the HPCSA as stipulated in the Health Professions Act 56 of 1974 (HPCSA, 1974). The Health Professions Act oversees the education, training and registration for and practicing of health professions, which includes psychologists through the establishment of the Professional Board of Psychology (PBP) within the HPCSA. Thus, in order to legally train psychologists to practice in the country, South African universities have their training programmes accredited and audited by the PBP (HPCSA, 2011).

Professional schools of psychology, outside of universities, have been established across the USA and in Europe in an attempt to focus more on the training of therapeutic skills as opposed to the component of psychological research. Whereas, in South Africa, the training of psychologists continues to solely be undertaken under the auspices of 16 universities, in 2017, where research forms a significant component, varying between 34% -50%, of the qualification to be a clinical, counselling or educational psychologist (Pillay & Kritzinger, 2007; Rhodes University, 2016a; University of Pretoria, 2013; University of Western Cape, 2013; University of Witwatersrand, 2013; University of Zululand, 2013) in line with the scientific-practitioner model (Pillay & Kritzinger, 2007; Van der Westhuyzen & Plug, 1987).

Similarly, Australian clinical psychology training constitutes theoretical knowledge, research skills and clinical practice (Gonsalvez, Hyde, Lancaster, & Barrington, 2008). Practical training is embedded in two settings: service delivery in external agencies and training in university clinics. Pachana, O'Donovan, and Helmes (2006) utilising a survey, asked 27 clinical directors of 19 clinical psychology masters programmes across the breadth of Australia to comment on the training of clinical psychologists. A key recommendation from their work is the establishment of a forum of clinical directors or masters course co-ordinators where questions can be asked and information shared to improve the training of professional psychologists across the country. On average Australian universities have an annual intake of ten full-time trainees and 3.5 students are assigned to a clinical supervisor per year. Most directors wanted to include new material particularly on treating elderly clients and indigenous clients in Australia. Eighty-four percent of Australian clinical psychology programmes adopt a CBT theoretical orientation

as their primary focus and more than 50% of the programmes adopt an evidence-based approach (Pachana et al., 2006). However, this is not the case within South Africa where a variety of theoretical orientations are taught in masters programmes (Peltzer, 2000).

2.4. The Competency-based Framework

In the USA, frameworks of competencies in terms of knowledge, skills and values have become endorsed by the APA as a way to achieve a national training standard for psychologists (Sperry, 2010; Spruill, Rozensky, Stigall, Vasquez, Bingham, & De Vaney Olvey, 2004; Thomas & Hersen, 2009). Kaslow, Celano, and Stanton (2005) advocate a competency-based approach to training psychotherapists where an explicit framework has been formulated to "initiate, develop, implement, and evaluate the processes and outcomes of training" (p. 338). Trainers focus upon trainees' ability to apply their acquired theoretical orientation and knowledge to real clinical contexts. Assessment of trainees is implemented using performance criteria that are linked to practice outcomes as an evaluation tool for trainees.

For psychologists, Overholser (1993) outlines a schema of five main competencies of factual knowledge, generic clinical skills, orientation specific technical skill, clinical judgment, and interpersonal attributes. Brems (2001) proposes that generally psychotherapeutic competence encompasses three interrelated core components. Firstly, self-awareness constitutes trainees committing to introspection and allowing their personhood to be developed to enhance conveying presence and authenticity to their clients within the therapeutic relationship. This self-awareness needs to be both observational and philosophical in that psychotherapists must be able to see what they are doing during psychotherapy as well as the personal ideas, beliefs and values that influence how they personally view the patient (Ellis, 1966). Secondly, acquiring knowledge and theories of psychotherapy is essential to provide psychotherapists with a sound rationale for what they do, when and how with clients. Lastly, the attainment of applied skills involves translation of knowledge and awareness into action. This process can include learning techniques, intervention strategies and formulating treatment plans.

Subsequently, from a behavioural and cognitive psychotherapy stance, Bennet-Levy (2006) has conceptualised the Declarative Procedural Reflective (DPR) model which involves trainees developing both declarative and procedural knowledge (Anderson, 1993). Declarative knowledge is metalinguistic knowledge of facts and concepts expressed as propositions, for example, knowing that Paris, is the capital of France or in psychotherapy understanding the

purpose of transference. Conceptual information is stored in long-term memory and organised into schemas that form networks or webs. These webs are utilised to show relationships to shape comprehension and inform interpretations. In contrast, procedural knowledge involves knowledge that is utilised in the performance of tasks. Such implicit knowledge involves action sequences and knowing how something happens in a particular way, for example, knowing how to ride a bicycle (Hiebert & Lefevre, 1986) or in psychotherapy conveying empathy towards clients. In addition, Bennet-Levy (2006) emphasises reflection skills as the third component of this model. He argues that reflection is essential as it is a metacognitive skill which involves an intellectual and emotional exploration of one's experiences to arrive at new understandings.

Lemma, Roth, and Pilling (2008) have drawn up guidelines for the British government National Health Services (NHS) briefly outlining generic therapeutic competencies across theoretical orientations as well as specifically detailing psychoanalytic/psychodynamic competencies for clinical psychologists who work within the NHS. Generic competencies included: an ability to build trusting relationships and to relate to others in a warm, encouraging and accepting manner, as well as knowledge and understanding of mental health problems, knowledge of a model of psychotherapy, and the ability to understand and employ the model in practice. Specifically, psychoanalytic/psychodynamic competencies involved: the capacity to demonstrate understanding the client's unconscious experience which will then involve the ability to utilise the transferences of the client within the therapeutic relationship as well as knowledge of the basic principles and rationale of psychoanalytic/psychodynamic approaches. In essence, psychoanalytic/psychodynamicpsychotherapists focus on the client's unconscious experience of the relationship. Importantly, Lemma et al. emphasise that fostering a good therapeutic relationship is central across all theoretical orientations.

Tuckett (2008) proposed three frameworks or lenses within which the psychoanalytically competent psychotherapist operates. Firstly, a participant-observational frame is defined as the manner in which the psychoanalyst interacts with and listens to the patient and the capacity of the psychoanalyst to explore, elaborate and reflect on the patient's material. Secondly, the conceptual frame involves the psychoanalyst being able to identify the transference and countertransference, to identify and conceptualise the development of the analytic process that resonates with the patient. These conceptual tasks draw from the psychoanalyst's capacity to think about the latent meaning of the material that the patient brings to sessions and to in a sense,

slot the clinical material into a theoretical model that enhances the analytic work. Here, the analyst's conceptual ability involves the ability to create meaningful links between psychoanalytic ideas and clinical material to bring about greater understanding of the therapeutic process of patients to bring about transformation. Thirdly, the interventional frame outlines the technical interventions that the psychoanalyst formulates and employs within psychotherapy and also the psychoanalyst's ability to apply interventions taking into account the patient's needs and doing so with appropriate timing. Sarnat (2010) highlights therapeutic relationship skills, self-reflection, assessment and diagnosis, and intervention as central competencies of psychodynamic psychotherapists.

Newman (2013) outlines core competencies that CBT psychotherapists need to demonstrate within the broader generic cube model of competency (Sperry, 2010). Firstly, conceptual foundations of CBT need to be taken hold of by the psychotherapist to be utilised as a road map to understand client functioning and dysfunction (e.g., negative automatic thoughts) and to direct the process of CBT. Secondly, relationship building and maintenance is prioritised by the CBT psychotherapist by establishing a positive and collaborative alliance as well as paying attention to ruptures in the working alliance with clients. Westbrook, Kennerley, and Kirk (2007) emphasise that the CBT psychotherapist walks alongside the client as a guide, educator and practical scientist in providing the client with a model to address problems. Thirdly, intervention planning involves initially assessment procedures of current problems and then constructing a case conceptualisation or formulation that explains a client's problems, how the problems may have developed and possible maintaining processes of the problems (Westbrook et al., 2007). Fourthly, intervention implementation, involves utilising the Socratic method of questioning, identifying cognitive biases, participating in role play and modifying core beliefs and schemata, as well as participating in behavioural or physical experiments, for example breathing exercises with clients (Westbrook et al., 2007). Fifthly, intervention evaluation and termination involves ongoing measurement of progress in psychotherapy, for example, frequency counts, self-ratings, diaries, questionnaires. Relapse management is also a key task of the CBT psychotherapist (Westbrook et al., 2007). Lastly, CBT psychotherapists prioritise practicising with a culturally and ethically sensitive lens (Newman, 2013).

Another example of competencies being explicated comes from the perspective of training family psychotherapists in the USA. Kaslow et al. (2005) have identified core

competencies that need to be harnessed in family psychotherapy trainees. In relation to psychotherapy competencies, firstly, family psychotherapist trainees need to become well-versed in systemic epistemology to effectively apply knowledge to practice. Secondly, trainees are taught intervention strategies that address "functional and dysfunctional relationships and processes within couples and families; how these processes impact the adjustment of constituent members; and the complex interplay between interventions, psychological disorders, and health problems" (Kaslow et al., 2005, p. 340). Competencies in family psychotherapy is a central aim of South African psychologists who are trained in a systemic theoretical orientation in relation to psychotherapy.

2.5. Moving Towards Therapeutic Expertise

Granello (2010), in a quantitative study gauging the development of cognitive complexity of American masters-level counsellors, found that an increase in managing cognitive complexity in relation to therapeutic work can be linked to the years of practice that the counsellor has accumulated in the profession. Similarly, to Ericcson, Krampe, and Tesch-Römer (1993), Granello identified the ten-year mark as an indicator of being an expert psychotherapist which needs to amount to 10 000 hours. However, Jennings et al. (2003), and Tracey, Wampold, Lichtenberg, and Goodyear (2014) caution that expertise, though desired by psychotherapists, remains elusive, in that expertise in psychotherapy is difficult to measure as psychotherapeutic skill is multi-faceted and the skills of psychotherapists are not static entities. Eells (1999) points out that therapeutic mastery does not hinge only upon accumulated years of practice but rather requires constant engagement on the part of the psychotherapist to improve their skills, acquire new theoretical knowledge and continue to have an openness to new experiences (King et al., 2014) as well as ask for critical feedback for others to enhance their skill.

Tracey et al. (2014) operationalise therapeutic expertise "as improved performance that results from greater experience" (p. 2). Experts compared to novice psychotherapists have a larger knowledge base which is more sophisticatedly organised and structured. Experts also have better automatic processing when needing to make clinical decisions. A notable vehicle of expertise is psychotherapists engaging in deliberate practice (Rousmaniere et al., 2017; Tracey et al., 2014) which goes beyond daily exposure or repetition but refers specifically to psychotherapists taking hold of opportunities to participate in a well-defined, specific task which is met with immediate performance feedback, followed by repetition until improvement is

experienced from the initial errors in one's performance. With this in mind, deliberate practice is not a common feature in professional activities of already qualified professionals. Tracey et al. (2014) report that experience improves accuracy of clinical judgement, albeit by a small margin. Self-reported confidence increases with years of practice, but according to Walfish, McAlister, O'Donnell, and Lambert (2012) this is not reflected in the clinician's actual performance. To improve performance of psychotherapists across their careers a nuanced understanding of how development occurs needs to understood.

2.6. Personal Characteristics of Psychotherapists

Within the USA, ideal psychotherapist characteristics of clinical psychologists can be traced to a report of the Committee on Training of Clinical Psychologists (1947) who compiled a list of ideal qualities of trainees: superior intellect, originality, insatiable curiosity, interest in others as individuals, self-insight, a sense of humour, tolerance, a lack of arrogance, an ability to establish warm relationships, methodical work habits, an acceptance of responsibility, tact, integrity, self-control, a sense of ethical values, being broadly educated and having a deep interest in clinical psychology (McFall, 2006). This list still holds sway seven decades later as such qualities are rated in referee reports and in selection procedures within South Africa (which is to be further outlined in 2.9.2.).

In terms of providing a depiction of a sought-after psychotherapist a 'list of ingredients' outlining desired personal attributes for psychotherapists has been proposed (Ackerman & Hilsenroth, 2003; Ahn & Wampold, 2001; Jørgensen, 2004; Kahr, 2005; Orlinsky & Rønnestad, 2005). Orlinsky and Rønnestad (2005) identified the following key characteristics of psychotherapists: strong interpersonal skills, intellectual strength, curiosity, flexibility, openness to experience, a reflective temperament and not having severe psychopathology. Jennings and Skovholt (2004) have identified a three-pronged depiction of a master psychotherapist. Firstly, on a cognitive level, master psychotherapists expect to encounter complex ambiguity, possess insatiable curiosity and a love of learning, demonstrate profound understanding of the human condition, and are guided by this accumulated wisdom. Secondly, in terms of the emotional dimension of personality, master psychotherapists possess deep self-acceptance, humility, high self-awareness, quiet strength, an intense will to grow, vibrancy, and a passion for life. Thirdly, in the relational dimension, master psychotherapists prioritise intensively engaging with others, possess acute interpersonal perception, work from a nuanced ethical compass of virtue ethics,

demonstrate generosity within limits towards clients, utilise varied relationship stances, and actively seek out feedback.

The following characteristics have been highlighted across Psychodynamic (e.g., Freudian, Sullivanian, Ego Psychology, Self Psychology), Humanistic (e.g., Rogerian, Existential, Gestalt), or Learning (e.g., Behavioural, Cognitive-Behavioural, Social Learning) orientations namely; self-integration, anxiety management, conceptualising skills, empathy and self-insight have been found to be evident in excellent psychotherapists (Van Wagoner, Hayes, Gelso, & Diemer, 1991). Najavitst and Strupp (1994) emphasise that effective psychotherapy hinges upon the warmth and affirmation capacities of the psychotherapist and ensuring that attacking and blaming is kept to a minimum.

Personal characteristics of psychotherapists have been studied particularly by psychotherapists from the vantage point of depth psychology (Israelstam, 2011; Kelly, 2007; Klein et al., 2011). Israelstam (2011) asked fifty four members of the Australian Society of Psychoanalysts, ranging from training candidates, junior members (five years or less experience after qualification) and senior members, to provide "a list of indicators of analytic capacities that they believed a candidate should be able to demonstrate and aspire to, in order to eventually be thought of as a competent analyst" (p. 1290). The results of this study of Australian psychoanalysts showed that the personal characteristics of the psychoanalyst and emotional regulation were regarded as the most important capacities according to the participants. Identified personal characteristics included: empathic understanding, attunement, humility, acceptance, respect, frustration-tolerance, patience, firmness, curiosity, creativity, authenticity, integrity, trust, ethics and a quest for truth. Management of boundaries, perceptual awareness, maintenance of an analytic stance, interpretative and conceptual (capacity for symbolic thought) abilities were then rated as necessary. The candidates, unlike the junior and senior analysts, held that management of boundaries was of slightly more importance than perceptual awareness.

Kelly (2007) argues that Jungian analysts are shaped by whom analysed them and in turn analysts teach and train in the ways that they were shaped, thus creating an analyst lineage by virtue of the personal analysis being central to training and qualification. Though the training analysis is separate from any other training or evaluation context, candidates qualify based on their personal development and maturity that has grown out of the training analysis as well as their knowledge base acquired in coursework. In terms of selecting suitable candidates, Kelly

(2007) proposes the following key questions: Does the applicant have the capacity to make use of what is offered in the training programme and show sufficient potential to warrant the investment? If someone dear to me or I myself needed help, would I consider consulting with or referring to the applicant? What is the quality of their presence and of relatedness? and, Does the applicant show a capacity to reflect on their process and be receptive to feedback?

With specific reference to psychoanalytic-orientated psychotherapists from an American vantage point, Klein et al. (2011) list good relational skills, love of learning, tolerance of ambiguity, capacity for little or delayed gratification, flexibility, resilience and inherent attitude, ethical and values suited to the profession of psychotherapy. Despite pinpointing ideal characteristics, Klein et al. (2011, p. 289) concede that candidates cannot possess all desirable qualities but rather trainers need to prioritise the candidate having most of the characteristics present resulting in "the more natural fit" between the candidate and the career of a psychotherapist. Klein et al. (2011) strongly advocate that trainers "have a responsibility to graduate only those who meet a reasonably high standard of competence and character to qualify them to practice" (p. 290).

2.7. Motivations for Becoming a Psychotherapist: Wounded Healer

> *Your profession is not what brings home your paycheck. Your profession is what you were put on earth to do, with such passion and such intensity that it becomes spiritual in calling* (Vincent Van Gogh, n.d.).

Chang (2011) speaks of eight Canadian masters-level counsellors having "foreshadowings" which contributed to them embarking on a career in psychotherapy. He explains that a foreshadow is a literary term that lets the reader anticipate an upcoming event or character change in the unfolding story. Participants reported that foreshadowings in their lives that led them to pursue a career as a professional counsellor included their early emotional attunement to others, standing up for the underdog and a 'helping others' disposition.

Burnley (2012), Merchant (2012), and Rice (2011), from an Analytical Psychology viewpoint, trace the notion of the wounded healer to shamanism. Rice (2011) defines a wounded healer as an individual who uses their vulnerabilities in facilitating the healing of others.

In terms of shamans and contemporary psychotherapists, Guggenbühl-Craig (1999) argues that good Jungian analysts potentially possess one or more of the following: a shaman archetype, wounded healer archetype or an alchemist archetype. The wounded healer archetype

is amplified by the myth of Chiron (Groesbeck, 1975; Merchant, 2012; Rice, 2011). Chiron, unknown by his father and abandoned by his mother, was left orphaned as an infant. Later his ankle was struck by an arrow from Heracles' bow, which never fully healed and remained unbearably painful. In light of his history, Chiron, went on to mentoring Asklepios (the god of medicine) in the art of healing. Similarly, Judeo-Christian beliefs also hold the notion of the wounded healer; Joseph as an example of being wounded by an angel in order to bring healing to the Hebrew nation and Jesus as being the wounded healer for human beings' transgressions (Martin, 2011; Nouwen, 1994; Rice, 2011; Sedgwick, 1994).

Key founders of psychoanalysis, Freud, Jung and Adler, document how their personal struggles shaped their psychological understandings of human nature (Dunne, 2009; Jung, 1989; Sedgwick, 1994). Additionally, Winnicott reflected on how as a child he was tasked with attempting to enliven his depressed mother. He wrote, enclosed in a letter, a poem entitled, *The Tree*, "Once, stretched out on her lap / As now on a dead tree / I learned to make her smile / . . . / To enliven her was my living" (cited in Phillips, 1988, p. 29). On reflecting on what he wrote in the letter, he asked, "Do you mind seeing this hurt coming out of me" (cited in Phillips, 1988, p. 29). Here the formative wounding of psychotherapists is shown to influence their choice of profession.

Sussman (1992, 1995, 2007) interviewed 14 American psychoanalytically-orientated psychotherapists from the mental health professions of clinical psychology, psychiatry and social work. One of the key questions posed to the participants included the projective question: "What would you guess might be the most common unconscious motivation of your average colleague?" In his study, Sussman found that the participants reported that they had become aware of a number of unconscious motives of why people (including themselves) become psychotherapists. Unconscious motives include altruism or a desire to give to others, a need to be needed, admired, all-knowing, all-powerful or in control. Psychotherapists, were found in Sussman's work, to often be driven by a need to rescue their clients like they wished as children to rescue a family member from mental illness or rescue other family members from abuse. Another key motive to enter the profession involves the psychotherapist's attempt to resolve their own psychological conflicts or disturbances vicariously, to address own self-esteem deficits, to make their parents proud by entering a respected profession, as well as to satisfy voyeuristic, stifled aggressive or exhibitionistic tendencies. Other general motives include

curiosity about people and human behaviour, and a need to find answers or solve 'impossible' problems. Furthermore, a fear of intimacy or a history of emotional deprivation may find the individual attracted to the unusual controlled intimacy of the therapeutic encounter that offers safety with expression. Henry, Simms, and Spray (1973) found that many psychotherapists reported coming from marginalised groups in society and subsequently, seeking safe intimacy inherent in conducting psychotherapy.

A history of painful experiences may compel one to become a psychotherapist to continue their masochistic way of relating with others, in the sense of self-sacrificially meeting others' needs at the expense of their own needs. Psychotherapists reported that from a young age they found themselves in the role of rescuer, confidante, negotiator/mediator, lightning rod, or scapegoat in their families and that they were in a sense "groomed to be a therapist" (Sussman, 2007, p. 160). Cohen (2009) reported that early childhood trauma is linked to a preference to choose a caregiving profession such as psychology and that personal adversity holds the potential to shape a caregiver personality. Yet Cohen cautions personal adversity is a "risky growth opportunity" (p. 215) as not necessarily does personal hardship become transformed into altruistic motives. In relation to power motives in the helping professions, Guggenbühl-Craig (1971) reflected "even the noblest deeds are based on pure and impure, light and dark motives" (p. 10). Even supposedly selfless motives are influenced by one's shadow which can contain impulses for power which can betray the unaware individual into making inappropriate decisions.

Reppen (1998) collated 31 American psychoanalysts' essays on, "Why I became a psychotherapist?" Motivations included for example, Eigen's "an attempt to mend the unmendable" (Reppen, 1998, p. 18) in relation to the death of his brother during his childhood. O'Leary (2011) interviewed eight senior psychoanalytic-orientated psychologists within the context of their established peer supervision group who reported about their motivations for entering the profession of psychotherapy. Motivations reported included the mental illness of a family member resulting in the participants as children assuming a caretaker or confidante role in their families, an early passion for stories and drama, extensive reading and interest in psychological works, personal experience of psychotherapy, political activism, and exposure to cultures other than their own.

In a similar vein, Bager-Charleson (2010) within the UK explored the motivations of psychotherapists which attracted them to the profession. She found a key feature of becoming psychotherapists was the parentification of themselves when they were children (parent-child role inversion).

Nikcevic´, Kramolisova-Advani, and Spada (2007) found that British psychology students (with aspirations to become psychologists who practice psychotherapy) compared to other university students reported a higher prevalence of sexual abuse and neglect in their childhood as well as parentification in their adolescence that had motivated them to pursue a career as a psychotherapist. Nikcevic´ et al. (2007), and DiCaccavo (2002, 2006) argue that such experiences may result in the internalisation of a caretaking role which can find expression in entering the mental health field. Glickauf-Hughes and Mehlman (1995), and Miller (1979, 1981) add that children who become psychotherapists, were often raised by parents with narcissistic traits. Such children, in order to survive, responded to their parents' emotional needs by developing "emotional antennae" which later were put to use as psychotherapists.

Rizq (2011) argues that the early attachment experiences of counselling psychologists in the UK influences how they respond to mandatory personal psychotherapy during training. Utilising Main and Goldwyn's (1998) Adult Attachment Interview (AAI) to explore each participant's representations of early childhood relationships as well as conducting phenomenological semi-structured interviews Rizq noted that insecurely-attached participants were more sensitive to a perceived disparity of institutional and interpersonal power within the therapeutic relationship. Leiper and Casares (2000) found that 196 British clinical psychologists scored higher on the attachment pattern of 'compulsive care-giving' in terms of insecure attachment styles. The psychologists' formative and current attachment experiences had influenced the quality of their therapeutic relationships with clients.

Zimberoff (2013) cautions psychotherapists that their rescuer personality can become professionalised, yet remain problematic. Rouslin Welt and Herron (1990) argue that the basic narcissistic problems of the psychotherapist (their own unmet needs) attract them to the profession of psychotherapy. In examining the narcissistic needs of the psychotherapists, Rouslin Welt and Herron found that obsessional traits featured prominently in terms of psychotherapists having a need to control and becoming motherly persons with chronic helpfulness which stemmed from their childhood of having to care for their caregivers. Unconsciously, the

psychotherapist hopes by meeting the emotional needs of others their unmet childhood needs for affirmation, love, gratitude, and care will be assuaged through the client acting as a substitute self-object of the psychotherapist offering approval and admiration. In light of the double-edged nature of the motivations to become a psychotherapist, Wosket (1999) advised that psychotherapists continually examine their functional/dysfunctional motivations for being psychotherapists. Chused (2008) argues that psychotherapists choose the psychotherapy profession as they have ghosts of the past that foster an "overdetermined need to "help" or "cure" (p. 679) and therefore personal psychotherapy is needed to rein in this need appropriately.

2.8. Personal Sources of Influence upon Psychotherapist Development

In 1956, Spiegel argued that family life events of the practitioner subsequent to being selected for training continued to influence the ongoing development of the qualified practitioner. Wheeler (1991, 2002) advocates a detailed personal development strand needs to be embedded within the training course of psychotherapy trainees. Rønnestad and Skovholt (2002) emphasise that the personal experiences of psychotherapists culminate into personal knowledge that informs psychotherapists' work with their clients.

Jensen (2007) demonstrates how personal and private experience can be an important framework for practicing psychotherapy in terms of the resonance that can occur between personal events and events that happen within the professional context of being a psychotherapist. Jensen found that experienced family psychotherapists' personal lives resonated within a client encounter which resulted in a paradigm case or an 'unforgettable case' influencing the psychotherapist's way of doing therapy afterwards. A paradigm case is defined as "a clinical episode that alters one's way of understanding and perceiving future clinical situations. These cases stand out in the clinician's mind; they are reference points in their current clinical practice" (Benner, 1985, p. 296).

Nissen-Lie et al. (2015) have found that effectiveness of 70 Norwegian psychotherapists (from various mental health professions) with clients was deeply influenced by the intersecting factors of personal and professional development. The study concluded that "the therapists must succeed in integrating their professional capacities and expertise with their personal attributes in a way that almost blurs the distinction between them" (p. 2). With the overlapping of both personal and professional factors influencing psychotherapeutic development, both the professional and personal trajectories will be explored in the current study.

2.9. The Current Training Landscape in South Africa

2.9.1. The Scientific-practitioner Model.

A watershed event, the Boulder Conference, in 1949, held in Colarado, USA, earmarked a critical milestone in the development of training American clinical psychologists, where it was agreed that trainees needed to develop both research skills as well as clinical skills in applied settings (Frank, 1984; McFall, 2006; Mittelstaedt & Tasca, 1996). The curricula of training programmes were to be tailor-made to provide specialised knowledge in psychopathology, assessment, diagnostics, as well as the theory and praxis of psychotherapies. Recently, neuropsychology and psychopharmacology, as well as evidence-based treatments have been added to many training programmes.

Within the British context, two models have informed the training of clinical psychologists namely the scientist-practitioner and the reflective-practitioner models (Wigg, 2009). More recently a constructionist-practitioner model informed by social constructionism and critical theory has been proposed in Britain (Corrie & Callahan, 2000; Schön, 1983). Within the Australian context, the scientist-practitioner model undergirds the training of clinical psychologists (Sheehan, 1994).

Similarly, some psychology training institutions within South Africa have based their training on the Boulder model which promotes the development of scientific-practitoner psychologists (Pillay & Kritzinger, 2007; University of Zululand, 2013; Van der Westhuyzen & Plug, 1987). Importantly, the significant research component of all current training programmes of psychologists in South Africa is historically rooted in a scientist-practitioner model. Stoltenberg et al. (2000) support university-based training for clinical and counselling psychologists, however teaching clinical skills needs to take priority over research skills to rather ensure practitioner-scholars as opposed to scientist-practitioners are available to provide quality mental health services after graduation. Afterall, Kimble (1984) outlines there are potentially two cultures in psychology, namely, scientific research and experimentation and in contrast a psychology that prioritises humanism and holism. Clinicians on the whole in line with their personality and attitudes identify with humanistic values and using psychology within 'high-touch' helping contexts despite being taught research competencies (O'Gorman, 2001; Ready & Santorelli, 2014).

Alongside acquiring the necessary content or knowledge base, trainees need to gain extensive and broad clinical experience, "real-world experiences with actual patients" (Klein et al., 2011, p. 293). As a starting point during university coursework, Stricker (2000) emphasises that students benefit from being taught psychotherapy from academics/lecturers who are actively conducting psychotherapy in the field as clinicians. Lecturers need to be able to demonstrate therapeutic skills to students proficiently and in practical ways (Walsh, 1990). Following on applied coursework, O'Bryne, Clark, and Malakuti (1997) recommend that trainees benefit from an internship to practice applying effective therapeutic procedures that they have learned with a range of clients. Exposure to varied clinical populations is therefore essential. Participation in a multi-professional team during internship is common practice internationally (Orlinsky & Rønnestad, 2005). Supervision, as well as mentoring, provides an ideal context to explore the application of professional ethics (Burke, Harper, Rudnick, & Kruger, 2007), and develop one's professional identity as a psychotherapist.

This, too, is the case with masters training within South Africa (Brown, 2008), as stated in the HPCSA guidelines for training institutions:

> Proper supervision of the intern's work is essential and must take place in the context of a multi-professional team in which the interns are fully integrated. The supervision of interns must take place under the direct control of at least one full-time, registered psychologist who has been registered for at least three years. This psychologist accepts the primary responsibility for the professional moulding of the interns. Under his/her guidance, the interns must gradually be allowed to assume progressively greater responsibility... interns must have access to a spectrum of cases which is sufficient to ensure the variety of exposure required by the programme (2005, p. 1- 2).

2.9.2. Selection Processes into Psychology Masters Programmes.

Research into the development of clinical and counselling psychologists as psychotherapists has as a starting point investigated the selection processes that training programmes have implemented to choose trainees that show potential to qualify as psychologists and in turn practice psychotherapy. After all, "in a very real way, admission into an advanced training program in psychotherapy is the first gate or 'rite of passage' in the journey to becoming a psychotherapist" (Guy, 1987, p. 34).

Nine of the 16 psychology masters training universities combine the coursework training years of clinical and counselling student psychologists together (Collocott, 2011). Scope of practice differences between clinical and counselling psychologists are seen most prominently during the subsequent internship year. There are 16 South African universities which offered masters training in clinical psychology (14) or counselling psychology (10), at the time of the data collection phase of the current study, and these are presented in Table 2.

Table 2: Masters Degree Programmes Offered in South Africa for Clinical and Counselling Psychology (adapted from HPCSA, 2011, 2017).

University	Clinical Psychology	Counselling Psychology
Midrand Graduate Institute (Pearson Institute of Higher Education)		MA Counselling Psychology (not offered as of 2016)
Nelson Mandela University (Nelson Mandela Metropolitan University, University of Port Elizabeth)	MA Clinical Psychology	MA Counselling Psychology
North-West University (Potchefstroom University)	MA/MSc Clinical Psychology	MA/MSc Counselling Psychology
Rhodes University	MA Clinical Psychology	MA Counselling Psychology
Stellenbosch University	MA Clinical Psychology and Community Counselling	
University of Cape Town	MA Clinical Psychology	
University of Fort Hare		Masters of Social Science Counselling Psychology
University of the Free State (University of the Orange Free State)	MA Clinical Psychology	MA Counselling Psychology
University of Johannesburg	MA Clinical Psychology	MA Counselling Psychology
University of KwaZulu-Natal	MA Clinical Psychology	MA Counselling Psychology

Sefako Makgatho Health Sciences University (University of Limpopo)	MA Clinical Psychology	
University of Pretoria	MA Clinical Psychology (2yrs)	MA Counselling Psychology (2yrs)
University of South Africa	MA Clinical Psychology (2yrs)	
University of the Western Cape	MPsych in Clinical Psychology	
University of Witwatersrand	MA Clinical Psychology	MA Community-based Counselling Psychology
University of Zululand	MA Clinical Psychology	MA Counselling Psychology

In Australia the average intake at each university per year is 15.5 but ranges from eight to 30 trainees (O'Donovan, Bain & Dyck, 2007). In comparison, within South Africa, RU in Grahamstown selected six clinical psychology trainees and six counselling psychology trainees for the 2017 intake, and Stellenbosch University (SU), and the University of South Africa (Unisa) at their main campus in Pretoria selected ten clinical psychology trainees each. In 2015, the University of the Witwatersrand's (Wits) community-based counselling psychology programme and Pearson Institute of Higher Education each selected eight counselling psychology trainees. In 2017, Wits had 12 trainee placements for their clinical psychology programme, and 12 trainee placements for their community-based counselling psychology programme available for 2018 (University of Witwatersrand, 2017a, 2017b). Over a five year period (1995-1999) 399 trainees qualified as clinical psychologists as recorded by the Health Professions Council of South Africa (HPCSA) (Pillay & Kritzinger, 2007). More recently, over a five-year period (2013-2017), it can be calculated that South Africa had approximately 426 clinical and 140 counselling psychology graduates entering professional practice as practitioners (HPCSA, 2017).

Studies of selection procedures. Selection procedures have been criticised for being imbued with selectors' bias and ambiguity and as such lacking objective criteria and measures to assess applicants' suitability (Louw & Fouché, 2001). Within the South African context, the selection processes of clinical psychologists have been investigated by Chippindall and Watts

(1999), Ivey and Partington (2012), Kaschula (2002), Louw and Fouché (2001), Mayekiso, Strydom, Jithoo, and Katz (2004), and Snyders (1979).

Louw and Fouché (2001) investigated the perceived suitability of selection criteria related to categories of clinical, counselling and research psychologists countrywide through recruiting 424 questionnaire respondents. University-based psychologists who train psychologists were asked to list the most important selection criteria when choosing clinical and counselling psychologists. Results from participants' responses indicated that the following was prioritised by both clinical and counselling psychology categories: sound academic ability and intellectual potential, empathy, a well-adjusted personality, and a high level of maturity. A further criterion highlighted as necessary for clinical psychology selectors was therapeutic potential, and for counselling psychology selectors good interpersonal skills was an additional criterion. These essential attributes are in line with international selection criteria.

Chippindall and Watts (1999) asked nine selectors of the Wits clinical psychology masters programme to evaluate six applications each of previous applicants to the programme in terms of suitable attributes to train as clinical psychologists. Participating selectors identified that suitable applicants exhibit a secure sense of self, the capacity for libidinal investment in others, and flexibility. However beyond these attributes that enable psychologists to empathically engage with clients, selectors also emphasised that applicants needed to show evidence of academic ability in order to meet the academically challenging requirements of the masters programme. In addition, selectors voiced that applicants having gone through and mastered early personal trauma or conflicts is necessary in order for the applicant to have the attributes that will enable them to engage in an empathic process with clients in psychotherapy .

Subsequently, Ivey and Partington (2012) asked ten selectors of the Wits clinical psychology programme to each evaluate the same six autobiographies of applicants in terms of the applicant's suitability for clinical training. In interviewing the selectors in relation to their choice of suitability Ivey and Partington noted any selectors' verbalisations regarding the applicant's "woundedness" and its relation to being considered or not considered as suitable for training to be a clinical psychologist. Ivey and Partington found that how the "woundedness" experiences were processed by the applicants influenced the selectors' decisions regarding applicants' suitability for training to be a clinical psychologist. Wits selection criteria (www.witsclinselections.wordpress.com/about/) recommend that potential applicants wait two

years at least following an admission to a mental health institution in order for resolution or treatment of the mental health issues to take effect.

As part of an ongoing quantitative research project, Nelson Mandela Metropolitan University (NMMU) makes use of psychometric testing in selecting trainees. Tests utilised constituted of the Revised NEO Personality Inventory (NEO PI-R), Minnesota Multiphasic Personality Inventory®-2 (MMPI-2) and the Myers-Briggs Type Indicator (MBTI). Using these psychometric assessments, Hurter (2009) investigated 247 NMMU applicants' personality traits according to the NEO PI-R and MBTI. The results indicated that overall short-listed candiates who avail themselves for the interview stage of selection are emotionally stable and well-adjusted. Smit (2010) investigated 44 NMMU applicants' personality types according to the MBTI. Out of the sixteen personality types the ENFP (13%), INTP (13%) and ISFJ (13%) were the three most common personality types amongst participants who were successfully selected for the masters programmes in clinical and counselling psychology at NMMU.

Uniquely, Kaschula (2002) a trainee from RU, examined the selection process at a South African university which, at the time, based its selection procedures and training upon the principles of Narrative Therapy and noted inherent paradoxes. On the one hand, applicants were found to enjoy an enriching and creative selection process yet on the other hand applicants verbalised that despite the non-pathologising stance of Narrative Therapy they felt the process still took place under an inescapable evaluative 'gaze' which maintained a level of uneasiness for students. The applicants to the masters programme reported that they found the narrative questions posed in the selection procedures prompted their self-reflection capacities. Nevertheless, applicants still approached the questions with the scrutiny of selectors in mind as such selectors still held the Foucauldian 'clinical gaze' which contributed to applicants' anxious feelings. However, Snyders (1979) argued that selection of candidates needed to go beyond assessing the intrapsychic dynamics of applicants, in that in vivo interpersonal situations where extensive use was made of ratings have shown high reliability when selecting trainees for masters training in clinical psychology.

Mayekiso et al. (2004) examined the demographic profile, selection criteria and procedures of candidates selected for clinical psychology training at eight universities in the new democratic South Africa from 1994 to 2004. The course co-ordinators surveyed spoke of shifts in selection processes. Race, language proficiency in an African language and/or capacity to

work with diverse clients and community involvement or volunteerism to address the paucity of psychological services accessible to all South Africans had become explicit criteria (Mayekiso et al., 2004). From 1994 to 1998, the number of selected African candidates rose from 13% to 14%, and from 2000 onwards African candidates increased from 25% to 31% of the total number of candidates selected for clinical psychology training.

Selection criteria emphasised by training programmes for clinical psychologists in South Africa included: academic performance at honours level above 60 to 65 per cent grade, flexibility, openness, insight, stress/workload management, congruence, psychological mindedness, interpersonal skills with individuals and groups, social consciousness in terms of community mindedness and involvement in community work. One university in the sample added that research skills and academic capacity beyond achieving an honours degree (fourth year after completion of three year bachelor's degree in South Africa) was also needed (Mayekiso et al., 2004).

Similarly, SU (2013) outlines the following selection criteria for applicants to their Clinical Psychology and Community Counselling programme: firstly, an academic ability of above 65% for their honours degree in Psychology (fourth year) as well as good essay writing skills, secondly, community experience and the ability to reflect on such experiences, thirdly, previous counselling experience and the ability to discuss the two-way process of counselling is regarded as advantageous, fourthly, socio-political awareness of the South African context and a willingness to contribute to the country's diverse population, fifthly, self-awareness and the ability to self-reflect on personal experiences and to understand the events that have shaped them as individuals, in that self-awareness is regarded as linked to understanding others in a psychological way, sixthly, personality functioning is assessed in terms of emotional stability and in terms of the individual's ability to identify and manage negative feelings, and finally, an awareness and articulation of the applicant's motivations for wanting to become a psychologist is needed. Afterall, O'Bryne, Clark, and Malakuti (1997) cautioned that counselling and educational psychology trainees in the USA are screened regarding their potential for sustained levels of motivation during training.

In collaboration, SU, UCT, and the University of the Western Cape (UWC) (2013) have asked referees to comment on the following abilities of applicants for their clinical psychology

programmes: intellectual ability, verbal communication skills, written communication skills, self-discipline, initiative, reliability, and research skills.

North-West University (NWU) (2013) asks referees to rate applicants to their clinical and counselling psychology masters programme in relation to the following attributes: flexibility, emotional maturity and stability, self-discipline and motivation, communication skills, interpersonal relationships skills, utilisation of own potential, dependability and responsibility, neatness and promptness, independence and creativity/originality. UJ (2013, p. 4) highlights that clinical and counselling psychologist trainees need to demonstrate self-discipline, emotional maturity and stability, resilience, responsibility, ethical behaviour, interpersonal sensitivity, assertiveness, flexibility, communication skills, skill in interpersonal relationships, academic potential and potential to be a psychologist. Similarly, NMMU (2013c) emphasises the following qualities for clinical and counselling psychology trainees: academic and research ability, verbal and expressive ability, written communication, empathic ability, regard and respect for others, flexibility, emotional stability and maturity, stress tolerance, personal insight, self-confidence, assertiveness, initiative, reliability and time management, originality, sense of humour, integrity, maturity and overall potential to be a psychologist. Furthermore, selectors from NMMU ask referees to comment on the applicant's most outstanding qualities as well as major limitations.

Universities in South Africa prioritise having masters programmes that represent and value the diversity of the South African context, arguing that "an understanding and appreciation of diversity precedes the achievement of excellence as a professional psychologist" (NMMU, 2013a, p. 3). In this light, NMMU selectors ask referees to comment on the extent to which they think applicants to the clinical and counselling psychology masters programmes would be willing and capable of offering professional services to meet the needs in the South African context. Similarly, the University of Pretoria (UP) (2013) adds that "clinical psychology aims to reflect the vital link between a changing society and the broad therapeutic needs of our communities, while reconciling the South African context with international development" (p. 9); and the University of Western Cape (UWC) (2013) designed their clinical psychology training to meet the needs of a transforming South African society.

RU (2013) highlights the importance of South African clinical and counselling psychologists being trained to work effectively in a challenging context arguing that "no psychologist can function effectively in South Africa without a sensitive understanding of the

social context, particularly to do with issues of race, racism, culture, gender, class, poverty, inequality and HIV and AIDS" (p. 2). Gerber and Hoelson (2011) note, "South African psychologists are required to practice in a highly complex systemic context. To function effectively in the contemporary interconnected and dynamic global context places exceptional demands on the biopsychosocial and spiritual qualities of trainees, practitioners and their training institutions" (p. 4). The ability to serve in a multi-layered context is imperative to serve all South Africans with "social consciousness" and "community-mindedness" (Pillay & Siyothula, 2008, p. 734) in order to counteract Apartheid's legacy wherein psychology as a profession was indicted as "elitist, inaccessible and classist" (Pillay & Siyothula, 2008, p. 732). After all, Cooper (2000, cited in 2014, p. 265) points out that "a mark of any discipline's relevance is its ability to keep pace with social dynamics and emerge competent to describe its purview in terms of social relevance".

2.9.3. South African Psychotherapeutic Development Studies of Trainee Psychologists.

Trainees' studies of their personal psychotherapeutic development. From a systemic orientation, trainees training to be clinical psychologists at Unisa, based in Pretoria, explored their personal journeys. Their accounts adopted a particular focus on their own development as psychotherapists (Clarke, 2002; Dlamini, 2005; Jansen, 2002; Lloyd, 2003; Makena, 2001; Prentice, 2002; Richards, 2003; Small, 2003; van der Merwe, 2013).

Clarke (2002) revealed that her personal experience of training to be a clinical psychologist within an ecosystemic orientation saw her having to shift from adhering to an absolute truth or answer to embracing multiple truths. She grew from a need for certainty to embracing uncertainty and doubt as her "intimate companions" (p. 73).

Dlamini (2005) explored her personal journey of becoming a psychotherapist in terms of negotiating the ecosystemic-orientated training context of Unisa and subsequently being confronted with the hospital setting. As an intern clinical psychologist, in contrast to her training, she reported having to engage with the dominant discourse of a diagnostic model and reductionistic views of patients' concerns.

Jansen (2002) in interviewing six clinical psychology trainees and two trainers at Unisa found that an awareness of power dynamics became prominent when doing practical work at Agape an "open-air psychotherapy clinic" (Richards, 2003, p. 36). Trainees reported being

challenged to integrate the theories of postmodernism, systemic psychotherapy and African traditional healing into the way they conducted healing encounters or conversations with people within the community setting of Agape (Wichmann, 2012).

From a systemic perspective, Prentice (2002) examined the tensions and incomprehensibility that clinical psychology training is often imbued with by reflecting on three stories of women in need of help, his own story of training at Unisa as well as interviewing five newly qualified clinical psychologists from five different universities regarding their masters training year(s) prior to internship (academic component at the university). From the viewpoint of a trainee, he contended that the choreography that occurs between the trainer, trainee and training context had far-reaching implications for the quality of clinical psychologist that served clients. He found that when the training context, authored by the trainer, was unreadable and therefore incoherent to the trainee, trainees could experience much discomfort and even psychological damage.

In reflecting on her personal journey of training to be a clinical psychologist through the lenses of developmental theories, Small (2003) outlined 'the double-edged sword' nature of training at Unisa where trainees were confronted with inherent paradoxes. For example, she revealed the complexity of managing different roles within the same person namely, "the trainee needs to acquire an understanding of the interpersonal boundaries of the supervisory relationship in order to distinguish between the paradoxical supervisor roles of "colleague" versus "professor" and "supervisor" versus "psychotherapist" " (p. 213). She also spoke of the challenge to take personal risks when conducting psychotherapy to show that one is emotionally available to clients yet not be too emotionally porous in a therapeutic context. Such complexity in psychotherapy sessions requires the psychotherapist to be both a professional and an effective container. In the sense that "the suppression of emotions may give the appearance of a lack of empathy, but the unrestrained expression of emotions might be considered inappropriate and should perhaps be reserved for a therapeutic relationship outside the training context" (p. 212-213). Small concluded,

> it is the exposure to the thorny paths of the various training and therapeutic contexts and successful negotiation of the accompanying paradoxes that lead to growth and development, resulting in differentiation and integration of self...

> However, the ultimate test of successful differentiation lies in the period after formal training has ended (p. 213).

In a similar vein, Lloyd (2009) investigated the experiences of nineteen trainee clinical psychologists at Unisa. She, in her second year of the training, interviewed fellow trainees, namely, eight first year masters students, six second year masters students and five intern psychologists. She found that trainees found themselves in a 'double bind' experience when confronted with the implicit and explicit learning contexts of training which exacerbated feelings of confusion and powerlessness in trainees.

Makena (2001) examined the ethical sensitisation that occurred during his years of training at Unisa to become a systems-orientated clinical psychologist. He related how his personal history of growing up fatherless, poverty-stricken and having endured the death of his twin brothers had influenced how he related to people in general and how such hardships impacted on his ability to be a psychotherapist. He stated,

> I not only dig deep into my own shadows as a guide to my ethical conduct in therapy, but also use self-questioning to look at how my own shadows can lead me to be unethical: a constant struggle of being self-critical… I feel that continuous self-questioning is essential (p. 62).

Makena challenged psychotherapists to consider how they vicariously meet their own needs through a client's psychotherapy and therefore how psychotherapists needed to be self-vigilant in terms of sometimes needing their clients more than the clients required their assistance. In the sense that the psychotherapist's unmet needs constantly impact upon their therapeutic interactions with clients. Makena acknowledged the blending of the psychotherapist as professional helper and infallible human being with unique personal complexities requires the need for continual self-exploration and self-monitoring on the part of clinical psychologists. After all personal and professional experiences need to become integrated within the psychotherapist (Klein et al., 2011).

Van der Merwe (2013), by means of autoenthnography, examined her journey of self-differentation during her two years of coursework (with a specific focus on the first 18 months) as a clinical psychologist within the context of Unisa's systemic-orientated masters training programme. She found that her own process of differentiation (individuation and emotional connection with others) gave her the abilities and credibility to assist clients with their own

differentation processes. Key features of systemic training involved increased self-awareness and autonomy, acknowledging that trainers and trainess are co-responsible for the training context and outcomes.

From a postmodern social constructionist perspective, Hall (2004), Nabal (2009), and Naidoo (2005) examined personal experiences of becoming a psychotherapist when training to be clinical or counselling psychologist in South Africa. Naidoo (2005) explored the journey of becoming a counselling psychologist at NMMU with a focus on the self of the psychotherapist. She found that merely qualifying as a counselling psychologist was insufficient preparation to practice as a counselling psychologist. In that a psychotherapist is continually challenged to use their personal self within psychotherapy to the benefit of clients. She found by developing her use of self she underwent transformational growth that can be seen as acquiring "soul tattoos" (p. 3).

Hall (2004), as a trainee at UP, examined the impact that training to be a clinical psychologist had on personal relationships. The five intern clinical psychologists interviewed described a predominant feeling of being isolated from their personal relationships as they experienced "emotional overload" during their training (Hall, 2004, p. 100). Other themes that emerged were that participants found themselves becoming aware of their own personal unmet needs and having to express them and renegotiate existing relationships. Participants also spoke of managing simultaneously the observing role and the experiencing role in their personal relationships, as when remaining only in the observing role participants felt a loss of spontaneity in their interactions. Personally, Hall (2004, p. 103) added that for her, training to be a clinical psychologist involved her "own expulsion from Eden, of my own a loss of innocence" and yet her also having gained wisdom in the process.

Nabal (2009) explored the contradictions between the personal and professional aspects of training to be a psychotherapist by using her journey of becoming a counselling psychologist at UP. After having experienced the traumatic event of an armed robbery during her training she found her personal value of wanting to help people had become challenged, and that she needed to reconcile her professional and personal values. In this reconciliation process, Nabal found that she moved from understanding the profession of psychology in a "static hierarchical manner" (2009, p. 86) of codes and registration to incorporating her personal values into how she practiced as a psychotherapist in order to practice psychotherapy in an authentic manner.

Attending RU, Anema (1981) provided an autobiographical account of how she became a psychologist as a second career after first having a career as a psychiatric nurse and then undergoing masters training to be a clinical psychologist. From a phenomenological stance, she particularly focused on the psychotherapeutic process of engaging with a client, and the aspects of her experience as a psychotherapist. She revealed that, "an attempt to hold a moment in psychotherapy became for me self-confrontation" (p. 112) which relied on the psychotherapist's level of self-differentiation and the ability to explicate the psychotherapy sessions with a client without getting caught up in one's shadow.

Kometsi (2001) provided a published account of personal experiences as a black clinical psychologist trainee in multi-racial clinical settings. Herein, Kometsi described incidents where two black patients at a student practical placement idealised the career of a psychologist assuming that one achieved material gains, for example a car, by virtue of pursuing a career in psychology. In stark contrast, Kometsi verbalised the pain of a potential client rejecting and devaluing one's therapeutic services outright on account of being a black therapist, as well as the subsequent pressure to succeed with a black patient. Kometsi's account highlights that the lens of racial segregation is still evident in post-democratic South Africa. Within the broader profession of psychology as well as within private therapeutic consultations, Kometsi's account also reveals how the painful frictions and schisms arouse deep-seated needs for a sense of belonging to one's own kin in an attempt to offset the pain of alienation and continued racial 'splitting' in all contexts, including healing contexts.

Indeed, the majority of trainees' studies have provided an 'inside look' into the beginning stages of psychotherapist development within the complex South African context. However despite the rich experiences relayed by each account, each study is limited by the uniqueness of the account as the accounts confine themselves to a specific aspect e.g., a specific therapeutic process, or the impact of training on the personal relationships of the trainee. Trainee studies of one's training process inherently confined themselves to a specific training context which makes the findings unable to provide a collective understanding of the psychotherapist development of the South African trainee psychologist, which is a much needed research endeavour.

Trainees' studies of psychotherapeutic development of trainees. McGregor (2010) examined psychotherapist development at the beginning stage with a particular focus on how trainees manage the first interview with a client. She found that trainees experienced anxiety and

verbalised an internal conflict between managing the twofold task of gathering relevant client information while simultaneously being attuned to their client while being scrutinised by their trainers.

Kay (1996), in a phenomenological study, explored the growth experiences of three clinical psychology masters students in their first year of training at SU. Participants verbalised personal growth, experiencing pressure to introspect, support from classmates and lecturers and undergoing a process of growth and development, and finding meaning within the training context.

While at UP, Kühn (2003), as an intern clinical psychologist herself, conducted a phenomenological study, exploring the experiences of four fellow clinical psychology masters students during their internship year. She found that interns experience a sense of apprehension, stress and fatigue. To cope interns drew upon family and friends and to a lesser extent sought out personal psychotherapy for emotional support. Supervision formed a major part of the internship experience. At the end of the year all participants reported feeling a sense of accomplishment despite the notable challenges during their internship year.

Ahrends (1995) interviewed intern clinical psychologists regarding multicultural aspects of their training. At the time of the study, a year after South Africans voted in democracy on the 27th of April 1994, participants voiced that similarities between people were emphasised in discussions as opposed to any differences between individuals and/or ethnic groups. Arguably, questions around the capacity of trainee psychologists to discuss multicultural issues within their training context is worth further investigation especially against the landscape of South African society two decades into democracy.

Through an interpretative lens together with critical theory, Nair (2008) specifically explored nineteen interns' experiences of diversity in clinical training within the Western Cape region and found that race was still regarded as a complex, painful construct imbued with oppressive experiences for participants. The trainees reported that race became particularly foregrounded when working therapeutically in cross-racial dyads where difficulties were encountered. Trainees reportedly felt that they had inadequate multicultural training when undergoing masters training.

In a mixed-methods study, Gerber and Hoelson (2011) explored intern psychologists' experiences at three different universities within three provinces of South Africa, in terms of

their levels of curiosity and feelings of uncertainty in their professional development. The quantitative results reported that trainee psychologists had moderate to high levels of curiosity, and actively pursued acquiring new information, and opportunities to enhance their personal growth. The qualitative findings from subsequent interviews indicated that trainee psychologists actively found ways to manage their uncertainty regarding their professional development through a number of strategies namely through supervision, peer consultation, self-growth, augmenting their theoretical knowledge through for example reading professional literature, positive cognitive self-appraisals and by ensuring self-care through seeking social support and leisure activities.

In 2014, Teixeira, utilising the international developmental stage model of psychotherapists' professional development (Skovholt & Rønnestad, 2003a) interviewed three counselling psychology interns about their internship experiences in Grahamstown, in the Eastern Cape province. She reported that interns spoke of the highly supportive supervision experienced during their internship year at a counselling centre under the auspices of a university.

Other studies in South Africa have focused on the effects of personal psychotherapy upon the psychotherapist's development. Ivey and Waldeck (2012) specifically explored the significance of mandatory personal psychotherapy for nine psychodynamic clinical psychology trainees at the Wits, Johannesburg. Eight of the nine participants strongly endorsed mandatory personal psychotherapy seeing it as indicative of the psychotherapist holding themselves to a higher-order ethical principle beyond the rules of conduct stipulated by the PBP of the HPCSA, which does not make personal psychotherapy for psychologists mandatory within South Africa. Furthermore participants reported that initially they had found going to psychotherapy as rather difficult but over time they found that they had claimed their psychotherapy as personally beneficial beyond a professional training requirement of their university.

Additionally, all participants in Ivey and Waldeck's (2012) study reported that their personal psychotherapy benefitted their training and professional development as clinical psychologists, especially as their personal psychotherapy enhanced their understanding of the psychotherapeutic process. Experiencing the vulnerability of being a patient enhanced the participants' empathy towards their own patients, led to a greater understanding of patients experiencing ambivalence towards psychotherapy and an awareness of the countertransference

process. An identificatory learning process also occurred where participants found themselves modelling their psychotherapist's body language, word phrases and techniques from having enjoyed "a first-hand experience of watching a therapist in action" and as one participant noted, "He was comfortable in his chair, comfortable in his skin, there were things I really wanted to internalise… to emulate as a therapist" (Ivey & Waldeck, 2012, p. 11). Overall, Ivey and Waldeck found that personal psychotherapy for trainees is seen as an "indispensable part of professional development by those who have experienced it" (2012, p. 17).

Trainers' studies of the psychotherapeutic development of trainees. As a trainer, Human (2006, 2013) examined the influence of adventure-based experiences during masters training on the development of counselling psychology trainees. He found that experiential learning through a physical activity such as a rope course or river-rafting uniquely enhanced trainees' awareness of personal anxiety and understandings of group dynamics. Which, in turn, highlighted for trainees the importance of boundaries and role definition in therapeutic work and in other interpersonal contexts.

As clinical psychology trainers, Kottler and Swartz (2004) explored training as a rite of passage at UCT in relation to clinical psychology students under their guidance as trainers. Pertinently, three phases were identified in terms of progressing from a lay person to a professional psychologist, in that training to be a psychologist "asks for a shift in identity" (2004, p. 69), and encompasses a number of transitions. Kottler and Swartz identified the transition from student to trainee, trainee with no clients to trainee working therapeutically with clients, from being trained at the university to functioning as a burgeoning psychologist in the role of intern clinical psychologist amongst other professionals in a professional setting, from trainee to qualified clinical psychologist fit to offer independent services to the public.

The first phase identified the trainees separating themselves from other university students, family and friends due to the confidential and almost initially mysterious nature of psychological work. Feelings of detachment and unpredictability were often felt as trainees become separate from their 'previous' life prior to training and become preoccupied with and absorbed in the training.

The second phase was characterised by trainees straddling their status as a student and simultaneously seeing themselves as having a professional identity as a clinical psychologist. Within this marginal phase of symbolic death, "each initiate experiences the annihilation of his

or her own sense of identity and all that he or she has come to know about himself or herself and the way he or she operates in the world… initiates have to find a way of constructing a new identity-a painful process of re-birth" (Kottler & Swartz, 2004, p. 58). Trainees in a sense find themselves "living a destabilised existence in the margins between two identities" (2004, p. 60).

The third phase saw the trainees reintegrating back into society as a qualified clinical psychologist. Kottler and Swartz (2004) argue that this three-phase transitional process of clinical psychology trainees can be viewed as an arduous rite of passage, an initiation (Turner, 1969).

Furthermore, Kottler and Swartz observed that trainees often identify strongly with one another and may even be rebellious as a group towards the training programme at times due to underlying anxieties about becoming a professional clinical psychologist. In light of the dynamics of this personal-professional process, Kottler and Swartz caution that there is "a fine line between a creative marginality in which psychological structure is fluid enough to accommodate substantial change and a potentially more damaging state in which little creative learning is possible" (2004, p. 68). Clinical psychology trainers at Wits, Eagle, Haynes, and Long (2007) note that trainees often "feel overwhelmed and threatened" by the nature of the clinical work that they are confronted within the South African context that of "clients who have experienced multiple losses, violence, abuse, deprivation and grinding poverty" (p. 136).

Drawing on his sixteen years of professional experience as a qualified psychologist within a government tertiary psychiatric hospital setting, Brown (2008) provides an ethnographic account of the psychotherapist training of intern clinical psychologists at Weskoppies Psychiatric Hospital in Pretoria, Gauteng. Herein, Brown offers a personal 'inside' picture of what a South African clinical psychologist experiences when working within a government psychiatric setting and the systemic tensions that often impact therapeutic encounters with patients.

Ruane (2015) specifically investigated multiculturism in the training of psychologists by interviewing eight trainers and 19 clinical or counselling psychologists at a historically white university. Broadly, her research found there is an urgent need for active measures, such as employing more diverse trainers, selecting more diverse trainees and implementing diversity-focused modules, to transform a historically white university's discourses and practices in order to train multiculturally equipped psychologists to service the country's population.

Trainers' studies of the psychotherapist development of trainees offers a necessary vantage point of development as trainers are responsible for being a catalyst for novice psychotherapists to effectively begin upon the career-long path of psychotherapist development. The specificity of the studies notably hampers the findings of the trainers' studies in providing an understanding of how trainers in South Africa are training students to become psychologists in the country. Of the five studies by trainers only two regions were explored namely Gauteng and the way in which clinical psychologists are trained at UCT in the Western Cape Province which is historically solely psychoanalytic in theoretical orientation.

Thus the perspective of trainers from all masters programmes on the psychotherapist development of South African trainee psychologists in the categories of clinical and counselling psychology particularly presents a golden opportunity for further research endeavours. For example, 'Does Brown's experiences within an urban tertiary psychiatric hospital setting reflect the experiences of other trainers situated at other hospitals (and at the secondary or tertiary level hospitals where interns are placed) across the breadth of the country?'

2.9.4. Experience with Patients During Training.

Psychology training clinics. Following the heritage of Witmer's brainchild, "psychology training clinics play a central role in training clinical psychologists" (Babbage, 2008, p. 157). Similarly to the USA, Australian trainees are introduced to client work through "university-based psychology clinics" or "in-house clinics" set up for postgraduate training programmes (Pachana et al., 2006). Today, Gonsalvez et al. (2008) note that every clinical training programme in Australia and New Zealand makes use of a training clinic for student clinical psychologists to practice psychotherapy skills with real clients.

Experience in the university clinics serves as a bridge for trainees to integrate psychological theory and research into real-world applied clinical settings and initiate professional identity development. The clinics provide opportunities for trainees to practice with clients in tandem with supervision to monitor and shape clinical skills which is different in timing and purpose of external practicum settings or internships where the foremost priority is on service delivery and training is situated in the near-background.

Importantly, observational methods such as one-way mirrors and audio or video-taping is prioritised in accordance with training standards in Australia and New Zealand. McCullough, Bhatia, Ulvenes, Berggraf, and Osborn (2011) have emphasised the need for supervisors and

trainees to view and rate video-taped sessions of other psychotherapists working with psychotherapy clients in such a way that it parallels airplane pilots having to accrue a certain number of in-flight simulations prior to being permitted to flying a real plane.

Within South Africa, in-house university psychology clinics have been established. For example, the Child Guidance Clinic at UCT (1935), Welgevallen Community Psychology Clinic at SU, Rhodes Psychology Clinic at RU in Grahamstown, UCLIN and Missionvale Community Psychology Centre of NMU in Port Elizabeth, the Emthonjeni Community Psychology Clinic at Wits in Johannesburg, the Khula Clinic at Pearson Institute of Higher Education, in Midrand, the Psychotherapy Clinic at Unisa in Pretoria, and the Itsoseng Clinic which was established and is managed by UP as a training clinic within the community context of Mamelodi, Pretoria. On average, student psychologists are expected to carry a caseload of three to five active clients at a time (Rhodes University, 2014; Wits MACC programme, 2014).

Practicums. In addition, South African universities prioritise regular practical exposure (placements) for masters clinical and counselling psychology students, beyond the university psychology clinic setting, situated within external agencies or institutions prior to embarking upon formalised internship training at government hospitals or clinics for clinical psychologists or university student counselling centres or counselling psychology practices for counselling psychologists. For example, SU has links with preschools and an under-resourced community (Van Wyk & Naidoo, 2006). Wits students attend regular psychiatric ward rounds at secondary hospitals, implement community interventions and offer psychotherapy in the communities of Alexandra and Hillbrow in Johannesburg (Eagle, 2005; Revington, 2008). Unisa students attend psychiatric ward rounds at a government tertiary psychiatric hospital, custody evaluations at the Office of the Family Advocate, implement community interventions and short-term psychotherapy at a care centre for physically and intellectually disabled children and at an under-resourced high school (van der Merwe, 2013). NMU students attend psychiatric ward rounds at a government tertiary psychiatric hospital, and conduct scholastic and developmental assessments at preschools and under-resourced primary schools (NMMU, 2013a).

Though the practicums are, indeed, situated at external agencies, the interventions by student psychologists are initiated by and directly supervised by university-employed clinical and counselling psychologists and are usually short-term in nature. The practicums offer student psychologists careful exposure to a variety of professional contexts of psychologists. In contrast,

the subsequent full-time internship year is a remunerated, formal, year-long job contract with a hospital, mental health facility or career and counselling centre where predominantly supervision and training is undertaken on-site by employed senior staff (Kühn, 2003).

Psychotherapists report that working with actual clients profoundly influenced their professional development; even if, at first, it was challenging and even sometimes traumatic (Casement, 1985, 1990; Folkes-Skinner, Elliot, & Wheeler, 2010; Klein et al, 2011; Skovholt & Rønnestad, 2003; Wolgien & Coady, 1997). Working with clients is coupled with the supervision of client work, which is also seen as a key source of professional development, therefore it is difficult to tease out how each individually contributes to psychotherapists' growth. Klein et al. (2011) advocate that during training students need to be exposed to abroad range of patients and a variety of presenting problems as well as different levels of problem severity. Students also need to become comfortable working collaboratively with other psychotherapists and other mental health professionals as this reflects the reality of the profession where treatment teams are commonplace in assisting patients (Brown, 2008).

2.10. The Current Practicing Landscape in South Africa

2.10.1. Qualified Psychologists as Psychotherapists.

The number of psychologists registered with the HPCSA who are qualified to practice psychotherapy in South Africa was recorded as 6526 in June 2017. In terms of the categories of psychologists: 3067 clinical psychologists, 124 Community Service clinical psychologists, 1737 counselling psychologists and 1598 educational psychologists were on the register as practicing within South Africa (HPCSA, 2017).

2.10.2. Studies of Psychotherapeutic Development of Qualified Psychologists.

Viljoen et al. (1999) investigated how qualified clinical, counselling and educational psychologists retrospectively viewed their training at the University of the Free State (UFS) in the years 1990-1996. The training at UFS at the time was an integrated training course for clinical, counselling and educational psychologists. Other universities such as NMMU, NWU, UJ, University of KwaZulu-Natal (UKZN) and RU also have an integrated training programme where the year(s) of theoretical training at the university involves counselling and clinical psychology trainees attending classes together. In this study regarding the training at UFS, 94.4% of respondents indicated that, on average, they spent more than half (54.8%) of their work hours with therapeutic work. This result corroborates with the earlier study of Bassa and Schlebusch

(1984) where clinical psychologists spent 44.5% of their time engaged in conducting psychotherapy. Thus Viljoen et al. (1999) make a strong recommendation that clinical, counselling and educational psychologists' development as psychotherapists needs to be a key priority in universities' training to stand trainees in good stead when qualified as clinical, counselling and educational psychologists.

By means of life writing, senior psychologist Manganyi (2013, 2016; Mbele, 2017) reflected on his journey of qualifying and practicing as a clinical psychologist during the Apartheid era as a black South African. Manganyi recounts the challenges and opportunities that he encountered as an intern clinical psychologist in 1969, at a time wherein overall clinical psychology as a profession was still taking root within South Africa and even more miraculously carving out his career path in a hotbed of racial prejudice. Manganyi's accounts are unique in offering a picture of the psychotherapist development of a South African psychologist spanning their career. However, it is a personal account and therefore studies that compare psychologists' experiences across the lifespan of their career is still a much needed area of research.

In terms of personal psychotherapy for psychotherapists beyond their training years, Haumann (2005) investigated the impact of current personal psychotherapy on the professional development of eight qualified psychodynamic psychotherapists from a relational and intersubjective model. Haumann found that the notion of the wounded healer featured prominently in her sample. She tentatively attributed this to asking the participants their reasons for choosing the profession of psychology and their motives for entering personal psychotherapy for the first time.

Comparison study of psychotherapeutic development of trainee and qualified psychologists: In step with the theoretical framework of the current study, I have previously (Laidlaw, 2010) utilised Skovholt and Rønnestad's (1993, 1995, 2003a, 2003b, 2003c) international developmental phase model of psychotherapists' professional development to explore the professional development of intern psychologists and registered psychologists with at least seven years post-qualification client contact. The intern clinical and counselling psychologists were training at NMMU at the time of the study and the established clinical, counselling and educational psychologists had either trained at the University of Port Elizabeth (changed to NMMU) or RU, which are both situated in the Eastern Cape province of South Africa.

The participants reported life experiences that featured personally wounding events or highlighted participants in a helper role. The theoretical orientation(s) of participants were found to be influential in their development yet adjusting to clients' needs was of overriding importance. Participants also emphasised a strong therapeutic relationship with clients as the centrepiece of psychotherapy and depicted the therapeutic process using diverse metaphors. Catalysts for professional growth of the participants included: personal psychotherapy , 'unforgettable cases', group supervision and for established psychologists professional workshops. Shifts in competency were recognised by intern psychologists, namely, dissolution of naivety, reduced anxiety regarding clinical work, greater flexibility in the therapeutic process, decreased inappropriate responsibility for clients' progress, and negotiation of their personal and professional lives. Whereas established psychologists voiced gaining more confidence through years of practice and yet acknowledged some anxiety which fostered humility. However, this study only focused on psychologists based within the Eastern Cape province.

Despite the worthwhile contribution of the above-mentioned limited number of studies, outined in this chapter, a comprehensive model of professional development spanning the entire career of psychologists as psychotherapists that reflects the South African context nationwide is yet to be developed.

2.11. Professional Sources of Influence upon Psychotherapist Development

Research (e.g., Orlinksky, 1999; Orlinsky & Rønnestad 2005; Spiegel, 1956) has identified a number of professional or formalised experiences that shape a psychotherapist's professional development over their career. An optimal set of experiences includes the following: didactic learning/clinical teaching in the context of formalised training and CPD seminars or workshops, direct experience with clients, supervision of client work, a mentoring relationship and personal psychotherapy (Klein et al., 2011).

2.11.1. Didactic Learning.

Klein et al. (2011) emphasise that curricula need to provide students with specialised knowledge and professional experiences to competently qualify and enter the profession. An up-to-date broad didactic knowledge of psychopathology, assessment, diagnosis and ways of doing psychotherapy interventions as well as research competencies that can inform clinical work are necessary. Additional competencies may include neuropsychology, psychopharmacology (Sexton, Legg, & Hammersley, 2006), and forensic psychology. Importantly, the transmission of

an accumulated body of knowledge needs to interface with and take into account political, economic, social, cultural and medical/health contexts which professionals and their clients are inescapably situated within. Furthermore, didactic learning of psychotherapy is well-suited to face-to-face tuition so that, within the animated interaction, knowledge can be imprinted for students in a way that can be interactively used later with clients (Schermer, 2011).

According to Schermer (2011), and Skovholt and Rønnestad (2003c) trainees need to become competent in at least one theoretical approach of psychotherapy in order to effectively assist clients. Ideally, the theoretical orientation should match the trainee's personality in order to promote congruence when working with clients (Arthur 2000; Schermer, 2011; Truscott, 2010). Furthermore, the trainee must be conversant in and capable of defending their personalised theoretical framework from which they work (Kelly, 2007). Teaching needs to assist students in building conceptual frameworks to conceptualise and organise clinical data and experiences by making use of psychological theories, schools of thought, change processes and a pool of factual knowledge (Buckman & Barker, 2009; Schermer, 2011).

Orr (2012) describes as a South African clinical psychology trainee learning theory about psychotherapy, in her case specifically psychoanalytic theory. She found that a deep theoretical understanding of psychotherapy provided her with a "solid foundation" (p. 107) to base practical training upon and as a safety net when feeling overwhelmed in consultation. Theory, in a sense, provides psychotherapists with a cognitive map to anchor themselves when faced with the ambiguities inherent in consultations with clients (Hillerbrand & Claiborn, 1990; Schermer, 2011). Orr (2012) also highlights that having to use one's self within psychotherapeutic consultations arouses fears of narcissistic injury from patients. In learning psychotherapy there also are tensions around evaluation grades and how these evaluation anxieties potentially hamper self-growth. Specifically, coursework which includes observing psychotherapists in live action or watching recordings of therapeutic sessions and participating in role-plays were seen as essential to grasp the concepts/theoretical aspects in order to apply them effectively in practice (Orr, 2012). Kit, Garces-Bacsal, and Burgetova (2015) have found that realistic role-playing sessions with immediate feedback from trainers where in turn trainees could reflect upon their performance enhances the acquirement of basic counselling skills in trainee educational psychologists; this is also advocated for clinical psychologists by Rousimaniere (2017).

During internship, hands-on experience is enjoyed in tandem with formal and informal didactic learning. Vehicles of learning include seminars, journal reading groups, workshops, and case presentations (Azara, 2009). The key areas of learning at the internship level focus on mastering diagnostic, prognostic and treatment methods (Schermer, 2011).

2.11.2. Ongoing Professional Development.

From an American perspective, Schermer (2011) also highlighted didactic learning continuing through specialty training for qualified psychotherapists. Specialty training involves an extended curriculum offered by free-standing institutes or professional organisations which grant certification on completion of learning a specific school of thought or specialised treatment protocols. For example, in South Africa the Institute of Psychodynamic Child Psychotherapy (IPCP) confers diplomas and certificates in relation to psychoanalytic psychotherapy with children (www.ipcp.co.za).

Ashton (1992) has cautioned that professional knowledge has an applicability for five years whereas Haines (1997) argued that the relevance of acquired knowledge could also be as short as between two to five years. Thus professional competency is a 'perishable commodity' and therefore obtaining a qualification acts as the entrance requirement for lifelong learning. Competency is also context-specific and geared to serve the practice environment that the psychotherapist currently works within.

Bradley, Drapeau, and DeStefano (2012) found that Canadian clinical psychologists reported that their feelings of competence were related to professional reading, participating in training courses or workshops, the accumulation of years being registered, and attending conferences. Feelings of professional value were related to age and participating in psychology groups and feelings of professional support were related to participating in supervision groups and networking groups. A moderate relationship was found between CPD activities being linked to feelings of competence, professional value and professional support.

Schermer (2011) contends that CPD has limited value as the concentrated learning of a few hours or a week is informative yet creates an "illusion" of competence which would actually require months of teaching and supervision to effectively implement the learning with clients. At best CPD events provide practitioners with opportunities to be introduced to new developments in the field which they may wish to pursue further with comprehensive specialty training. Thus the value of CPD needs to be invesigated further.

2.11.3. Psychotherapists' Own Psychotherapy.

Since Carl Jung recommended to Sigmund Freud that aspiring psychoanalysts needed to undergo a training analysis before practicing as psychoanalysts (Balint, 1948, 1954; Freud, 1912/1966), psychotherapists have been strongly encouraged to undergo a training analysis or personal psychotherapy while training to be psychotherapists. Salvador Ferenczi, in 1914, was the first psychotherapist to go for personal psychotherapy while training to be psychoanalyst, as such a training analysis (Berman, 2004). However, Rake (2009) points out today it is not a mandatory expectation of clinical psychology training couched within scientific-practitioner model that trainees pursue personal psychotherapy, as the scientific-practitioner model prioritises evidence-based practice over more personalised ways of learning. Daw and Joseph (2007) highlight that counselling psychologists in Britain are required to undergo 40 hours of personal psychotherapy; however this stipulation does not apply to clinical psychologists.

Notwithstanding, the advantage of personal psychotherapy is that it acts as a powerful vehicle for psychotherapists to link their personal and professional development effectively (Rake, 2009; Rake & Paley, 2009). Yet after the Boulder Conference, Blau (1959) highlighted that a clinical psychologist who provides psychotherapy "should be aware of his own possible inadequacies, blind spots, and psychological traumatizations" (p. 5), by means of attending personal psychotherapy by a professional.

More recently, Farrell (1996), and Rizq and Target (2010) argue that personal psychotherapy provides a window into what it means to be a patient and on a personal level for the psychotherapist to become aware of the hidden aspects of their own psyche. Personal psychotherapy also provides a space for psychotherapists to participate in and enhance their emotional regulation skills. Participants in Rizq and Target's (2010) study also expressed the desire for their psychotherapists to serve as models of how psychotherapy should be conducted.

Andrews, Norcross, and Halgin (1992) identified six benefits of trainees undertaking personal psychotherapy: firstly, psychotherapy improves the personal functioning of the trainee, secondly, psychotherapy provides a deeper understanding of intrapersonal and interpersonal dynamics; thirdly, psychotherapy assists in alleviating stress associated with being within the helping profession, fourthly, psychotherapy acts as a socialisation experience; fifthly, being in the client role sensitises trainees to the reactions and needs of their own clients; and lastly,

psychotherapy provides an one-on-one opportunity to observe therapeutic methods within an ongoing real process.

Wiseman and Shefler (2001) found that experienced Israeli psychoanalytically-orientated psychotherapists in personal psychotherapy enjoyed a greater integration and flexibility in relation to their personal self and professional self. An awareness of internalising a number of experiences from personal psychotherapists during their careers that continued to influence them when in consultation with clients was acknowledged. Experienced psychotherapists also found personal psychotherapy to be a fruitful context to contribute to their individuation process in developing greater authentic relatedness with their clients.

Daw and Joseph (2007) found that 48 British counselling psychologists reported that personal psychotherapy was viewed as an enriching method of personal self-care. In terms of professional development, participants reported that experiential learning led to a deeper understanding of psychological and psychotherapeutic theories, models and processes. Furthermore, being in the client role enhanced their respect and empathy for their own clients.

Within South Africa, personal psychotherapy is not a mandatory requirement of the HPCSA. However, personal psychotherapy is a stipulated requirement of the MA Clinical Psychology programme at UCT (2004), UWC (2013), and Wits (2013, 2017) and strongly recommended in course material by the MA Community Counselling Psychology Programme at Wits (2016). This stipulation of personal psychotherapy by psychoanalytic-orientated masters programmes in South Africa is understood as a key facet of their training model and therefore applicants agree to the ethos of training model when selected as a student. The MA Clinical Psychology programme at Wits (University of Witwatersrand, 2017a) states that the personal psychotherapist needs to be a senior psychotherapist working from an "exploratory insight-orientated approach" (p. 12). Trainers at UCT see personal psychotherapy as a "sacred and private space" for trainees with no communication between the personal psychotherapists of the trainees and the training programme (Kottler & Swartz, 2004, p. 64).

2.11.4. Supervision of Psychotherapists.

A therapist who is not in supervision should be regarded either with suspicion or awe (LeShan 1996, p. 91).

Internationally, supervision is regarded as a "distinct activity" (Bernard & Goodyear, 2014), as one cannot assume that being a good psychotherapist generalises to being an

outstanding supervisor. Furthermore, supervision can be seen as core competency domain for psychologists (APA, 2014; Fouad et al., 2009; Kaslow et al., 2007; Rodolfa et al., 2014).

Psychotherapy supervision, by definition, occurs when "the supervisor is focused primarily on the clinical and professional development of the supervisee. Thus, the supervisor is always perched on the border between teaching the student and therapeutically addressing the implicit developmental impediments to the student's learning" (Alonso, 2000, p. 56). For example, Leszcz (2011) highlights the importance of supervision in assisting psychotherapists in managing their countertransference towards their patients as well as offering a space for reflection, self-examination and refining skills. Supervision is known to be laden with oedipal anxiety and competition, fear of error and shame around instances of incompetence, anxiety around the well-being of patients and being under the evaluation and scrutiny of the supervisor (Alonso, 2000; Leszcz, 2011).

Importantly, Alonso differentiates supervision from personal psychotherapy by advocating that "the psychotherapy supervisor in effect must listen with a clinician's ear and speak with a teacher's mouth" (2000, p. 56). Yet, supervisors need to be aware of the life developmental stage of their supervisees as well as their professional developmental stage in order to assist their supervisees in integrating their personal identity with their professional identity and to scaffold the development tasks of the supervisees (Hess, 1986, 1987; Stoltenberg, McNeil, & Delworth, 1998).

Trainees' attachment styles have been found to be consistently expressed in supervision. In an investigation of 90 supervisor/supervisee relationships, it was found that trainees benefitted most from supervisors who epitomised a Bowlby-inspired secure base and safe haven when providing instruction, support and constructive feedback in a reliable setting with adequate scheduled time, and being available should a crisis arise (Foster, Litchenberg, & Peyton, 2007). Supervision involves the creation of a safe, non-defensive space for psychotherapy trainees to engage in disclosure of client work and introspection that improves their understanding of processes and use of self in their psychotherapy consultations. In doing this, supervision offers support and modelling that builds "memorable clinical lessons" which make a valuable contribution to the professional development of psychotherapists (Klein et al., 2011, p. 295). Other formats of supervision namely triad supervision and group supervision have also been used in training contexts.

Satisfaction with psychotherapy training has been shown to be directly related to positive experiences in supervision (Leszcz, 2011) and as such, constitutes an essential part of professional development of psychotherapists. Fall and Sutton (2004) in studying supervisors, who had been psychotherapists for 15 years or more, found that the supervisor was charged with the tasks of being the translator of psychological theory into practicing and assumed much responsibility for the professional development of the supervisee and guiding the effective treatment of the supervisee's clients. Yet, disturbingly, Granello (2010) found that one in six American supervisors lacked the necessary cognitive complexity skills to effectively supervise trainees. Alonso (2000) cautioned that being a competent supervisor goes beyond the accruement of years in the profession as a psychotherapist.

Qualified professionals, in continuing their professional development, make use of communities of practice, peer supervision or peer consultation to discuss their clinical work without necessarily the guidance of a more senior psychotherapist (Billow & Mendelsohn, 1987; Grant & Schofield, 2008; Klein et al, 2011). Grant and Schofield (2008) argue that psychotherapists need to "build a culture of reflective practice" (p. 8) as such "creating a professional watering hole" (p. 11) by participating in regular supervision. Gibson et al., (2014) found in six focus groups of American counsellors, who had a masters degree, yet had different levels of expertise all spoke of the need for a mentor or an "experienced guide" (p. 6).

2.11.5. Mentoring of Psychotherapists.

Barnett (2008) argues that mentoring is essential in the professional development of psychologists. He defines mentoring as a more experienced elder in the profession offering both career support and personal caregiving to a younger (or less experienced) individual in the profession. Gayle (2011) recommends that mentoring of psychotherapists is successful when encased within a relational framework. He further highlights the importance of a mentor being chosen in light of their ethics, professional expertise and ideological integrity; and a mentee being an individual who holds aspirations and expectations as well as motivation and the capacity to self-reflect. These qualities are seen as essential for a mentorship relationship to be beneficial for both parties.

Mentoring differs from clinical supervision in that it often functions outside of evaluation contexts and is often informal and collegial in nature, yet still needs to be wary of dual relationships, conflicts of interests or triangulation. Unlike clinical supervision, mentoring

emphasises as the primary focus the long-term self-growth of the mentee and their use of self in psychotherapy as opposed to focusing upon casework (Gayle, 2011).

2.12. Conclusion

Chapter Two has endeavoured to outline the theoretical framework of psychotherapist development for the current study in light of key international studies of psychotherapist development and studies that have been conducted within the South African context.

To begin with Skovholt and Rønnestad's five-phase Developmental Model of Psychotherapists (2012) has been explicated as the main model, utilised together with a more flexible, yet only theoretical five-phase model proposed subsequently by Klein et al. (2011), for the current study. Secondly, the concepts of competency and expertise have been elaborated in terms of their applicability to psychotherapist development and their impact on the training and ongoing development of psychologists. Thirdly, the current study has contextualised the profession of psychology by providing a picture of both the landscape of trainee and qualified psychologists who conduct psychotherapy drawing on local studies to provide an understanding of psychotherapist development and the status of psychotherapist development research studies within South Africa. Lastly, the sources of developmental influences upon the career development of psychologists conducting psychotherapy has been outlined by drawing upon key studies.

The following chapter outlines the qualitative research design and methodology employed within the current study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

This chapter serves to outline the research design and methodology utilised in the current study. The current study is steered by a social constructionist epistemology. Furthermore, this chapter will elaborate upon key features of the qualitative research paradigm employed in the current study namely: stratified purposive sampling, semi-structured interviews, and Tesch's (1990), and Braun and Clarke's (2006) model of thematic analysis of data. The quality of the data was consistently checked against Guba and Lincoln (1985), and Shenton's (2004) guidelines for data verification. Lastly, the ethical considerations and procedures implemented during the current research process will be outlined.

3.2. Epistemology

"Paradigms serve as the lens or organising principles by which reality is interpreted" (Nieuwenhuis, 2013, p. 48). The naturalistic paradigm wherein the chosen epistemology social constructionism is situated (Madill, Jordan, & Shirley, 2000) needs to be understood not as an all-encompassing worldview but rather a consensus that researchers reach in a specific area of study regarding what constitutes meaningful questions for inquiry and which methods are able to answer those questions most effectively. As such the paradigm becomes defined as "a community of scholars' perspective" (Creswell, 2009, p. 103).

Kenneth Gergen explains that "constructionism opens the door to multiple ways of seeing the world; it is an invitation to creativity, and it asks the researcher to think carefully about what is being contributed to the culture and the world (Yang & Gergen, 2012, p. 128). Arguably, as social constructionism covers a wider set of linkages it is being understood as a paradigm or as

an alternative metatheory to understand knowledge creation (Yang & Gergen, 2012). Gergen, in 2012, advocates that researchers need to widen the net of psychological exploration to ensure that psychological discoveries can adequately hold and offer "a culturally informed dynamic intellectual space" (cited in Misra & Prakash, 2012, p. 122). Perls, Hefferline, and Goodman emphasise "there is no indifferent, neutral reality" (1951/2013, p. 233). In agreement, social constructionism has been at the forefront of pointing out the existence of multiple realities. Gergen encourages social constructionism to not be seen as an alternative belief system as it does not offer truth claims but rather constructionist ideas invite practices and these practices are relational and create multiple meanings which can be likened to poetry and music (Gergen & Yang, 2012). "The move from the notion of objective reality to reality as construction opens the scope of interchange, collaboration, and sharing" (Misra & Prakash, 2012, p. 122).

Anderson (2012) captures the shifts that social constructionism has ushered in the fields of psychology and qualitative research which are entwined in the current study. Firstly, she outlines that social constructionism embeds the individual into the wider context of the social and cultural spheres. Secondly, social constructionism is responsible for pointing out that knowledge does not originate from an individual's cognitive constructions but rather in communal engagement. Thirdly, language is not representational but rather is best understood as a dynamic social process, which means, fourthly, that the person is no longer needing to be understood as a bounded self but rather the person can be understood and related with as a multi-being, in other words, an individual needs to have a repertoire of available selves in order to engage with the multiple realities that the individual finds themselves situated within. "Words do not map the world; there are no words that are more accurate matches to the world than others" (Gergen, 2015, p. 37).

In relation to how social construction views the individual, Mary Gergen (2012) adds that psychological processes are no longer viewed as residing in the individual but rather as situated within relationships. Therefore social constructionism defines an individual as "a matrix of multiple relationships" (p. 239).

In light of the above-mentioned underpinnings, the social constructionist paradigm (Burr, 2015; Gergen, 1985, 1994, 2001; Holstein & Miller, 1993) is well-suited to be expressed in face-to-face, semi-structured interviews that can accomplish comprehensive and rich accounts of clinical and counselling psychologists' professional development as psychotherapists across the

career lifespan. Here the development of the psychotherapist was explored by looking at the therapeutic development of clinical and counselling psychologists at distinct career levels, from their own perspective, in face-to-face interviews and the resulting transcripts (Poland, 1995) were analysed for themes (Orlinsky & Rønnestad, 2005).

3.3. Research Design and Method

When beginning the research process, it was my intention as a researcher to conduct a mixed methods study involving a nationwide quantitative survey and qualitative interviews (See Appendix D), however due to recruitment challenges this was not feasible. Therefore in light of constraints the study became a purely qualitative study.

The qualitative approach is seen as part of a postmodern movement within the social sciences (Hein & Austin, 2001; Maree & van der Westhuizen, 2007). The current study adopted a qualitative approach as Mason (2006) argues that phenomena in the social sciences, such as human relationships, are inherently multidimensional and therefore require a research method particularly 'built' to hold and illuminate such complexity and capture "the 'heart and soul' – the essence or the multi-dimensional reality-of what is taking place" (2006, p. 12). Babbie and Mouton (2001), and Coyle (2007) note that the primary goal of qualitative research is to describe and understand human behaviour contextually and ideographically, by means of in-depth 'thick' descriptions, rather than seeking explanations of human behaviour. Husband and Forster (1987) describe qualitative research as "an effort to uncover and record findings sensitive to the uniquely human dimensions of experience, such as personal identity and individual and social meaning" (p. 50).

Qualitative research allows the study of participants' lives from their own perspective (the 'emic'/'insider' perspective), and therein the researcher provides participants ample space to voice their viewpoints in their unique context (Holloway, 1991). As the qualitative methodology of the current study highlights the subjectivity of the participants, the study will acknowledge that the subjectivity of the researcher inescapably and deeply influences the interviews (Coyle, 2007; Jarviluoma, Moisala, & Vilkko, 2003). Thus in the tradition of qualitative research, the subject positioning and reflexivity of the researcher is a critical point of discussion (Gubrium & Holstein, 2003; Smith, 2006). Secondly, the qualitative interview, by offering a discussion of the participants' subjective reality, lends itself to thematic analysis whereby means of a predominantly inductive approach the generation of themes and understandings of

psychotherapists can be captured (Burnard, 1991, 1992). Such methodology values the capture and discovery of meanings and permits the study of themes and motifs (Braun & Clarke, 2006; Neuman, 1997).

3.4. Recruitment and Selection of Participants

The target population was registered South African psychologists who practice psychotherapy within the categories of either clinical or counselling psychology. To access a sample of psychologists the PBP of the HPCSA was contacted in 2012 to obtain the register of psychologists (See Appendix C). The Register of Psychologists held by the HPCSA is a public document constituting the names and postal addresses of practitioners registered in South Africa (Pillay & Johnston, 2011), it was purchased to gain access to potential participants (See Appendix C).

The number of psychologists across categories registered with the HPCSA as of 31 March 2012 was calculated at 7180 registered psychologists across categories, 780 intern psychologists and 963 student psychologists (HPCSA, 2012a; 2012b). Within the total number of psychologists (7180) there were 6201 registered clinical and counselling psychologists at different levels of experience within South Africa which served as the pool of potential participants.

In terms of recruiting participants, the HPCSA, delegates at the Psychological Society of South Africa (PsySSA) national conference in 2013, were invited during a paper presentation by the author and after the presentation via conversation. In addition, CPD groups as well as psychology departments of universities and hospitals were approached through announcements, pamphlets for potential participants to be invited to complete the interview. Using the register's contact information, qualified psychologists, intern psychologists and student psychologists (masters students) within the clinical or counselling categories registered with the PBP of the HPCSA were approached as potential participants for the current study.

Probability sampling was pursued by using the e-mail addresses of eligible participants to send out invitations requesting their participation (Vehovar & Manfreda, 2008). The email provided information of the study (See Appendices D and E). Within the email, all potential participants were provided with a letter requesting their participation in the study (See Appendix E). On receiving their positive responses to the invitation letter indicating their willingness to participate, participants were purposefully selected from each identified developmental level of

psychotherapists. In line with Potter and Hepburn (2005) information given to potential participants regarding the study's purpose was made available to indicate on what basis the participants approached the interview, as such all participants knew what they had signed up for and were thus highly articulate to the questions posed within the interview setting.

A saturation point needs to be considered in qualitative studies however it has proved rather difficult to operationalise. For the current study, it was anticipated that approximately 20-30 participants, situated at different career levels, would constitute the purposive sample required to provide rich accounts of psychotherapists' development. However, saturation expectations needed to remain inherently flexible in the research planning phase. Berteaux (1981) advocates qualitative research should have minimum samples of 15 participants whereas Creswell (1998) recommends a range between 20 to 30 participants. Adler and Adler (cited in Baker & Edwards, 2012) advocate that the "good round number" of 30 interviews "offers the advantage of penetrating beyond a very small number of people without imposing the hardship of endless data gathering, especially when researchers are faced with time constraints" (p. 9). According to Crouch and McKenzie (2006) the general size recommended is less than 20 participants in order to strive for in-depth interviews. Emmel (2013) highlights that overall theoretical saturation is pegged at 12 interviews.

Importantly, for the current study, Guest, Bunce, and Johnson (2006) reviewed the literature that outlined best practice regarding sample size for qualitative studies. Guidelines ranged from four to 60 participants. With such a broad recommendation, Guest et al. decided to conduct a methodological study to work out what constitutes an adequate sample for qualitative studies. Their findings indicate that by the twelfth interview in a qualitative study saturation is accomplished, yet notably the basic elements for meta-themes were evident by the time the first six interviews are conducted. Hence, in terms of time and economic constraints, Guest et al. recommend that six participants is the magic number in qualitative research.

The size of sample in the current study was flexible to accommodate potential varied responses (Plano Clark & Creswell, 2011; Robinson, 2014), and thus not be overly pre-meditated (Mason, 2010). Despite recruiting efforts taking place over four years the sample remains unrepresentative of the demographics of the population of South African clinical and counselling psychologists and especially the scope of practice with the study having only four counselling psychologists as participants.

The current qualitative study managed to recruit 34 participants (See Table 4) which constituted the final sample (ten student psychologists (A), seven intern psychologists (B), seven early career psychologists (C), five experienced psychologists (D) and five senior psychologists (E)). The final number of interviews was determined when a feasible data saturation point was reached, keeping in mind each phase of psychotherapist development identified by the literature (Emmel, 2013).

3.5. Data-gathering Procedures: Interviews

Gergen (Yang & Gergen, 2012) believes that knowledge is an outcome of collaborative dialogue and is inherently generative by and for the community. As such knowledge(s) is not found in isolating monologues but comes about through a communal construction where persons as relational beings relate to one another to create a multiplicity of meanings. Gergen values the subjective basis of knowledge-making:

> When we talk about the world, it is not a mirror of the world. It is a way of using words for some purpose, one interpretation among a possible infinity. So there is no truly true account, no truth with the capital "T", no objectivity that is opposed to a subjective account (Yang & Gergen, 2012, p. 128).

Vaismoradi, Turunen, and Bondas (2013) emphasise to understand a phenomenon the researcher needs to investigate the phenomenon "from the perspective of those experiencing it" (p. 398). In the current study this was paramount, as in order to understand the development of psychotherapists it was imperative to ask psychotherapists how they have developed throughout their career life. The semi-structured, face-to-face interviews were approximately 45 to 90 minutes in duration. The interview protocol comprised eleven main questions (focus areas) with a number of sub-questions (See Appendix C) to provide potential questions to ask participants in order to explore psychotherapist development, without being overly prescriptive of what psychotherapist development may or may not entail.

Questions were posed to direct the conversation towards the previously identified areas of interest, without dictating the process (Barker, Pistrang, & Elliott, 1994; King, 1996; King & Horrocks, 2010). Poggenpoel and Myburg (2003) point out that the researcher is not a non-reactive nor passive participant in the interview process (Glensne & Peshkin, 1992), but rather is an active co-constructer of knowledge with the interviewee. Gergen offers that the role of monologist and authority is antithetical to the underpinnings of social constructionism (Yang &

Gergen, 2012). “What one takes to be the real, what one believes to be transparently true about human functioning, is a by-product of communal construction” (Gergen, 2001, p. 806).

The knowledge gathered is influenced by the researcher’s qualities and methods of interviewing.

> It is through the researcher’s facilitative interaction that a context is created where respondents share rich data regarding their experiences and life world. It is the researcher that facilitates the flow of communication, who identifies cues and it is the researcher that sets respondents at ease. This also contributes to a therapeutic effect for the respondents because they are listened to (Poggenpoel & Myburgh, 2003, p. 418).

Nelson, Onwuegbuzie, Wines, and Frels (2013) outline essential steps for the interviewer to keep in mind to ensure successful interviews with participants. The steps found to be relevant for the current study included establishing and maintaining rapport with each interview participant; investing time collaborating with the interviewee to contextualise the interviewee’s unique experiences. Secondly, the interviewer needs to sensitively match the language and style of the interviewee, maintain flexibility and curiosity in the conversation; attend to the subtleties in the process of the interview. Thirdly, the interviewer prepares focused and open-ended questions to ensure appropriate pacing of the interview. Lastly, the interviewer ends the interview process by asking for feedback about how the process of the interview was for the interviewee, while attending to time constraints.

As I am also a South African psychologist who conducts psychotherapy it was important for me not to assume I understood what participants meant when talking of their psychotherapist development but rather to ask for elaborations in what they were sharing of their experiences. The role of not-knowing was adopted by me (Anderson & Goolishian, 1992), in that my understanding of the participants’ experiences was to strive to not be limited by pre-determined theoretical points of view or my prior experiences of being a psychotherapist myself or by my previous research into psychotherapist development but rather to continually remain open to their unique experiences (Nelson et al., 2013).

In line with Paré and Sutherland (2012, p. 184), from “my house” of ideas of psychotherapist development and each participant’s “house” of ideas of psychotherapist development 34 “our houses” were co-constructed as part of the landscape of the current study,

situated against the backdrop of the local field of knowledge and the much larger international field of psychotherapist development.

3.6. Data Analysis: Thematic Analysis

Once the interviews with the participants were completed the recordings were then transcribed by a professional transcriber who adhered to the confidentiality agreement (See Appendix G). The transcripts were then analysed by employing the method of thematic analysis.

The analysis of the qualitative data is to first examine the data for themes within each interview, and then secondly to conduct an across-interview analysis to identify important themes about psychotherapist development. Braun and Clarke (2006) indicate that thematic analysis can be implemented in studies that are held in a social constructionist paradigm. With this in mind, thematic analysis was undertaken by applying Ryan and Burnard's guidelines (2003). As such the qualitative data were analysed to achieve "thematic description" (Sandelowski & Barroso, 2003, p. 913). Analysis of qualitative data needs to utilise "explicit, systematic, and reproducible methods" (Greenhalgh & Taylor, 1997, p. 740).

The broad aim of the qualitative approach is to analytically work through texts by dismantling the text, for example from transcribed interviews, into smaller units of meaning and deriving description of the phenomenon from the identified meaning units (Sparker, 2005). Thematic analysis, in the current study, was the method of choice to analyse the huge corpus of data as it is regarded as a flexible method which is able to hold complexity and in the process provide a thick description of the data (Braun & Clarke, 2006). Research methods are "living entities" (p. 399) and as such qualitative research at its best is an organic process.

Both deductive and inductive thematic analysis were undertaken within the current study. Inductive thematic analysis is often used where there are few prior studies in the field and the themes and categories are derived directly from the data (Hsieh & Shannon, 2005), this was important as few studies have been conducted in South Africa, utilising Skovholt and Rønnestad's (1993, 1995, 2003a, 2003b, 2003c) international model of psychotherapist development, in order to be sensitive to possible unique findings in a new context. In contrast, a deductive approach in analysing the collected data was also used within the current study in order to compare the findings with similar studies conducted internationally.

To be illuminative, analysis of research data needs to be connected to the originating context. After all, social constructionism has prioritised that each individual is woven into their

context (Yang & Gergen, 2012). This has serious implications for the current study for the contextual frames from which the psychotherapists practice weaves their individual developmental processes. The researcher's understanding of this larger context contributes needs to constructing a meaningful construction of the phenomena whereby the data can answer the research question posed (Downe-Wamboldt, 1992; Krippendorff, 2004). Thematic analysis offers both a systematic and meaningful analysis of the data within a specific context (Loffe & Yardley, 2004). This qualitative study makes possible a contextualised in-depth understanding of the developmental experiences of a small number of South African psychologists as psychotherapists.

Tesch's (1990) eight-step approach was implemented to analyse the research data in a comprehensive manner. Firstly, I read through all 34 transcripts in five sets (ten student psychologists, seven intern psychologists, seven qualified psychologists, five experienced psychologists and five senior psychologists) to cross-check each transcript with each voice-recording of the interview, to verify accurate transcription from the recording, to obtain a sense of the data collected as a whole and to initiate the process of generating ideas about the information gathered. Secondly, I randomly chose one interview transcript from each set and started to annotate the meanings underlying the responses given. I then chose another transcript from each sub-sample of participants randomly and implemented the same process of annotation. Thirdly, I compiled a list of tentative themes. Similar themes (units of meaning) were grouped into clusters, and possible major and minor themes were outlined and notes about divergent themes and contradictions where noted. Fourthly, with the list as an organising scheme, I then returned to all the transcripts and began to carefully highlight, code and sort across interviews all appropriate segments of the text, aiming to capture the essence of what the participants shared in their interviews.

The literature review provided "sensitising concepts" and a "skeletal framework" in order to meaningfully sort and hold the data (Boeije, 2010, p. 23) to begin a concentrated analysis. Concepts were drawn and coded from an individual sentence or even paragraph of the data from the data corpus of over 600 pages of transcribed interviews. Concepts were then organised to identify distinct themes or patterns which placed the concepts into a meaningful interlinked whole. Importantly, a theme is a crystallisation of what participants conveyed in their words. Themes are established by "bringing together components or fragments of ideas or experiences

which often are meaningless when viewed alone" (Leininger, 1985, p. 60). How the themes cohered, ultimately, reflects the researcher's subjectivity and rigour in tandem with the current knowledge base of the field (Leininger, 1985).

Fifthly, to organise and hold the data, categories were constructed. Categories were initially constructed deductively from the literature on psychotherapist development and finalised based on themes and sub-themes inductively found in the data analysed during the research process. In consultation with my two research promoters I "sounded out" the labels of the main categories in order to enhance the credibility of the current study (Niewenhuis, 2013, p. 109). Over-arching categories were identified and formed domains of the research which extensively organised the large data set.

Sixthly, the categories were sorted in alignment with the how psychotherapist development is seen to unfold. Seventhly, each category was analysed to generate meaningful discussion points and to allow for formulations about psychotherapist development. Thematic analysis involves looking for patterns within the data or the common threads as well as variances within each interview as well as across the various interviews. The common and diverging threads enable a holistic yet nuanced account of the analysed data. Finally, I reviewed the analysed data, together with the stakeholder's checks to see where recoding was required to ensure accurate and credible findings.

Anderson (2010) indicates that the findings and discussion of the qualitative data can be meaningfully combined together when reporting on a study. With this in mind, the Findings and Discussion of the current study will be reported together in a holistic manner in Chapter Four.

3.7. Data Verification

Quality considerations of the research "permeate" the entire research undertaking (Boeije, 2010) and assessing the trustworthiness of the data analysis and the interpretation of research findings is regarded as the "acid test" of qualitative research (Niewenhuis, 2013, p. 113). The underpinnings of qualitative research, unlike quantitative research which stresses validity, reliability and generalisation, are based upon four criteria of trustworthiness namely, credibility (as opposed to internal validity), dependability (as opposed to reliability), transferability (as opposed to external validity or generalisability) and confirmability (as opposed to objectivity) as explicated by Lincoln and Guba (1985), and Shenton (2004).

Similarly, Whittemore, Chase, and Mandle (2001) advocate evaluating qualitative research primarily in terms of credibility (reflecting participants' experiences plausibly), authenticity (the emic perspective allowing for subtle differences), criticality (critical appraisal of data), and integrity (recursive and ongoing checks leading to humble findings). Rolfe (2006) points out that 'validity' in qualitative studies is understood and hinged upon "appraising" (p. 308) the quality of the individual study according to its own merits in terms of consensus as opposed to evaluating quality in "blanket application of predetermined criteria" (p. 305).

When conducting the data analysis I implemented measures of quality to meet the criteria of data trustworthiness outlined (Drisko, 1997; Flick, 2007, 2009, 2014; Krefting, 1991; Loh, 2013; Morrow, 2005; Saville Young, 2016; Tracy, 2010). The themes and interpretations generated remained closely reflective of the participants' responses and conceptualisations, in an attempt to stay true to the meanings of the participants themselves and the distinctive purpose of the qualitative approach of the current study.

The following recommendations of Shenton (2004), and Merrick (1999) were implemented to enhance credibility, firstly, prolonged engagement in the field of psychotherapist development was undertaken (Creswell, 2009; Creswell & Millar, 2000; Lincoln & Guba, 1985; Maxwell, 2005, 2009; Merriam, 2009; Yin, 2011, 2015). A key facet of credibility is addressed, in the current study, through transparency in the qualitative research design and implementation of the study and in-depth description of the thematic analysis of the data. According to Morrow (2005) credibility can be achieved by prolonged engagement with participants as well as observation and immersion in the field of interest.

Fassinger (2005), and Shenton (2004) point out that background, qualifications and experience of the researcher aids in enhancing the truth value or credibility of research. As a South African clinical psychologist in independent practice since 2012, I am familiar with the phenomenon of psychologists' development as psychotherapists and have previously conducted a qualitative study with a sample of eleven participants (Laidlaw, 2010) of the psychotherapist development of clinical and counselling psychologists. I also form part of the training team that teaches student clinical psychologists completing their masters training at Unisa, especially in relation to teaching psychotherapy and supervising their therapeutic work with clients at the university psychology clinic. My research promoters were a senior clinical psychologist and senior research psychologist and thus well-acquainted with the field of the current study.

Secondly, the qualitative interview of the current study adopted a line of questioning that has been used in a number of studies within the research area of psychotherapist development. Each question posed had been used in one or more prior qualitative studies (See Appendix C). The data analysis method of thematic analysis has been used in previous comparable projects as well. All data gathered underwent thorough analysis (Shenton, 2004).

Furthermore, I interviewed participants originating from various contexts within South Africa in order to access as many vantage points of psychotherapist development of South African psychologists as possible. Thus site triangulation was of central importance in the current study, in that recruitment of participants was purposefully broad to allow for a wide variety of participants in an attempt to reduce local factors inadvertently giving a skewed picture of psychotherapist development in South Africa. Different universities and their milieu have different emphases in their psychotherapy training and CPD activities. For example, in Stellenbosch, Westen Cape an equal emphasis is placed upon CBT and Psychodynamic Therapy as well as specifically Emotionally Focused Couples Therapy for couple clients. In Johannesburg, Gauteng, a strong emphasis is placed upon the psychoanalytic schools of Object Relations and Interpersonal psychotherapy (www.witsclinselections.wordpress.com/about/). In Pretoria, Gauteng, systems psychotherapy and psychotherapy being informed by an African epistemology and traditional healing methods are emphases (van der Merwe, 2013). Sampling a range of psychologists from various contexts in the country was critical in order to ensure that the study has circled reality/ies sufficiently to provide a stable picture of being a psychotherapist (Dervin, 1992).

The use of debriefing with research promoters and scholars in the field of interest and negative case analysis in terms of looking for participants who had differing opinions to other participants was prioritised. Stakeholder checking of the findings was also implemented (Niewenhuis, 2013). Stakeholders in the current study reviewed the credibility of the findings. The stakeholder process involves “allowing research participants and other people wo may have a specific interest in the research to comment on or assess the research findings, interpretations and conclusions” (Niewenhuis, 2013, p. 114). Stakeholder checking is differentiated from member-checking as it focuses more on the holistic picture of the research process together with the embedded findings rather than a participant verifying exactly what they said in isolation to what the other participants contributed. I asked a clinical psychologist who is well-versed in

practicing psychotherapy, training and supervising psychotherapists as well as familiar with a qualitative research approach to read and critique the findings of the current study. The stakeholder provided feedback on all the findings and found that a focus on the ingredients of psychotherapists though interesting detrated from the just of the study which is focused on describing developmental processes of psychotherapists. In addition, the research promoters offered input regarding the refinement of the extensive findings.

This study prioritised reproducing detailed extracts (Niewenhuis, 2013) to both honour and capture the way psychotherapists make sense of and talk about themselves and their work. As seen in the lengthy extracts, within Chapter Four, psychotherapists by nature and training, formulate and tell stories of actual experiences to make an argument and having given an answer to my interview question they then tended to then give an example of where their argument or formulation would *not* apply, as open-mindedness and alternative viewpoints is valued by many psychotherapists. As a researcher, I became rather 'torn' as to how to represent the essence of the data. Over six months as I poured over the transcripts (Bird, 2005), I attempted to stay on the side of brevity, however in reducing the length of the extracts from the data corpus I often found the relayed anecdote, vignette or experience losing its richness and complexity thereby becoming bland and linear.

> There are no shortcuts to the demanding process of reading and re-reading the data, and searching to unfold the meanings constructed by the participants to your study. Only the human mind can begin to see and understand the world through the eyes of the participants (Niewenhuis, 2013, p. 117).

The final extracts of the current study represent a compromise of sorts between capturing the essence and yet the rich fullness of the participants' sharing.

To ensure the dependability of the current study a detailed description of the design and implementation of the study has been be explicated so that readers of the study can assess the extent which correct and feasible ways of doing qualitative research have been adhered to. I also continually appraised the effectiveness of such procedures to increase the dependability of the current study (Shenton, 2004).

Importantly, the strength of qualitative research lies in providing findings from real-world contexts (Willig & Stainton-Rogers, 2008). Transferability is enhanced in the current study through the use of a diverse pool of participants from different contexts in South Africa to

capture alternative perspectives. Applicability to other contexts or the transferability of the current study in the future (Krefting, 1991; Shenton, 2004) will be aided by keeping and providing on request an audit trail of the research process and anonymous data should future researchers wish to conduct comparisons with other research endeavours. In addition, potential future transferability was achieved by providing sufficient information about myself and the research context and processes so that the reader can determine how far the findings can be meaningful to other contexts. As the data of the current study come from a diverse South African sample in a particular time period (2014 to 2017) and context, the findings' transferability needs to be carefully considered by others when contemplating future studies in relation to psychotherapist development.

Confirmability of the current study occurred through the self-reflexivity (See 5.2) or personal reflexivity of the researcher (King & Horrocks, 2010; Krefting, 1991). Yet to further enhance overall trustworthiness of data a reflective journal/log was kept to track the subjectivity of myself as the researcher throughout the current study and keep track of potential points of discussion to raise and disclose in the writing up or reporting phase of the current study (Morrow, 2005; Ortlipp, 2008; Smith, 2006).

3.8. Ethical Considerations

Research ethics formed an integral part of the methodology of this study. As especially in professional development of clinical and counselling psychologists, one is confronted with issues that are sensitive both in personal meanings of the participants and their relevance to the participant's professional context (HPCSA, 2004).

Firstly, the research was conducted with the permission and recommendations of the University of South Africa's ethical committees (See Appendix E). Secondly, informed consent was obtained from all participants who volunteered to participate in the study. The letter of consent of the research acknowledged that identifying information would remain anonymous and confidential throughout the study by means of codes, and the findings would be reported via anonymous extracts and themes (Kays, Gathercoal, & Buhrow, 2012). Participants were informed that they could withdraw at any time from the research being undertaken (See Appendices E & F).

Furthermore, the qualitative interviews were conducted in a conversational style that fostered a non-intrusive approach (Kvale & Brinkmann, 2009; Sudman & Bradburn, 1974). My

interviewing skills as a researcher and clinical psychologist were used in terms of showing a keen interest in their personal stories yet in tandem showing respect and demonstrating sensitivity and empathy to the participants and their personal information.

In addition, the participants who took part in the study were informed that the interview being conducted would be recorded, transcribed and following transcription that the recording will safely be stored for five years and then erased by myself. A confidentiality agreement was undertaken by the professional transcriber of the interviews (See Appendix H). Thirdly, participants were referenced by means of a pseudonym (a letter of the alphabet for phase of development and number within the phase, e.g., A1) to uphold their privacy.

3.9. Conclusion

The research methodology employed and the description of the sample in this study, were the focus of this chapter. The study drew on the epistemological lens of social constructionism which prioritises multiple realities deemed essential to capture the unique experiences of psychotherapists within such a diverse country as South Africa.

The current study which investigated clinical and counselling psychologists who practice psychotherapy across the careerspan employed a qualitative research method with non-probability purposive sampling. Data captured included demographic information of each participant and a face-to-face interview, comprised of a number of semi-structured questions drawn from previous studies, with each participant.

The recorded interviews were transcribed and the data were analysed according to the aims of the study using the procedure of thematic analysis and adhering to the stipulated trustworthiness measures and ethical requirements throughout the research process undertaken. The qualitative findings of the current study will be presented and discussed in conjunction with the research being conducted in the field of psychotherapist development across the world, in Chapter Four.

CHAPTER FOUR: FINDINGS & DISCUSSION

4.1. Introduction

In this chapter the findings of the current qualitative study are presented. These findings are discussed in conjunction with international and South African research on psychotherapist development, ranging from choosing a career in psychology to retirement from conducting psychotherapy with clients.

4.2. Sample Profile

The purposive sample of the current study consisted of 34 South African clinical or counselling psychologists. In line with selection criteria of the current study, all participants had been trained in South Africa as either a clinical psychologist (30 participants) or counselling psychologist (four participants). At the time of the interviews all participants were practicing registered psychologists who conduct psychotherapy in South Africa. The last criterion was to have at least five psychologists who practice psychotherapy per phase of development as sketched by the international literature.

Through a lengthy recruitment process over four years (2014 to 2017) the study secured 34 participants whose demographic details are shown in Table 3. The five phases (A-E) were represented by varying numbers of black (total of 7), white (total of 25), and Indian (total of 2), female (25), and male (9) psychotherapists. Of the 17 qualified psychologists, 10 participants were in full-time private practice during the data collection phase of the study.

Of the sample, two early career psychologists, two experienced psychologists and four senior psychologists were currently or had been trainers at universities that train psychologists and supervise trainees and qualified psychologists. In addition, two experienced psychologists had supervised trainee psychologists at internship-level and one senior psychologist supervises psychologists within the context of private practice. Of the 16 universities that train

psychologists in South Africa, 11 universities feature in the current study as masters training institutions (See Table 3).

Table 3: Demographics of the Sample.

Phase	Duration	Ethnicity	Gender	Scope of Practice
A: Beginner student	**< 12 months of seeing clients (student psychologist)**			
1.	2015 (M2 student)	White	Female	Counselling
2.	2015 (M2 student)	White	Female	Counselling
3.	2015 (M2 student)	White	Female	Counselling
4.	2015 (M2 student)	White	Female	Clinical
5.	2015 (M2 student)	White	Male	Clinical
6.	2015 (M2 student)	Black	Female	Clinical
7.	2015 (M2 student)	Black	Female	Clinical
8.	2015 (M2 student)	Black	Female	Clinical
9.	2015 (M2 student)	Black	Female	Clinical
10.	2015 (M2 student)	Indian	Male	Clinical
B: Advanced student	**1-2 yrs of seeing clients (intern psychologist)**			
1.	2015 (Intern)	White	Male	Clinical
2.	2015 (Intern)	White	Female	Clinical
3.	2015 (Intern)	White	Female	Clinical
4.	2015 (Intern)	White	Female	Clinical

5.	2015 (Intern)	White	Male	Clinical
6.	2015 (Intern)	White	Female	Clinical
7.	2016 (Intern)	White	Male	Clinical
C: Early career professional	**>2-9 yrs of seeing clients (qualified psychologist, independent practice)**			
1.	2011 (Com Service)	Black	Female	Clinical
2.	2012 (Com Service)	White	Female	Clinical
3.	2011 (Com Service)	White	Male	Clinical
4.	2012 (Com Service)	White	Female	Clinical
5.	2012 (Com Service)	Black	Female	Clinical
6.	2011 (Com Service)	White	Female	Clinical
7.	2009 (Com Service)	White	Female	Clinical
D: Experienced professional	**>10-19 yrs of seeing clients (qualified psychologist, independent practice)**			
1	2005 (Com Service)	White	Female	Clinical
2.	2004 (Com Service)	White	Male	Clinical
3	2001 (Internship)	White	Male	Clinical
4.	2004 (Com Service)	Indian	Female	Clinical
5.	2003 (Com Service)	White	Female	Clinical
E: Senior professional	**>20 yrs of seeing clients (qualified psychologist, independent practice)**			
1.	1978 (qualified)	White	Male	Clinical
2.	1989 (qualified)	White	Male	Counselling

3.	1997 (qualified)	Black	Female	Clinical
4.	1982 (qualified)	White	Female	Clinical
5.	1974 (qualified)	White	Female	Clinical

4.3. A Framework of the Findings

The findings of the current study were organised according to categories which constituted of a number of main themes, and in some cases, key sub-themes.

Table 4: Findings according to Categories, Main Themes and Sub-themes.

Category	Main theme	Sub-theme
Motivations for being a psychotherapist	• Wounded Healer • Other Personal Influences • Born This Way • Drawn in by Media • Encounters with Psychologists • Curious Minds • Woundedness Spans the Developmental Journey	
Unskilled and Unaware as Aspiring Psychotherapists		
Awareness Develops Along with Skills		
What to Do with a Tower of Psychobabble?: Theoretical Orientations	• Developing a Framework • Theoretical Orientation as Part of Trainee Development • Internalising Theory as Part of More Advanced Development	Assisted by: - Personal Psychotherapy - Supervisors - Mentors
Dealing with Not-knowing and Circuitous Journeys		
In the Hot Seat: Personal Therapy for the Psychotherapist	• Personal Psychotherapy During Training • The Wisdom of Group Psychotherapy • Personal Psychotherapy *Ad Infinitum*?	- Mandatory - Recommended
Supervision as Providing a Bird's Eye-view	• Blow-by-blow Supervision: Live Supervision via the One-way Mirror	

	• Trainees' Horrible Experiences of Individual Supervision • A Very Fine Line: Supervision or 'Personal Therapy' of Supervisees • Group Supervision During Training • Post-qualification Reading Groups or Group Supervision • Having a Fresh Eye: Post-qualification Individual Supervision • Supervising Qualified Psychotherapists	
Mentoring as Inspirational Watching Over		
Advanced Psychotherapist Development	• Distilling the Process • Learning from Patients • Success vs. Failure	- Complexity vs. Simplicity
Embracing the Pothole-filled Journey		
Personal-professional Overlaps	• Going Back Home as an Official Psychotherapist • Redefining Friendships • "I Am Not Your Patient": Interpersonal Challenges with Partners • Boundary-making with Loved Ones	
Learning to Care for the Self		
Sharpening the Saw: CPD		

4.4. Motivations for Becoming a Psychotherapist

Your journey is already planned, you just need to walk it. The soul has already signed the contract (Participant E2).

The participants of the current study delineated both conscious and unconscious reasons for pursuing a career as a psychologist. Across the developmental spectrum, participants conceded that they felt drawn to the profession due to their own personal wounding, wounding within their family-of-origin or of their peers. Additional reasons voiced by participants included possessing a helping disposition, a desire to develop self-understanding, a desire to be close to others, curiosity about human nature and interpersonal dynamics, and glamourised portrayals of the profession in the media. These motivations will be explored in detail below.

4.4.1 Wounded Healer.

The wound is the place where the Light enters you - Rumi

The Jungian concept of the wounded healer is rooted in the Greek myth of the centaur Chiron who is wounded by an arrow from Heracles' bow. Chiron survives, albeit with unbearable pain and yet becomes a legendary healer in Ancient Greece (Groesbeck, 1975; Waterfield & Waterfield, 2012). A split intrapsychic relationship exists within the wounded healer Chiron, wherein developed intellectual aspects are split from the instinctive bodily aspects in a kind of higher man/lower horse entity. Chiron's job then was to teach the achingly wild Achilles the art of medicine, and how to be a good man.

Farber (2017) speaks of the personal wounding of psychotherapists as an opportunity for psychotherapists to take hold of post-traumatic growth. Adams (1992) believes that the reasons one became a psychologist are inseparable from the type of psychologist one becomes. In the USA, Murphy and Halgin (1995) compared 125 social psychologists to psychotherapists as to their reasons for pursuing a career in psychology. He found that psychotherapists enter the profession of psychology for a host of reasons, as will be referred to below.

Participants, in the current study, disclosed in a particular manner which is worth noting. A pathway of many reasons merging into a process of pursuing the qualification is the commonality, in that becoming a psychologist was not attributed to one reason, nor was it a clear-minded career goal with the set outcome of qualification. Rather, participants spoke about an accidental chain of events or a burning passion that was filled with uncertainty of whether the ultimate dream of being a practicing psychologist would become a reality.

> *I think there were many events and experiences growing up that led me into becoming a psychologist without me even realising it. So, I can talk about my first year of varsity (university); being misguided by a counsellor. But, I think the process was already set in motion, from very early on… I definitely was more of the healer growing up, a parentified child if you want. Who, in turn, needed my own kind of healing, which I have gained over the years…* (Participant C7).

> *I think so much of who I am as a therapist is who I am as a person with all my history, that's contributed. And sometimes you know, [laughs] in the initial stages; your history ends up, you know, confronting you within a therapeutic space* (Participant D3).

Jung argued that "there is no essential difference between two people engaged in a healing relationship. Indeed, both are wounded and both are healers. It is the woundedness of the healer which enables him or her to understand the patient and which informs the wise and healing action" (p. 85). Psychoanalyst Christopher Bollas (1987), in agreement, holds that in order to be effective in psychotherapy the psychotherapist needs to find the patient within himself/herself. Groesbeck (1975) goes as far as to say without the psychotherapist activating their inner patient (wounding) it is impossible for the psychotherapist to activate the inner healer within the wounded patient to effect change for the patient/client's benefit.

Arguably, the capacity for the psychotherapist to be in contact with their primal wounding supports the pursuit of personal psychotherapy as providing the aspiring clinical or counselling psychologist a space to test out their calling (A6, and E2) to become a psychologist prior to assuming the mantle of a registered psychologist.

Hill et al. (2013) point out that investigating motivations by means of self-report has inherent limitations as "motivations are often implicit, multilayered, unconscious, and fluid, it is doubtful that researchers could ever obtain a complete portrayal of motivations, particularly those that are less flattering" (p. 289). Participants in the current study revealed painful motivations for entering the field. However, in the current study, no participants reported having particularly voyeuristic or aggressive ie. 'shadow' reasons for entering as found in Sussman's research (1992, 1995). Participants (A1, B2, C1, D3, and D4) voiced that they had experienced attachment trauma and difficult or adverse childhood experiences (ACEs), such as abuse, substance abuse, mental illness and divorce within their family context (Dube et al., 2003; Felitti et al., 1998; Herman, 1992; van der Kolk, 1994).

> *So, painful experiences in terms of just my attachment injuries with my parents, … and I think I was still, in spite of that, very secure actually and functioning and doing well, but the small, little injuries and some perhaps not so small, definitely. Ja (yes), definitely impacted on who I became… I mean part of wanting to become a psychologist is-, for me, is wanting to understand myself, wanting to understand ... 'Why did this happen, you know? Why did my father behave like this? Why did my mother behave like this?' Then my reaction to it, what happened with me, to understand the loss from that, work through the loss* (Participant C2).

Psychotherapists experiencing childhood trauma finds support in a number of studies (Elliott, Guy, & James, 1993; Little & Hamby, 1999). The career choice of clinical psychologists were more likely to have been influenced by a history of distress in their families of origin than were social psychologists' career choices (Murphy & Halgin, 1995). As such, Murphy and Halgin (1995) found that clinical psychologists reported having had the experience of an unhappy childhood.

> *I think that the way that you are shaped… to relate and develop a kind of empathy and intuition that's at a different level as someone else- or a feeling for others … I believe because of difficult things that have happened or the way you were brought up… And, then I think a programme would just… enhance that…*
> *I didn't start out studying thinking that I am going to become this and do this. I think things worked out that way. But, I have always been intrigued and I think for me, personally, one of the biggest motivators… as much as I love them, I don't think my parents had the capacity to deal with things like that or that I bring things like that to them… a lot of it is has been influenced by… what I felt I needed during those processes… having someone that says, "Okay, what do you need to do this?"… (that) really shaped me as a therapist, hearing from what my clients need or what the patient needs to be able to handle or tolerate this*
> (Participant B6).

In London, Nikcevic´ et al. (2007) set out to investigate whether training sensitises mental health professionals to recognising and reporting adverse childhood experiences as compared to individuals who have not undergone such training. With this in mind, the sample consisted of individuals who were not already trained mental health professionals. The study tapped into a history of abuse, trauma, parentification, anxiety and depression. The psychology undergraduate students with aspirations to be a mental health professional reported a higher prevalence of childhood sexual abuse and a negative family environment as well as higher levels of parentification during middle adolescence in contrast to students pursuing a degree in business and students pursuing psychology with no clinical aspirations.

In the current study, participants spoke about how psychology offers individuals a platform to no longer be silent about trauma. Two participants (B2, and C1), specifically spoke of how important it was for them to become unsilenced about their own pain prior to entering

training so that they could actively help others to find their own agency. Additionally, participants (B2, B3, B5, C1, and D4) spoke of how they valued psychology as a profession of 'unsilencing' that prioritises giving a voice to that which was previously unspoken about and hidden behind closed doors in families within the South African context of widespread and yet intimate oppression. Arguably, psychology as a profession can be understood as a deeply personal form of social activism on the part of its practitioners.

> *Both my parents were alcoholics, my mom ended her life in suicide. She suffered from depression, bulimia… I'm quite parentified and tried to look after her… there's many internal dynamics which I have become aware of through therapy… That have led me to be a therapist. And, also there was a time where I almost had to sit back and decide, 'Why am I doing this? You know, is it to save my mom, you know, through other people? What is it?'... I will always be looking in, 'Why have I chosen this profession? What is my internal drive to do this?' Because we all have. It's not an easy job. It's not. And, also to be a clinical psychologist I want to work with children, people will always say to me like, 'What is it? Why? Why do you want to do this?... it's a process… And, I don't know if I'll ever know* (Participant B2).

> *I applied at U- then I wasn't accepted, but then part of my not being selected was that during my selection one of the panels asked me, "What issue is wrong to me?" like, "What sort of childhood issues am I still sitting with?" and that was in 2002. And, so then, I said to her, "My issue is that I was sexually abused when I was 8, 9, 10" and then as I spoke about that I broke down. So, then she picked up that, "No, that is your issue, you need to go and work on that". Then I decided, 'Okay', then I started going for therapy. So my therapy-, then I realised that, 'No, it was because of going through therapy that I got a handle on my sexual molestation'. So, I decided that, 'If somebody was helping me to accept something that happened like 15 years ago, I could do the same for other people'. So then, that's how my love for psychology was renewed* (Participant C1).

> *In terms of my own upbringing... The biggest thing that influenced me to go into psychology, probably, very unconsciously, was the concept of silence, and, a very*

negative silence that I grew up with. And, I always used to think to myself that, 'When I grow up, I don't want this resounding silence to follow me'. And, I constantly looked for ways to break the silence and very much ineffectively. But, it was that for me that I could not stand how much silence followed relationships in my life. People couldn't communicate very effectively and that led to a whole lot of things that were just, you know, very painful (Participant D4).

So, I have to make that distinction as well, like a person is not all-good or all-bad. I think it has developed. Uhm, where it comes from? I would probably say, it's from my family if that makes sense because my family are the typical Afrikaans family. So, we keep quiet about it [chuckles.] So, we put everything under the rug. If anything bad happens, we don't talk about it… I don't want to be that way. I appreciate when people are honest with me and direct with me. Then I know where I stand with you! But, otherwise we're playing this game of dancing around… and I don't like that. So, I think that has had an influence, to be vocal, to not keep quiet (Participant B3).

In the current study, three participants (A2, D3, and E1) voiced that they have found that their experience of being adopted had influenced their journey to becoming a psychotherapist. Punnett (2014) in her Jungian study of how the orphan complex undergoes transformations throughout one's life in terms of making sense of being alone in the world and yet being able to form attachments as a conscious endeavour shows how a psychotherapist's own life history informs their work with work. Similarly, Hylton (2007) points out that "adoption is a lifelong process" (p. 7) which needs to be reworked especially when encountering milestones along one's lifecycle where identity is impacted. Using an Object Relations lens, as adoptees have two sets of parents, Hylton highlights how psychotherapists who have experienced adoption have experienced loss at a very young age, potentially have a sensitivity to feelings of abandonment, notable experiences with carving out identity formation, and attachment, which can richly inform their work with others in pain.

I attended therapy throughout my life because I'm adopted. So, of course, you can imagine the type of therapy you have to attend for that. And, my parents were acutely aware of me having access to a therapist if I need to speak about anything

at any time. So, I've been in therapy sporadically from a very young age, and it helped me tremendously (Participant A2).

As an adopted child in a weird family set-up; I always knew, 'I'm different; I'm kind of the outcast'. You know, even my mother still struggles with issues surrounding that-… my adopted mother. That's why we have a love-hate relationship because it's complicated. But the adoption put me kind of on the side of family, on the side of relationships, or always on the outside looking in… the tragedy of the rejection, of being different, being on the outside, being lonely, being isolated; caused my personality to form in such a way that it – … to be able to sit and hold people… problems, heartache, sadness and loneliness, isolation, in other people.

… I can build a rapport in therapy very quickly… I can engage with people because I had to engage with all kinds of different people in order to serve a need of loneliness and isolation. So, the amount or the degree of empathy, the insight into people's mechanisms, workings, processes; I think had a lot to do with the fact that I was adopted because you take nothing for granted.

… that was an advantage for me when I grew older, was the ability to be removed. Being able to look at things for what they were. But, also then; to have the compassion and then later on the passion of being able to be with someone in a therapeutic space where anything can come out, where people's worst heartache and sadness almost... But, yes, it gives you a different perspective on life, on things when you are on the outside. And then again, the intensity of what you are able to sit with because you have been there yourself… I know what this looks like (Participant D3).

Participants (A2, and D4) highlighted that their mothers had a chronic physical illness, and participants also voiced having to confront the psychiatric illnesses/mental health difficulties of their parents (B2, B7, and C4) or peers (B4), or the family trauma of crime (A10). Participants also disclosed how confronting their own psychological struggles (A2, B4, B7, D3, and E2) influenced their decision to pursue a career as a psychologist.

The only significant thing I can think of right now is when I was a lot younger we did experience, my family and I were hijacked, and I think I can't remember too much about it, I must have been ten or eleven… what stands out for me is my family after that. So, like I remember everybody was very, very different. And, I couldn't understand why… that could have been the start of what drew me into psychology, kind of unknowingly. (Participant A10).

Similarly, Murphy and Halgin (1995) found that clinical psychologists had experiences of physical illness in one's family of origin. Such exposure to serious illness resulted in participants at an early age being confronted with having to make sense of life, the shadow of death and the complexity of suffering and pain. In a sense, participants bore witness to Chiron's incurable wound. Simultaneously, participants (B2, and B7) were cast into a role of necessity caring for themselves and/or caring for family members (Miller, 1981).

Participants (B2, B5, C2, D3, D4, E1, and E4) spoke of trying to as children make sense of their parents' struggles and conflicts, and how they hoped this understanding would enhance their self-understanding. Student psychologist participants (A4, and A6) spoke of being exposed to the profession when they attended psychotherapy when their parents were divorcing. Specifically, participants made reference to actively trying to make sense of their mother's struggles, working out her behaviour or the inner workings of her mind or attempting to console her (A7, B2, B7, C2, C3, and D3) and/or their father's struggles (A2, B2, and C4).

My dad suffers from anxiety and depression… But, he was undiagnosed for a lot of my childhood… And, so I think unconsciously we were all being therapists, in different ways... being okay for him so that he could have meltdowns… I must have been about eight or ten, when he was diagnosed… I realised that there was a way to get help. And, I think it was probably also quite a relief to not have to do that anymore? … I think it was all totally unconscious, I'm quite sure – I have no memory of being 'aware' at ten that I felt relieved that somebody else was carrying this. But, I do think that it trained me to be aware of other people's... their emotions, and to know that, 'It's not all about you'. And, be able to separate it out. I didn't have the skills or know what to do, and it also wasn't my job to do it. But, I then became aware that there was a whole fraternity of people that could do something, uh, with emotions that were uncontained (Participant C4).

Look, it took me a long time to realise some of the earlier events that have shaped me. It always felt like they haven't had a huge effect on me. I'm one of a twin and my father passed away when we were five years old of cancer… I became hyper-attuned to my mum's needs, to her emotional needs, to being what I needed to be to keep her okay… interestingly, even as an infant, my twin brother and I-, apparently he had a much more frantic cry and I had a much more subdued cry, which meant he was always attended to first… So, even in terms of breastfeeding, apparently we would breastfeed at the same time. He would suck and I wouldn't even really latch. I would just allow the milk to trickle into my mouth.

And, it's almost as if my needs were never truly met and I've only realised this many years down the line… with my father's passing… having to be very attuned to a mother who I think has always struggled emotionally, and always could have done with therapy herself, but never went that route…

I'm almost hyper-attuned to the other, but when it comes to me and what's going with me, I find it very difficult to put into words what's happening, what I'm experiencing, what I'm feeling… I think it's improved with time, and specifically over the last few years, but it's been a very difficult thing for me (Participant B7).

Vollhardt (2009) articulates a particular type of altruism is often evident in the helping professions, namely, altruism born of suffering. The psychotherapist develops a desire to help others in distress as a result of having experienced suffering themselves. This paying it forward is borne out of having had human suffering as a companion early in life.

Participants (B1, C1, and D4) voiced that psychology had the personal benefit of providing oneself with self-understanding. This finds similarity in Murphy and Halgin's (1995) research where motivations to pursue psychology as a career includes the wish to increase self-understanding. As a senior psychotherapist, Participant E2 felt being "*a brilliant psychologist is different to a therapist*". As those psychologists who practice psychotherapy need to make sense of their personal wounding as such, *"How did your wounding start to transform? Your passion needs to develop so that suffering gives you meaning"* (Participant E2).

Participant E2 felt that an understanding of suffering needs to be developed by the psychotherapist. Masters training develops students' capacity to contain the clients' distress and

helplessness; Larisey (2012) argues that this ability is developed from one's own journey to confront one's own pain.

> *I was quite severely bullied when I was very, very young. From junior school all the way through to high school, I was just that kid that everybody picked on. … So, I don't know if it came from that, wanting to understand, 'Why, do people act that way? Why do people treat me this way, when I won't treat them that way?'… And, almost conversely, 'I don't understand why being mean to them-, and now, they were not mean to me anymore', you know? I think that that experience shaped a lot of things in my life… maybe, that was one of them…* (Participant B1).

Participants (B1, B5, D1, and E2) proposed that a motivation to enter the profession of psychology is rooted in an empathic identification with the victim, the underdog, or those in need (Chang, 2011). Freud recalled the humiliation of his father on a street corner being spat on because of him being Jewish, making an indelible impression on him (Appignanesi, 1979/2003; Storr, 1989).

> *If somebody's taking advantage of somebody else, it's always me that wants to save that person. I think that's where the therapist in me has come out* (Participant B5).

> *When someone was hurt or someone was bullied, I was the one talking to them in private… You know, try and console them… help them* (Participant D1).

> *The wounded healer archetype was activated. I always cared for children who were abandoned and rejected. I reached out to children who were poor, to take food for them. The wounded healer archetype was constellated very early in my childhood* (Participant E2).

> *I think there's something to be said about psychologists and all people who want to help… or rescue other people. I think we're all people who have been downtrodden in some way… some kind of difficult experience in our lives, of being a victim, and it's almost like we want to help other victims* (Participant B1).

Zerubavel and O'Dougherty Wright (2012, p. 482) point out that "woundedness lies on a continuum". The focus needs to be on the psychotherapist's ability to draw on their personal woundedness in the service of facilitating healing for their clients. Specifically, "being wounded

in itself does not produce the potential to heal; rather, healing potential is generated through the process of recovery" (Zerubavel & O'Dougherty Wright, 2012, p. 482).

Miller (2010) advocates that "only therapists who know well of the painful stories of their own childhoods can respectfully and effectively deal with the suffering of their patients" (p. 1). Gelso and Hayes (2007) highlight that the psychotherapist's wounds enhance the psychotherapist's ability to form an empathic connection with clients as well being a guide to their clients along their own unique journey of recovery. Participant C2 considered that personal wounding contributes to being an effective psychologist, in that personal losses and injuries help psychologists to empathically assist others.

> *You are the instrument as a psychologist, … and, I don't know if one were to be brought up in a perfect world with perfect relationships that you would necessarily need to become a psychologist. I don't know, but who has that in any case, you know? But, I think it would be difficult to be a psychologist… without having had your own losses, being aware of them and having had to deal with them* (Participant C2).

> *I can relate a bit more with people who are going through difficulties because I have been through difficulties as well and they have shaped the person that I have become… certain people go through experiences in life that shape them… may make them have more empathy to people or better understanding or listening… I think therapists are people who have had experiences in life that make them see the world differently to someone else [laughs], and, that's why they are therapists. I think it's a calling; it's not something you can just do as a simple job* (Participant A6).

Similarly, to Participants A6, and C2, senior psychotherapist Participant E1, found that when selecting psychotherapists it is important to assess their capacity for process empathy which is more likely developed in the crucible of wounding experiences of the aspiring psychotherapist.

> *By the way, there are people who come from what I call, 'perfectly everyday families', perfectly everyday existence… they are good all their lives. They make shit therapists, generally… I don't think they have that level of suffering and process empathy. And, the suffering doesn't have to be, you know, a major*

suffering… developing process empathy in difficult contexts, I think that's very good training… I think if you grow up in a normal family, you don't develop anything except reading and writing, maybe. You know, I'm exaggerating… and, how you use this as energy rather than as debilitation… you don't have to be a victim or a sufferer for the rest of your life. You can use that training- of suffering (Participant E1).

Participant E1 has found that the difficult personal life experiences of effective psychotherapists enabled them to develop "*process empathy in difficult contexts"* as such "*trial identification"* using that "*energy"* to effect change.

Early career psychologist Participant C1 found that it is important to be aware of one's own feelings in relation to the clinical material but cautioned that one's personal wounding needs to be appropriately self-contained when in the session with the client and after the session appropriately worked through.

I think it is very important that as therapists we go for therapy or supervision or some kind of different thing where you offload your issues. Because, like for me, the sole issue was being abused as a child. And, now, I'm working here at hospital, we have a centre… for abuse, sexual abuse… each time I see them it reminds me of where I was 30 years ago. So, had I not dealt with this, I don't think I would be able to even be of value to these kids, because I would simply break down. So, it's important that you deal with your blind spot so that the blind spot does not stand in the way of effective therapy. And, then I also, from time to time I get sad, I feel helpless, the way people are treating children, especially with the sexual molestation. But, now it's not mostly coming from, 'Because that is me', it's also coming from, 'Their experience, as they experienced'… maybe, I had to go through that to have a better understanding when people come, because sometimes I get the sense that when you have not experienced it, you take it for granted, the gravity of their pain.

But, in the same vein, my pain should not overwhelm me to such a point that I think that because I felt like that, automatically that is how they feel. So, the balance is that, 'No, I have an awareness of sexual molestation that my colleague might not have, because she has not been there'… it could be negative because I

could be over-identifying with patients. But, then the awareness that I do have is that when they come in here, 'It's not 10-year-old (C1), its 10-year-old so-and-so. So, now, it's not about me, it's about them'. But, the awareness that I was once there, will always be there. Just as long as it does not overflow into the therapy session (Participant C1).

With the psychotherapist's personality playing such a critical role in the success of psychotherapy for clients' benefit, Jung underscores the need for trainees to undertake their own psychotherapy. Jung advocated for the psychotherapist's own transformation as such the "self-education of the educator" (1929a, p. 74). In that Jung (1913) realised that psychotherapists can only help their clients go as far as they themselves have gone. In the current study, participants, across the developmental spectrum (A2, A4, B3, C1, D5, and E2) spontaneously voiced that they too hold the belief that they can only help another individual make sense of their wounding to the extent that they themselves have confronted their own personal wounding and blind spots.

Jung pioneered the idea that personal psychotherapy is an imperative training element for psychotherapists as a personal psychotherapy process demonstrates to the trainee the need for self-reflexivity and reinforces the psychotherapist's capacity for self-exploration. Psychotherapy is not an unwanted, resigned surrender to some sort of 'lock me away' endorsement of one's pathology. Rather psychotherapy is a valuable Gift one gives oneself in order to enhance one's enjoyment of Life and one's worthwhile responsible investment in one's relationships with others within the circle of Society.

I always go back to times when I'm on the receiving end of therapy. When I was a patient: 'What would I have liked my therapist to do?' So, that is listening to people (Participant C1).

After decades of clinical practice, Jung became convinced that the wounding of the psychotherapist was not necessarily dangerous. On the contrary, Jung voiced, "it is his [sic] own hurt that gives him [sic] the measure of his power to heal" (1951, p. 116), and "only the wounded physician heals" (1961, p. 134). After all, it is impossible for the psychotherapist to hide their personal wounds or weaknesses. Yet the use of personal wounding in a psychotherapy process with a client is only effective in the hands of a self-aware psychotherapist. "The therapist must at all times keep watch over himself [sic]… over the way he [sic] is reacting to his [sic] patient"

(Jung, 1961, p. 134). Herein, countertransference is refashioned as a primary instrument in the therapeutic process.

4.4.2. Other Personal Influences.

Participants (A7, A10, and C3) elaborated that their reasons for going into psychology go beyond the societal understanding or persona of the profession of a desire to help others.

> *So, later on as I grew up, I just realised that I wanted to become a psychologist, not only to help people get through their issues as I'm sure 90% of everyone who's in psychology thought that at first, 'To help people'. But, to also just working with people, being in that dynamic everyday where you are actually in an interaction* (Participant A7).

Specifically, participants (A7, A10, B1, C2, and C3) explained how psychology equips one to see what is underneath, unconscious, beyond the obvious or beyond face value. This ability to read between the lines, or to make not-so obvious links is enhanced through undertaking training to be a psychologist.

> *I didn't want to become a psychotherapist… I wanted to become a medical doctor. I thought that the best way to help a person is to definitely cut them up, open them, see what's going on in their bodies and then remove this organ or include this. So, my mum is the one who suggested being a psychologist to me. She said that I have the qualities in that I am critical and I just don't accept things at face value. And, I told her that people who are psychologists are very calm and soft-spoken… they're kind and they do all those things, and I'm not like that. I will be like, "You know, listen, this is not right! Wara! Wara!" I had that kind of personality* (Participant A7).

Racusin, Abramowitz, and William (1981), and Sussman (2007) argue that psychotherapists enter the profession with a need to control the closeness-distance in interpersonal relationships. In the current study, Participant C3 voiced that he attributes his desire to be a psychologist who conducts psychotherapy is rooted in his desire to be close with others. This motivation is similar to the findings of Henry, et al. (1973), and Murphy and Halgin (1995).

> *This kind of closeness with my patients, in a way allows me to create the same closeness that I experienced with my mother, the early closeness. But it's a safer*

closeness with my patients… it doesn't hold the same dangers… I am more in control of and it's a closeness that I can in a way regulate...

I am not the one who will tell you, "Oh, I came into this profession to heal people". I came into it not knowing beforehand, but knowing it now after years of practice that I actually like being close to people… these are quite narcissistic reasons… it is safe for me because I am still the therapist, so there aren't dangers in this kind of closeness that there are in other close relationships, you know like intimate relationships. Of course there are other kinds of dangers, you can't get too close because then you will violate something sacred about the therapy… I think you can hear from my words is that I am not just talking about the patient being close to me or me being close to the patient, I am talking about a mutual sense of something is right here between us… (Participant C3).

Haynes (2007) reflecting as a psychotherapist on society notes, "We punish curiosity, difference variation: ambivalence scares us" (p. 5). Participants, within the current study, recalled not being easily accepted by peers or others in society (B1, C3, and E2), which often placed them in on the outskirts or margins of social circles as an outsider or in an observer role looking in. Participant C3 speaks of being on the fringes or perceived as 'Other'.

I think about me being on the fringe… And, that relates to me still being on the fringe because of my sexuality, my homosexuality, but also a very early sense in an ongoing sense of grappling with this being on the fringe… I think that in therapy nothing is safe and this is true, and this is something that not a lot of people will admit. But, I think nothing-, there cannot ever be an assumption that something in the relationship is safe. There always has to be the struggle on the therapist's side to regulate things so either to rein things in or to expand. And, I think this kind of regulation constantly happened in myself. So I had, to either rein things in or figure out when I could expand, so, my self-state; my homosexual self-state, or when it was dangerous to present that? Or, when it was the time to open it?... But, it is always in flux. It's not static… that kind of internal struggle is probably, if I think about it now, is the most important indicator of how I work with my patients now. Because, that's essentially what I am doing with each patient, is working with something that is Other, my patient is Other and it's-,

'Can I find a home for this Otherness?, and, it's important about, 'When can I find a home for this Otherness?' And then, when can't I-... So, 'When do I reject what the patient brings to me?' (Participant C3).

From an early age, I was exposed to a lot of wounding due to being different, due to living in a conservative culture and which said, "Who I am is wrong!", "My essence, my core is wrong" which created a lot of wounding" (Participant E2).

Foucault in 1961 pointed out to a journalist from *Le Monde* that, "Madness exists only within a society… it does not exist outside of the forms of sensibility that isolate it, and the forms of repulsion that expel it or capture it" (cited in Miller, 1993, p. 98). The idea of being different to those in society finds similarities in the role of the traditional healer in societies. Bromberg (1975) traced the history of shamans to psychotherapists in assisting people with mental illness. Von Binsbergen (1991) studied the training of sangomas in Botswana. Systems psychotherapist, Bradford Keeney (1995, 2002a, 2006, 2007, 2010) has extensively investigated the healing traditions of medicine men and women across the world, namely, healers in the Kalahari (1999a, 2003, 2005, 2011, 2015), Brazil (2003), Bali (2004), Japan (Keeney,1999b, Keeney & Keeney, 2014) and the Shakers of St. Vincent in the Caribbean (2002b). He has drawn parallels between shamans and Western psychotherapy (Keeney & Erickson, 2006).

Participants (A9, B4, C, C3, and E1), in the current study, spoke of being observers of people's behaviour and trying to assist peers/siblings (A7, B4, C6, E2, and E4) and people (A10, B5, C6, and E3) at a young age.

I don't know. I woke up in Standard Seven and I decided I was going to be a psychologist ...[laughing]. I don't know where I had actually learned about that, because I came from a very small town, there weren't any psychologists there. But I, and actually at the beginning, it was, 'I wanted to be shrink'. The naïve idea of it… it was a fascinating field for me in terms of helping people… I wanted to share a journey of helping people. … I went to a career psychologist… that was my first exposure to a psychologist and it was a positive one for me… my mom was a nurse so she is a caring, giving person… I come from a family who really does want to help a lot of people… Probably, through my training, I became more aware of a dynamic between one of my siblings and myself… She was a needy sibling. So, I was always there for the sibling… I had to please to

maybe get attention. This is the dynamic that we had. That I had to be the good girl, I had to be neat and tidy because my sister needed the attention and I just had to be there. So, I was always fixing and making, creating some harmony… in the chaos that was happening (Participant C6).

The answer to that is very simple. Ah, I studied civil engineering at Stellenbosch (University) and I think it was in my third year that I decided, 'This is not for me. Sitting next to a dam wall or road'. So, I had a bursary with HSRC (Human Sciences Research Council) here (in Pretoria). And, I had to work back my bursary. And then, the head of the engineering division said, "Well, we don't need an assistant right now. Go up to the hill" In the old farmhouse was a guy called R- who ran the selection division… And, he looked and he said, "You don't look like much use to anybody. Why don't you come and work for me? I need a psychometrician, I want somebody who knows the tests. And, then you study psychology while you're about it". I said, "What is psychology?" And then, of course, I studied the BA of Psychology and Criminology through Unisa, while working. And, then I did the Honours in Psychology. And, then I applied for a job there. And, in those days you could still sort of get in with an honours as a lecturer…

And then, W- was the clinical professor who said, "Why, don't you come and do the clinical course for two years?" I said, "I don't want to work with mad people! Are you nuts? I like the personality psychology, the research, the social psychology". He said, "Come". So, I did it. And, I got in. So, if you say, 'What predisposed me consciously to this profession?' No, it was a series of mishaps and ill luck or good luck.

I think though subconsciously and unconsciously, uhm, I was adopted and it was a difficult situation before I was finally adopted by the third couple who had me. And, I had a lot of issues and difficulties in the system of origin and I was very different from them. I knew that from the age seven… So, what I became there was an observer of process and I tried to fit in as well as I could, I suppose. And, they didn't ill-treat me or anything. But, I became interested in, 'How come this

happens and that- this happens? And, this one says that?'. You know, the typical imbroglio, the embroilment of biological family systems. The plots, the instigation, the counter-plots, the coalitions and realliances. And, I was fully aware of that, uhm, even as a young kid, even at primary school. I was curious about it. 'How does it work?' There it started, but I didn't know… You must have that kind of serendipitous, I don't know what, processes operating in your life (Participant E1).

4.4.3. Born This Way.

The idea of the natural, "informal helper" (Chang, 2011; Rouslin Welt & Herron (1990), unofficial, lay psychotherapist, or adopting the psychotherapist role or the *"go-to person"* (B6) within one's family of origin is evident in the current study. Training to be a clinical or counselling psychologist could be understood as an important formalisation process of what the individual already is.

So at a very young age… I was a natural therapist in the family, looking back now, and I stayed that until my parents died. And, even still for my brother and sister and they will kill me if they hear me now. But that was true… - I was triangulated into [chuckles] my parents' relationship, but I was a good therapist, they stayed together (Participant E4).

In 1979, Safinofsky cautioned that an applicant "must already be a concerned, compassionate, intelligent, and sensitive human being before this training even begins. Training may mature and refine the experience of his [sic] concern and empathy, but it cannot supply what does not exist in the first place" (p. 195). With this in mind, Nissen-Lie and Orlinsky (2013) speak of therapeutic talent that predates training of psychotherapists. Selection of trainees could potentially be described as a process of identifying the unofficial healers in society and the subsequent training a recognition and a refining of the individual's natural role (Mullenbach, 2000) and way of being which will now become a socially recognised and remunerated career.

In my high school years where I started to acknowledge that people were very naturally drawn to me in a different way, in a way that they wanted to share something difficult that was going on… and I think there was an arrogance in me because I believed, I remember after school thinking, 'Well you're either born a psychologist or you're not', and, 'Why should I study it because what difference

will that make?' And, I ended up going and studying Medicine for a few years… But, after three years of struggling in Medicine and realising I also have struggled my whole life-, well not in my whole life but since early high school, like till now with quite severe depression and also Body Dysmorphic Disorder, and things fell apart in Medicine completely and it was almost like something just said to me, 'I need to go to Psychology'. Not because, it was never a sense of 'I need to go there to heal myself', but it felt like this is one thing I think I'm quite natural at (Participant B7).

I know it's like clichéd, but like… the profession chooses you. You don't really have a choice. Like I said, I was going to be a special needs teacher... growing up… I had to manage and feel a lot for my parents… and had to work with their stuff … I think, naturally, I was an empath. So, maybe that's what brought me to the profession, and drew me to this?… I'm quite a natural, you know, therapist, just naturally, I am who I am, I do bring my personality into that (Participant B2).

In step with being attentive to others' feelings, participants relayed that being a good listener and confidante of others (A5, A7, B3, B1 and E4) stems from childhood and is a continuing role definition.

Now, if I reflect back?... I think I was always sensitive… I was also always sensitive to people and people's emotions (Participant E4).

So, when I look at my childhood, I'm hypersensitive to other people's emotional needs… and I've also experienced some trauma. That probably makes me hyper-aware or attuned in some way to what's going on in- with a person (Participant B3).

My family dynamics played a big role... I was like the comforter in the family and that's the role that I assumed (Participant A5).

I found amongst my colleagues, we all really suck at talking about our own problems, because we just want to talk to everyone else about theirs, … I was

always an approachable, empathetic person. I think that's just part of my personality structure. And, because of that, people always come to me. And, maybe, because of that, I became interested in that kind of field of work (Participant B1).

Always as a teenager, as a child, I just always used to find myself in situations where I just gave advice or where I would just be there for someone. To listen to them or to even offer them tissues if they were crying. So, I think it's something that's always been in me sort of. In that, the seed was always there… (Participant A7).

4.4.4. Drawn in by Media.

Reading psychology books was spontaneously mentioned by participants, namely, Freud's works (D2), Viktor Frankl's *Man's search for meaning* (A4, A6, and A9), Tory Hayden's books about children with special needs (B2) and self-help books (A4) as feeding their fascination with the mind and human behaviour and making meaning of suffering which in essence spurred them onto formal study in the field of psychology. Psychologists always need to be *"holding and growing in the suffering"* (Participant E2).

And, I think as an adolescent growing up in quite a difficult home environment; reading something like that, it also – And, I read it (A man's search for meaning) again later, and if to read something like that and to show that you can grow through difficult things, but if you find meaning in it; it's no longer suffering or something bad… (Participant A4).

I actually, love the work of Viktor Frankl. I truly believe that there is sort of meaning in suffering… and therapy is a way of them trying to make sense and make meaning of everything that they've been through. And, this also ties in to what I've also been through… I feel like usually I can get meaning from it. And, that actually helped me look forward to the future I think (Participant A6).

Psychology in the public domain is understood as helping people with their personal problems and is categorised alongside other helping professions, namely, counsellors, and social workers (A8, and E3). Since the 1990's television in South Africa has provided a caricature of psychology, however, psychiatry and psychology are often understood interchangeably by the

general public (A9, and C5). Agony aunts in the print media (C4) have also provided a glimpse of psychotherapy (Kent, 1979; Weinberg, 1989; Wilbraham, 1994). However, often the expectation of psychologists held by members of the public is that of clients being stigmatised as crazy and therefore due to this severity in need of a psychologist's help (E2). Furthermore, a common expectation held by the man or woman in the street is that the psychologist needs to dispense cure-all advice and solutions to clients who are in distress (A10).

Participants (A1, A9, B1, C1, C4, and D4) acknowledged that the media, namely, magazines and television gave them a picture of what forensic psychology and psychotherapy entailed which ignited their curiosity in the profession and to learn how to investigate behaviour utilising abductive reasoning like that of the iconic, fictional detective Sherlock Holmes (B1). However, participants voiced that the cinematic portrayal of the profession is vastly different from the actual profession, in that it is rather glamourised in the media. This dissonance, however, did not deter them from the entering or continuing in the profession.

> *I used to have mentors that I looked to on television… there was a show called, '3Talk' where they would occasionally invite psychologists on the panel to come and comment. So, witnessing that used to be like motivation for me, that 'Ah, these people are so together'. The way that they feel an individual and the way they try to understand an individual was just intriguing for me to learn from* (Participant A1).

> *I think I was sixteen when I decided I wanted to be a psychologist. Or I said, "I wanted to be a psychiatrist." I didn't know the difference at first [laughing]. I saw on TV, I think, there was one of the like - the soapies, there was a psychiatrist… then the people would lay on the couch, and then she would do psychotherapy with them, just listen to what they are saying* (Participant A9).

> *There's all kinds of things along the way, that I read, I watched shows. I've always been fascinated with hypnosis, when I was young… How does it work? Why does it work, and that. Pathology, serial killers and split personalities… I loved that stuff… bullshit, pop culture psychology, kind of helped me to remain interested… You know, its people watching Boston Legal or other legal shows that want to be lawyers… something hooked you earlier on and then it stuck to*

you. And, then you learn to appreciate the discipline for what it really is… I really was interested in forensic psychology, because I thought you could get like a profile there, like you know, "We're looking for someone with a lisp, the limp left hand, you know, probably walks with a swagger, short hair, has a moustache, probably wears jeans and a brown belt", … the idea that you get into someone's head like that was fascinating… that you could understand someone so deeply that you could figure out how a mind works (Participant B1).

I had always watched like criminal- like CSI and I would watch those and I felt, 'No, I think I would like to investigate the mind of criminals'. So, that's how then I decided on criminology and psychology (Participant C1).

My first experience of the profession was in the Huis-Genoot magazine … Oom Marie Jansen or something [Ask Uncle Marie]… from when I was about ten or so, eight, nine, ten and started to read magazines, because I would just read everything. I saw people posting these questions, "I'm struggling with this and this and this", and I would always think, "But, I know what they should do, this and this and this and this"… I could not page through a magazine without reading the agony uncle or the agony aunt, it really drew me… I became aware of the profession through… magazine articles: 'What type of personality do you have?'… it was always just such an interest (Participant C2).

4.4.5. Encounters with Psychologists.

Participants who trained in the last decade (A1, B4, B5, C1 and C6) spoke about undertaking psychometric testing to confirm that they were well-suited to the occupation of a psychologist.

So, when I was in marketing, in my previous occupation or career, having to change everything and reengage with studies was quite a leap and quite a commitment financially and lifestyle wise, and somebody had said to me, "You know, why don't you go for a career assessment, and just make sure that this is something that you can do?" So, I went for a full battery of career assessments with the very particular question in mind, like 'Should I engage in becoming a psychologist or a psychotherapist?'… So, they confirmed or affirmed this notion that I can do it. (Participant A1).

I did an aptitude test with some educational psychologist at our school… and, he said to me, "Look I don't think pharmacy is for you, because of your introversion", or I don't know, I can't remember what he said, and one of the career options that he said was I must become a psychologist. And, I was like, 'A psychologist, really, I know this is cool and I like giving people advice, but like really?'

... then one day I had a mate who said, "Let's go to the right hand side for a change", and I did, and there was a lecturer at that stage, and that guy is still one of my mentors today, … I was like, 'Whoa, mind-blowing! What is this about?', and then I went to his lectures for my entire first year, every week and I was like, 'This is really cool stuff'. And, then I was sort of, like my second year I started to develop a real interest for it, a passion for it,… then in Honours you get exposed to therapeutic psychology and I thought, like, 'Wow, this is good!', so then I applied to do masters and became a psychologist (Participant B5).

When I was in matric, in 1994, I wanted to do business management… so, I had applied for the programme... then my dad took me to his workplace… for some psychometric assessment, then through the assessment they picked up that my strength is more with people, as opposed to a business setting. So, I took that to heart. And, then after passing matric went to Unisa, registered, my dad helped me to decide which course... He said, "No, because those people said, 'people', do something people-related". So, I registered… BA, majoring in psychology and criminology… (Participant C1).

Trainee participants spoke specifically about undergoing psychotherapy as children (A2, A5, A10, B1, and D3). Participants (A1, A4, A6, C1, C2, C3, and E2) in the current study relayed that they had gone to personal psychotherapy prior to entering masters and how it contributed to them wanting to be a psychologist in order to also help people in ways that they were helped. Additionally, their own experiences of going to psychotherapy prior to masters continues to inform how participants offer psychotherapy to their clients. Participants (B1, D3,

and E2) felt that personal psychotherapy prior to undertaking masters training helped to interrogate their personal reasons for wanting to be a psychologist.

> *I was in high school and my one grandfather died and I really struggled with adjusting to that as well because he lived in the home with us. So, my parents thought that it is a good idea for me to go to a psychologist… and my first experience wasn't very good with the psychologist, I didn't felt like that specific psychologist understood me or was able to help me in the process… I don't think all therapists will work for every client* (Participant A5).

> *I started going for therapy when I was eighteen… and I was doing my first year in psychology… I think after going for therapy, I actually knew that this is actually what I would like to go into and what I feel that I would like to help people in this way and provide them with the necessary space or the safety where they can talk to me and I can give them that support because I felt that at that time of need… with my parents divorcing… I felt like I was in the middle. So, therapy provided me with that safety where I could actually just be congruent about how I'm feeling because I felt that I couldn't in the context that I was in…*
> *that first therapy actually taught me and I still cherish what I experienced even then that it's really not about all the techniques… but at the end of the day, at times it's what you can provide your client with in their time of need and that's warmth and support… I'm still using it, even today to just trying to give my clients the best possible chance or the best context that I can provide and hopefully they'll feel safe enough with me* (Participant A6).

4.4.6. Curious Minds.

Participants spoke of their curiosity and fascination with the human mind and interpersonal behaviour. Participants (A9, B1, C2, C5, and C6) found that they were attracted to psychology as it provided a way in which to understand other people and their behaviour, which at times felt unusual or incomprehensible (Murphy & Halgin, 1995).

> *When I was very young I wanted to be a pediatrician for some reason, and then I wanted to be a child psychologist, and then I wanted to be a psychologist…*
> *Round about Standard 6, which is Grade 8 now, I was firm, I wanted to be a*

psychologist. I chose my subjects for school based on that… I followed that through… I was fascinated with human behaviour. I wanted to know why people acted the way that they did. I was very interested in knowing, 'Okay, what causes someone to do X instead of Y. Your whole life is choices. (Participant B1).

They've always nurtured this part of me that was always curious… though it was, "Okay, we've never experienced someone who is always wanting to know everything, but go with it"… it's something that was received with positivity in the household… It didn't feel like I was doing something wrong… I felt like, I can actually pursue this career. I can actually try it. I mean, even when I was changing careers and quitting my job, and saying, "You know what, I think I want to go back to school and study further and see what happens". So like, "We don't understand it, but if you want to do this and you feel like it's important. You understand why you're doing it. Go for it!" So, having that as well, backing you up… it helps…
I know when I was doing my undergrad, Viktor Frankl was one of my favourite theories… it just captured everything that people go through and people talk about. In terms of people do things because of the meaning that they attach to whatever it is that they're doing. So, it kind of helped as well, to clarify some of my assumptions about what was happening in high school. Why people decided to do things in a certain way… (Participant A9).

I know when I started thinking about it… early high school. At first I thought I would like to be a lawyer or a psychiatrist. And, then I looked, and said, 'Okay, what does that really mean, because a lawyer was just based on what I saw on T.V., then I thought, 'Not that'. 'A psychiatrist, maybe?', and, then I was thinking, 'What does a psychiatrist really do?', and, then I thought, 'I don't want to be a doctor'… what attracted me to that was the analytic nature of those things. So, having to speak to someone or understand behaviour… so, it wasn't about just wanting to talk to people or help people as such, it was more around, 'How do people think?' and interest in that.

… there was no one, I had no exposure to psychology, but, it is just something when I read up on it, and, it just seemed to fit… maybe, why at first I was thinking psychiatrist, I think I didn't know at the time, but, initially, it was more the psychopathology… that really intrigued me… I thought that people like this are very misunderstood or very automatically treated in a certain way or stigmatised, and that kind of linked to, if one takes one step further and tries to understand-, I think that is how it all came together (Participant C5).

Similarly, Adams (1998) speaks about his love of imagination that drew him toward being psychotherapist. Participants spoke about their curiosity in making sense of people's behaviours (B4, and C2) and minds (C3). Participants also spoke about being fascinated by abnormal (C5, and D4) or deviant behaviour (B1, and C1).

When I was 15, I said, "I want to be a clinical psychologist". Not just psychologist, I don't know how I got to that. Obviously, there was a lot of unconscious stuff going on. But, what I'm aware of is that I've always been interested in abnormal psychology and like if I can say as the weird and the different things that are out there. So, not just take things for face value. So, I do have a love-hate relationship with the DSM - but I love the DSM and I think the psychiatric clinical experience and exposure-. So, it was important for me. So, I think initially, it was just: it's something different and you work with people, but in a different way (Participant B3).

I would always, be the go-to person as a child, but I would play a-, I used to call it, 'The guessing game' in class. So, children would like, scratch their heads or fall asleep or yawn in class, and like do certain non-verbal cues, and then I will always try and guess like, 'Okay, if he is scratching his head, what is he thinking now?' Or, he is yawning, 'What is going through his head now?' and like trying to, you know, read their body-language and things (Participant B4).

That was sort of the cornerstone for me, very young… it's a child who learns to read someone on a very intimate level… there is something about that process of reading your mother-… Or reading a parent… it is not just reading, it's- because reading implies something more higher cognitive for a child-, it's also just about

wondering. You know, the child makes sense of wonders… it's got like a certain fluidity to it. You are not just reading… you are always in reverie to your mother (Participant C3).

4.3.7. Woundedness Spans the Developmental Journey.

Painful events and personal losses continue (A5, D4, E4, and E5) to occur in the lives of trainee and qualified psychologists. As such partcipants voiced that though they were trained to assist people in distress this does not make them immune to distress or personal struggles. Participants felt that no-one is cured or healed completely (C4) as pain and concerns re-emerge at different stages of one's life (A1).

4.5. Unskilled and Unaware as Aspiring Psychotherapists

Arrogance or overconfidence as a novice can be a serious stumbling block to becoming a competent psychotherapist. Kruger and Dunning (1999) found that incompetent people often suffer a double burden of not only can they not do something properly, but they also do not have the commensurate ability to recognise that they do not have the necessary skills. As such they are "unskilled and unaware of it" (p. 1121). Senior psychotherapists (E2, and E4) spoke of how young psychotherapists start off with a sense of overconfidence (B4) and through the years one learns one's limits and how humbling the profession makes one. Participant E2 reflected, drawing on developmental psychology, that "as a young therapist there is narcissism in that, 'There is so much I can do', whereas now the complexity of life becomes more real. It's not so easy". He felt that initially when one starts out there is a "tendency to oversimplify therapy". Over time, he found that young psychotherapists "grow out of that narcissism and realise that, 'Suffering is real. I actually have to sit with it'".

I was young when I trained as a clinical psychologist in my 20's. So, I was really young and inexperienced…, and I think you are aware of that, even just dealing with these students, that being selected as a clinical student, you are arrogant, you think you can already change the world by being selected. So, that was unfortunately, with my first patients, I realised is that, 'I'm not the guru and I don't have any wisdom. I only have techniques and that is very superficial if I'm not there in the here and now'.

… I remember vividly after I've met Rogers, I realised that I need to find inner peace. I need to be in the moment and to be with my patients. And, I couldn't do

that. I was out there talking… It was, 'I need to perform, I need to be the expert' And, I wasn't an expert then. I wonder will we ever become experts? But, that I realised I needed- and I had a lot of discomfort in myself, coming from a certain background etc. So, that was a wake-up call, when I realised, 'I don't have the patience. I complete sentences for my patients… (Participant E4).

I think last year it was (masters coursework year)- I don't know if it is just because being like a brand-new sort of therapist… You climb onto, or I did, climb into this one-upmanship, that: 'I have got like seven years of theoretical knowledge, I am going to teach you, I am going show you'… Where this year (internship), it is just been like, coming down to earth and realising these are people, everyday people. Young/old, different races, different genders… mental illness can affect anybody… And, that they too can teach you something, and, you know, you too are sometimes damaged… So, you can't be yourself as this perfect person, who is going to change everyone… And, definitely learning. I think starting off my process last year was like, 'Oh, I am going change everyone, and I am going to teach you how to be better, and you can't change everyone'. And, I think that, you know, people want to change themselves (Participant B4).

I think when you are a newly qualified therapist you have so much knowledge. You have been given so much knowledge. You think you know a lot and sometimes you think you know what your clients are needing based on theory, based on what you have learned, all the reading… you try and impose that on your clients… it's good to hold that knowledge in the back of your mind, but to listen to where your client is at the moment and what they are needing at the moment… The anxiety is comforted by, 'I have got knowledge. Let me give knowledge. Then I am making a difference'. I am working too hard essentially… Imposing on them… it's a key skill a good therapist needs…to wait and distinguish… 'What do I think the client needs?' and… 'What is the client illustrating they do need?' (Participant C6).

Rousmaniere (2017) speaks of how young psychotherapists avoid sitting with a client's pain. He proposes that a key task of developing psychotherapists, which is a unique

developmental task of psychotherapy, is psychotherapists needing to learn to tolerate and work with the suffering and anxiety that clients bring to session. Rousmaniere elaborates that psychotherapists need to hear and accept a client's suffering without trying to compulsively resort to solving it. Being receptive to what the client exactly brings as they bring it conveys to the client that the psychotherapist can honour, manage and work with their distress as well as respect the client's ability to confront their own problems. To offset the psychotherapist's "experiential avoidance" (Rousmaniere, 2017, p. 98), psychotherapists need to relate to their clients as they show up rather than relating in ways the psychotherapist wants the clients to be (Frederickson, cited in Rousmaniere, 2017, p. 100).

> *We used to joke in our training and when I was just out of training, that you get two kinds of therapists or psychologists: 'You get a therapist and you get a psychologist. And, a psychologist has learnt all the skills and practices them by books and does what they do in therapy. The therapist is the one that really engages'.*
>
> *And, I think the successful therapists can be both… You get psychologists that are very successful by the number of clients that they see, the money that they are making, and it becomes a revolving door – not a revolving door, but like a sausage factory. Then you get those therapists that invest and really sit with their clients in their struggles, and I think those become very good therapists. And, they are able to deal with clients and their very personal issues. So, it's the ability to sit with difficulties* (Participant C7).

Research indicates that psychotherapists need to learn to tolerate and work with the negative emotions of the client (Castonguay, Boswell, Costantino, Goldfried, & Hill, 2010). "Our personal emotional capacity serves as a glass ceiling that limits our professional effectiveness" (Rousmaniere, 2017, p. 101). Highly developed emotional self-awareness and non-reactivity of the psychotherapist is directly linked to the success of therapeutic work with clients which reiterates how the professional and personal functioning of the psychotherapist are so inextricably entwined. American poet Mary Oliver (2006), voices in *The uses of sorrow*, "Someone I loved once gave me a box full of darkness. It took me years to understand that this too, was a gift".

> *I know what this looks like. I know how it feels like… bring it on almost because I have been to the depth of wherever. You know? I know darkness… I know being totally in a whirlwind of emotions and turmoil. I know it all. "You can give it. It will be okay. I can hold"… … It is interweaved because I cannot see how you can be a psychologist separate from who you are yourself as a person… it's a fascinating journey* (Participant D3).

In other words, psychotherapists need to put their personal "box full of darkness" to work. To assist psychotherapists in facing the impact of negative emotions in their work, personal psychotherapy for the psychotherapist has been highlighted as an effective strategy to become more comfortable with distress (Rousmaniere, 2017). However, in addition, Rousmaniere advocates that psychotherapists need to learn the discipline of disidentification in that one learns that emotions flow through an individual rather than emotions being the individual, this emotional awareness fosters a space that enables psychotherapists to respond to client's distress more reflectively. It is from a stance of mindfulness that psychotherapists' capacity for empathy and compassion can increase, as well as enjoy improved self-insight, skills and self-efficacy together with decreased stress and anxiety levels and defensive responding to clients (Rousmaniere, 2017). Emotional-attunement training needs to be a central competency prioritised in training psychotherapists.

> In psychotherapy, it's like we're a pilot but the most terrified passenger is sitting in our lap. Or we're like a surgeon, but the patient is not sedated and we have to maintain eye contact and keep asking her how she's feeling during the surgery. Or we're like a dancer or musician, but we have to maintain eye contact with the person in the audience who has the worst agoraphobia (Rousmaniere, 2017, p. 105).

As such clients fear coming to psychotherapy and do not want to feel pain and yet psychotherapists need to accomplish the task at hand despite clients' proclivity to want to abandon psychotherapy altogether.

> *I think that is part of the danger… that being arrogant as a young therapist, because that, 'feels so natural for me' but that was in that lay counsellor's role. I confused that… a lay counsellor's role and to be a clinical psychologist… Not just giving advice. That was difficult* (Participant E4).

Previously being an unofficial or lay psychotherapist can be problematic for trainees. Participants (C3, D2, D5, E2, and E4) all spoke of how psychotherapists in reality cannot save people and that in the process of becoming a psychotherapist, this idea of rescuing people needs to be relinquished. Participant E4 as a then-student and now-trainer has found that masters training is also a process of 'unlearning'. When an individual enters training they may come with lay helping skills such as providing comfort or giving advice to people in distress. These skills and identity aspects of being everyone's ear or the fixer/rescuer/saviour need to be reworked in neophyte psychotherapists in order to effectively practice as a qualified psychotherapist (D3).

> *I will look, 'Do you want to be a saviour?'... Or, 'Do you actually want to follow a process with the person?'… "No, we want to save him!", 'You know you have got to try and help as many people as-', that's not therapy. Therapy is you have to actually got to follow. You are not a leader…, you don't lead somebody else's life. Remember, you are taking their power away, you are taking their way of decision-making* (Participant D2).

> *We sometimes end up thinking that we know enough and we are able to sum up our clients in the first session and, "Therefore…!" - which is counterintuitive if what you are working with or working toward has changed or facilitated the change-. So, if you know everything about the person and you have already summed them up, where does it leave their capacity for change, or yours?... the other thing is the capacity for change in terms, not of becoming fickle, but, in terms of actually becoming more grounded and learning more all the time* (Participant D4).

> *Coming in as a masters student, you are a raw diamond. You need to open your mind and think. Because, so many students come here. And, why do they want to do clinical psychology? Is that they want to help people. And, that is a very dangerous position to see yourself in. 'I am the helper, I am the saviour of people'. We know that is not how it works. It's a co-creation of healing, you and your client. Of course, you come with your expertise, but it is not you that trains a client to be better* (Participant E4).

Experienced psychotherapists spoke of the learning curve they had experienced in terms of the conundrum of responsibility towards the client in tandem with the self-responsibility of the client. Experienced and senior participants, particularly, spoke of how the need or expectation that psychotherapists have to save or rescue those in need can actually be problematic (D1, D2, D3, D5, E1, E2, E4, and E5). Cain (2000) found that unprocessed personal difficulties can lead to psychotherapists over-identifying with clients and therefore displaying over-responsibility towards clients which proved to be counterproductive for clients' treatment.

4.6. Awareness Develops Along with Skills

Many of the reasons as to why psychology was pursued, according to participants (B3, B5, B7, E4, and E5), lay dormant for years since childhood and only became known with increased self-awareness through the years of training and maturity. Self-awareness (A1, A6, B1, C2, D3, and E1), introspection (B1, and B5), self-understanding and self-knowledge (B7, and E1) or self-reflexivity (E3) was deemed essential by participants as a key evolving feature of psychotherapists' development. Loevinger's model of ego development (1966, 1983) positions self-awareness as developing from 25 years old onwards.

> *I think it is something part of this profession that we are not just doing work in terms of learning theory and trying to apply it. We're forever having to examine our own selves and how we are impacting in the therapeutic room or the relationship and all of that… I think if you are not willing to sit here and examine yourself then don't bother. Don't come into the profession. Because, you are the relational tool, here, you know, and I do think it's something, probably something essential, that differentiates us from other professions* (Participant A1).

> *Firstly, the actual masters training, I would say is the most influential. It's the biggest change, literally, that I have experienced in my life… it changed who I am as a person. It changed how I am as a therapist… when I started the training I learned how little I knew about myself* (Participant B1).

> *I think a big part of their (psychotherapist's) life needs to be dedicated to understanding who they are, knowing who they are. Not necessarily being at ease with who they are, because I think therapists, uhm, I struggle with anxiety. I think lots of therapists do* (Participant B7).

We are so introspective all the time. That it affects our own self-regard because we are constantly thinking; "Where am I? Am I doing this accurately? Am I right? Am I on the right track?" And, checking our process in relation to other people… it breaks a person down to some degree and it can also build you up, but putting that in context it made a lot of sense to me. Because we never just... I'm very much self-aware all the time (Participant B5).

To be open to examining yourself as you do this work, to understand why you… with every single thing that happens: 'What's your reflection?', 'What's happening for you?'; because that helps you also understand your client better... to be able to be brave and curious about yourself and about your client, not just about your client… in a one-down position and diagnosing them (Participant C2).

Participants felt the level of their self-awareness grew significantly during training (A4, A10, B1, and C4) and over time practicing as a psychologist (C2, D3, and E4), through feedback on how they come across to others and confronting their personal history.

The feedback from lecturers, the feedback from colleagues so I would say feedback in general as opposed to just supervision. I think supervision is more client management. There also feedback on yourself, but it's more with regards to the case. Feedback in terms of me as a person, I think that was also quite influential (Participant A10).

I think as the years progress, it's also a lot about sorting yourself out. Getting to a point of comfortability where I know my shit. I can face my shit. We can talk about my shit right now… I think that puts me in a comfortable position as a therapist… where I don't have the need to perform (Participant D3).

The boundary between what an individual consciously knows (conscious knowledge) and what an individual knows or feels unconsciously (repressed knowledge), is not clearly demarcated and a process of relevation needs to occur. What stood out for Participant E2 is the psychotherapist's ability to have relationship with others and oneself. *"Your relationship with your own inner Africa is a priority… The relating with the inner and outer needs to be created"*. This is an *"absolute first priority"*.

(Self-awareness) it can be learned, it can be fine-tuned. But, I think you have got to have something to start with… A tiny, tiny spark… we started with little reflective pieces… a lot of "I" questions that confused me because it was very different from my undergrad where everything was in your textbook, you learn it, you regurgitate it… after starting this training I think it kind of picks at you. So, like chipping away at ice, so the little questions or the little exercises about, "How was this for you? How, what are you feeling? Why are you feeling that way, or what's the impact of it on you?"
The little questions that got me focusing more on myself and less on the theory… to slowly build my self-awareness… to self-reflect as in what am I genuinely feeling... it was very difficult for me, because the idea that I came into this course was that as a therapist… 'We are detached. So, I have got to be okay all the time. Even if I am not okay, I need to put on a face that I am okay and deal with client… It does not matter what you are going through, that can wait, that needs to be packed away'… that is not the case. I have got to be aware of my emotions and how that plays out in therapy (Participant A10).

Self-aware… I think you can bring about awareness… But, I think that there's a – probably an inherent ability as well… I think some people, because of the situations that their lives have created for them, are inherently more aware of others and feeling and emotions that others might not be… But, they might not be aware that they are aware of them… Well, I suppose you can be trained to become conscious of it (Participant C4).

4.7. What to Do with a Tower of Psychobabble?: Theoretical Orientations

… learning therapy is like learning a foreign language: each has a vocabulary and grammar all of its own. When each theoretical school believes itself to be correct and to be practising the most insightful or appropriate form of therapy… this leads to a 'tower of Babel' of psychotherapy (Owen, 1992, p. 76).

To my mind, in dealing with individuals, only individual understanding will do. We need a different language for every patient (Jung, 1961/1995, p. 153).

each institution seems, in South Africa at least, to have its own flavour, I guess (Participant D4- UP).

I think similar things are spoken about in the same way, using different language (Participant C7- Unisa).

In South Africa, fourteen universities offer masters training in clinical psychology and as of 2016, ten universities offer masters training in counselling psychology (24 programmes in total). The main orientation of Psychoanalytic Therapy is taught at the UCT and Wits (C2) which stipulates that psychoanalytic personal psychotherapy is mandatory for trainees to attend throughout their training as an integral part of their training model. Unisa has a history of prioritising a Systems perspective across client populations and modalities (A4, A5, A6, A7, A8, A9, A10, and C7). The Medical University of South Africa (Medunsa, now Sefako Makgatho Health Sciences University (SMU)) trains from a Systemic orientation and a specific systems-related homegrown method, namely, Interactional Pattern Analysis (IPA). Participants (A4, B1, C1, and E3), who had trained at Medunsa or Unisa voiced that they had been trained in IPA developed by Vorster (2003, 2011).

Integration of theoretical orientations is prioritised in many South African masters programmes (Peltzer, 2000). UP has a long history of teaching Psychoanalytic Therapy (E2), this has shifted to include an emphasis on CBT, Family Therapy and Narrative Therapy as well as Group Therapy (B2, and D4). UKZN teaches Psychoanalytic Therapy as well as CBT (C4). RU currently prioritises two orientations, namely, CBT and Psychoanalytic Therapy as well as seminars in Solution-Focused Therapy for time-limited contexts such as mental health services provided during trainees' two-week practicum on the Phelophepha Healthcare Train. For counselling psychology students at RU integrative child psychotherapy and career counselling are additional foci. UJ (B5, and C5) and UFS present many theoretical orientations to their masters students (D1, D2, and D5). NWU in Potchestroom presents an integrative model including CBT (B4, B6, and D3). Similarly, NMMU (now NMU) presents to both clinical and counselling psychology an integrative model which starts off with Person-Centred Therapy, integrative child psychotherapy and career counselling in the first semester and workshops on Object Relations, CBT and Transactional Analysis, Group Psychotherapy in the second semester

with two workshops on the integration of theory. Trainees at NMMU, during their internship year, are evaluated by means of two oral examinations by their university lecturers and an external examiner regarding their proficiency in two theoretical orientations as applied to cases (C3, and C6).

From a British perspective, Owen (1992) points out that even though mental health professionals of various orientations and schools of thought have conflicts, ambivalences and deep schisms they continue to operate within "a shared field" (p. 68). Dyne (1992) points out the need to reach a level of consensus in terms of common factors of psychotherapy and ethics of psychotherapists in order to define the profession or role description of a psychotherapist for both practioners and the public. He argues "a sound field theory is the grounding for all professions giving reference points to everyone" (cited in Owen, 1992, p. 68).

Legally, clinical, counselling and educational psychologists more often than any other mental health provider/professional within the South African context can comfortably use the term *psychotherapy* in line with their scope of practice, without fearing that the public or court would deem them unfit to practice psychotherapy. They are regarded as the most trained and qualified professionals in psychotherapy, and thereby the most recognised main providers of psychotherapy. Exceptions to this rule are internationally-recognised psychoanalysts (www.sapsychoanalysis.org) who practice Psychoanalysis, or Jungian analysts (www.jungsouthernafrica.co.za) who offer analysis based upon Analytical Psychology, or psychiatrists who have had training in psychotherapy who render paid services to the public using their title of psychoanalyst or psychiatrist.

The centrality of theoretical orientation to psychotherapy becomes a growing awareness as trainee psychologists undergo their masters training. In the current study, participants (A5, B1, and C2) were primarily relieved to be selected to do masters training that the theoretical orientation of the institution was not a deciding factor of where to apply to train as a clinical or counselling psychologist in South Africa.

> *No, it wasn't a factor at that moment, I think my main goal was just to get through … to get into a masters programme, yes,… I applied to numerous universities* (Participant A5- Systemic orientation at Unisa).

> *It was quite difficult to make peace with this type of training because this was the university that selected me. I was fortunate to be selected by a university that did*

this or to just be selected full stop… You don't have a choice. People are just so grateful to be selected… You apply to all the universities, regardless of their orientation… then you make the best of it. And, when coming into that training was I thinking, 'No, I don't know, this is not really me.' And, then having gone through that process it was a that because it's developed aspects in me (Participant C2- Psychoanalytic orientation at Wits).

Participants (A1, A5, A10, and D4) pointed out that their exposure to various theoretical orientations stems back to their undergraduate years and honours year (fourth year). Participant D4 recalled that, through an assigned experiential exercise, she discovered that psychotherapists' beliefs differ according to how they make sense of personality, and change processes.

Learning about theoretical orientations in undergraduate is, it's all good and well that we get taught it out of a textbook and that. But, I think it only really comes alive when you get to do some kind of experiential work and that isn't necessarily having to go out straight away and do lay counselling or supervised counselling or whatever…

I think it was Personology, and, we were asked to draw up our own theoretical framework … toward the end of the year, from all the theoretical frameworks that we had been exposed to- 'What was our belief around the make-up of human personality? How do we see change and stability?'… I got to start thinking about how I thought, rather than just how everybody else thought… it became more valuable for me to understand theoretical perspectives… I then understood how one therapist's beliefs can be so different to my own and how that can impact then on a patient in so many different ways (Participant D4- UP).

Participant D4 also emphasised the need for theoretical orientations to not remain too abstract but rather be rooted in human experience. By masters training, the applicability of theoretical orientations to trainees as individuals and their actual patients becomes of central concern.

I was in a space where Object Relations spoke to me the most. And, our trainer that was working with us, she mainly used Fairbairn, and that was great for me because I discovered Fairbairn in earlier years… it was something that on a personal level I understood and I could make my own… it didn't seem

complicated to me, because, it just seemed right. It seemed to fit my understanding of what people were and how they were… so that was great (Participant D4- UP).

As a masters student, Participant D4 recalled that she found a certain theoretical orientation she could understand on a personal level which enabled her to make the theoretical orientation her own and *"it just seemed right"*. During training it seems that an identification process with the theoretical orientation is important for learning to take place and for students to take hold of a model (E2). As a result of being in a training programme as a trainee, trainer or supervisor, participants became very aware of debates surrounding how a trainee's personality, training and theoretical orientation(s) intersect.

I have been trained in a Systemic perspective for Family Therapy, so that's the paradigm that I am most comfortable at the moment… For me, it's like the theology part played an important part in the therapist that I became… religion and my faith is an important part of me, so I needed to integrate that… what was very nice in the Unisa course and System theory is that you can integrate parts of yourself in the course… family life, friendships all of that forms part of who you become as a therapist… I do prefer systems above the other perspectives at the moment (Participant A5- Unisa).

I think that (the Systemic orientation) fits very nicely with my personality. I'm not a necessarily a very directive kind of person, so things like CBT would not fit comfortably with me as an overarching framework (Participant C7- Unisa).

The debate of a main orientation versus an integration of theoretical orientations for training programmes is one filled with complex trade-offs.

I think there are pros and cons to both of them… It's not that simple. I know the Wits approach, it's strictly Psychoanalytic and there are problems, some of the clients we had to see or they had to see. I did a lot of supervision with those, and those clients were just not suited to Psychoanalytic work. So, it was-, the work didn't flow, it went nowhere. They (therapists) lost a lot of clients within the first few sessions because the clients didn't know what was going on and they didn't adjust. They weren't allowed to adjust actually.

> *So, it's a very good, basic frame, to think in terms of those Psychoanalytic terms, to know about transference, to know about countertransference, to look for it in every client that you see. But, I think they need some more broad exposure to other, definitely to some Dialectic Behavioural work (DBT), to some Narrative work- I found very, very useful later on. Of course, the Gestalt. One learns so much from everything. Look, I'm a reader… I've read every book here, and you'll see the diversity and you don't see only Psychoanalytic books there… I get irritated by people who are too narrow* (Participant E5- Potchestroom University (now NWU)).

A similar sentiment is expressed by Sexton and van Dam (2010) who regard expertise as psychotherapists possessing the ability

> to apply and adapt one's knowledge in a way that is meaningful to and ultimately helpful to a particular patient in the context of a unique therapeutic dyad in which distinctive subjectivities, needs, cultural values and influences and interpersonal modes intersect. Theoretical knowledge that cannot be made relevant to the person suffering, and by extension the unique treatment, is not helpful (p. 142).

Duncan and Miller (2000) have found that a perspective "must be acceptable to the client in order to have a chance of being successful" (p. 24). Jung (1961/1995), Scharwz, Chase, and Bransford (2012), and Rousmaniere (2017) caution that theoretical orientation zealots do not bode well for clients, as each client requires an organic, flexible process, which they too can contribute and influence. In light of the epistemiology of social constructionism "ideally therapists are able to draw on a range of perspectives and discourses in interacting with clients" (Paré & Sutherland, 2012, p. 181). As voiced by a senior psychotherapist (E3) in the current study, psychotherapists can put too much energy into proving that their specific theoretical orientation or way of working with clients is the way of doing psychotherapy, and thereby ultimately not achieving the real purpose of psychotherapy.

> *I would say my call is to: Stop complicating psychotherapy or complexifying it… Because, we end up selling the toys to people and we end up saying, "This toy is better than that toy". And, psychotherapy is not about that. It's not about what being better than what and it's not about competition. It's about understanding people's pain…*

We are commercialising therapy and we are addressing it fancily, unnecessarily. So, let's stop dressing up therapy and keep it simple and straight to the point and help people with their pain. That's all there is to it… Is it really addressing the need? Or, are we telling the world that, "I'm this sophisticated therapist. Therefore, I can be better than the other therapist". I think we're missing a point (Participant E3- Systemic orientation and IPA model at Medunsa).

All senior clinical and counselling psychologists in the current study voiced how a psychotherapist needs to connect with the theory and make clear and proficient use of theoretical frameworks. As such theory is used to arrive at cogent sense and to make meaning of what the client is sharing (Sexton & van Dam, 2010) and of their distress in order to assist them effectively. In light of the South African context, Smith (2014) advises that "it is prudent to advise trainees not to marry their theories but to have affairs with ideas and concepts instead" (p. 41).

I was at Unisa for two years (coursework). That was Systems trained… it does resonate with me and I do like it. And, I think it was nice that I was trained in one specific thing. So, at least I'm good in one thing (Participant B3).

It was pure, in the sense that- or more purest in the sense that- all our practical work was done from the Psychodynamic orientation… I feel very grateful for it because it has given me a lot of confidence... I feel comfortable with the orientation because I understand it very well. And, I find that definitely the strength of that way of training was that I-, by the end of that year, I felt quite comfortable sitting and working with the patients in a Psychodynamic way (Participant C2- Wits).

I've met people here (internship) who've had integrated training, and they came here feeling like they know a little about everything, but nothing about anything… like 'A jack of all trades, master of none' kind of vibe, right?... I felt very grounded and very happy and very confident in a lot of things, and I felt like those people all felt very insecure and very not confident. Because they feel like, 'I don't really know what I'm doing'. I didn't feel like that coming in. I had a lot of confidence from this paradigm and then it also gave me the confidence to

incorporate other things freely without worrying (Participant B1- Systemic orientation at Unisa).

Participants who explicitly studied psychotherapy utilising one main theoretical orientation during their coursework at university voiced that they felt competent (B3), *"confident"* and *"grounded"* (B1, and C2) when embarking upon their internship with the increased client load. Despite participants (C2, C3, E2, and E5 - Psychoanalytic and A4, A5, A6, A7, A8, A9, A10, C1, C4, C7, and E3- Systemic) being trained in one main orientation during masters and finding it valuable, none of the participants interviewed indicated that psychotherapists *must* practice solely from one theoretical orientation as evidence of an identification with the theoretical orientation, such as being and promoting oneself as only, for example, a Psychoanalytic Psychotherapist, a Cognitive Behaviour Psychotherapist or a Systemic Psychotherapist. That is not to say in South Africa that there are not psychologists who practice psychotherapy from only one theoretical orientation as one need only to look at South African psychologists' business profiles and practice advertising to see that there are psychologists who feel psychotherapy is best practiced from one specific theoretical orientation. In such cases, a theoretical orientation becomes the practitioner's identity as a psychotherapist for example, Psychoanalyst.

With this proviso, it is worth noting the reasons given in the current study as to why participants felt that one's theoretical orientation needs a certain level of flexibility.

My background and where I'm still at is Psychodynamic. I've got a Psychodynamic framework, but a strong Humanistic touch with it. But, all in all, I would describe myself as a very integrative psychotherapist. I tend to adjust what I do in therapy to my client. So, I don't have one way of working with people. With every client, it's different. That's why I can still do this work because it's so interesting, because every client brings me something different and asks something different from me. So, it depends a lot on my clients (Participant E5- Potchestroom University (now NWU)).

I am not strictly Systemic and CBT. I find myself looking at what the client presents with, so what works within that therapeutic relationship… for example, when a Person-Centred approach is more called for or I feel creates more

rapport, then I find myself leaning more towards that and seeing what works with the client… I would not say I stick rigidly to those… I don't stick specifically to one theory or the other, but I also feel I lean a lot towards a Person-Centred approach and I think that reflects more of my style (Participant A10- Systemic orientation at Unisa).

After assessing the client I think, 'Okay, this client might need this approach or this might work best for them' (Participant C5- Integrative model at UJ).

A key reason voiced by participants (A10, C5, C6, D3, and E5) was the need for the South African psychologist to constantly take into due consideration the unique needs, cultural and contextual factors (Gibson et al., 2001; Ruane, 2010) impacting each client that they see:

I think for me it (Psychoanalytic Therapy) just made sense for me. I think I could identify with that structure more than others. I naturally gravitated towards that, if that makes sense. I found a good fit with me in the sense that-, for example, some of the basic things like, boundaries and frame instinctively, I could relate to that. I think it fits with my personality. However, I have found that with some clients, I don't find it as useful.

So, for example, I see couples as well, I think there I find it useful to them to adapt my approach to what the client brings. I do therapy in different contexts as well, apart from the private practice, and in some contexts the more Cognitive Behavioral, or Systemic theories I find more useful…

I do some part-time work for--- and there it is really just about preparing the patients for surgery. That is a very specific kind of thing, but also sometimes the mothers of the patients are referred for some individual sessions… I find that with some of the patients that are coming… that is may be not as psychologised if I can put it that way, I don't find it works that well. And, sometimes as well when there is a language or cultural difference, then I don't find that it helps that much, especially, when the role is more supportive, then it is more useful to even just use the basic counselling skills, Human(istic) approach… Sometimes, I have Family Therapy sessions and it is also a lot of the time, time-limited, where the intervention is an intervention… but, I think that also depends largely on the place where I am doing that consultations. I work within their system, with a co-

therapist and their kind of way of doing things (Participant C5- Integrative model at UJ).

As described by Participant C5, the relevance and suitability of models of psychotherapy which mostly originate within a Western epistemiology need to be critically interrogated and adapted to the unique client and the context in which the client resides. Training curricula and psychotherapy practices have undergone little change within South Africa in order to effectively assist African clients from their own frame of reference (Ahmed & Pillay, 2004; Watson & Fouché, 2007). Pillay (2016) advocates "it is also necessary for South African Psychology to stamp its mark on its teaching content… concerted focus on the inclusion of theoretical models that incorporate African psychology perspectives is essential" (p. 152).

I do think there is a difference in terms of, you know, all these other different professions that also provide a service of personal contact, but it might look very different and have a very different function.

But, then I also think particularly in South Africa and also through my own experience with a moreso underprivileged community, there is still not a clear idea of what therapy actually is… there should be some sort of clarification of what it is.

To give you an example, when we went on the Phelophepha train; we had a psychology clinic and people would come to us and say, "I want a job, get me a job" or, I know somebody to another colleague lifted up their shirt and said, "This and this is wrong with my body". And, I don't think people always understand psychology, also psychiatry versus doctors, because in that context they linked it with quite a medical understanding,

… (psychoeducation) it's personally, important because I can see how it helps people to contextualise the service and also to add some preservation or growth to the industry and how people start understanding it (Participant A1- Integrative model at Pearson Institute of Higher Education).

Psychotherapy if it is to be relevant in South Africa and across the African continent needs to commit itself to understanding the clients it sets out to assist. Jansen (2002, cited in Pillay & Ahmed, 2004, p. 650) challenges South African academics to being open "to theorise from the ground up" and "create new meanings, new concepts, new theories based on detailed

descriptions of everyday life" on the African continent. After all, a profession "is only of use if it moulds itself to meet the needs of the people" (Pillay & Ahmed, 2004, p. 651).

> *It's sad for the client and for the therapist. The therapists lose their trust, their faith in what they're doing, they're doing something wrong. It's not something wrong, it's just a bad fit and the client does not benefit, and they leave therapy with the idea, 'Therapy is not for me', it's not okay* (Participant E5- Potchestroom University (now NWU)).

> *I have had to adapt and change that was a big developmental aspect for me as a therapist… the diversity of our county has informed the needs that I need to fulfil and how I need to adapt and change and meet specific needs* (Participant C6- Integrative training at NMMU).

> *I think in practice… I had to consider, and I don't know what it means for the profession going forward but-, and I don't know if it goes back to the theory part of it and the different orientations and taking that into account in the South African context where we have so many different cultures-, or whether it comes from the therapist being aware and being able to adapt… I find that some of the concepts or the way that I am used to being in therapy, doesn't always work. And, then I have to think about, 'Why not?'… for example, I had someone come, much older lady and, immediately either from the way that she talks or if it is me projecting something. But, there is already culturally a certain way in which you would address someone who is older than you, whatever the context. But, then if I am being strict and focusing on the frame and boundaries- and sometimes it is not always understood…* (Participant C5- Integrative training at UJ).

Participants raised concern over managed care as a constraining economic factor for when needing to choose which theoretical orientation to assist clients from (Smith, 2014). Contextual factors included limited sessions covered by medical aids/insurance forcing psychotherapists to practice briefer psychotherapies in private practice (A1, D2, and E4) as well as the limited number of sessions available to each patient in both private and government hospitals (E4). Limited income of potential clients to assign to personal medium or long-term mental health care and poverty are a primary reason for individuals' inability to access mental

health care services within the South Africa context (Gentz & Durrheim, 2009; Ahmed & Pillay, 2004; Pillay et al., 2013), and the overriding power of consumerism (Carruthers, 2007).

> *I think there's a matter of disparity though between what I would like to be as a practicing therapist and what society will allow for instance… I believe that if psychotherapy was more affordable, it would be much easier... I believe getting to the root of the problem is the only way that is going to be able fix the problem… I think that in this country CBT is pushed quite heavily, medical aid-wise,… it's a quick turnover rate… Look, I don't know if it's not necessarily in patients' best interest. You do get that person that comes in and goes, "Just plaster me up, I want to go", kind of thing, which is fine. I mean you can't sit there and force them to dig deep. I think CBT is a fantastic paradigm, I really do... I just wish in some other way that in society, it would be more [sighs]… allowable to use Psychodynamic as a paradigm. I mean who can afford like a whole year of therapy? Who can afford that, even longer? That's ludicrous! And, I mean therapists need to… earn a living… I am feeling a little bit disenchanted with Psychodynamic therapy in our society. Perhaps in a country where therapy is free or medical aid will cover a person's processes, maybe it can be used* (Participant A3- Integrative model at Pearson Institute of Higher Education).

> *Today, especially, because I work with a lot of hospital patients… So, I find it very limited… So, maybe, I have one or two patients that I can go on a long-term work with… it's very brief -, a lot of the guys you see from different provinces, in Bloem(fontein) and they get admitted and they come from the mining towns which is four, five, six hundred k's, kilometres away… today when, you know, medical aids, five, six, maximum ten sessions, after that they say they don't have the cash to come… unfortunately, we are almost result-driven now* (Participant D2- Integrative model at UFS).

> *I am in a rural environment where there aren't many psychologists available. So, yes, I have got to meet my community that I am around… I have almost got to be like a chameleon… I think my anxiety levels are maybe higher than many other people… I have got to just blend in with any client that is coming to me…*

Whereas, had I been somewhere else I would have wanted to be the master of one thing. Because there I'll feel like, 'I am in control, I know what I am doing'. But, at the moment, I am working with everything. Anybody who walks through my door I need to try and help them because the next available one is sitting three hours away… I have had to trust myself a little bit more, trust my abilities, trust my knowledge; because those are things that makes you anxious. 'Am I good enough? Do I know enough? Do I have the experience? Do I…?', you question yourself all the time (Participant C6- Integrative model at NMMU).

Nsamenang (1995) argues that, "Psychology is an ethnocentric science, cultivated mainly in the developed world and then exported to sub-Saharan Africa... (yet) Africa has her own frames of reference and social reality" (p. 733). Psychotherapy is often cast in the South African discourse as 'beluga caviar'. Foreign in terms of being imported, unfamiliar and not necessarily relevant or suitable to the palate of South African realities (A1, and E5); a luxurious delicacy: affordable and accessible only for the elitist to enjoy (Swartz, 2007).

Psychology is supposed to be giving therapy or providing therapy to the population. We have created a business model that doesn't serve it… It doesn't fit in this context. Maybe, forty, fifty years from now, when everybody's level of socioeconomic standing is much more elevated... the ethics around who is in charge of our professions: Does it actually reflect psychology and psychotherapy in South Africa, or are we using models that don't fit our context? (Participant D4- University of Pretoria).

Psychotherapy is yet to be regarded as 'a pilchards staple' at the macro-level within government institutions or national decision-making bodies, despite South African society being so traumatised and in dire need of extensive psychological interventions (Cooper, 2012; Pillay, 2016; Rock & Hamber, 1994, Ruane, 2010). In contrast, the National Health System in Britian has made mental health a national priority for the last 70 years. In line with the clarion call for Universal Health Coverage (UHC) of the World Health Organisation across the globe (Harlem Brutland, 2017) the South African government has issued a White Paper advocating the implementation of a National Health Insurance (NHI) model by 2030 (Pillay, 2016; Smith, 2014). "The aim of the National Health Insurance is to provide access to quality and affordable healthcare services for all South Africans based on their health needs irrespective of their socio-

economic status (Thulare, 2016, p. 6). The effective implementation of accessible mental health services to all South Africans is yet to be realised in terms of feasibility.

Participants (A3, C6, D2, E1, E2, and E4) also highlighted the urgency factor that is heightened in a resource-strapped society as is the case in South Africa.

> *I think it is difficult and especially with the medical aids, they don't pay. You see that is the other problem. If you only rely on private practice, in the middle of the year, clients don't have funds anymore. If they then can't pay you, what then, if you're only in private practice? I think it is very hard, but on the other hand, if you deliver a good service, you will always have clients, even if they pay you off* (Participant E4).

Participants spoke about time pressure (A1, B1, C6, D2, D3, E1, E2, E4, and E5) being a determining factor in what informs the therapeutic process. Participants, across the spectrum of experience, spoke about the pressure to achieve miracles in an instant (A1, C4, and D2), and having to upfront with clients in dispelling the myth of quick results or quickly overcoming a mountain. The 'in-an-instant' culture that is now prevalent worldwide is at odds with philosophies of how humans develop and how psychological healing takes place: *"Our brains are slow, the human being can't rush!"* (Participant E2).

The 'immediacy' economic framework of customer and delivery of service by provider is a misfit of frameworks which creates strain on both the psychotherapist and client's expectations (A1, D2, and E4). Clients have the expectation of arriving psychologically where they need to be in the most expedient manner possible which can be likened to a precarious journey of a time-pressured taxi bus speeding along pothole-roads in South Africa (E2).

Participants particularly highlighted that the process of psychotherapy is not an instant or quick process, but rather it involves journeying (D2, and E4*), "sifting things out"* (B1), *"unfolding"* (A1). Rogers (1980/1995), and Landreth (2012) likened therapy to gardening and growth unfolding overtime, Rogers spoke of therapy as a "growth-promoting climate" (p. 225). Freud (cited in Pankejeff, 1972) likened analysis to a slow, unearthing of ancient treasures hidden under years and years of sediment in an archeological dig. The unforced, cautious unfolding over time element of both these metaphors is at odds with the instant expectations foisted on people by the technological advances that have taken place on a global level and the

cost-saving business model of managed care or medical aid insurance that has become an institutional strait-jacket to the profession of psychotherapy in contemporary society.

Psychotherapists are pressured into working in a constrained atmosphere which has on a level created a crisis of therapeutic method and outcomes (McFall, 2006). To address this juncture, briefer therapeutic methods with more measured and short-term goals in terms of improved psychological health have been adopted and also chosen as training models. Within South Africa, a psychotherapeutic process in private practice was generally found to be completed in less than 20 sessions (Bassa & Schlebusch, 1984), and in the governmental services, patients were reported to access psychotherapy for less than two sessions (Ahmed & Pillay, 2004). For some psychotherapists (A1, B1, C6, E4, and E5) this poses conflicting ethical dilemmas which are difficult to reconcile for each client. The best treatment is not necessarily the most accessible or viable treatment.

> *As therapy became more and more expensive, I think the pressure is harder to see results… I would sometimes think that this person would be an excellent candidate for more kind of Jungian kind of therapy, but there's no time and there's no money for doing that. And, I would either then combine or I would change to something which hopefully will also be successful, but would make me work faster. But sometimes, I feel it is more superficial than it could have been because I need to work faster* (Participant E4).

Participants (B4, B5, B7, C5, C6, D1, D3, and D5) relayed that their masters training exposed them to a number of theoretical orientations.

> *We integrate various theories and we train in all of them, but very briefly… maybe, a workshop in CBT… or a workshop in Psychodynamic or whatever, then it would be say one or two months' workshop, and then we would know about that. So, it's really 'a jack of all trades but master of none'. Really, that's the theory we get from UJ* (Participant B5- Integrative training at UJ).

> *At Tuks (UP), we touched on a number of models… we didn't do a lot of work in Family Therapy. But, having seen families at - (Tertiary Psychiatric Hospital) and having worked in the adolescent unit, I think at times, I felt disenchanted with the Psychodynamic approach with an individual because specifically when you're*

working with a child and adolescent, because far often, it's much more Systemic… I don't feel very competent in it … Psychodynamic perhaps feels a little bit too focused on the individual and I think that's also why I feel a need to be flexible in that approach. So, it even feels strange for me to say that I'm primarily Psychodynamic. It's sort of where I feel more comfortable, where I feel I've got the most knowledge but… I feel [chuckles] inadequate when it comes to theoretical approaches… I think there was a time when I had a better grip of them than I do now (Participant B7- UP).

The training was very eclectic. So, we got trained in most of the modalities … we did like all sorts. Then we did very short Psychodynamic, but not involved. So, I'm not sufficient in that. The main orientation was CBT, Cognitive Behaviour. With the children we got really good training… very comprehensive… my personality, I work more non-directive. So, I resonated with Person-Centred approach in my approach to people and then at the back of my mind, I have a strong Jungian influence, but I think in a way, I've modified it to suit me… It was a bit too much, but sometimes, I just used an aspect of the therapy. I know it's not always very favoured… it's not pure in that regard, but I think the positive of that is I can adapt quite easily (Participant D5 – Integrative model at UFS).

Viljoen et al. (1999) when surveying UFS-trained psychologists found that 50% indicated that they regularly followed an eclectic approach and/or an integrated approach (55.9%). This is supported in the current study as all interviewed UFS-trained participants (D1, D2, D5, and E4) were open to learning and applying a number of theoretical approaches as indicated by the clients' needs, however two participants voiced not applying CBT (D1, and D5). Viljoen et al. (1999) reported that on average participants used 4.2 psychotherapeutic approaches often, and eight psychotherapeutic approaches regularly or sometimes. Their study found that 61.1% of UFS-trained psychologists expressed the need for depth psychology, namely Jung's Analytical Psychology (30.6%) and Psychoanalysis (22.2%), to be included more extensively in the university's masters course.

Participants in the current study spoke of the need for theoretical training on working with more than one person in the room (B5, and B7). Arguably, all training institutions across the country need to consider theoretical models that are suited to individual work, parent work,

couple work (Hill & Perkel, 2014), child work (Viljoen et al., 1999), family work (Pillay, 2016), and group work (Bantjies, 2016; Viljoen et al., 1999; Pillay et al., 2013). And, ensuring that it is covered at a competent level in the syllabus in order to equip trainees to assist the client modality they will be confronted with in a variety of practice settings (D5).

> *Maybe, this is the best way to put it: That on the one hand, I found it useful that the training at UJ was more integrative, I found it useful at the time: 'Okay, I can learn a bit about this and a bit about that, and, then try and put it all together'. Then the other side of that, was that it felt like that, it felt a bit kind of all over the place and then one had to figure out for myself what works for me* (Participant C5- Integrative model at UJ).

Coscollá, Caro, Ávila, Alonso, Rodríguez, and Orlinsky (2006) found that Spanish psychotherapists embrace integration and eclecticism in terms of working from theoretical orientations. Importantly, the idea of being trained in many models in-depth and comprehensively is different than being trained in numerous model over a short period of time at only one stage of development. Rizq (2006) argues that theoretical pluralism though honouring the theoretical assumptions of the postmodern position of multiple realities, places notable emotional strain and provoke a 'crisis of confidence' (Mitchell, 1993) in trainees.

> *On the one hand, the positive thing of being trained in most of the therapy modalities is that you look at things more realistically and to think to find your own way. The drawback is sometimes you're not proficient enough with one… I was like really confused, 'Where do I start? , ... I was very anxious when I started my internship. I didn't feel competent, but through my own process (personal psychotherapy), I began to understand how to really conduct more in-depth therapy and that helped me develop as a therapist* (Participant D5- Integrative model at UFS).

> *I think having one main modality or having one orientation is beneficial. I think it grows you as a therapist and develops your skills more sharply. But, I do think it's also important to at least have some exposure… into how to apply other orientations into a therapeutic perspective. So perhaps, you know, have a few cases a year or I don't know, per semester where you would practice a different*

kind of orientation. But, I do think having one main one is more beneficial than having bits of pieces.
I know a couple of therapists who were trained at various different universities that are taught several orientations. You know, ten weeks of this one, six weeks of that one, a week of that. You know, one weekend of group therapy and I find them to be not all over the place, but unsettled. And, 'choose one piece here, one aspect there'. And, it doesn't fit all the time (Participant C7- Systemic model at Unisa).

Because, after that initial feeling like, 'Everyone, in this new context knows so much about something that I only know a little bit about', I think after getting through that part of it and finding out what works for me, I feel more comfortable and more grounded in the theory and orientation… for example, with a certain client that comes forward and I do the formulation and I think, 'Okay, I am able to draw on, maybe, something that I would otherwise not be able too, because I have, maybe, an idea of the different orientation, that I find useful, and that I am able to try and draw from those'… though there are times that I felt I wish I just focused on one thing and that is what I do and then I can pick up other things later (Participant C5- Integrative model at UJ).

From training interns… when I did supervision there, the hospital took interns who came from several universities, and you could see who had proper masters training and who did not… your eclectic people… usually were the ones that could listen well and, maybe, engage well but the therapy did not progress well, because they didn't receive the proper in-depth training, supervision, in specific theories. They just bundle everything together and hope something comes of it (Participant D3- Integrative model at NWU).

Therefore the problem of more than one main theoretical orientations during masters coursework was described as: "*it felt a bit kind of all over the place* (C5) and "*a jack of all trades and a master of none"* (B1, B5, and D3) and trainees feeling *"intimidated"* (B4) *"very confused"* (B4, D4, and D5) or *"very anxious"* (B4, and D5) or *"unsettled"* (C7) may not be

necessarily a question of many models being problematic as participants appreciated that theoretical diversity exists in the profession, "*I value the variety of theories"* (D1).

> *I almost felt like I left the university knowing a lot- No, I will say like, you knew something about everything, but you actually knew nothing… So, very nervous and anxious when I started my internship year. I didn't have a perspective from which I worked. I felt very confused… I feel like being one year it was crammed and they tried to get as much as possible done in one year… And, you sort of lose track of like what you know. You don't really get to find yourself in the theory... So, internship has really helped me to find out where I fit in the theory, which theory I can take, which I can be… I think, you take in everything during your first-, you know, the theoretical year… you just like so confused, and then, as you go along in your internship something sits, you remember something. You know, you can go and research about it. So, I think it does have disadvantages and advantages because you have been exposed to a lot of different things…*
> *Then it's up to you to go and research and find out more, and, "What do you think will fit with you?"… I know in the beginning it was very annoying… I just felt, 'Well, now you have left me to go and do all of this'. And, I must say, I felt quite intimidated, starting the internship with everyone who sort of had a theoretical perspective, and knew what they were doing in therapy…*
> *But, looking back now, at the end of the year, I am so grateful for that, because it is not like I had something forced upon me, you know. So, the extra hours of researching things, actually was nice, because you do. It is just you that gets to choose what you like, what you don't, and what you would like to read-up more on… Looking back now, I would stay integrated. I liked that. But, I would say, definitely over two years. I still think a year is pushing it* (Participant B4-Integrative model at NWU).

But rather, trying to compress them into two-three years of masters training (including internship) needs to be addressed (C1, and D3). Arguably, useful integration happens after decades of in-depth study of each orientation that the individual practitioner finds applicable to their actual client base.

> *My therapist and I have had numerous conversations about what paradigm she*

uses. And, she feels, 'You don't place me in a box', she's much older. So, she wasn't trained under the umbrella where we place people in boxes. She's a bit more eclectic. So, what's funny is even though she works in transference and countertransference, she also has a very Rogerian outlook on things.
And, I know eclecticism has a bad name in the industry and I know people say that, "You don't do that!" But, she has a very good mix. So, I wasn't with a purist… She wasn't just Psychodynamic and that's why I also understand where other modalities are important and other paradigms do have a value. And, I learnt that from her, and what was lovely about the space we had, I could find myself in that space… we will play with these terms. Play with them and figuring out a little… (Participant A2- Integrative model at Pearson Institute of Higher Education).

I think that if someone had tried to box me, say, for example, I had been to a university where they do only CBT, I don't know if I would still be doing the job. Because it wouldn't of resonated with me and I would of thought, 'I can't do this'. Rather then realising that there was another way to do it… I can see the value in it, but I think it would feel like a lot of hard work – it wouldn't feel like a natural fit for me. And, I think that to go to work every day and its hard work – I don't think that's sustainable. So, I think that people do need to find a thing that fits… (Participant C4- UKZN).

In the current study, participants whether main orientation psychotherapists or very integrative psychotherapists strongly resisted the idea of being rigidly or narrowly confined to only one paradigm (C4, C7, D1, D3, and E5). Participants spoke about 'incorporating' ideas (A3, B1, and C5). As such, one theory does not fit all people. However, across the spectrum, participants felt that an open-mindedness towards many ways of working need not amount to anything goes. The notable value participants placed upon maintaining a flexible theoretical stance (theoretical breadth) in order to actively prioritise the client's needs, did not negate the priority that senior psychotherapists voiced that an identification with a theory is critical for the trainee to have a handle on clinical work and to contribute to their burgeoning identity as a psychotherapist.

I first went to a therapist whose paradigm I am not sure, I still can't pinpoint it up to today… it was probably the worst therapy I ever engaged with… it could also be that person's personal style, and I do think they brought too much of themselves into the room… if I look back on that therapeutic experience, I can't really remember a lot of the work I did personally... it was probably two or three months because it didn't really work for me…

I am very careful not to overshare. I actually think as a Psychodynamic therapist, don't really share much about my life, that's what I take from it, it's the client's time in the room and we can look at relationship elements and processes that come out, but I think the detail of my life ... isn't, shouldn't be in that space, that's what I take from it. And, I also think, it makes me believe quite strongly in having a theoretical underpinning to influence my work. Because, I get the sense that she was hovering… that makes me think, 'Okay it's important to have some kind of grounding' (Participant A1- Integrative model at Pearson Institute of Higher Education).

4.7.2. Personal Psychotherapy, Supervision and Mentors in Developing a Framework

Participant A2 felt the extent that your personal psychotherapist's orientation would influence one as a trainee is hinged upon whether their paradigm resonates with one. Senior psychologist E2 recalled how his personal psychotherapist shaped his identity as a psychoanalytic psychotherapist. The psychoanalytic orientation *"fitted me to the tee"*. Participant E2 highlighted that *"personal therapy fitted with my theoretical orientation"* in terms of masters training.

You are so vulnerable when you start psychotherapy you will organically grow into that theoretical orientation… First year as an undergraduate I went to a therapist. The five years of therapy moulded me in that realm of how to experience myself. I thought of myself in a Psychoanalytic way- the unconscious (Participant E2- Integrative model at UP).

She was just my ideal of a therapist... I was blessed with the most wonderful therapist. She was trained by Winnicott actually. She was Psychodynamic, but not at all rigid. She could take anything, everything, work with it. Uhm, not laidback,

intense with me… That was a big factor-personal therapy was-, I couldn't have done it without that. I was fortunate that I had someone who I wanted to internalise. It would have happened anyway. It happened very strongly, but she was a very relaxed therapist… she wasn't overly anything. She was just herself. She had her own way of doing therapy and she was just fantastic (Participant E5- University of Potchestroom (now NWU)).

For Participant E2 learning a theoretical orientation and personal development of the psychotherapist were significantly interlinked. *"Your identity as a psychotherapist is a priority then explore other theoretical orientations, as patients don't necessarily fall into your frame of reference"*. He emphasised the importance of being exposed to *"a proper theoretical basis"* in order to learn effectively. He then felt *"after registration, then explore"* and work towards integration of theoretical orientations.

Obviously, when you are in masters you are consumed by what you are doing and what you are studying. But, shortly after that I was – I always had a questioning mind about, 'What are the other orientations about?'… in order to, I suppose, develop my own repertoire, I sought out personal therapy with a therapist who comes from the Psychodynamic orientation (Participant C7- Systemic orientation at Unisa).

The findings of the current study suggest that student or intern psychologists choose a specific individual who they admired to help them make a theory their own.

In training I enjoyed them (supervisors). They, obviously, guided the process to a large degree, but also brought an element of looking at your own development as a therapist. And, I think to a large degree also influenced my therapy… she (supervisor) exposed me to it (Psychoanalytic Therapy)… So, in terms of the reading she would say, "Ah, have you read about this one?... I would not have read about those… I would not have gone there because I didn't know. So, she really did guide me… I was also lucky… we gelled well! I might have been with… a different supervisor and felt quite differently about supervision (Participant C6 - Integrative model at NMMU).

But, I think my main paradigm which I resonate well with is Psychodynamic… I just sort of linked myself with the philosophy of it, with the understanding of sitting with a human being and working in the here-and-now transference, that's something that really.
… I think it was also a large portion to do with the lecturer that took me… she's brilliant and she's so passionate with it. And, she literally showed it to me in a very experiential way... She said, "Read the textbook and then we're going to discuss what the chapter says and then we're going to practice it". And likewise, my supervisor did the exact same thing, helped me to identify what the transference was… I had to transcribe all my therapy sessions from last year, and then hand it to them and then she would read them and we would go through them and she would stop and say, "How do you feel here? What was happening here? What was there? Why did you say that? Why did she say this?" So, in a sense she taught me to learn process, to read process through that way and then also identify how I was feeling and what was transference interpretations… I just developed that passion for understanding people and sitting on that human level… it for me sits with an individual in a uniqueness as opposed to a prescribed set of- this is Cognitive Behaviour- "You're thinking' this and that's why you"-… I don't totally agree with that (Participant B5- Integrative model at UJ).

Slowly, but surely, I think the experience I had with clients led me to start working more Psychodynamically… access to theory, so to kind of original readings… and, I think there is a lot to say about how lecturers guide you in terms of what to read and where to dig in… I think in your honours years you read a textbook and you go, 'Oh, okay, it kind of makes sense?'. But, when you take a client and it's a live client, and you take Freudian theory and Oedipal stuff and you apply it with that client. And, everything just starts fitting like a puzzle and making sense and giving you direction; that was quite exciting for me and very valuable. And, I think that contributed to the shift… they presented that in such a way that it started making sense in terms of which paradigm will work for me.

I went into my second year of masters and I started using a lot of the theory we had learned and applying it to cases. I could bring that to supervision and entice that kind of discussion and then get more value out of it as well. So, I really want to say the theory and the application of theory is something that I think has contributed a lot to my development in terms of how I work, what value I get out of supervision and reflecting on cases (Participant A1- Integrative model at Pearson Institute of Higher Education).

Participants spoke of their personal psychotherapists (B6, E2, and E5), specific lecturer(s) who enlivened theory (A1, A10, B5, C1, E3, and E4), or supervisors of their casework during training (B5, B6, C4, C6, and D3) or after qualifying (C4) that acted as a crucial link to digest or ground oneself (A3) in a specific theoretical paradigm.

The lecturers tend towards one paradigm, that's what I mean, and it helps that we've got so much rich information from this one paradigm and I feel very equipped in it… I identify with it… I do believe I ground myself in the Psychodynamic paradigm because it makes sense to me, it resonates with who I am as a person and how I've grown up to be, but not only that, Existentialism as well. So, it shows me that by me integrating, grounding myself in Psychodynamic Therapy and incorporating aspects of Existentialism, shows me that it wasn't the influence of my lecturers only… (Participant A3- Integrative model at Pearson Institute of Higher Education)

In speaking of their 'theory translator' it was evident how animated and enlivened the participants became when recalling how important this person was in their growth. This suggests that a psychotherapist's theoretical orientation or an additional theoretical orientation reaches traction when they were able to foster a connection with a well-versed psychotherapist who embodied a theory that created a resonance with them. Participant C4, from the UKZN, recalled how a peer who could not identify with Psychoanalytic Therapy was assigned a CBT supervisor to ensure that he benefited from an identification process during training. Sound theoretical training was emphasised by participants (D3, and E4) who train or supervise masters students (E4):

I think in terms of theoretical orientation, I think you only know so little when you're an honours student. You need lecturers that open the world of therapy to

you. You read about it and you think 'Ah this is interesting!' Until you see it and you need to find a supervisor or a lecturer that is passionate about a specific-, and must be very good in what he or she is doing. If I now think in terms of the Humanist Existential lecturer, excellent in his work. Excellent! He was really a person that you could learn from.

At the same point, Prof. G ... and the other people that I've met that all came to South Africa, you could see without arrogance, they were so just- excellent, they could make a change. And, that I think is the thing that stands out for me: 'To make a change, to see how I can change things'; which I realised is a very powerful thing, but it is also a very challenging aspect (Participant E4- Integrative model at UFS).

Henderson et al. (2007) regard entering the training context as likened to a "birth" and highlighted that its main purpose lies in providing the psychotherapist with a sound theoretical foundation to work with clients therapeutically. Whereas, internship is a specific milestone in the training period as it is specifically geared to practically testing out one's training in daily client work, which will continue over the years in a refining process.

Knowledge is not sufficient and it does not make sense, unless and until you make it to make sense to you. And, how it makes sense to me, it's through lived experience. It's through testing out over and over, and over again. And, making sure that the theory that I was given makes sense to me… Over a number of occasions or years… I want to see how you understand that theory, I want you to display or demonstrate to me how you understand theory. Then, I will say, 'You are knowledgeable' (Participant E3- Systemic orientatation & IPA model at Medunsa).

4.7.3. Theoretical Orientation as Part of Trainee Development.

In the current study, it appeared that clarity and comfort with an applied theoretical orientation starts to become an essential need when the trainee has to demonstrate their skill at applying theory effectively to assist a caseload of clients therapeutically.

At the moment, I practice very Psychodynamically… the Kleinian theory really resonates at me. So, it is something I am drawn to and I find that when I sit with a client, it's often where my mind goes… they literally laid out all the theories like

on a platter and went into depth; into each one. We had to read the original works, and, then they kind of said, "Pick one that resonates with you". Which was a long process, it was like a year and half, "Discover yourself, work with your client", kind of process.

And slowly, but surely, the psychodynamic theory just really resonated with me. I think the reason for that is it always gets to depth for me, with psychodynamics. And, it is rich… I could take it and evaluate my own childhood and make sense of certain things and how I have developed as a person. So, I want to say that theoretical backing was strongly influenced by perhaps how I was raised (Participant A1- Integrative model at Pearson Institute of Higher Education).

Daily client work, particularly during internship, in a sense, instigates psychotherapists deciding on a major theoretical orientation to draw and work from.

And, what else makes me feels excited about cases is starting out as a therapist you haven't seen everything… It is no longer like reading it out of a textbook… just being new to everything and you wake up and every day is going to be different. There is no way it will be same as yesterday. So, I think that really just energised me and made me excited for what is coming (Participant B4- Integrative model at NWU).

Only as I started to work in my internship… did I start to find my feet (Participant C4- UKZN).

To demonstrate proficiency of cognitive reasoning (Hillerbrand & Claiborn, 1990) within applied contexts becomes felt by intern psychologists, especially in professional forums (ward rounds, grand ward rounds, and case presentations). Therefore interns' verbal case formulations and written reports are being scrutinised by hospital supervisors and qualified members of the multi-disciplinary team (psychiatrists, medical doctors, social workers, occupational therapists, psychiatric nurses, physiotherapists, and already qualified psychologists) and intern psychologists from other universities, as to their level of understanding and contribution to the client/patient's treatment and recovery.

I do feel that personally it resonated with me. But, it feels like a chicken or egg scenario where, 'Does it resonate with me because that's how I was taught and led to believe that this is the way to do things? Or, is it something personal in me

that it does resonate with?… what I liked about the Systemic theory was that things tend to fit together. And, when you're doing a kind of psychological formulation, you're just kind of describing a narrative almost. That's how it felt to me, and you can incorporate different things. So, "This person is experiencing this, this is how they experience the world around them, this is how it's impacted them, this is how their family relationships maintain their current behaviour", so that all fit together and all kind of made sense to me.
The very hard-core Psychoanalytic stuff didn't. I didn't like the idea of, "Well, he's got castration anxieties", because I can't find-, 'What the hell does that even mean?' It was so abstract for me. And, it kind of felt like this is what people don't like about psychologists, you know. We start talking about penis envy and castration anxiety, and it doesn't resonate with anyone, and it would only make sense to us. And, it felt like this club where we all speak this intense jargon to each other, and only we understand, and we sound clever, but everyone else is left feeling, "Oh, what are you guys talking about?!"… I appreciate the Systemic, because I use it here at (Tertiary Psychiatric Hospital) and the psychiatrist can always understand what I'm saying… So, it feels very natural, it feels very fluid to me... (Participant B1- Systemic orientation at Unisa).

We are a part of the Multi-Disciplinary Team here. So, the IPA (Interactional Pattern Analysis)… it's not easily accepted within the hospital… so it's difficult to be talking about impact with the psychiatrists. So, what I then have to do is go back to my DSM (Diagnostic and Statistical Manual of Mental Disorders), so we talk in terms of personality disorder… So, you apply what needs to be applied, depending on the need, on who you are working with. So, as I'm working with my colleague… fortunately, we trained from the same university… we talk on IPA and Systems, and it makes better sense to us… we have to change the way you talk… If you want the doctors to see you as being clever or understanding what we're talking about, you have to talk with MSE (Mental Status Examination)… and psychiatric language… in that sense, I find that the IPA does not neatly fit into the environment, so I have to put it aside and apply it… for certain types of

therapies and not for others (Participant C1- Systemic orientation & IPA model at Medunsa).

Participants (B3, B5, and E5) highlighted that during their internship they also spent considerable time sharing ideas with peer colleagues who had been trained from other theoretical orientations or in specific psychotherapy models. This investment was pursued by participants to increase their knowledge and widen their perspective of their clients or sharpen their skill base.

Being at - (Tertiary Psychiatric Hospital) and being exposed to a lot of Psychoanalysis, and I've found a lot of it very useful. I think some of the more contemporary stuff, like Object Relations and things like that… Defence mechanisms, those kind of things that are very useful to us… the very intense over-sexualised Psychoanalytical stuff that turns me off a little bit... I am quite happy to incorporate the aspects that I like. I don't feel like I'm betraying epistemology or a paradigm, or anything like that… as long as my end product of how I think about someone fits together, it feels fine for me.

I don't mind. I don't feel the rivalry between paradigms… I think that part of the thing I like about Systemic, or the way we were taught … 'You can incorporate other theories if you so desire', and I liked that aspect about it. I think I had a couple of bad experiences with very Psychoanalytic people who… spoke very dismissively about other paradigms. Which I didn't like, which maybe turned me off a little bit as well. But, I like that aspect of, 'Ja (yes), you can integrate'. Sometimes, integrative sounds like a swear word, in some places. People don't like the idea of combining paradigms, they feel like, 'You don't know what your epistemology is!', or they clash. But, I feel like a lot of them complement each other. A lot of them are saying the same thing in different ways (Participant B1- Systemic orientation at Unisa).

Participants valued being exposed to an array of theoretical orientations and prized maintaining their spirit of teachability or not feeling constricted, boxed in nor indoctrinated into practicing strictly within one theoretical paradigm (A1, B1, B3, B4, C2, C6, C7, D1, D2, D3, D5, E4, and E5):

I would go and read up on stuff. And, also other interns have had different exposure and different training institutions. So, I would learn from them. We have

exposure like video presentations, psych ward rounds, we work in teams… but it was difficult (Participant B3- Systemic orientation at Unisa).

My internship at - (Tertiary Psychiatric Hospital) definitely had a great influence on what I believe in: what I can do, what I can't do. I learnt a lot in that year, that was '73, from my contact with colleagues… because we were quite a diverse group, very diverse group (Participant E5- Integrative model at Potchestroom University (now NWU)).

And, then it helped a lot to from there (a main Psychoanalytic orientation at Wits) be able to then go to other types of training, attend other trainings or experience other training to learn other ways of doing things and then either change my framework, expand my framework or understand it from my framework, incorporate it into my framework… I think the training that happened in many other models very much happened during my work at - (Tertiary Psychiatric Hospital), which was during my internship and also during my Comserve time (Community Service year) where there was a certain training programme… So, there the various personnel could present their orientations… and I was exposed to it (Participant C2).

Even if it's just a colleague, like a fellow intern and they'd be like "Ja (Yes), this is what I did with this person", and then I'd like, "Oh, that's actually a cool thing to – or a cool way of thinking about it". So, a friend of mine, he's a colleague and intern in the department now, he's a Systems-based therapist, and I've learnt probably about 90% of my Systems therapy from him, because I just go and bounce it off him, because he studied it, that was his mode of learning at university. And, then I'd be like, I'd go to him and say, "Okay, what would a Systems therapy person say about something?", and he'd say, "Ja (yes), it comes down to conditions at home" or whatever it may be, you know. And, I'd be like, "Wow, okay!", you know, and you think about it in that way, and then you go read up about it a little bit more (Participant B5- Integrative model at UJ).

According to participants their choice and depth of theoretical orientation developed beyond their years completing university coursework. The year of internship (B3, B5, C2, and D3) and the Community Service year when daily seeing many clients, notably, prompted the participants to develop and refine their theoretical framework in order to assist clients effectively. “People do not grow by having their realities only confirmed. They grow by having them challenged, as well, and being supported to listen to rather than defend against, that challenge” (Kegan & Lahey, 1984, p. 226).

> *I think coming from UJ, it is largely… well, I regard it as largely integrative. However, because my practical internships and Community Service, I also then gravitated towards more towards the Psychoanalytic theories, and I think currently I would say, largely integrative, however, I mostly use Psychodynamic theory to formulate the clients. I think that is pretty much it* (Participant C5- Integrative model at UJ).

Participants who were trained integratively by the time they were in their internship were able to indicate which theoretical orientations they felt did not fit with them personally when working with clients (A1, A2, A3, B4, B5, C3, C5, D1, D2, D3, D4, and D5). Participants (B5, C5, and C6) felt that experiential learning/supervision of one’s casework in a particular theoretical orientation, beyond lectures and theoretical reading, was a key marker of having attained proficiency in working with clients using a specific theoretical orientation.

> *I think the other theories and stuff I’m not so well-versed in, and I wasn’t so well taught in because I didn’t get supervision. Like for instance systems, I think systems is a very, very useful theory, and that I’m learning more and more as we go. But, I was never supervised in it, I was never trained in it, so I can’t say that I can practice it. I can’t say that, like, I know what a system therapist does… you can be taught a theory and what these things say. You can be given a textbook of systems, but… you’ll never know how it works unless you’re actually taught the experience of it* (Participant B5- Integrative model at UJ).

In addition, participants personally invested in a specific direction that they felt drawn to in terms of choosing a personal psychotherapist with a specific theoretical orientation (B6, and E5), what they spent most of their time reading on (B4, B6, and C6), and crystallising their beliefs and assumptions about psychotherapy in line with certain theoretical orientations (B6).

As a result, participants developed a strong preference for a theoretical orientation, though they voiced they valued not becoming closed-off, but rather remaining open to new possibilities or opportunities.

> *But, then it's up to you to pick a paradigm to – which you want to work from. So, I do tend to find myself integrating a lot of theories when I need to and I feel like I need to, when I'm sitting with a patient* (Participant B5- Integrative model at UJ).

> *I am largely drawn to Psychodynamic Psychotherapy… I have a very, very firm belief in not just treating symptoms. I really believe in getting to the root of wherever the symptoms come from. I feel like you pick off fruit from a tree that the roots are rotten… I also believe in long-term therapy… I am not closed to doing short-term or any other technique. I have been trained integratively. But me, personally, I have always been more to a Psychodynamic approach and that is the thing that I read up on more and I also go for that type of therapy for myself and that's what I relate with* (Participant B6- Integrative model at NWU).

In the current study, participants (B5, C2, C3, and C4) voiced how despite having had some training in CBT, they did not practice using this theoretical orientation.

> *So, UKZN Pietermaritzburg was very Psychodynamically orientated. They do have [laughs] some Cognitive Behavioural Therapy workshops, but they are even given by the lecturers sort of with tongue and cheek kind of, "We don't really do this, but we will entertain it"* (Participant C4- UKZN).

> *I don't like CBT, even though I do think that sometimes one or two of the techniques can work, but it has to be a given. It has to be like, "I see this person's got a trauma so now we can desensitise him slowly, by systematic desensitisation or something", then I think it has incredible merits. But, as a mode of practice, especially in the population of a hospital, and also the clients that I've worked with, like, personality problems… I think it's for me personally, useless. I don't think it's very one-on-one, I don't think it's very personal… I don't like the whole idea of setting a prescription on somebody, like "This is what we're going to do now and this is how you're going to get fixed". Whereas, sometimes a human*

being just needs that connection, and I don't think that CBT offers that connection, like those reflections and this empathy reflection,… that sort of thing is not really present in therapy in CBT (Participant B5- Integrative model at UJ).

Two participants who were trained predominantly in CBT, decided that they personally did not resonate with CBT and as such sought out additional training in depth psychology (D1, and D5).

So, sometimes I bring aspects of different modalities and it works. I do see results… I've started to integrate it… with a far more in-depth type. So, I don't do CBT, that's not my approach… although that's just a strong one we were trained in. I would look more on a deeper level… I use my intuition a lot of the time (Participant D5- Integrative model at UFS).

Two qualified (C5, and C6), one experienced (D3), and four senior participants (E1, E3, E4, and E5) indicated alongside their personal style of working they would include CBT aspects or techniques where they felt it was useful for a specific client or goal of psychotherapy.

I am still arriving ...[laughing]. I really do work client-based. So, probably quite eclectic, if you want to call it. I tend to think in terms of more Psychodynamic, so I try and look at relational issues and early relationship issues, attachments. Those kind of issues are quite significant for me in terms of where they are today, their ego and their personality structure informed by that.

But, in therapy when I am working on a time-limited frame I do work from a CBT perspective, because I sometimes feel that my clients leave the therapy with a specific tool in order to survive on, between our sessions. And, sometimes I also feel that when they have got something concrete to leave with, some processing might happen between the sessions.

But, if they are leaving after a session which may have been subconsciously quite significant, that hasn't rung as being significant they might almost create a barrier to the therapy and feel that it is pointless or does not help or even though it has been possibly potentially effective. So, giving them something to leave with, depending on the clients, because sometimes they also don't engage with the client, they don't want to do a progressive muscle relaxation because… it doesn't

fit well with them. So, really I work quite dynamically depending on the client. And, I see a diverse client range (Participant C6 - Integrative model at NMMU).

In the current study, participants who had trained integratively at university voiced a strong preference towards Psychoanalytic thinking as a product of their undergraduate exposure (C3), university supervisor (A1, A2, A3, B5, B6, and C4), personal psychotherapist (A2, B2, D5, E2, and E5), internship site (B2, B4, B5, B6, C5, and E5), reading group (D1, and D5), and CPD workshops (B2, and C6). Future studies may wish to specifically target CBT-orientated psychotherapists to explore how CBT is practiced within South Africa, as the current study did not have participants who voiced strongly adhering to or solely identifing themselves with CBT.

In the current study, participants strongly resisted the idea of strict orthodoxy or indoctrination (E5) into adopting a specific theoretical orientation. Yet, participants voiced that it was important to strongly guard against being perceived by colleagues as all over the place (C4, and E4). Participants prioritised choosing selectively and carefully what they immersed themselves in and how they applied different theoretical facets or ways of working with each client. Participants as they became more comfortable working with clients relied upon their intuition to fit the theoretical framework to the specific client (B5, C5, D1, D5, and E2).

I feel comfortable with what I do and I use my intuition a lot. When I speak to people and then with the expectations with regards to: "You have to do this, you have to do this", then it sometimes conflict because then I wonder 'Well', you know, 'the balance between finding your intuition and being a clear therapist'. Sometimes, that's a conflict for me… So, that's where I stand, but if I disregard that and I follow my intuition, usually I feel that it's more successful (Participant D5- Integrative model at UFS).

Participant D1, when reflecting on her training highlighted that her university (UFS) *"exposed"* trainees to a variety of theories and models of psychotherapy (theoretical breadth) through three focused modalities: adult, child and group. However despite a variety, Participant D1 noted that the university had a *"main frame of reference"*, namely, CBT, which she could not strongly relate to. She relayed, "*I was more Jung-orientated, more meaning to life. Which linked to my more spiritual side. I am very much interested in the spiritual and how the universe works"*. In light of her beliefs about human beings and wide interests, Participant D1

demonstrated how psychotherapists take ownership of their preferred theoretical orientation and embark upon post-training after qualification:

> *So, what happened is I joined the Jung reading/study group… we read up on Jung and talk about that and had (a Jungian analyst) come down and do some workshops with us and then I got exposed to bodywork…. And, then my husband saw a course on Somatic Experiencing, Peter Levine, and this fell into neurology and this was also something I have been interested in- the brain… so now, what I do is I integrate… So, I am combining a lot of these* (Participant D1- Integrative model at UFS).

Here, Participant D1 spoke of self-initiated nature of pursuing additional training after qualification. She spoke of being exposed to other theoretical models not covered during her university training and combining them with her training and her personal interests that she has held for a long period of time. What became clear in the interviews of the current research is that South African qualified practitioners actively seek out additional training that they feel personally resonates with them.

Senior psychotherapist E1 outlined that his masters training in the late 1970's at Unisa focused on three major schools of thought, namely, Client-centred therapy, Behaviour therapy, and the interactional model from Utrecht in Holland, during the training, and that after qualifying he sought out further training:

> *I got dissatisfied with what I was doing and how I was doing it. I didn't think I knew enough. So, I started practicing '78. While I was at the varsity (university as a lecturer, post-qualification) we started a practice. And, then I started looking around and eventually I ended up with Maurizio Andolfi in Rome. And, that was the sort of more Family Systems orientation.*

He found that he spent a number of years developing further skills in therapeutic models not covered during his training at university by seeking out international training by pioneers of new therapeutic ways of working.

> *I went there every second year for about six weeks from the early, ah, from the late let's say '87, - I think I started. And, through him I met people like Carl Whitaker. I spent some time with Whitaker in Wisconsin… And, of course people, like, ah, Dick Aueswald, the ecological thinker, he was a psychiatrist. By the way,*

these guys who influenced me post the masters were all psychiatrists and they were all Psychoanalytically trained, all Psychoanalysts… Then they became the Family Therapy pioneers. So that, I'm talking about Whitaker, Minuchin, Andolfi, and Elkaim from Brussels. Aueswald was a psychiatrist, you know, Sluzki from Argentina, all these guys… I was the convener of a conference, family therapy conference in South Africa… the second one …
I met Andolfi and he said, "Why don't you come for the first-?" what he called, "practicum". I said, "Okay, I'll go," because I was also looking for somebody who could train me. Somebody, I had respect for, because I think I'm a difficult pupil in that sense. You know, I don't suffer fools gladly in the training business and he was feisty enough and assertive enough. So, I liked him and we got on. We also became good friends afterwards. But, that's how I started. And, I tried that. And through that, it took me along the various models or paradigms in family therapy itself. And, so it became really kind of a new world that opened for me (Participant E1- Unisa).

After qualifying, a number of participants specifically indicated that they reached a milestone in their careerpath, one to nine years after internship/Community Service, where they decided to invest additional time spanning years and significant finances in attending international trainings, externships or qualifications in pursuing a specific theoretical orientation or therapeutic model at an advanced level so as to achieve a sense of expertise or specialisation which is often recognised or certified internationally. Many of these models were not covered in the participants' university training. Experienced and senior participants voiced how seeking out individuals continued beyond their training years, often founders (E1, and E4) or prominent figures of psychotherapy models (E2, E4, and E5), who embodied their theory benefitted them. Live exposure and/or valued time with these psychotherapists demonstrating their work created memorable shifts in how the participants themselves worked as psychotherapists to this day.

Together with the priority placed on ongoing reading (B3, B5, B6, D5, E4, and E5) what became evident in the current study is that engaging with admired psychotherapists in person exemplifying their way of being has an indelible influence upon psychotherapists' work. The current study suggests that experienced psychologists seek out specific and advanced training from founders of therapeutic models and commit to many hours of training in that specific

therapeutic skill set. For example, participants referred to: Nancy McWilliams' Psychoanalytic Therapy workshops (C6, and E5), Somatic Experiencing (D1, D2, and D5), Eriksonian training (D2), Hypnotherapy (E4), Intersubjectivity (C3), Analytical Psychology (D1, and D5), Sandplay (D1, D2, D5, and E2), Emotionally-Focused Couples Therapy (C2), Circle of Security Parenting (C2), Parent-Infant Psychotherapy (C7), Carl Rogers' Client-centred Therapy workshops between 1982 and 1986 (E4) (Rogers, 1983, 1986, 1987; Rogers & Sanford, 1987), sex therapy (E4), and various family psychotherapy models (E1). Participants invested in this additional specialist training to in a sense become much more effective with clients, which had the additional benefit of becoming known for utilising a specific psychotherapy model by psychologist colleagues and other health professionals within South Africa in assisting clients effectively.

> *I can really find that therapy has deepened… I've realised since I've been exposed to more people from overseas, and that helps… We need more, yes. I think we haven't, in the country, developed enough. Uh, we are very isolated and the money plays a role, financial constraints and so. But, I really feel I need to move out to experience more… you're just so much more exposed to different type of things* (Participant D5- Integrative model at UFS).

With the lifting of sanctions and the advent of democracy in South Africa it is likely 'specialisation' or developing a professional reputation in a specific psychotherapy model will continue to be a growing trend in the profession of psychology within the country. Participant E2 cautioned that the more isolated a profession and its professionals are the more narrow it becomes. He felt that South Africa *"for a long time we lost that lesson"*, wherein now he felt that currently there is a focus on *"ongoing development"* as such *"a new renaissance"*. And, that this has led to psychotherapists being exposed to different ways of being supervised and a necessary move back to the *"inner development"* of psychotherapists.

Participant E1 after having focused on three main models during his masters training and extensive international training in family psychotherapy models post-qualification voiced that he has in a sense over the decades of being a psychotherapist become *"a mixed salad"*. The achievement of a*"very good mix"* as a senior psychologist was positively recognised by trainees (A2). Expert psychotherapists, according to Sexton and van Dam (2010), do not utilise theory in predictable ways or the way they learnt it years before. But rather, over the years in the

profession, expert psychotherapists adapt and extend their knowledge based on their experience with clients. This becomes evident in how expert psychotherapists conceptualise cases in more comprehensive, elaborate and complex ways which demonstrates higher levels of abstraction. Such sophistication is attributed to expert psychotherapists using theory and their cognitive abilities to understand the patient allowing themselves to make use of flexibility, creativity and innovation as opposed to attempting to fit the patient into fixed theoretical assumptions (Hillerbrand & Claiborn, 1990).

To achieve such expertise, involves a lengthy process of leaning into and living out one's theory which Sexton and van Dam (2010) depict as "metabolizing theory" (p. 144). Such immersion or organic absorption of theory is deemed essential to achieve the finesse required in the psychotherapeutic hour. As Mahoney (1998) emphasises that, "ours is a profession located strategically at the crux between theory and practice- an area of tension" (p. 50).

> *It reminds me of in Systems they talk about learning a technique… but, then at the same time forgetting it… So, I think that resonates quite well with me and before the technique was in the foreground and I lost myself... But, what's changed now is the techniques are still there, it's not lost, but it is not as prominent and it's not a barrier* (Participant A10- Systemic orientation at Unisa).

> *I've… grown from being this anxious, academic therapist as to being a more believing, experienced therapist… sort of leaving the books… Kind of like hanging from the books… Almost, like the books are the washline and the experiences are hanging from there and we tie those experiences together. So, like the framework and then your experiences hang on the framework. And, you can link those together and create similarities (and)... different experiences* (Participant C6- Integrative model at NMMU).

Sexton and van Dam (2010, p. 144) advocate that,

> We cannot merely swallow knowledge wholesale without synthesizing, assimilating, and transforming it to make it useful to unique and ambiguious clinical situations. Metabolization is the process of bringing ideas and concepts to live inside one's mind and psyche so they become part of self and identity.

4.7.4. Internalising Theory as Part of More Advanced Development.

In essence, this new body of knowledge, internalisation of theory, changes the way the psychotherapist sees the world (E1, and E4). Participants, in the current study, voiced that they started to see people differently (A6, and B1), and that they now had a particular lens in viewing interactions whether in consultation or not (B1, and E4).

> *What I like best about being a psychotherapist is that I get to learn more about people. I get to learn more about myself in that context as well… I think it's widened my perspective on human beings in general. I think that's why I've got an appreciation for the different aspects of a person because of therapy and what it provides for a person* (Participant A6- Systemic orientation at Unisa).

> *I think the way it was presented was very helpful in the sense that I understood it, not just from the book. But, for example, role-playing in class helped me to make more sense of the theory as opposed to just reading it… we acted out the entire telephone interview and (the) power of the referring person… I have learned about Systems, in my honours, and to be very, very honest, I remembered nothing…*
>
> *But, when you are role-playing it, when you are actually doing it, there is so much of subtleties, so much of dynamics, that you see that can't be written down, it's experience. And, that I really appreciated. And, you see that you are able to pick that up more quickly in clients. So, when I saw client then in clinic, when I saw behaviours, it didn't remind me of theory, it reminded me first of, 'Ahh that pattern looks familiar, what is it?' And, then it took* (Participant A10- Systemic orientation at Unisa).

Goldfried and Padawer (1982) outline five common ingredients that contribute to effective psychotherapy: psychotherapists facilitate expectations that psychotherapy will be helpful for the client, develop a good therapeutic relationship or alliance (Levitt & Williams, 2010), increase client awareness through feedback processes, encourage corrective experiences, and emphasise continued reality testing. In light of these common principles, trainees would benefit from developing a deep understanding of how to facilitate change processes with a client, rather than becoming concerned with which specific model or theoretical orientation is best.

Student psychologist A7 shared how she experienced a shift in her ability to absorb and utilise theory in her therapeutic work, when she allowed herself to start linking theoretical knowledge to her personal knowledge about her life experiences:

> *Whatever we experience in our lives personally, these are things that we deal with on a therapeutic level or in the psychotherapy profession. For example, many therapists who developed the theories that we use today, they learnt of them in their personal life. Like when they were sitting at home drinking coffee, looking at their kids play with each other. Then, they realised that, 'Hmm, maybe, we can use this, you know, as an intervention strategy or something like that?'.*
> *So, there is a relationship between the two, and I don't think we can separate them or divorce them from each other… I had never asked myself, 'Can this actually be possible in my own life?', and I never wanted to challenge myself to observe it in my own life. But, the minute I did, and I actually saw certain patterns revealing themselves… I learnt then to understand theory better, and to grasp it better because I applied it in my own life* (Participant A7- Systemic orientation at Unisa).
>
> Schools, models, and orientations to psychotherapy can be understood as portraits, exteriorizations, or rationales for the people who invented them. They are simply examples of different people's ways of evolving a style that fully utilizes their own unique resources in a particular context (Keeney, 1990, p. 3).

Participant E5 reflecting on her four-decade long career shared that a psychotherapist's theoretical orientation undergoes alterations over the period of one's career.

> *However, all in all, it was quite a journey…. it was psychodynamic, some cognitive influence, cognitive behavioural, gestalt to a great extent, but it all fits in, you know. It all fits in actually.*

Choice of theoretical orientation(s) can be likened to a favourite book that can shift as the person develops through the lifespan:

> *You think about: What was your favourite book as a child?… and, while that book might remain your favourite throughout your lifetime, it might change. And, if you go back and you read it today, it might not speak to you in the same way…*

> *because it was where you were at and what you were doing at that stage that made it what it was* (Participant D4- UP).

4.8. Dealing with Not-knowing and Circuitous Journeys

Experienced psychotherapist D2 felt that he spent much of his role as a supervisor of interns helping them come to terms with 'not-knowing' (Andersen, 1980, 2001) and not trying to provide clients with set answers or solutions. Paré and Sutherland (2012, p. 185) argue that the effectiveness of psychotherapists is

> Not necessarily about demonstrating skills or techniques or producing correct answers on a test assessing professional knowledge. Rather, it is about being able to participate in relationships with clients therapeutically… being responsive to the client's pace, concerns, goals, and theories of change… showing willingness to explore unplanned directions, being open to their ideas being contested by clients or improvising with language to find shared ways of moving forward in a conversation.

Hoffman (2009) points out that "the patient is not putty in the analyst's hands. He or she has a mind and will of his or her own right from the start along with a capacity, even if partially compromised, for conscious collaboration" (p. 619). Gergen (1999) adds "it is not the therapist's task to 'lead the way to knowledge' but to collaborate with the individual (or family) in generative conversations" (p. 170). Not-knowing is an ethical and philosophical stance which Andersen (Anderson & Goolishian, 1988, 1992; Anderson, 1997) deems essential to "inviting, creating, and sustaining collaborative relationships and generative dialogues" (p. 350). Anderson (2001, p. 350) clarifies:

> Not-knowing refers to a therapist's intent: how they *position* themselves with what they know or think they know and to a willingness to keep their therapist knowing open to question and change. Not-knowing has been misunderstood as a therapist lacking knowledge, feigning ignorance, withholding knowledge, avoiding suggestions, or forgetting what they know. It has been misunderstood as an expertise or a technique… I do not know better than a client how she or he should live their lives; I do not want to use my knowing to lead a client in any direction. I want to promote dialogue in which possibilities can emerge.

From the perspective of the trainee (A3) when reaching an 'okayness' with not-knowing, she found her psychotherapy improved with clients. After all, there is no set 'cookbook' to emulate in order to be an effective psychotherapist (Rogers, quoted in Kirschenbaum & Henderson, 1989).

> *The ingredients is basically if you want to go with them into the maze you just listen and follow… you don't lead somebody's life… that's the worst assumption you can make, is you think, 'Uhh, I will lead you!' But, remember you can't lead someone in their own maze. You follow them… and then you get to the middle and, 'Here I am in the middle,' and then you chat to them… 'if you get lost in the maze… then I walk with you and we will get there"… You regularly get lost, you will. I mean, I have walked in how many mazes? And, I mean do you ever get it first time?... Never. But it's a process.*
> *… they come to me, "Now, I have got this problem and I want to solve it now", and I tell them, "Ja (yes), I can, we will get there, but not now"…my now is like later… it's not like immediate gratification, 'Okay, we will get there'. And, then they realise, "You know, it was meant to be like that'. And, "If you want results now, uhh, I don't have results now. Okay, cool then, maybe you need to see somebody else? Because, I can give you the solution now… I can give you an answer, but it is not an answer!"... it means nothing to that client… And, then they come back again after three weeks and say, "I can't cope, nothing is happening" and you go, "Well, what answer would you like now?"*
> *… therapy is not about control… let them be in control, let them lead, let them be the decision makers. You are just there to say, "Okay! Okay, cool! We at a fork in the road, where would you like to go?"… 'You know, in the maze, you come to a dead end, it's no problem. It's not the end of the world, we just turn around'. And, then you look for the next path* (Participant D2).

> *I am drained and exhausted… when there is no space for me… often, when people come in, they are anxious and they become louder and seemingly obnoxious. And, there is no space – they want you to fix – but, they don't create any space for you to do anything. And, then I find myself very frustrated and exhausted because I*

can't even say, "I'm not going to be able to fix you in this session…" because they have taken up all the space. That generally goes away after three sessions, when they settle down and there is space for both of us… (Participant C4).

I'd want them to know that their participation in therapy – they mustn't come to me thinking that I'm the expert with all of the answers. They need to realise that they have value and their story and their worth are so important for the process as well. So, if they don't bring anything, I can't give anything. So, it works both ways. And, for it to be really valuable and beneficial; it has to be a two-way thing, it can't just be me… (Participant A4).

It's like we always have an answer and I reached a new level of therapy the second I became comfortable by not knowing the answer, and that's fine. Mind-blowing… (Participant A3).

I think self-awareness develops, what is very important for me is to stay respectful. If I take a client as a client or a patient, I'm co-responsible. I should never ever be arrogant and think, 'I've arrived and I have all the answers'. I also go through own personal challenges… I think the importance is to stay humble (Participant E4).

People becoming dependant on me within therapy does not sit well with me. I can understand, you know, that certain processes needs to be worked through … I make sure that the patient benefits to the utmost. But, when someone starts coming to see me just because it is habit or… I'm kind of like a fizzy tablet that makes them feel okay for the next seven days and then again. Then, I will address it and say, "Hold on!" (Participant D3).

As a senior psychotherapist, Participant E4 voiced her positioning herself as an active co-participant involved in the process directly as opposed to positioning herself as a more sideline observer or viewer detached from the therapeutic movement of the client.

I think therapy can be described as a river. You can either be on the side or you can be in it. I would prefer to be in the river with my client and do therapy. Sometimes, the water is quiet and sometimes the water is not so quiet. But, I want

to be in the river with my client. I like my comfort. So, I would prefer the nice boat to be in with my client, but I think my client should also see that, 'We can either be in therapy and just sit in the boat and sit here for weeks and weeks or we can start moving and see the rest of the river as well. 'Where are we going?' and we need to address the challenges in the river, and how long are we going to be there…

I think that's part of my personality… I become bored. So, there needs to be movement for me as well. I'm not uncomfortable going back. Sometimes in therapy, you need to go back to certain aspects that haven't been, uh, covered in-depth enough but- I'm comfortable with that. But, there needs to be movement… Of course there is that, "Where are we going?" So, we cannot be in the river forever. We use the space to move. 'Where are we going to dock?, 'Where are you going?' (Participant E4).

Participant E4 also viewed psychotherapy as needing a clear and spoken about direction with the client in order to achieve shifts together with the client. She, together with participants (A5, and D3), cautioned that psychotherapy needs to have an endpoint in mind and as such clearly defined goals enable that endpoint to be reached successfully. Yet, she stated that clear mutually decided upon goals did not necessarily amount to a smooth process as obstacles and diversions are part of a therapeutic course. However, for her, active progressive movement overall was a key marker as to whether psychotherapy was proving to be ultimately beneficial to the client. Along similar lines, Participant C4, in her metaphor of the psychotherapist and patient traversing mountains also drew upon a journey through nature as it is.

It's about a journey; and it's a different journey for everyone. Some through very tumultuous ways that you don't know where you are going; with others, you recognise the journey even before the therapy is into the second or third session… a never-ending journey (Participant E5).

Participants (A5, A7, C5, and D2) indicated walking together; or hiking or running a race which requires a notable degree of self-effort and personal grit as the agent of movement in psychotherapy whereas participants (D3, E2: a bus or taxibus, and C7, E4: a boat on a river) drew on the idea of utilising a vehicle for change to emphasise the need for psychotherapy to

have sufficient energy to propel or facilitate the movement of the client forward as such a vehicle for change is necessary for processes to occur.

> *And, I suppose at some point it would be fast-flowing and other points would be a lot calmer and restful. At some sections it will be a lot deeper, others a bit shallower and I think that speaks to doing your therapy…we have conversations around that there will be times that it will be uncomfortable or could be more painful uhm, and other times you might walk out here thinking, 'Well, did we even do work?'… I suppose there's times when you will be closer in the river or in the river itself and you rushing through and feeling all the emotions. And, other times you are on the boat or on a ledge somewhere watching the river flow… I suppose not all clients can be in that reflective stance… others try and avoid being in the middle of the river, or in the middle of the emotions because it's too painful for them… but, I think that is the process of being in therapy… It's that in out – or being in it and being out of it* (Participant C7).

Participants (C5, C7, D2, and E4) chose images which imply some level of 'to be expected' unpredictability and difficulty/struggle. After all, inherently, a maze is difficult to navigate and a river is forever-changing by virtue of the weather conditions and shifting landscape. With this in mind, it appears experienced psychotherapists do not expect predictability or set processes, nor do they explicitly impose a specific, pre-determined structure on the new territory. Rather, experienced psychotherapists appear to prioritise the collaborative power of the therapeutic couple (psychotherapist-client) to absorb and make sense of the unique landscape encountered and their therapeutic ability with the client to engage in recalibration in order to arrive at the client-desired destination.

Participants, in the current study, valued psychotherapy being a mutual, equalised endeavour between psychotherapist and client (B6, C3, C4, D3, E4, and E5). Participants voiced that they purposefully refrained from the imposition of solutions for their client (C6, and D2). Participants voiced that clients in distress are vulnerable to being imposed upon and therefore it is critical that the agency of the client is respected and fostered. Participants C1 and E3 spoke of aiding the client in developing an assertive voice in their relationships. Participant D2 spoke about holding himself back despite being provoked by the client to spout forth answers in order to ensure that rather the client arrived at their own answers. Participant D2 illustrated the

importance of psychotherapists facilitating the client achieving their own goals and experiencing their own competency at arriving at a self-derived successful outcome.

The ability to as a psychotherapist to gain a handle on one's feelings of fear of the unknown, 'tie oneself to the chair' and remain still and 'not-knowing' is a skill learned and appreciated over time (Anderson, 1980). Initially, psychotherapists are too invested in their own need to perform (B1, B5, C3, D3, and E4) and to demonstrate that they are indeed capable of helping people in distress that they are too quick to rescue (D2, and D3) and slow at allowing their clients to get good at swimming. After all, psychotherapy involves psychotherapists facilitating a healing "process over which they have no fundamental control" (Rogers, 1980/1995, p. 325).

4.9. In the Hot Seat: Personal Psychotherapy for the Psychotherapist

The British Psychological Society (BPS) requires that trainees in counselling psychology programmes attend at least 40 hours of personal therapy/counselling or personal development workshops related to their chosen theoretical orientation or model, in which they assist clients.

The European Federation of Psychologists' Associations (EFPA) requires at least 100 hours of personal psychotherapy or personal development be undertaken by aspiring psychotherapists (Rizq & Target, 2008). Laireiter and Willutzki (2005) point out that personal psychotherapy and/or self-directed experience is a legal requirement of psychotherapists practicing in Austria, Germany and Switzerland.

In contrast, within South Africa, the HPCSA does not currently stipulate mandatory personal psychotherapy for trainees, however universities who prioritise a Psychoanalytic orientation outline in their selection processes that personal psychotherapy is a mandatory or obligatory part of their masters programme that trainees agree to and need to make personal financial provision for. Ogunfowora and Drapeau (2008) found that personality traits are related to theoretical orientation preferences and hence to the pursue or not, of personal psychotherapy during training. Other universities prioritise group experiences with the trainee's fellow trainees and/or "recommended" or "strongly encourage" trainees to enter personal psychotherapy which is not strictly monitored in terms of attendance.

Grimmer and Tribe (2001), and Kumari (2011), report on trainees undertaking mandatory personal psychotherapy experiencing stress as well as valuable input.

I don't think everybody can afford it nowadays. It's expensive… So, it's hard to say, "You've got to go for therapy". But, if the opportunity is there, I would prefer people to do that… it's always been useful. It's always been informative. Probably, because I was voluntarily there… Because psychotherapy is a voluntary act on both sides. The therapist must want to-, you know, want to see you and you must want to see the therapist… I think voluntary work is necessary (Participant E1).

Orlinsky (2013), a proponent of personal psychotherapy, cautions that mandatory psychotherapy may prove to be counterproductive as trainees should not be mandated to have personal psychotherapy if the training requirement is the sole reason the trainee is seeking out personal psychotherapy. Internationally, the cost of personal psychotherapy for trainees has also been highlighted as a barrier to trainees' decisions to enter psychotherapy (Holzman, Searight, & Hughes, 1996; Stefl & Prosperi, 1985).

In the current study, many participants (A1, A2, A3, A4, A5, A6, A9, A10, B1, C1, C2, C3, C4, D3, and E2) had experiences of personal psychotherapy prior to entering training to become a psychotherapist. Reasons included personal struggles and/or to experience psychotherapy prior to embarking on becoming a psychotherapist to see for themselves what happens between a psychotherapist and a client (B1, and C4). In the current study, participants (A1, A3, A9, B1, and D3) reported negative outcomes of personal psychotherapy prior to masters training, as well as experiencing unhelpful psychotherapy during training (B2, B5, and B7). However, participants reported positive outcomes of personal psychotherapy with a subsequent psychotherapist, or openness to another psychotherapist.

I went once when I was, a few times when I was a child, when I was like 12 or so… My first experience with therapy was not good. I didn't like this woman, this therapist, I didn't like her at all! And looking back on it, I feel like she's one of those people who did her masters 40 years ago, and hasn't been to a conference since or something… I don't like her style, she's very confrontational, … luckily that didn't put me off for some reason, I guess. It's just interesting that it didn't… I went more recently when I was applying for masters, because I thought it was something that you needed to do… I liked her very much and I enjoyed the experience, and I feel like in the short time… I gained a lot of introspection… I

got to see a little of how therapeutic process works… I feel like it gives you a nice blueprint for therapy, I think everyone should do it before they do masters, just so that they know. Even if you liked the way that she opened therapy, just copy it for your first session… (Participant B1).

Oh! When I was in my honours (fourth year) I had been to see a psychologist just because I wanted to see what it was like (Participant C4).

Even before I even decided about psychology, I tried therapy and it really wasn't for me… I've always sought for a motherly figure in a therapist. So, that's the transference that I want in therapy that I've obviously needed to work through in the years. And, my first experience of a therapist was a male- so that could be a contributing factor. So, it couldn't just be him. There's, obviously, stuff about me that didn't happen in a therapeutic situation with him. But, he wasn't warm, he wasn't empathic, he didn't hear, he didn't listen. That really frustrated me and I was going through a very bad patch at that time. So, I just closed the book on it and I said, "Never again"… sorry, before him, was another one and then I tried that guy and then I was like, "Never again!"… I started engaging in personal therapy again in my masters year and it was the most amazing process ever, and I'm still in personal therapy at the moment. And, I think I will be for a while (Participant A3).

A part of me still believes that I'm also still very open to and I actually want to… but, a long-term process (Participant B7).

"Personal therapy, whether individual or group, is concerned with a deep internal searching and working through unresolved conflicts aiming at personality changes" (Malikiosi-Loizos, 2013, p. 36). Personal psychotherapy provides psychotherapists with numerous personal and professional benefits (Zerubavel & O'Dougherty Wright, 2012). The advantages include: a greater capacity to demonstrate empathy to clients, a deeper, inner knowledge of how painful experiences can be and how difficult disclosure of such experiences can be for clients, a sensitive appreciation of how difficult psychotherapy can be from the client's perspective, patience and tolerance when encountering resistance or slow progress with clients, a felt knowledge of timing

and pacing of the rhythms and intensity of each session and the string of sessions, and a greater faith and confirmation that psychotherapy can be effective in assisting people in distress.

The psychotherapist needs to be well-acquainted with their own psyche to be of real assistance to their patients. “The patient, by bringing an activated unconscious content to bear upon the doctor, constellates the corresponding unconscious material in him [sic]… Doctor and patient thus find themselves in a relationship founded on mutual unconsciousness” (Jung ,1966c, par. 364). Swiss Jungian analyst and founder of Sandplay, Dora Kalff (1980) emphasises that what psychotherapists want to mediate for others should emerge from their own therapeutic experience. The psychotherapist should possess an openness that is the fruit of an open encounter with one’s own dark and unknown sides, and an experience of one’s own deep-seated positive potential. Kalff found that an inner security in the psychotherapist enables one to create a protected space for clients. Creating psychological safety was also highlighted by Bowlby (1988) noting that clients need both a safe haven for nurturance and a secure base in order to be encouraged to explore and embrace life. Sergei Pankejeff (1972), a patient of Freud, reflected that he felt Freud created a sacred therapeutic space that offered shelter from modern life and was a sanctuary of peace and quiet for patients.

> *To integrate negative parts of self, you know, shadow. It means I can be all of these things and it is okay to be all these things…Yoh, there are many shadows, complexes. Therapists may be driven by the saviour complex, god complex even, you know. I think part of the shadow is you can take power away not respecting what their choices are… I think you need to work on your process. I have done that. I have been in therapy for many years* (Participant D1).

Participant D1 also prioritised acknowledging the negative aspects of self or the shadow and integrating and accepting that, *“I can be all of these things… and it is okay”* from a non-judgmental stance. Participants (D1, D2, and E2) voiced that the profession has complexes such as a saviour complex or even psychotherapists can be trapped in a god complex wherein they can take people’s power away, by wanting to be the rescuer (D3). To prevent this ego inflation participants emphasised the ongoing commitment to self-reflection in order to attain greater self-knowledge: *“You need to get to know oneself” (*D1). Similarly, Alice Miller (1987, p .1) advises trainee psychotherapists to get to know their own wounding experiences:

First try to discover your own childhood, then take the experience seriously. Listen to the patient and not to any theory; with your theory you are not free to listen. Forget it. Do not analyze the patient like an object. Try to feel, and help the patient to feel instead of talking to the patient about the feelings of others.

Many participants (A1, A2, A4, A5, B2, B5, C2, C3, C4, C6, and E2), specifically, verbalised attending individual psychotherapy during their masters training prior to the internship year. Personal psychotherapy is mandatory at Wits, and UCT, as well as strongly encouraged, for example, by the UJ and RU, and a list of psychotherapists offering reduced fees is often made available to students (Kottler & Swartz, 2004).

I think UJ recommended, but it was never-, I think 'strongly encouraged' is a good way to put it, because they didn't say compulsory, but that is kind of what it means. I think it is good… I think it was an understanding. I think different kind of members of staff would mention it, 'That this is something, they encourage you to do', and they gave us all a list… they said, "If you need referrals or you need the list of people that we recommend or people who said they have reduced rates" … we were to make the initiative. But, it was really emphasised as something important in terms of our personal growth. Which is what I also encourage people to do… I do believe it is something that is important for a therapist. The self-awareness, and, also in my mind, if you don't buy into it, then how can you- (Participant C5).

Because I've experienced it in my own life, my own therapy, I believe in it. I've bought into it. It's like an investment [chuckles]. You did your research… I could see the pattern based on what they talk about in my own therapy. So, that's why I bought into it, because what they wrote there (in theoretical books), I experienced myself. It wasn't something that someone told me, "I just need to believe that"; it was part of my process (Participant A2).

I think it's helpful in that sense but we also experience things as therapists. We go through some traumas that are just horrible to deal with on your own. So, I think it is beneficial to go and see a psychotherapist. Why sell something, sell a

product, if you don't believe in it? Or, if you haven't tasted it before or tried it? (Participant A7).

It also helped me to believe in the process of therapy and to know that it's worked. Where often I think you get a place in therapy where it looks hopeless and it looks very sad… And, I have been through that earlier in my therapy process I was like questioning, 'Does it even work, why do we do this?... Why do we need to talk about this,'… I think that has given me, especially given me faith in the process and faith in myself… I am the type of person that wants to know something works… Authentically… I don't want to sit here and do something with you and not know, or not actually believe we are going to be able to help you or that it actually doesn't work, 'You actually just need your meds' (Participant B6).

Participants (A2, B6, C4, C5, and D3) voiced that one can only really ethically provide psychotherapy, if one has personally made use of it and found it to be effective.

I often worry that it comes across as quite arrogant, but I just feel that there are really a lot of really bad therapists out there… Where you can just feel that they're not truly present, or they're not congruent, or they're not able to truly connect, or the empathy doesn't feel real, or they're jumping into their bag of tricks where they are now reprogramming the way you think in half an hour. It scares me. It often makes me feel like, 'Well, I'm going into a profession where I don't even believe in it, because I feel therapists never really helped me'. What has helped me has been experiences outside of therapy… something's clicked or changed and maybe realised something, but not therapy [chuckles] (Participant B7).

As such psychotherapists need to personally 'buy into' what they 'sell to' others as beneficial to be perceived by potential clients in the public arena and clients as ethical. Increased conviction that the theory of psychotherapy actually works in the real world, is felt by psychotherapists who enter personal psychotherapy.

Interestingly, participants spoke about entering personal psychotherapy for the first time specifically during internship (B3, B4, C7, D5, and E4), or shortly after qualifying (E5). Two aspects may influence: Firstly, internships are remunerated in South Africa which makes

psychotherapy a financial possibility for many trainees. Secondly, the amount of psychotherapy with clients increases dramatically when trainees enter into full-time internship which prompts trainees to evaluate their psychotherapy work with clients much more independently as a supervisor is not necessarily witnessing each session in detail. Trainees are to a greater extent self-evaluating whether they understand the process at the level they are required to in order to assist numerous clients beyond the basics and needing to hold a greater level of intensity. To manage the "deep end" (B7) or the trainee's "first real world exposure", Baird (2014, p. x) highlghts the importance of personal psychotherapy for interns to assist them to make sense of this intense threshold of learning which is regarded as one of the most influential times of one's career as a helping professional. After all, there is "no substitute for real experience" (Baird, 2014, p. 1).

> *So, when I went to do my internship, I actually went for my own process and I ended up with the psychologist who was psychodynamic, very Kleinian and then with a very strong Jungian interest. So, then I started to attend Jungian groups: reading groups and workshops… so I've been for my own therapy from 2001 to 6,… it's a must-have, not a nice-to-have… you have to work through your own process and of course, you work more in-depth. It complemented the lack of that in my training. So, for me, I've found I really resonated with the more depth therapy* (Participant D5).

> *I only attended my first therapy during my internship… So, I do think it's important and also to limit burnout* (Participant C7).

> *I think this year only, in my internship. Maybe, because you are so much more involved with clients, whereas in masters, you're not. So, 'you should be a therapist now!' So, they throw you in the deep end and so there's lots more to deal with. Not just with patients but workplace stuff and ja (yes), it's like you have to be an adult [chuckles] and I don't always feel like an adult* (Participant B3).

> *I was quite reluctant to go to my own therapy… I was too frightened of, you know, what can come out, what can they see… I only really started therapy this year, during my internship… I was quite upset with myself, for not going before,*

because I did have quite a nice experience, and I have been able to see the growth in myself… the varsity (university) can't make it compulsory, I know they can't, but it would be nice… it must be when you start seeing patients… you go home at night, and you have to process all these things that happened during the day… it is quite an isolated profession, because you can't go home and say, "Oh family! This is what happened with this person today?'… so, you are left to process that on your own (Participant B4).

4.9.1. The Debate of Mandatory Personal Psychotherapy During Training.

Jung recalled that,

> Freud himself accepted my suggestion that every doctor should submit to a training analysis before interesting himself in the unconscious of his patients for therapeutic purposes… We could say, without too much exaggeration, that a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient. This, and nothing else, is the meaning of the Greek myth of the wounded physician (Collected Works, Vol. 16, 1946, p. 115-116).

Participants (A3, B3, B4, B5, C2, C3, D3, D5, E2, and E5) emphasised that personal psychotherapy should be a requirement. Participant E2 felt that personal psychotherapy for trainees *"should be mandatory"* like "*the old days in analysis straight away"*. As mandatory personal psychotherapy would help to ensure *"less shit in our profession"*.

I think it's essential for emerging therapists to go to therapy. And, if they can make it mandatory on some level, I think that would be great. Like I say, so you come to therapy and you think, 'I'm going to be this therapist', but there's like a whole world of your own stuff impacting on you, and so if you are not aware of it, it's going to play out in therapy. You're going to sit in ethical dilemmas, you are not going to know what you're doing. So, nobody is perfect and that's fine, but I think it's important to work on your own stuff. So, you know how far you can go with someone. And, I think if you're like a masters student and its part of the programme that you must go for therapy, it would offer more emotional support and personal growth. So, not to just get through the course, but to work on issues that's impacting you. So, I think it's almost like a safeguard…

I only started going to personal therapy this year, which obviously facilitates the unlocking process more and provides emotional support, but in masters at Unisa, as we were doing training… I started to realise things about myself, about my family, patterns … I just thought about it and then I just threw it aside for a while and like saying, 'Okay, I will get to that' … And, then at some point, you have to face it and work through it…
I had one (therapist) and then I didn't like the way she did things. So, after six sessions, then I went to somebody else... for me, that was very daunting and intimidating and I always think that's probably why I took myself in the client role. 'If I went to a therapist, what do I want? Then I walk out of the room, 'What type of person do I want to sit with?'… the previous one has vast knowledge of Object Relations, but for me, she wasn't in the room. And, obviously, that's my own stuff that I need to deal with that. I couldn't deal with just a blank face, or that was extremely anxiety-provoking, and then I moved… where she's also older and got lots of experience. Not as old as the previous one, but she was just chilled. She was herself, she was real with me. She would get in with me like, because I told her in the beginning, "I'm too scared, this is not going to work" And, she was like, "But how do you feel?, Is this working?, You would know by now?" So, it was simple things like that, that I felt a real connection with her and she also shared a little bit of herself. And, if I'm scared about what I'm saying, if that's impacting on her, she would actually answer me in a therapeutic way, not in a social way. Whereas, the previous one wouldn't… and the no-judgment, because the first one I felt very judged for various reasons. And, then with the second one, I didn't feel judged because I felt like she accepts all of her, the good and the bad. And, I can also see that she goes to her own therapist to work on her style. And, so I don't know, it just normalises things for me; that made me feel better (Participant B3).

I guess if you asked that question last year this time, my answer would have been different… I would have said, "No, it's supervision, personal therapy isn't that important". It was only this year when I went through my own personal crisis that

I realised really how important that therapy is outside of-, your work ... and, what you do every day and that, you need that as well to grow in the process. What was interesting is I went to personal therapy for my crises. But in the end, it helped me to become a better therapist, because my therapist helped me to reflect on my own journey as a therapist and what I can work on as well… I would have lost out on my own process in a sense… I think personal therapy just made me aware of that growth and that I am not the same person I were two years ago when I started the programme… then also, maybe, reflecting on different contexts and different situations and just making me realise that every client is an individual. And ja (yes), that helped me to become clearer (Participant A5).

I think you're being silly if you don't go, to be honest! Because, I think I'm so grateful that I went during this whole process, because people say to you in the beginning that it's a really rapid growth process and you change throughout it. And, I know in the beginning, I thought that, 'What are they talking about? I'm not going to change. [laughs] But now, at the end, like I can see I have changed and it's not a bad change, it's like a growth … I found so many jewels and gems through that experience and it's really helped me [laughs] just to like take a meta-perspective of everything because masters is so busy! You have no time to really reflect on things. So, I think to force yourself to take an hour… every two weeks [laughs] just to reflect. I think that's really important (Participant A6)

Being in the masters class and starting to see patients, you do go for supervision, and they do help you client-based… But, they didn't really focus on you emotionally or your well-being, and, "Are you looking after yourself?" and, you know, it is just sort of going along with each patient and not the impact the patients have on you (Participant B4).

I think it should be compulsory… The fact that even if you might not be ready for a very big process right now, to go into some of your very deep stuff or whatever the case may be-because I feel like you have to be ready for that, otherwise… you're going to do therapy till you're blue in the face, but if that person is not

ready for therapy they're not going to make any shifts-… But, I think that it should be compulsory in the sense that it gives you a model on which to counsel. Often, if you've been in therapy yourself… you know what irritates you as a client, you know what works for you, you know what doesn't work for you.… and you're able to learn off that vicariously almost.
… he taught me a lot, because I'd often bring my own experiences with supervision, my experiences with clients, and then he would help me with my stuff through that… how I felt, "Why did the supervision hurt me like that?" or whatever. That was a nice process. But, it also helped me in the sense that like I know exactly what not to do because it really got under my… skin,… he would check the clock four or five times during the session, and I would be very cognisant of it… your client notices, I noticed every single time he did it. And, it kind of made me feel like well, 'Are you bored?', or '… do you have somewhere else to be?'… so it interferes with the connection… I know not to do that… I often used to complain about him talking so much, he used to talk, like almost lecturing, so much and then I made a slip the one time to a friend, I was like "Ja (Yes) my lecturer said this…", and it was actually like, "I mean my therapist". So, I was like, 'Wow! That's obviously how I feel about it'… I learnt not to do that too because… finding that balance of when to talk and when not to talk and just sometimes listen and be silent… But, l learnt also how to… what worked for me so the opening up of the therapy session, "What was that about?", or "How have things been going?"… A kind of model thing (Participant B5).

I learn a lot from other people. So, I see what other people are doing and I'm like, 'Okay, note to self: don't do that!' or 'Note to self: yes, incorporate that for yourself' (Participant A3).

I was forced to, well; it was a course requirement to have therapy for two years, and which I would also not have chosen for myself… thinking back on that I can't help but laugh and think, 'Well, it's really good that it worked out like that'…. you can't really give an opinion on whether one needs to go for therapy or not if you have not been in your own process. So, you can't be judgmental of something

or against something, or not see the use of something if you have not experienced the usefulness of it.

… if I've never had it I would have said, "Why, it's not necessary, you're never going to be the client… you are working with the client, you are the therapist so it's not necessary to have it." But, having had the experience I see the absolute value. And, for me there's no way that you can truly be a therapist without that experience because being a therapist is so much about empathy and about the connection with the patient and the acceptance and the understanding of the patient instead of apologising, or being in the doctor role…

I experienced it as very positive, not initially, not the first six months… very, very difficult to be in therapy myself, which perhaps goes to highlight some of my own prejudices… but, after I completed, I've completed four years of weekly therapy all in all… It's been so beneficial (Participant C2).

Participant C2 confessed that she felt forced to go to psychotherapy as it was a mandatory requirement of her university course and initially found it a very difficult experience. However, over an extensive period of time, including self-chosen time in psychotherapy, she reaped numerous benefits, which initially were not apparent.

Firstly, I think it's so important because it's experiential learning…you learn how to be a therapist by experiencing a therapist- that is what I really felt… I would not have been the same therapist as I am today without that experience, I hope it makes me a better therapist, I think it does … (Secondly) having much more empathy with the client, … being able to put myself in their shoes because I've been there, I have had more therapy than any of the clients that I have seen so far. So, I've been in there… So, it's really improved my empathy… and therapeutic alliance… thirdly, having the corrective emotional experience, experiencing how powerful therapy is and how healing therapy can be and how useful and good and transformative therapy can be. I only know that, I believe in it and I can have confidence in therapy because I've experienced… the healing effect in my own life… these three things I feel I really only got in personal therapy… learning my theory and understanding theory by living it and by experiencing it and by understanding it (Participant C2).

> *There's also value in going for therapy. Because for me, therapy and consulting with another therapist does not only benefit me on a personal level in terms of the problems that I'm experiencing it also adds more to my reservoir of skills. Because when you go for therapy, you also learn as a therapist, you also benefit as a client… So therapy, it's a very funny kind of animal* (Participant E3).

Participant C2, together with other participants (A4, B1, B5, D3, and E3) highlighted that personal psychotherapy during masters training benefits the trainee professionally as it provides a unique individualised context for experiential learning of what a psychotherapist in a real-life context does. Secondly, by being a client her empathy for clients helps her to really know how difficult it is to engage in a psychotherapeutic process. Thirdly, by personally benefitting from help in relation to her personal experiences she is a product of the transformation that she is now offering to assist clients with. Furthermore, Participant C2 emphasised that these three key learnings can only be obtained from the context of personal psychotherapy itself, and as such cannot be obtained through theoretical training. In a similar vein, senior psychotherapist Participant E5 explained although reading and theoretical knowledge is always vital and an ongoing priority throughout one's career as a psychotherapist, knowledge acquired from books cannot give the psychotherapist the necessary human experience that is required to be an effective psychotherapist for one's clients.

> *I think it should be mandatory. I feel quite strongly about that... Because no book can tell you what therapy is about. But, another person can demonstrate it, working with your psyche. You're not going to learn in a book what you experience in an interpersonal relationship with a therapist. And, I can't see people having the chutzpah to work with people therapeutically if they haven't been through this. They must have sat in the other chair… The human experience, the person-to-person, the inter-mind, being with someone… you can only get from your own therapy. But then, it has to be with a certain kind of therapist. I think it has to be with a psychodynamic therapist… Because someone else won't give you that same experience. The depth, the how to handle a crisis. Uh, you won't get that from someone with a superficial training. I don't believe that* (Participant E5).

> *The therapy that she's done with me is also different from what I've been trained in at… like us speaking through part of myself… because of a lot of what I went through was when I was younger… to experience some - a different approach for myself has been interesting and I learn through that and she also recommends books that I can read, like as a therapist-training as well… So, it's nice to learn different spheres* (Participant A4).

In agreement, participants stated that personal psychotherapy gives more than intellectual knowledge, but offers trainees' self-awareness which is a vital competency in therapeutic work with clients.

> The doctor can no longer evade his own difficulty by treating the difficulties of others: the man who suffers from a running abscess is not fit to perform a surgical operation (Jung, 1933/2001, p. 53).

> The psychotherapist, however, must understand not only the patient; it is equally important he should understand himself. For that reason the *sin qua non* is the analysis of the analyst, what is called the training analysis. The patient's treatment begins with the doctor, so to speak… In the training analysis the doctor must learn to know his own psyche and to take it seriously. If he cannot do that, the patient will not learn either (Jung, 1961/1995, p. 154).

Participants advocated personal psychotherapy as helpful in terms of making psychotherapists aware of what it means to be a client and to know this through one's own experience of being a client. The belief that psychotherapists' effectiveness is linked to having confronted one's own struggles is supported (Larisey, 2012).

Thirty-six-year old neurosurgeon Paul Kalanithi (2016), in his memoir, *When breath becomes air*, as he faced his own imminent death from lung cancer came face-to-face how powerful one feels as the health professional, in contrast to, how vulnerable one feels as the patient. Similarly, Rachel Naomi Remen (1997, 2000) who herself has the chronic condition of Crohn's disease, has dedicated her medical career to aid health professionals to remember the humane aspects of the profession, and to constantly keep the patient's point of view uppermost in their minds when treating patients who are in pain and distress.

Larisey (2012) states, “the most skillful clinician, rather than being a strong and capable model of good health, is one who has suffered from all sorts of illnesses and is being transformed by those agonies” (p. 12). In the current study, participants felt that in order to be a genuine and effective psychotherapist one needs to demonstrate an ongoing willingness to confront one’s own “demons”, pain, struggles, and conflict in order to foster self-understanding which in turn can then benefit one in helping the patient develop their own insights.

Participants (B1, B4, B6, C1, C3, C6, D1, D3, E1, and E5), specifically, voiced that personal psychotherapy develops the capacity of trainee psychotherapists to genuinely empathise with their clients and to what it means to sit in the client’s disclosing, vulnerable position and how difficult it is to make changes in one’s life.

> *I think that’s definitely something that is beneficial in a sense that it sort of gives you the behind-the-scenes of what really happens in a client’s position when they are sitting across the seat, and you get to experience it. Before being a Chief, a leader, you always have to be an Indian first, a follower* (Participant A7).

> *How can you have empathy for someone in therapy if you don’t know what it’s like to be in the other chair? I mean that’s absurd in a way. You need to know what it’s like… to have the other person asking the tough questions. To be there sharing intimate details of your life with what is essentially a stranger. You need to have that experience because you can’t have empathy without it… Aside from all the growth and everything you get from therapy, even with that aside- just pure empathy perspective… you need to know how that person sitting across from you is feeling. Did you feel nervous the first time? Did you feel uncomfortable sharing things?... if you know that, then you might have a little bit of insight into how they might be feeling. And, I think it’s easy for us because you go through masters and you get so used to sharing all this personal stuff that you forget what it’s like to have someone sit down and ask you, “Okay, tell me why you’re here?”* (Participant B1).

> *I am a firm believer in therapy for a therapist. I don’t know if I would have made it without my own therapy and the things I have learned. I think the most valuable*

thing when I started with therapy I said, "You will never ever, ever know the anxiety the client sits with and comes in with and experiences… when you haven't been on the other side"…-I think lifelong supervision is needed-. I don't know, I am still in my therapy process now and I will stop it when I feel, 'I am fine now'. But, I think at least you have got to have one intense, in-depth, long therapy process…
it has guided me a lot… picking up little things and how I would often reflect on what goes on, during-, in the week… something my therapist said and the words she used … this year I have realised, we often see so many clients… 'They are not even thinking what I have said and you know'. But, I carry that one therapy session with me through the whole week and reflect on it the whole week. So, I must be more careful with my words… being very respectful to the way I go about it (Participant B4).

I feel, as a new therapist, you know, going into this profession, that it would be good to work through some of those things, and just have someone listening to your difficulties… again I think will help with the blind-spots… which clients or patients presses buttons of yours. What reaction they have on you. So, I would've just definitely wanted to have started therapy last year already… Beginning of this year, I must say, it was a very frightening experience for me. I sat that there feeling like,'This person who knows everything that is going on through my head. They read so much into things'… It like really annoyed me and it was really difficult sitting for those 50 minutes or an hour, you know, in the therapy, and just listening to all these yucky things.
And, then I realised, if I am feeling this way, every single client or patient that walks through my door, will feel the exact same way. They don't want to be here. They don't want to hear what you have to say. It is not nice. So, that was quite good for me in the beginning of the year, just to put myself in their shoes and to, you know, to be on the other side of the chair and know, this is what it feels like. And, that also breaks that one-upmanship of, 'I know everything. And, I've got so much years of theory, I am going to teach you'. That broke that for me.

I would recommend therapy for every new therapist going into it, because… so much therapy happens outside of the therapy room. Like you would hate sitting in that session for your 50 minutes, and you would go home:… You reflect at night or wherever, and you start making links and you start gaining insight and changing certain behaviours… I think if you've done certain habits for so many years of your life, you can't fix it within a month or so... I suggest one long-term therapy and then just like, going for touch-up sessions (Participant B6).

I wish I could have more therapy… I think it really puts you in the position of your clients, and that's a thing I usually share with my clients right from the beginning because they arrive… They are nervous and then I share a bit of myself and I say to them when I took about six months to pick up the phone to book my session for the therapy because I felt anxious, because you are going into something you aren't expecting… you don't know what's going to come out of therapy... It gives you some idea of what your clients might be feeling… my own therapy was helpful in terms of that. But, I was in training and probably anxious because you are in training. So, I think it would be even more helpful now when my anxiety levels are lower and I feel more competent in being a therapist or comfortable in being a therapist. So more open to exploring issues… I think it can really develop you.… (Participant C6).

The experience of being a client also highlights how natural defence mechanisms or resistance (D1) is for all individuals when trying to ward off unbearable pain. Without experiencing psychotherapy from the 'inside out', psychotherapists are at risk for under-estimating how difficult psychotherapy is for human beings that are in distress or cut-off from their psychological landscape to taking a risk to be exposed to another person.

In the beginning, I actually did not take the client's experience into consideration at all. And, then when I was put into that position, it changes everything because it's a perspective issue. So, when I was on the other side of things, it opened up a world for me where I started to see things differently, and when I would think, 'Oh well, if I was my own therapist, if I was the patient going to (B3) and she said this, and she was like that'. And, then I would think back about things I've said to

people that maybe they weren't ready for or it was too harsh or the way I come across as maybe judgmental, or 'She thinks she's better than me'… it was very telling about yourself as a therapist.

… it made me much more empathetic towards their experience and I realised how difficult it is to share horrible stuff about yourself. And that, nobody can teach you. That you have to experience. You can read up about it as much as you would like to, but I can't imagine somebody being a therapist but they've never been to therapy. In my mind, it just doesn't make sense (Participant B3).

I felt vulnerable… I also felt resistant towards the therapist. So, it makes you much more aware that these things can happen. You can't prevent it… I didn't want to expose that as I'm a very private person. So, I could relate to that in a client (Participant D1).

Yalom (2001) speaks about the psychotherapist having many patients, but the patient having only one psychotherapist and thus the psychotherapist looms very large in the life of the patient. This lived truth of being a patient helps the psychotherapist to be acutely aware of what it means for the individual to be in the therapeutic relationship as a patient. To, in a sense, enable the psychotherapist not to underestimate what it means for an individual to go to psychotherapy and adopt the patient role, but rather to always keep in the forefront of their mind 'the other side', the vantage point of the patient, which is often imbued with fragility, vulnerability, dependency, distrust, futility, hopelessness, idealisation, Eros, and uncertainty. And, a whole myriad of emotions and thoughts.

Student psychologist, Participant A1 found that her *"obligatory"* personal psychotherapy during training has been *"a great experience"* and *"very valuable"*. She believed that it is *"essential"* for young psychotherapists.

I must have been able to face my own demons in order to help someone else face theirs. And, I believe that is the foundation of any therapy. If you as a therapist cannot sit with your own stuff, then you cannot possibly take a client there. And, we all will have new stuff that arises. It's not like you sort it out once and for all. I will have to go there again, but I think it's taking the courage to go… being vulnerable in the space where vulnerability is not necessarily allowed and being

able to be true to myself and being able to face shame that I've dealt with, and this is a very big theme in my masters… I cannot imagine being a therapist and not knowing what it feels like to be a client. In fact, I don't know how you do that, point blank (Participant A2).

I had a year-long process with somebody... Where we worked through quite a bit of stuff, but I don't feel like I even scratched the surface of it yet. But, he did make me see things in a (very) different light… (Participant B5).

I think personal psychotherapy, in some form or another, is essential for the simple reason that one needs to get feedback and interact with a person who is not a family member or a trainer preferably or whatever. To sharpen that self-reflective capacity. It's also important to feel what it feels like to be on the other side of the desk. Just the experience, being under scrutiny, you know, being observed, and observing the therapist. What kind of therapist or you know, that depends (Participant E1).

I definitely think people should go… There is always stuff that you need to work on… I don't believe in the person that has ever (been) cured or analysed. But, beyond that…it's nice to feel that closeness… except this time it's on the opposite end. So, I am not the one controlling the closeness, I am actually the one in the seat…
I am going back into therapy now. And, if I had to tell you what I look forward to is not what is gonna be explored, but it's the feeling that I get in moments in that room that are quite transformational for me… I am not going back to talk about X, Y, and Z in my life. Of course, I will be talking about things, but the thing that I enjoy is the feeling of being with someone else in the room. And, it's not always a good feeling, it's not always painful. It can be uncomfortable, but it's the awareness that comes with that feeling, that you have done something to get to this feeling (Participant C3).

Early career psychotherapist, Participant C3 reflected on his previous experiences of being in personal psychotherapy which occurred prior, during and after training. Uniquely, he

highlighted that the closeness provided for the client is key and has led to transformation for himself. Self-awareness from expression of feelings was deemed a key highlight of the benefit of personal psychotherapy. Early career psychotherapists (C1, and C2) spoke about the personal transformation they experienced undergoing personal psychotherapy. Participants highlighted that personal psychotherapy offered psychotherapists a context to express, explore and gain a fine-grained understanding of emotions, and how to work with emotion.

> *I think those moments you try and recreate in your therapy with your own patients… but not what you have learned about yourself necessarily, it's what you have- experienced it yourself… So, when you experience something with your therapist and it's-, and any feeling has like ten different qualities to it, you will know. Firstly, you will be comfortable feeling those feelings in relation to your patient… and also to honour them in your patient… it's an unsaid thing, if your patient experiences something in the room. Let's say your patient is very sad and there is a silence, you are able to sit with that, because of what you have been through, not necessarily in your own personal therapy, but, you can honour that kind of space... It's not a head knowledge, it's an awareness knowledge* (Participant C3).

> *I kind of feel it's arrogant to not go… Kind of- "Who do you think you are that you can help others in this thing that you say works so well, but then you can't be bothered to do any self-reflection and maintenance?" Even if you have done all the work, I think there still needs to be some level of maintenance… "You expect your patients to show up every week… you expect them to work hard; why would you think that you could just go home and not work on you? You are your school. You need to be able to get in touch with what is going on"… I think that going to therapy while being a therapist – [laughs] really makes you self-aware. Maybe, it's not as regular as it would be at the beginning… But it's always some place you can touch base…*
>
> *'How can I sit here and expect people to be vulnerable when I ward that off?' And, I can't do it… So, when they ask me do I go to therapy, I say "Yes." It's not a lie… I think it is helpful for them, and we will talk about whether they find that*

helpful to know… maybe, once every six months somebody will ask me if I go to therapy… I will say, "Yes". And, I think that allows us to talk on a more even-playing field than – 'No, you are the sick one. I don't go to therapy. I am fine – I am the healer' which for me feels really arrogant [laughs]. Because, I don't think any of us are healed (Participant C4).

4.9.2. Personal Psychotherapy as a Recommendation During Training.

Participant C2 and C5 highlighted the ethics of psychotherapists having been in their own psychotherapy conveys credibility of what the psychotherapist is offering, in that the psychotherapist conveys a belief in its efficacy. As a participant-observer, being in psychotherapy provided participants the opportunity to see and feel psychotherapy which is usually confined to a confidential space. As such the profession does not allow individuals to observe client work in real time, the closest is through one-way mirror work which does not necessarily convey the internal impact of the process or what it means to be the client.

Internationally, 10-15% of trainees who attended personal psychotherapy report negative outcomes (Orlinsky et al., 2005; Williams, 1999).

I think the personal therapy, I've had has been pretty awful… I don't feel it's helping much. And, I don't know if it's because I've accessed that therapy in times in my life where I haven't really been ready for it? So, I've had probably three or four very short processes. Most of them I would say quite supportive in a way. One was literally one session and it was a guy who did Neuro-Linguistic Programming and after that session, I should have supposedly felt that everything just changed. It didn't. I feel very disillusioned. I feel very much like it's incredibly difficult to find a good therapist. And so, while I feel that it would be hugely beneficial for all therapists to be in their own personal therapeutic process, I feel like, 'How the hell do you find a good therapist?' [chuckles] (Participant B7).

When discussing their personal experiences of psychotherapy, participants relayed that their experiences as a client also taught them how they personally would *not* conduct psychotherapy (Geller, 2013), namely, extensive self-disclosure on the part of the psychotherapist (A1), a very confrontational style (B1), adopting a classical Freudian 'blank slate' approach (B3), being perceived as judgmental (B3), continuously glancing at the clock

(B5, and D3), or yawning in a client's session (A3). In a sense, being on the receiving end of psychotherapy as a client can sensitise and shape a nuanced style of how each psychotherapist internalises their training. As such personal psychotherapy allows each psychotherapist to see what works for them and to think carefully what interpersonal dynamics, techniques or skills fit with them or makes sense to them as individuals when in the therapeutic endeavour (Rake & Paley, 2009). Regular personal psychotherapy inculcates in psychotherapists the need to constantly consider and sensitively adjust the therapeutic process in light of working out the perspective of the client moment-by-moment.

> *The thing that I have been reflecting on recently is about identifying when something comes up in the room – 'Is it yours? Or is it theirs?' And, because I have a better sense by going to weekly therapy, of what is mine, I'm sometimes struck with the same thing can come up with somebody else. And, it helps me have more empathy for them because I can feel it... Before I make a reflection… it slows me down… it allows me to have greater empathy because it's maybe something that I have been trying to bring up in my therapy… I have often heard my therapist's voice in my head, when I am trying to make a reflection of something that's similar, and I have had to say, 'Is that her voice for me or is that something that's helpful and I am thinking about it because it's helpful for them?"… better thinking space for my patient and for me… So, even in therapy… I can sometimes have an 'Aha' moment about something of my own life. And, be aware enough to know that, 'That's mine and not theirs'… Even if its silent engagement with what is going on in the room…* (Participant C4).

Participants, who worked psychoanalytically, specifically voiced that their personal psychotherapy helped them to believe in unconscious processes at work, work with the transference and countertransference in their client work as they could see through their own personal psychotherapy how valid these psychoanalytic concepts were (A1, A2, C4, D1, D3, and E2).

> *To become aware of transference and countertransference… to learn more in-depth… It's harder to pick things that might not (have been) in my experience within therapy. But, those things that I have experienced I can usually pick up* (Participant D1).

I do think as a therapist there is so much emotion, transference and countertransference that is important to unpack… it helps me to sit with a client, and really realise, 'Am I bringing something that should not necessarily be part of this process or topic? Are they setting off things in me? Or is it really the client in their own process and development?'… I know a lot of the courses, you know, like our masters programme and my future internship make it obligatory… You need your own space… - and differs from supervision-…be yourself, do depth work, reflect, sit with your own losses, your own difficulties in your life… (Participant A1).

Then also I have learnt a lot about being in therapy from my therapist to become a therapist, and the way that she works in transference and countertransference, I could see it in a room, I could almost learn from it by me being the client because 'Where else would I have seen that?' … you can watch glorious videos on YouTube as much as you like [chuckles], but it's not the same as being in your own therapy… I learnt way more in my own therapy… how to phrase things, when to make an interpretation that I would never have learnt anywhere else. I would not have learnt it. And, I will never be able to thank my therapist enough (Participant A2).

Participants (A1, C1, and C4) felt that personal psychotherapy offered a safeguard against contaminating clients' concerns with one's own personal concerns. Personal psychotherapy provided a space for the psychotherapist to sift through what aspects belonged to their clients' struggles and what actually was a personal concern or a blind spot of their own (B1, B4, C1, and C4). The metaphor of the psychotherapist having blind spots that need to be acknowledged and effectively dealt with is strongly supported by Benedek (1953) and Kernberg (1963). Kernberg advocates that psychotherapists need to vigilant in terms of their countertransference in order to make sense of the emotional impact of their unconscious blind spots. Benedek found that personal psychotherapy of the psychotherapist lessens the likelihood of the psychotherapist's blind spots from negatively impacting clients' psychotherapy.

The main reason is that the therapist usually understands what you have gone through because they've been through the similar process…

Secondly, to support your family as well. The moment you go through a process like these feedbacks or the unpacking of your life, it's actually not fair to dump all of that on your family because they are also confused, and they are also completely taken aback by how insane this process is [chuckles]. So, you need therapy to dilute some of your emotions before you bring it to your family… they should also be supported knowing that you are supported externally…

(Participant A2).

Participants (A2, and B2) also indicated how their personal psychotherapists assisted them in managing the arduousness of the training process and helping them to reflect upon and take hold of their burgeoning professional identity.

I constantly felt like I was not good enough for this position… they (lecturers) kind of roast you and throw you (out in) the cold and throughout that process, I constantly felt like, 'Why did I put myself through this? Why am I doing this to myself?'… 'Maybe, I shouldn't have been here?' And, through a lot of therapy, I went at least three times a month… I realised that I am good enough for this position. And in fact, I'm actually perfectly cut out to help people… But, it was a very long road to reach to that place [chuckles] (Participant A2).

4.9.3. The Wisdom of the Group Psychotherapy.

Prior to entering training, Participant A1 relayed that she had attended group psychotherapy which she continues to draw upon in her work with clients.

We worked through so much and after six years the group's work was done. There was almost nothing more and people then moved on… seeing the beginnings of groups, the middle, the storms of groups and then the endings, you know, and the termination cycle of groups was.. quite a wonderful process to be part of… I think I do keep it in the back of my mind in terms of group work… And, life cycles of groups and so on, and also the different places people could be in their lives, particularly women -women's psychological health- the challenges (Participant A1).

A therapeutic group acts as a substitute for a person's actual family, as the participant is making sense of their family dynamics and how it impacts them in their lives (Meese, 2005; Satir, Bitter, & Krestensen, 1988; van der Merwe, 2013; Yalom, 1970/2005). In a similar vein, participants reflected that as systemically-trained student psychologists (A10, and B1) they have personally benefitted from a two-year experiential group process which has had the knock-on effect of enhancing the effectiveness of their therapeutic work with clients.

> *At first, I was quite skeptical of group therapy… it was people I have never known before that want me to sit and discuss my personal life with 12 or 13 other people. So, it was very uncomfortable for me… I was very guarded. I was very worried about 'What would you think of me?'… 'You don't know me, I don't know you', 'Can I trust you?'... so, this was in the first year. And, I have gotten feedback on that as well from lecturers, from my exam… 'That I am not being congruent' … In the second year, I started trusting the process a bit more… I have really found the benefit of group when I took the risk. So, when I started becoming vulnerable, when I started putting myself out there. So, it kind of felt like I am standing in the middle of the field just exposed… I was afraid of being judged or being evaluated-, but when they actually, not gave me advice, but provided feedback or similar experiences, it helps me to change my frame… look at the problems differently… and that gave me an idea of what the client feels when you are in therapy.*
>
> *… group has been very important for me, personally as well as a therapist … I think the books are important… theoretical knowledge is important, but I think the experience and applying that is more important for me* (Participant A10).

Participants who worked from a systems orientation, which is the main orientation of two universities in South Africa, spoke of how they personally benefitted from the group psychotherapy that they participated in with their fellow trainees during their masters training at the university. Virginia Satir (Satir, Bitter, & Krestensen, 1988) and Carl Whitaker (Minuchin, Lee, & Simon, 2006) both emphasised the importance of psychotherapists exploring their own self in a group in order to enhance their competence as psychotherapists. The experiential group usually consists of several hours or months of group work, where trainees explore their own behaviour and develop an awareness of their impact upon others as they receive feedback from

their fellow trainees and the group facilitators. Students in group psychotherapy "experience the uncertainty of an ambiguous situation, the fear and anxiety of disclosing personal information and depending on others, and the satisfaction of receiving feedback and developing insight" (Davidson-Arad, Stange, Wilson, & Pinhassi, 2002, pp. 81-82). In the current study, senior psychotherapists (E1, and E3) emphasised how important the group experience of weekly group psychotherapy over four semesters is for trainees in order to receive feedback on how they come across to others and internalise the systemic orientation.

> *One can also do some sort of quasi-therapy of course in a university setting, in group therapy… exchange of emotions and understanding, experiences among peers, if they have a group therapist… There's nothing as potent in terms of feedback as your peers… I mean from me as a professor, they expect feedback and they can take it or leave it, or they might take it seriously because I may fail them. But, a peer has nothing to win or nothing to lose giving you feedback. Of course, they are also coalitions and strategies. But, I think it's very powerful, but it's underutilised. And many, many people in different university contexts do group therapy, but they don't take it seriously because they don't studiously follow a model… you've got to be conscientious about it. Then it works. I had some very good quasi-substitutes for individual therapy* (Participant E1).

> *I think a big one for me was that group therapy… having people be like, "You know, you don't really share anything"… for me that was the biggest turning point, it's not because I didn't share parts of myself, I didn't even acknowledge it myself… it's something I'm still dealing with, is that introspection. I feel like other people think more than I think about themselves… I've been bottling things, just dealing with them by myself. Or also just dismissing them. It's like I'm not good at sitting with anxiety… conflict between me and someone else. So, I'm very quick to just minimise it or dismiss it. Which in some ways is great, because I'm not a very stressed person, but in other ways it's not good, because I'm pushing things away instead of processing them… it made me realise something about myself.*

When we spoke about our families and what is allowed and not allowed in our families… (during) internship, like a workshop… And, that's when I had to confront this idea of sadness; is sadness actually allowed in my family? Which is another big introspective thing which linked to the previous one that people had told me, "We never see you upset". So, I feel like a big turning point to me have been the ones that have made me look inside (Participant B1).

As student psychologists (A5, A6, A7, A8, A9, A10, and B1) who were trained systemically, participants reported that they found the peer feedback in weekly group psychotherapy over two years very helpful to gauge their individual professional and personal growth alongside peers' growth. "With integration of personal attributes and professional training, the individual contextualizes the new identity in a professional community in which the "self as professional" is tested via feedback from others" (Gibson et al., 2014, p. 22).

I feel like they are more on my level as training therapists, and they experienced similar situations that I do. And, it's just helpful to check in with them what their opinion of how would they handle the situation differently: 'What would have they done if they were in my position?'… Checking in with them, 'Where I am at?' and giving each other feedback… over a period of two years… It would be weekly for about two hours… it would include both professional and personal events in our lives… we got chances to give each other feedback where we think the other person as a therapist can grow, and where they do. Or, even if they are doing something right -… even if someone else got feedback it was important for me. I could reflect myself, 'Where I (was) in that feedback. Do I do similar things that they do? How am I as a therapist similar to them or different than them?' (Participant A5).

4.9.4. Personal Psychotherapy *Ad Infinitum*?

Senior psychotherapists (E4, and E5) commented that it can potentially be a different dynamic, initially, when a qualified psychotherapist consults a psychotherapist for psychotherapy (E5) until the the psychotherapist eases into the patient role and allows themselves to bring their vulnerabilities as a human being. And, in tandem, the other psychotherapist eases into helping a fellow human being, without being intimidated that they are assisting a colleague with their personal vulnerabilities.

That is really easy for me. I think it is more uncomfortable for the therapist, realising that he or she deals with an experienced psychologist, but I always make sure that we really define our roles: "I am here as your patient, I don't play clever and I don't question you". Of course, I think there is a bit of that, but I would really claim the space for me as… a patient, when I go for therapy (Participant E4).

They expect a lot. Ja (yes)… - so the first, uh, few sessions, they'd be quite awkward, finding out what they expect, where they are at. But, then it becomes more comfortable and then it's just therapy like anyone else. Then I almost forget that there's a therapist sitting there, ja (yes). It's not really different. It's just the initial phase (Participant E5).

In the current study, participants voiced contrasting ideas around the duration of personal psychotherapy. Participant C5 adopted a questioning stance as to how long would personal psychotherapy be of benefit to the psychotherapist, as such when is the 'working through' of personal psychotherapy sufficient.

Obviously, through training and all your studies, you have to do this and then you have to do that and you are directed the whole way, you don't really have much choice. Then when that ends, it is kind of like, 'Okay, now what?' Although, I knew that, 'Okay it is important: supervision and to attend this and to attend that'… you can go into many different directions…. 'Yes, it is beneficial in the sense that certain patterns of characteristics, you become more aware of those, and times where you were very stressed you still have that space where you have your therapy'. But, other times I think, it becomes this thing, 'Do I need to be in therapy forever, and why? And, if not, then what does that mean?' So, it also creates that other sort of questions around it (Participant C5- UJ).

Participants who attended personal psychotherapy advocated leaving an open-door policy towards returning to personal psychotherapy at different stages of their life (A1, A3, A6, B3, B6, C2, C3, C6, C7, D3, and E4) as growth is ongoing (A3). Personal psychotherapy is utilised by psychotherapists to address personal material and also offers an avenue to express creativity, spontaneity, and imagination (Wilkins, 1997). However, it is also important for psychotherapists to not overdo their introspection yet rather also "get on living with your life" (p. 11).

I realised how important it was to go in-depth for my own life, in my own therapy, if I was going to sit and do that with client… I understand there might be breaks in it, here and there, when one wraps up a process or a particular issue and it will probably reemerge (Participant A1).

For me therapy has been very beneficial… I don't think I can ever have enough, like too much therapy. [laughs]… I think I'll always be in therapy at different stages of my life… (Participant A6).

I think it's important for all therapists to go to therapy… probably, not forever. So, you go for a while then you stop, and then you go for a while, then you stop. I don't know if you can be in therapy for 80 years [chuckles] (Participant B3).

I don't necessarily think you need to be in your own therapy for ever and ever, amen. Or, for it to be a continuous lifelong process, but I do think there needs to be a period or several periods in your training at least– especially early on in your career… because it can be a very stressful profession, and a lot happens in therapy (Participant C7).

I think it is important to have psychotherapy… but, I don't think it is necessary to be in therapy forever. I think you need to be aware of your own psychological processes and needs and then as any normal patient, other patients, you should ask for therapy and then go for therapy. I remember vividly after the loss of my parents, I lost them in two years' time. Then I went… Not so much for the loss of parents, they were not young anymore. But for closure in terms of my own family dynamics… I realised that, uh, 'I'm stuck, I'm becoming depressed now and I have-, all of a sudden, I'm irritated and frustrated, and there's like a lot of anger inside me. I realised but this is not normal mourning.... I need to do something about this'
… go to different therapists [chuckles]… That helps … Remember, where I am now in terms of your network, you know who's good at what. So, you would say, 'I need it to the point, or I need somebody that understands family dynamics. I

don't want to go for 30 sessions. I need to work through this and I will have two months to work through this' (Participant E4).

I think that all psychotherapists should be in therapy indefinitely. I believe that we are ever-growing… we are always evolving,… finding out new things and I think that that's something that should always be taken to therapy… it might come to a stagnation in therapy at some point and then take a sabbatical for a month or so. But, I think that after that, you should go back… I think that we should always be in therapy, no matter what. And, supervision, both (Participant A3).

Participant D1 also spoke about the *"tremendous growth"* that can happen after termination of a psychotherapeutic process in that psychotherapy is a *"continuation"*. The process continues. For example, after her psychotherapy she recalled her psychotherapist's voice.

Orlinsky et al. (2005) and Bike et al. (2009) have found that psychotherapists across the world report a number of benefits of psychotherapists attending their own psychotherapy. Reasons for the necessity of personal psychotherapy for psychotherapists include the benefit of enhanced sensitivity and awareness. Participants in the current study highlighted that being in the patient role themselves increased their empathy for clients.

'Psychologists can talk the talk in therapy.' And, I was looking for somebody who could challenge me enough to look past all the psychobabble and me intellectualising my own situations… I think that could be a challenge for therapists finding their own therapist… I actually Googled her (Participant C7).

In sum, Participant B1 highlighted that personal psychotherapy alerts psychotherapists to their blind spots. As such personal psychotherapy contributed to improved mastery of technique or the psychotherapist's way of being with clients.

Similarly, Farrell (1996) found that personal psychotherapy assisted psychotherapists to understand the position of the client and this experience reduced the blind spots of the psychotherapist and decreased the likelihood of unethical behaviour on the part of psychotherapists. In stark contrast, Masson (1992) contends that personal psychotherapy for psychotherapists is unsubstantiated indoctrination. Within the current study, no individual psychotherapy was reported by two participants (A9, and A10). However, no participants, in the

current study, held the view that that personal psychotherapy was unnecessary and merely a classical psychoanalytic relic.

Personal psychotherapy also has the added advantage of alleviating some of the emotional strain (A1, A7, A10, B3, and C7), or overload of the profession for psychotherapists (Norcross, Strausser-Kirtland, & Missar 1988). Research is divided as to whether personal psychotherapy of psychotherapists effectively addresses personal symptomatology or psychopathology to reassure the profession that qualified professionals are "healthy". Personal psychotherapy at best enhances psychotherapists' emotional well-being which indirectly moderately faciltates the therapeutic process and therapeutic outcome (Beutler, Crago, & Arizmendi, 1986, p. 273).

> *We do tough work, and as a person I need a place to unpack it and to go and speak about also my own feelings. Because of the boundaries in terms of confidentiality, because of perhaps relatives, like husbands, or my friends, they won't ever really quite know the depth of this work or what the quality of emotional work. It's something that we get trained in and it's something that the general public does not always understand… it is not something you can just unpack, you know, with a family member* (Participant A1).

> *It is important for self-care. So, you are dealing with strong emotions, you are dealing with literally people at their worst. Every day! And as much as you would like to think that it doesn't impact on you… It does sit with you and it's going to reach a point where you know, as you tell your client, "You can't bottle it up all the time. You have got to find a way of venting, you have got to find a way of releasing that!"… when I feel emotionally tired, when I feel burned out... I can't empathise with this client. That's when I know that, 'Okay, something's not right'* (Participant A10).

> *I've always pictured it, 'What tows a tow truck?' I've always given it that metaphor when thinking about psychologists going to see another psychologist, that, you also need that big tow truck that tows another tow truck* (Participant A7).

4.10. Supervision as Providing a Bird's Eye-view.

Clinical supervision is regarded as "the signature pedagogy" of the mental health professions (Bernard & Goodyear, 2014, p. 2) and a key feature of development of psychotherapists. Nepo (2007) refers to a metaphor that can in a sense depict supervision: "Consider the *Chien*, the mythic bird of ancient China, an enormously colourful bird that has only one eye and one wing. It was believed that each Chien had to find another in order to see and fly" (p. 120). This bifurcated bird can provide a picture of supervision for it is an opportunity for two practitioners to have a bird's eye view of what is happening with clients and to offer dual vision or co-vision. Without another individual's point of view a psychologist runs a very high-risk of being stuck only in their own frame of reference in helping their clients. This mythical bird also speaks to the supportive context of supervision which enables psychologists to reach newer heights and further destinations with their clients.

> *Supervisors that aren't unsupportive can make or break you in this process… We spent most of the time talking about their stuff and then the feedback I got from them was completely out of the blue! And, that's kind of where I need to find, 'Wait a minute, where is this coming from?' Is this is my stuff?'… It forced me to go and look and then decide "yes" and, "no"… having a supervisor that is burnt out and uncontained is extremely difficult… I would seek external supervision to help me with clients in that case because it was also difficult. We would access the faculty then and say, "We have a problem, we're struggling with supervisors". They would not give the support that we expected* (Participant A2).

From a family psychotherapy perspective, Stinson et al. (2013) outline seven pivots that constitute the supervision system, namely, power, trust, communication, respect, flexibility, creativity, and the self-of-the-supervisee with the self-of-the-supervisor within a relational context. Importantly, Bateson (1972, p. 293) emphasised the importance of trainees "learning how to learn" at the level of meta-messages as opposed to merely accumulating additional knowledge, or trainees merely relying on supervisors dispensing expertise into passive eaglet mouths. Furthermore, Stinton et al. debate whether supervision processes are isomorphic to therapeutic processes, but rather suggest that supervision requires unique models and processes, and a strong systemic lens on the supervisory process to address the developmental needs of supervisees.

Supervision is understood as a complex task. Supervisors according to Lee and Everett (2004) need to hold multiple roles to foster the development of their supervisees such as teacher, social facilitator, monitor and comforter/supporter.

> *It's on different levels. When you work with students, trainees, interns, it's so very basic. It's very directive often. You actually tell them what to do, what not to do; and that falls away when it's a qualified people. You are much more collegial, more on the role of the listener, gentle support, guiding but you're not so much the mentor who is there all the way every step. There's more trust to let them do their thing and share it and just make decisions about it.*
> *It begins more concrete, more specific, more directive… because they're unsure of themselves. You can't just leave them… you have to listen to their cases, you have to see them. And, these days we can, because everybody knows an iPad, everyone can show you what they've been doing… in the beginning phases…*
> *Later on, not so much, no. I still like working for case material, not just theoretical, in the air. "Let's get a case and then from there, we discuss it"… you can't ignore the personal stuff. You can't. That's what you're also working with* (Participant E5).

Student psychologists spoke about their initial experiences of supervision of being in a one-down or dependent position of needing to learn about how to work with clients therapeutically from a more experienced psychotherapist. The supervisors are deemed more knowledgeable and are relied upon for guidance as they are regarded by students as familiar with the terrain. Supervisors explained directly to novice supervisees how to implement therapeutic interventions with clients.

> *I had a positive experience of supervision, I took a one-down position in that I am in training so it was important for me to go to supervision to get extra information or extra skills where I can better myself as a therapist, but that was very imperative for me, the supervision part… my supervisor has been in the profession for a while now, so the experience that they have is a lot more than I have, so I actually saw that I can learn from them…*
> *I think for the next few years… I will still have that position of wanting to learn from my supervisors and other therapists that have been in the field for years… it*

takes a long while…-, I don't think you ever stop growing as a therapist. It's something that goes throughout your profession and your personal life and, especially, starting at the hospital or anywhere that you are going to work as an intern or a Comserv (Community Service) psychologist. I still think that supervision is a very important part of your growth process…
So, certain areas I have noticed myself growing and getting better… I think that's where the supervisor played a big role as well, because I have a tendency to doubt myself often and going to the supervision, they would say to me, "No, you are still fine. You are on track here". I think that is also something that started to shift, trusting myself more in the process (Participant A5).

It was comforting to know from my supervisor that with time you get better at actually being able to take a perspective and being present. Because I felt like… I had reached a block… I think it provides the necessary safety that I need as a therapist… someone you can always go to… if you need to work through whatever it is that's causing the stuckness… But, it also provides you with the necessary feedback on where you can improve and how you can improve. And, you are receiving advice from someone who has experience, who's more knowledgeable,… someone who may relate what the process that they went through to be the psychotherapist that they are now. So, they are able to give you feedback… that's appropriate to where you are as a therapist…
The challenge is, at times, I would feel lost in supervision, because I feel like I'm not the professional yet… there's a reliance on my supervisor. 'But when there isn't a supervisor what is actually left of me to do? Can I actually manoeuvre or conduct therapeutic sessions or, without the supervision?' Or even in terms of formulating where you're stuck… at times that's the major challenge because I, as much as it is a safe space for me, it's also scary that that person can be removed and you won't have that person and learning to acclimatise when you have a supervisor who might have a totally different approach to your old supervisor… it challenges my flexibility on whether I'll be able to be flexible enough to adjust to a new supervisor (Participant A6).

How I monitor myself is… through the supervisor who can then deliver comments in terms of how they see it or how they see some kind of progress or some challenges at times…
The first supervisor I had actually was not very theoretically anchored… I think it's something that I longed for. So, as I went into my second year of masters and I started using a lot of the theory we had learned and applying it to cases, I could bring that to supervision and entice that kind of discussion and then get more value out of it … the application of theory is something that I think has contributed a lot to my development in terms of how I work (Participant A1).

Baird (2014) points out that "the quality of the internship experience is closely related to the quality of supervision received"(p. 4). Supervision offers a context for the psychotherapist to take one's self-doubt, and uncertainity so as to be comforted or reassured about one's clinical work with clients. Supervision provided beginner psychotherapists with skills, ways to overcome blocks with their client work, and a sense of safety. In the training context, supervision provides protection for the fledging psychotherapist. However, the supervision context also is known for criticism.

We were a strong group and we supervised each other. So, it was peer supervision… very, very helpful, very important… One can't do it on your own. It's too much stress, too much doubt, too much-, you need the sharing. You need the input from another point of view. It's very supportive mainly… listen to their case material, providing my case material, getting other inputs, viewpoints. It's extremely, extremely helpful (Participant E5).

Supervisors and qualified members of the MDT during internship were often seen by trainees as harsh. The supervisor's feedback prompted trainees to engage in self-refection about how they are working with clients.

I had a psychiatrist (in the MDT)… who didn't give psychology much of a voice, he would say, "The patient's psychotic that means psychology you don't need to say anything. You don't have to formulate or anything like that". And, that used to upset me quite a lot… and then I went to speak to a mentor about this, and I was, like, "The psychiatrist is like this, says, 'This person is psychotic, or this

person is you know, this person's delirious' or whatever the case is. Like, is there nothing really we can do?" I became very disillusioned with what psychology is about and if it really works...

And, then I think a very, very valuable lesson came to me… my supervisor at UJ had sent it to me in a farewell email to me, and she said, "Never lose your humanity for the sake of a diagnosis". And, I never knew what that meant until I was actually in that moment, and something told me to go and read that email again, … I saw it now! I just sort of had that realisation that there's a person in front of me, whether or not they've got psychosis or whatever it may be … you need to be real with that person… and that's still making an impact on their lives. So, that sort of made me become a lot more calm in what I'm doing, because I believe that even if I'm not necessarily giving them… a fantastic interpretation, or a fantastic like empathetic response… I'm still sitting with that person for who that person is, and listening to them. So, that's when that shift came, it was round about June, July this year (Participant B5).

Eighteen months into training as a psychologist had created a shift for Participant B5:

Now, I can laugh and smile with my patients… I found myself now at a point where a patient has really confided something in me which they haven't before, and I'm really getting touched by that… show him, tell him straight, "You know, what you just said to me really touched me" or you know, just showing him that realness. There are still parts of me that goes back to the original defensive self where, 'Okay, I'm the therapist I've got to remain with the blank façade'… I'm able now to recognise when that's happening, and explore it… with myself (Participant B5).

The process of supervision is deemed critical to the training of mental health professionals (Barnett et al. 2007; Bhola, Raguram, Dugyala, & Ravishankar, 2017).

I'd use my supervision to the best of my ability so that I could not,-I'll never say because I might have hurt someone in the process in my training- but I didn't want to. So, I've tried to prevent that as much as possible… I'm just the kind of person I don't strive for mediocrity… I want to be the best that I can be… maybe that's just an innate thing (Participant A3).

My very initial experiences in supervision were quite varied… So, you had to forge relationships really quickly… to be quite confident within yourself to be able to get the best out of supervision right from the get-go because you were only going to have three months of it… I think supervision at the beginning stages… forced me to think about what I wanted to say, be sure I wanted to say it and be confident about it. But, then also to be open to ideas… because they all were different, all the time and you constantly had to mould with them and shift with them.
And, it also meant that because you were exposed to so many different types of therapists, you didn't have to agree with all of them. So, then I also had to stand up for my work and I had to stand up for my patients… I didn't just get lulled into a routine with one supervisor – I was constantly challenged, "Why are you doing that with this person?", "Why are you doing that?" And, I had to be able to stand by it. So, that meant in my work had to be very thoughtful, because I knew at some point I was going to be challenged (Participant C4).

I have had quite mixed experiences in supervision… before when I was doing my honours internship… There was one supervisor that was quite, quite authoritative, quite imposing… So, that was a very negative experience for me… I felt very inadequate… It was something that I dreaded… So, the 'teacher-student, you know, the teacher knows what's best. If you don't do it as the teacher does it, you are wrong. You know, you are not learning, 'You are stupid,' essentially'… And so, the next set of supervision… another organisation… that was a lot better for me because I was allowed to bring my own ideas into supervision. So, I felt it was more collaborative… And, that made me feel more adequate, it made me feel like, 'Okay, I am doing something right. Not everything I do is wrong!' …
then I entered into the masters programme and the supervision that I got, firstly from the clinic supervisor, I really, really enjoyed that! It was quite a different experience for me … she viewed me in therapy, so the feedback that I got was based on firstly it was in the moment, and that helped me to pick up where I was

going wrong. So, as soon as I do something wrong, "Okay, you know what? Try this, or watch what you say with this", so that made me more aware of myself… it was very collaborative, I felt like it wasn't somebody telling me what to do, but more, me and this person working together and I really appreciated that (Participant A10).

During my M1, my supervision was mostly frustrating… we had two supervisors… I found that with C, his style was open door, in the sense, that I was allowed to question his thinking. If he said something and I didn't agree with him, it was okay for me to say, "But C, you're seeing it this way, I'm seeing it this way, how about…?" And then with R, it was, 'I'm the supervisor, do as I say, and that's it'… I find that in a place where I am not allowed to express my opinion, I feel very frustrated. And, then so as a result it demoralises me. 'So, you don't always have to accept my opinion, but allow me space to express it, and then your one might be the one that wins in the end. But, at least you know where I stand, and that's all'. So with supervision, that I found to be accepting of my opinion, I found it helpful, even if my opinion at the end is rejected. But, at least give it a listening ear. So the one that crushes me, I feel discouraged and I don't want that (Participant C1).

Look, you do get students who don't accept it, but I place great value on supervision because I realise I have minimum time left. Until, this is completely my problem [chuckles]. I must learn as much as I can (Participant A2).

Supervision is understood best as a collaborative process between a more experienced, skilled supervisor and a trainee who is learning the competencies necessary for becoming a successful psychotherapist (Barnett, 2011). It is a process that involves "observation, evaluation, feedback, the facilitation of knowledge and skills by instruction, modeling, and mutual problem solving" (Falender & Shafranske, 2004, p. 3).

So, the kind of supervision style that I take with them is one that says,"Tell me what you think, I will tell you what I think, and then I will tell you what the policy guideline is about. And, then let's try and meet in the middle". And, then I find

that because of this style, I have very cooperative students… And, that comes from me having been supervised by so different supervisors, 'So this works, this could work better', I build my supervisory style based on what I thought could be beneficial to the person you are supervising… 'Let's make it work' (Participant C1).

The terms 'supervision' and 'consultation' are often used interchangeably to denote the collaborative relationship. However, in some instances 'consultation', 'inter-vision' or 'co-vision' is typically used by qualified professionals who seek out another perspective from a peer or senior colleague, as the power differential is regarded as different to that of being a trainee who has to be supervised, as seeking out supervision is a voluntary developmental activity when qualified (Rousmaniere et al., 2017).

Participants elaborated on a broad range of activities that perform the function of supervision of their clinical work. Importantly, the tasks of supervision were not only met in the traditional format of one-on-one supervision between a younger psychotherapist and a more senior psychotherapist overseeing their work. Participants provided a broad array of options namely, live supervision with a reflecting team, peer supervision, case presentations, and reading groups that met their supervision needs. Alongside input regarding casework, supervision forums offer support and normalisation for psychotherapists.

In the academic year, the coursework year, we had maybe three clients. It was one-on-one supervision with someone at UJ. And, then internship it is one-on-one supervision and peer supervision… I can't remember how often, but, then we will have a case presentation, which I regard as some form of-… I see the value in it… the other is reading groups that are focused on, maybe, bringing a case… getting input from other people, I find that very useful for me (Participant C5).

What I appreciated at Unisa when we did clinic, and we did group supervision, that was quite nice because then you hear other people's impressions of a case,-of a person- and other people's thoughts… almost like peer supervision in a way, but then you have your main supervisor that guides everybody. So, there I've learnt a lot and the focus is on giving feedback for you to grow as a person… if I think about the practicals we did at Family Advocate, and then we went to

Soshanguve (township north of Pretoria)… we would go out and do something, and then immediately in a group, you would have supervision. So, that was really helpful and beneficial (Participant B3).

4.10.1. Blow-by-blow Supervision: Live Supervision via the One-way Mirror.

Then I got live supervision from Andolfi… which is scary… It gives you different levels of complexity. There's the relationship between the therapist and the client which is the one level… There's the relationship, supervisor-therapist-client which is the other level… Then there's the relationship, supervisor-group behind the one-way mirror which is another level of complexity. And, then the therapist comes out, maybe, … so the case is always sort of seen from different levels. And, the relationships are seen from different angles. So, you have binocular vision… psychotherapy is adding complexity to a particularly reductionistic way of looking at things in life. Staying there, you know. So, I don't think it's everybody's cup of tea to do that.

… we suffered a lot later on, when (X) came… we had the telephone, you had the bug in the ear and you have the family or couple talking to you. That is a very schizophrenic experience… You had the voice… The telephone was ringing while the couple was talking, you had your own thoughts… It became complex. I'm not sure a beginner therapist wants to complexify it that much (Participant E1).

Initially, it was nerve-wrecking knowing that there are people behind the mirror who are watching you… it kind of impacts how you interact with your client… And, at times, you can be more aware of what you're doing with your client, as opposed to what is actually happening for your client, and what the overall process of what your client is going through… that was the one thing that took getting used to, knowing that there are people behind the mirror. But, as soon as you reframe that to a more supportive structure and that they are there to assist you, then that alleviates the anxiety about being watched by your team (Participant A6).

I must say it was very nerve-wrecking doing the live therapy in front of everybody! But, it's weird in that I can't see the expressions on their faces as I'm doing therapy and the way they're reacting because it's a one-way mirror. So, that when I show a video, I check other people's expressions and what they think of me… I felt like at Unisa, okay you do it… you get the feedback, but it's almost done in a nice way. So, the person digests for you and I think it's because you're still a student… it was very easy for me to take it and then do something with it. But, sometimes, it can be harsh (Participant B3).

Participants as trainee psychologists were initially self-conscious, very nervous, anxious (A4, A6, B3, and C7), and even frightened (A5) about being observed during client sessions, fearing judgement and criticism from their supervisors and peers (A5, A6, and A10)

There is definitely a difference with live supervision. You have, for instance, in my reflecting team, there was seven or eight other psychologists as well, giving input on what is going on. So, you almost- you are in the therapy session and you don't realise someone else is seeing it from a different view. And then when-, as soon as they give their view, you realise, 'But, this just became more complexed' and you have to integrate that as well… I found it definitely valuable. In that once I got stuck there was other people in the reflecting team that could tell me, "But why don't you take this position, or why don't you try this technique, rather than this?" And, that really helped me to start the process again…

It's frightening in the beginning… not seeing what's going on behind the one-way mirror and at the same time focusing on your client and being present. But, also knowing that people behind the mirror talking about you and the client and discussing the case… it felt in the beginning like judging. But, as the process went on, like I actually saw it as a resource, that they were helping me. So, I didn't see that judging anymore, but more like constructive feedback that they gave me (Participant A5).

There is something very special about watching yourself on tape, and having other people observe you in therapy. I remember my very, very first client… the feedback I got from my supervisor was I fidget. And, I didn't feel myself fidgeting

at that time, but when I watched the recording; I fidgeted a lot… it had a lot to do with being nervous and anxious with my first session on the recorder… So, watching myself; definitely helped me focus more on my non-verbals… Not only the non-verbals and my physical being, but how I speak to clients and how I process things (Participant C7).

In referring to their professional development many participants drew on their experiences of beginning to see clients within the context of university clinics. Trainee psychologists (A4, and A5), as they begin to see an increasing number of clients, start to shift from the need to succeed at declarative knowledge, which up until client work was a priority in order to gain access to a masters programme, to now having to demonstrate their ability to practice psychotherapy to others in view of the reflecting team who are observing (performative knowledge).

What I have noticed that in the first year… the selecting process and all of that, it's a very competitive profession… You have to be constantly fighting almost your way up the ladder. And, then I think sitting there behind the one-way mirror and knowing that other people are looking at you. I think that came into play for me, that we are still competing as a group… as the year went by like- I realised, 'But, we are not competing anymore. It's not about marks. It's about personal growth and personally to become the best therapist that you can be'. And, I really experienced the group as helping me to achieve that (Participant A5).

Even though it was nerve-racking, I got supervision while it was happening... I think it's important because the comments and feedback I got on myself I would not have gotten if no one was watching me [laughs] because they would not have seen the mannerisms that I had and commented on it… it was such a great experience for me because I was finally able to forget about the one-way mirror and just be in the session, – and I did feel like for the first time, very happy in my therapeutic role through that supervision.

… also being able to watch yourself back, because I would often watch myself on the clips where perhaps my supervisor said, "You did this here, and look at how this shifted. And now, go and look at the clip." And, to actually be able to go and

see myself, that was really beneficial as well… I think psychology is – it's such an important field and you can easily mess up someone's life if you don't handle the therapeutic situation properly… So, I think the more supervision you can have, the better and to be observed in that way. I think it's brilliant because… now going into internship, I feel more confident now that I've had the supervision I've had. Because someone has actually watched me and they are happy with how I'm performing, 'So, why should I doubt myself going into internship?' (Participant A4).

There have been instances where the reflecting team picks up something that I haven't picked up. And, that it's quite scary that you'd be sitting with a client and you won't be fully aware of what's happening because you're in there with the client. So, it does help to have a team that can actually see or look at the interaction with you and your client… if you are taking a stance maybe imperfect to your client… then, you can get feedback (Participant A6).

In 1942, Rogers highlighted the value of trainees viewing recordings of their client sessions to improve their effectiveness. "I know of no other way of combining the deepest experiential learning with the most highly abstract cognitive and theoretical learnings" (Rogers, 1980, p. 62).

You are getting live feedback… And, as much as you try to block whatever you are going through, somehow they pick it up… in process… in body language… in transference and countertransference, from the client. And, as soon as they press that buzzer and they ask you, "You know, what is going on? Is everything okay?" You know, after the session when you are writing the process notes, you reflect on the process from yourself …

… it's brilliant, it's in the moment, when they tell me I did this and this wrong, or I did this and this in a different way. It happened literally a few seconds ago or it happened at most an hour ago. And, so it's still fresh in my mind so I can recall what was going on. And, what I also love about the live supervision is that if they buzz me and tell me you know, "You are sitting very close to the husband as opposed to the wife", it's something that I can change in the moment. And, I

> *noticed that when I do that, or when I move my chair or when I become aware that I am aligning too much with the wife, or too much with the husband. As soon as I change that I can see literally in the moment the change that happens with myself and the client… It was very, very powerful… very, very valuable for me, if I wish I could have live supervision [laughing] with every session that I do* (Participant A10).

Haggerty and Hilsenroth (2011) emphasise that trainees need to be directly observed conducting psychotherapy:

> Suppose a loved one has to undergo surgery and you need to choose between two surgeons, one of whom has never been directly observed by an experienced surgeon while performing any surgery. He or she would perform the surgery and return to his or her attending physician and try to recall, sometimes incompletely or inaccurately, the intricate steps of the surgery they just performed. It is hard to imagine that anyone, given a choice, would prefer this over a professional who has been routinely observed in the practice of their craft (p. 193)

Rousmaniere (2017, p. 9) comments that, "our memory is a petri dish of biases, blind spots, ulterior motives, and projections – all totally unconscious- driven by our desires, fears, past experiences, self-image, vanity, shame". In the current study, participants (A4, A6, A10, B3, E1, E4, and E5) emphasised how important voice or video/ipad recordings as well as verbatim transcripts (B5) of sessions were in terms of profoundly improving their own or their supervisees' work with clients. Reviewing recordings with one's individual supervisor or in a reflecting team was seen as particularly helpful and necessary during training as well as solitary self-reviewing of the recordings. Rousmaniere (2017) adds that psychotherapists reviewing their own videotapes of sessions is notably an effortful deliberate practice that reaps much reward. As together with role-plays, actively reviewing videos of one's work with reflective exercises enables "behavioural skill rehearsal" or "simulation-based training" (p. 117).

Importantly, in reviewing videos or thinking about their session work, partcipants spoke of paying attention to their countertransference and resistance (A10, B5, and D3) their own feelings and internal experiences (experiential reflection). For example, supervision of the therapist's experiences of emotional pulls or personal physical sensations in relation to the client during the session as well as pinpointing when and for what purpose during the session the

psychotherapist intervened according to their preferred therapeutic model needs to be undertaken. After all, psychotherapists need to make sense of what was happening within the therapeutic process with their clients. This can be understood as being aware of one's countertransference or more generically as "experiential self-awareness… your thoughts, feelings, bodily sensations, anxieties, hopes, fears" and "experiential avoidance… the urge to avoid uncomfortable experences like anxiety, fear, doubt, sadness, anger, guilt" (Rousimaniere, 2017, p. 126-127). Each psychotherapy needs to be a bespoke process for each psychotherapist-client dyad (Beutler, 1999; Bohart & Wade, 2013; Hill & Knox, 2013; Hilsenroth, 2014).

> *I could access my recordings and actually view how I presented in therapy. And, that was also useful because I would usually take the recordings and watch them at home and just see what am I doing in the therapeutic context… to reflect on how I experience that session, not within the session, but outside. That also helped me kind of monitor, what was happening for myself and my client… it gave me an opportunity at a fair time to just concentrate on what's happening within my therapeutic session… I could also reflect at that time on what was happening for me at that time and maybe what can help. 'Maybe I got bored or something?... what was going on?' to actually conceptualise what was happening for my client and… my own personal growth, 'How I can improve?'* (Participant A6).

> *I think the best way to learn is to watch your own videos of your own. Uh, if that doesn't drive you to either alcohol or suicide, you won't ever be a psychologist… I still do that… make tape recordings of patients with their consent and I would listen to that… just to hear how you say things, the way that you listen to people. Because, of course, I'm still a bit impatient, too impatient… So, I'm very careful that I, for example, don't complete sentences for my patients because, 'Come, come, come… let's get to the point'. So, that is part of my own growth, continuous growth to listen (to) my own… tape recordings of my therapy sessions* (Participant E4).

> *I think it was very incisive… we had to bring tape recordings of our work. - We didn't have videos in those days- we had group supervision… we were normally three… the supervisor would play the recordings, look at your notes, listen to you*

explaining. It was post-session. So, we didn't do any live supervision at that level (Participant E1).

Senior psychotherapist E4, voiced that she still at times voice records sessions with the client's permission so as to enhance their work together, by her self-reviewing sessions. The participants' experiences are in line with the international trend of prioritising deliberate practice to improve expertise. Rousmaniere and Frederickson (2015) have found that to foster therapeutic expertise, supervision or consultations need to be focused upon videotape case review, role-plays to aid skill development, and live one-way-mirror supervision. Baird (2014), Kaslow et al. (2005), McGaghie and Kristopaitis (2015), and Taylor and Neimeyer (2015) recommend psychotherapists actively watch videos of experts doing psychotherapy utilising a specific model in order to improve their own work. Such an exercise emphasises the trainee actively pausing the video prior to each psychotherapist intervention within the session in order to first indicate how they as a psychotherapist would respond to the client before witnessing the expert respond to the client during the session, and then proceeding to reflect on the possible rationale of the expert intervening or responding in that particular way.

Deliberate practice states that psychotherapists' self-report of their therapeutic work with clients is insufficient to foster expertise in psychotherapists, as psychotherapist mistakes are more often than not invisible in psychotherapists' process notes and memory recall. In the current study, participants voiced how nothing was hidden when recorded (A10, and B4). Video recording is regarded as crucial during clinical training (e.g., Bernard & Goodyear, 2014). Psychodynamic psychotherapists have also seen the importance of video recordings to improve training (e.g., Eubanks-Carter, Muran, & Safran, 2015; Haggerty & Hilsenroth, 2011; McCullough, Bhatia, Ulvenes, Berggraf, & Osborn, 2011).

Specifically, Rogers felt that the training of psychotherapists could be improved by conducting "trio empathy labs" (Heppener, Rogers, & Lee, 1984, p. 19). Alternatively, he proposed using videotapes of trainees' client work, or a trainee and an experienced psychotherapist both conducting a client session together. Over nearly two decades ago, a need was expressed by 39.2% of UFS-trained South African psychologists (Viljoen et al., 1999) for more exposure during training in which practical techniques and methods could be mastered and how theory could be applied in practice, which supports the recent American model of deliberate practice (Rousmaniere, 2017).

However, in the current study, reviewing video recordings with a panel of consultant psychologists and peers at the hospital was experienced as unnecessarily hyper-critical at times, even though constructive feedback was also received as voiced by intern psychologists who were presenting or observing the case presentations.

> *You need to show at least 20 minutes of the session… So, you try and like pick out your best bit for the 20 minutes… But, going through it you just realise you watch this 50-minute video, and you like repeat things… you see how you communicate non-verbally and that also can be a shortfall… When I watched it I got so irritated with myself, I was like, 'Why do you keep saying this word?' Or, 'Why do you stop yourself from saying things? Why do you bite your nails?... 'You need to reflect that to the patient or the client sitting in front of you, and saying, 'Well, I am feeling anxious now, what is this about?' And also, 'If I am getting irritated with myself, how must the other person feel?' Oh, you are so confronted with things!… you sit and you are like, 'Oh, is this what I look like?'… small things like the seating arrangements, and like you see everything. Like nothing can be hidden… that really did help, you know, find blindspots* (Participant B4).

> *I think, specifically, feedback from like my supervisor and then when we do these case presentations, we also do psychological ward rounds or the videos especially where I do therapy and then they watch it. Which is horrible! But, you get a lot of feedback… so daunting and exposing and I feel so vulnerable. 'Now, I literally have to do like therapy. So, everything changes when you put the i-Pad or the camera in the room, the video camera, not just for me, but for the person as well, and on top of that, there's a consultant watching and they give you feedback. And, it's not all been horrible. The feedback has been constructive and it's really- it does help, but it's that your experience of it is absolutely horrible.*
> *I've seen other people's videos… I felt so sorry for the intern afterwards because I felt like, 'After a while, it's not a critique of their work anymore, but they're like dissecting the person and they're just hammering!' And, there was times where I felt like standing up and just saying, "Enough! He got it or she understands! You*

don't have to say it a million times". So, maybe, it's the process that just makes it into this ugly monster [chuckles] (Participant B3).

The methods and the manner of providing feedback to trainees need to be carefully thought through by trainers as trainees felt it can become an *"ugly monster"* (B3) wherein trainees are roasted or thrown into the cold (A3) by the panel of lecturers during their oral exams or that presenting videos to a panel of trainees and supervisors during internship can be experienced as unnecessarily *"hammering"* the trainee (B3).

I always expose myself to… some form of feedback. Being trained at Unisa was very difficult on that level because feedback was not granted often. And, I would actively seek it out and I think that was to curb my lack of confidence… So, as much as feedback helps me grow; it was also a symbol of my lacking in confidence and needing reassurance from others. And, over the years; the meaning of feedback has shifted. It's not the lacking of confidence anymore, but checking in every now and again (Participant C7).

Rogers (1980/1995) emphasises that feedback needs to be provided through the lens of empathic understanding of what it means to be the student: "When the teacher has the ability to understand each student's reactions from the inside, has a sensitive awareness of how the process of education and learning seems to *the student*, then, again the likelihood that significant learning will take place is increased" (p. 272).

4.10.2. Trainees' Horrible Experiences of Individual Supervision.

In the beginning years, supervision was horrible! I never felt I got what I wanted which was 'continuing growing' not just criticising my session (Participant E)

It (During internship) was ordinary - (Tertiary Psychiatric Hospital) supervision. It really didn't help me a lot… The specific year or the unfortunate year, the person was a drug addict and she slept more and she didn't do supervision… (Participant E).

Across the spectrum of years as psychologists, participants also reported "*superficial", "terrible*", *"awful"*,*"horrible", "absolutely horrible",* or *"horrid"* experiences of individual supervision during training (A3, B2, B3, B7, D3, D4, E2, and E5). A number of reasons were provided, namely, supervisor impairment, unethical behaviour towards the supervisee (B), intern

supervisees witnessing their supervisors being unethical, or displaying immaturity (B, D, and E), feeling betrayed by the fuzzy boundaries (B), being highly critical (D) or *"nailing"* (B), and being unhelpful in assisting supervisees with their client work (E). Trainees felt that some of their supervisors were completely absent in the room (A), dismissive of serious trauma casework (A), disinterested (A, and B), unempathic (B), burnt out and uncontained (A). In this light, trainees verbalised the need for *"good supervision"* (B). Similarly, Viljoen et al. (1999) reported that UFS-trained psychologists expressed the need for more supervision during training years: 17.9% held the view that their supervision was very good/good, 31.1% rated it as poor/very poor, while 41.0% saw it as average.

Recently, Bhola et al. (2017) reported that 94 clinical psychology trainees across eight training programmes in India had on average three hours of supervision per week. Supervision by 49,9% of trainees was regarded as supportive and useful in providing specific inputs and direct guidance. However, 27% of trainees voiced that supervision was inadequate due to the limited availability and inaccessibility of their supervisors, 23% of trainees reported that the quality of supervision was inadequate, 7% of trainees felt that supervisors had inadequate knowledge and training as supervisors, 19% of trainees voiced experiencing interpersonal difficulties with supervisors and 7% of trainees highlighted supervisors' criticality and lack of appreciation of their efforts. Thus South African trainees and Indian trainees express similar sentiments in relation to the complexity of supervision in contributing to psychologists' development as psychotherapists.

> *I would say the first four months… It was absolutely horrible. It (Internship) takes over everything… I think it depends on the type of person who is your supervisor, if they are interested in supervising you or not… in the beginning, I feel like because, 'You are here as refined as supervisors'… She didn't want to, and then when we did have supervision, which once in a blue moon, it wasn't supervision. She would be on her phone or Facebook or speak about her dog. And for me, I probably should have said something, but I just felt like I'm entering into the workplace, I'm an intern, I don't have a leg to stand on…*
> *my experiences then have changed because the person (different intern supervisor) was actually interested in my growth as a therapist and giving me feedback where I can grow. Like what am I doing right, what am I doing wrong,*

and they'd take an hour. And, they're there for you and they want to talk about a case and they want to hear your difficulty. So, I would definitely put that high up in the list, there must be a match between the two people (Participant B).

Supervisors, warns Jacobs (1991), may use their evaluation power in order to meet their own self-esteem needs which disadvantages the supervisee. Supervisors may attempt to bolster their own competence by relating to their supervisees in a rigid one-down position (Pinderhughes, 1989). Of concern is when this interactional style is replicated by the supervisee in relation to their clients, in a parallel process, whereby the supervisee-psychotherapist models their supervisor's way of relating towards them.

4.10.3. A Very Fine Line: Supervision or 'Personal Psychotherapy' of Supervisees.

Very quickly, it became very personal. I think even the first supervision session, I walked out crying. It felt as if the supervisor felt, … 'That the quicker they get to the core of your conflicts or your issues, the quicker they make you feel vulnerable, the better they feel as a supervisor', and so quickly, that supervision moved into a very therapeutic more than supervisory space. At the time, I was working in the firm that deals with personality disorders, which I think already also made me vulnerable because it's something that I've always been grappling with… working through those dynamics. So, it wasn't an easy experience. It was a very good experience, but I was under a lot of stress, emotionally, psychologically. And, supervision now was just therapeutic…

So, at some point, I progressively just started to… feeling like I'm no longer at grips with myself at all and, 'I'm completely losing the plot'. And, I did lose the plot, and I went one night and I used crystal meth. It was a once-off thing. It seems incredibly extreme because it's like going from zero to hero in terms of substance use... I now had this safe supervisor slash therapy space that I felt I needed to take to. I didn't go to work the next day because I knew I couldn't see anyone… I contacted the supervisor. I said, "This is what's happened. I am scared that in the process that I shared a needle. I need to get onto ARV's. I'm bringing this to you, because I feel safe to bring this to you and I need to handle this in the most responsible way possible. I didn't see patients in that state"… It felt like my life had fallen apart. It felt it was something that I could really easily

not have shared with my supervisor and no one would have known any different! But, for me it was a brilliant illustration of the danger of blurring supervision and therapy, of creating the illusion of an incredibly safe and holding space which I don't think it was that (Participant B).

When I qualified as a registered counsellor, I went to supervision and my supervision kind of overlapped in personal therapy, which blurred the role for me a little bit… I learnt from that and I'm like, 'Okay, that's not how it's supposed to be' (Participant A).

Luckily, with my own therapist, sometimes I would talk about the fact that I'm struggling with a client… she would not give supervision, but we will dilute emotions and feelings that I have in this process. It helped a lot. So, that's why therapy is so important because it's like a net underneath this whole process, that if you don't get the support in that space, then at least you have something to fall back on. And, I feel that the therapy is something I will access for the rest of my life…

We had a lot of supervision… different supervision for every practical… and lecturers would sometimes take on a supervising role where, "Are you guys, okay?" Phew, those things were difficult for me because my one lecturer would say, "Let's check in" and then everybody would start crying and freaking out… that was also difficult, but it also created a space where sometimes you just need a good sulk (Participant A2).

Participants (B1, C2, D3, and D4) in the current study related how closely supervision and personal psychotherapy can look, especially when the countertransference of the supervisee towards their patients is extensively analysed and prioritised in supervision.

I used to start a supervising relationship where I say to the supervisor please can we discuss what your boundaries are in terms of supervision, topics you like to discuss and I'd like to discuss. I opened the floor on a very open, straightforward position so that we knew where we stood with one another. Some supervisors don't like bringing in other experiences. They just want to talk about clients.

Other supervisors feel, "No, let's talk about all the experiences and bring them together" (Participant A2).

My experience of supervision has been positive for the most part. The type of supervision that I like is when you can discuss your patients that you're seeing and the impact that they have on you. But, then also into why they have that impact on you. So, be able to go into the deeper stuff, "Okay, so that had this effect on you! Where do you think that comes from? What is it about you that reacts so badly to this?", or "What do you think it is that made you feel that way? Why do you think you felt that way?" So, almost like a therapy scenario in a kind of way, but it's based around the addressing part of yourself, that you need to address in order to be an effective therapist… you can't expect a client to share everything without being the type of person who is willing to share as well. You have to be comfortable going into your own stuff as well… that something is going to have an impact in therapy. Because, 'Why are you afraid to go there? Is it part of yourself that you are not acknowledging?' That's a scary thought. …with you being the tool, like you need to know, if you've got like a wonky handle… a loose screw somewhere… not that you have to fix it, but you have to know it's there because you have to know how to work with it… I feel like when I don't have a supervisor any more I will have to go and see a therapist, because I think it's important (Participant B1).

Additionally, Participant E5 voiced that lines between personal psychotherapy and clinical supervision cannot be easily drawn as supervisors need to monitor the effectiveness of their supervisees in light of their mental well-being.

Hmm, it's tricky. Those boundaries are very tricky because if a supervisee has a bit of a breakdown, gets very depressed, I have to point that out, I have to work with it. And, then personal stuff comes into it and we give it a name. We say, "Today is more like therapy" and then we carry on with supervision. If it's more than today or two, three times, then of course, the person has to go into personal therapy. But, one can't just divide the two like this in a terribly exact, rigid way. The one will flow into the other because you're working with a human being. And, therapists get very depressed, therapists get very anxious. I understand it because

I've been there. So, I can hopefully take some of the weight off there (Participant E5).

It takes a very special type of supervisor to be able to balance both the raw emotional impact of the therapies that you were doing with your patients on you, with also the particular case in front of you and all the technical and ethical things that come with it. And, obviously, there is also the time limit, you know, so you can't always discuss both all the time. And, if you don't have those kinds of support systems in place you might feel robbed in some ways… there is the very specific things that I would take to my supervisor around reports, around ethics, around the dilemmas or the intricacies of a particular case. And, there was always very limited time then to discuss the impact of the case on me. And, so, I think that your own therapeutic process needs to come into play there and it is something that you should, I think, from day one be running (Participant D4)

I don't think you can be a therapist without a supervisor. But, I think the choice of supervisor is also very important and that, I think, which is now perhaps sitting on three chairs. But, I think your supervisor should also be trustworthy in terms of your own personal growth as these two need to go hand in hand. Your supervisor should know you well enough to identify personality hiccups and say, "Be careful, I'm not hearing this and this? Where is this now coming from?" So, it is not only focused on the client, but it is also you as a therapist, "What are you doing?" because I think that is what my experience is, to see younger psychologists for supervision. They want an answer for their clients, "What should I do with my client? What should be my first [claps] and second and third step? What other techniques should I try?"
… I've reflected so many times on that and I had so many discussions on that with (another senior therapist)… You identify personal problems in the students, that is hindering the student's professional growth. But, you cannot address, you cannot become the therapist as well. But, I think the relationship between you and the student, or you and the supervisee should be good enough that you can point that out. And, even if you just ask questions, "How do you perceive this? What is the

meaning of this?" So, hopefully,… the student will realise, 'I need to take care of myself'. And, then go…

… the role between a supervisor and the therapist is a bit blurred because you need to trust your supervisor the same way that you need to trust a therapist. But, your supervisor should be able to identify and point out to you, "Perhaps it is you who is the stumbling block, and not the client or the technique?" (Participant E4).

Intern psychologists (B1, B6, and B7) spoke about their experiences of the overlap between supervision and personal psychotherapy during their internship being determined by the hospital-based supervisors' chosen ways of working.

I think the supervisors here act like therapists a lot of the time, which is good. You need them to. Because therapy is like very personal, and trying to disconnect those two things I think is futile… And, also you are under the supervision of psychologists, so they can't ignore their natural pull to turn everything into a therapy session, right? But, I think it's critical. I think you cannot practice psychology in a vacuum, because I think you need people to point things out to you that you cannot see for yourself… therapy, if you're doing it properly- I feel like it's taxing on yourself as well. It's deeply personal for you too, it evokes things in you, and you need to deal with those things to be an effective therapist. I think who your supervisor is, makes an enormous difference. There are supervisors here who will talk to you about, "How's it going with your patients? Okay! And how are you doing? Okay, that's good!" you know, and giving you advice. "Oh, are you stuck here? Maybe you can do this and this and this. Are you stuck with this? Maybe try this"… very focussed on the patient. There are other supervisors here who you will leave like crying, because you've been to this- like deep, dark well of your own psyche (Participant B1).

The further she went with me, in supervision, as like a therapy, and digging in my own personal experiences, and going to these raw places that make you feel vulnerable and icky… then I saw that the more I dug into those places, the more I could take my patients there, because I know it…

I had three different supervisors here (internship). And, everyone was different. So, I kind of have like this blurry idea of what supervision is and what therapy for the therapist is. Because I started out, or my first experience of it was, it was more therapy and very personal. And, you would hardly ever speak about patients. You would go to a raw place in yourself. And, you could just think like which patients would feel that way… my second supervisor was very like theoretically-based, just like, "Read up on this" and you know, "Do that"! And, my final supervisor, as I believe is what I would like to become as a supervisor one day. It was very much about the patients and learning. This sort of integrating your theoretical work with your patients that you see, and your personal work (Participant B6).

The definition of supervision and the definition of psychotherapy has not been clearly delineated. The reasons for this fuzziness or blurriness (D3) may be in part due to supervisors being psychotherapists themselves and when supervising junior colleagues slip into their psychotherapist role and superimpose the patient role onto the supervisee (B1). It may also be due to the necessary role-modeling function of supervision, in that the supervisor demonstrates to the supervisee how to be with clients (B1, and B6). Arguably, supervision falls into personal psychotherapy when psychotherapists or trainees lack a personal psychotherapy process, in that supervision is fulfilling a gap that is being neglected that ethically should be fulfilled by an independent separate psychotherapy process which does not have the overhanging scepter of evaluation of work performance or competency as a trainee or junior colleague. As Participant B1 considered he may need to see a psychotherapist when supervision is no longer a mandatory part of his training, as he would like to continue with a space to reflect on how he impacts his work with clients.

In contrast, four participants (C5, D3, D5, and E4) felt that personal dynamics of the psychotherapist can be briefly pinpointed to the supervisee in the supervision context as in need of further exploration. But, in-depth exploration on a personal level is best left as the prerogative of personal psychotherapy. Rather supervision needs to be defined as a space where the client's interests remain the priority and over-riding focus of the clinical supervisory context:

How I understand supervision is that it should not be devoid of emotion or looking at those things that a client might elicit for you. But, I do see it more as a space where you can sit with the difficulties and challenges of being a therapist;

perhaps with a particular client and perhaps starting to identify the processes that might be coming up with that client… it's more about the difficulties and then how to direct your future therapy with that client. Yes, you might pinpoint things that it is eliciting for you, but I think then that is something you take to your own therapy to unpack the origins of or the depth of… the supervisions, is what is in the client's best interest or how is what is happening in the room, with me in the room, impacts the process with the client (Participant A1).

I think potentially it can be quite difficult. Especially, if you have got therapists and a supervisor who work very differently, or conceptualise things very differently. But, at the same time, I think it can be very beneficial. It worked for me, because I was able to separate out the two and say; "This is about work…", and I would bring cases in and we would talk about… me as a therapist in relation with the case… that was a boundary that we created. And, we actually spoke about that… my supervisor did know that I was in therapy and my therapist knew that I was seeing a supervisor. And, they were both very good at keeping me focused on our purposes… One of the beauties for systems therapy is to meta-communicate… or think about what you are thinking about. I think it's necessary at times to make sure that there is no… [sighs] contamination is quite a harsh word, I don't like it-, but to make sure that things are not being sabotaged because of two different processes. For me it worked though.
It can be very beneficial for therapists, especially early on in your career… it gave me two different spaces to talk about two different areas of my life. If let's just say hypothetically-speaking; I was in supervision or in therapy and both contexts were merged… I think it would have been very difficult for me process things because I would be grabbing a bit from here and a bit from there; trying to talk about everything at once. So, for me delineating the two areas was a benefit in knowing that, 'This is my work space and this is where I can talk about cases, clients, therapy, management of the centre or whatever the case may be'. And, all the struggles I had there. Whereas, the personal therapy was about me as a person (Participant C7).

> *It is complicated, I know now with an intense reaction to the client and I know there is a lot of my stuff, then I will rather take it to the therapist* (Participant D5).

Teixeira (2014) investigated the internship experiences of three counselling intern psychologists in Grahamstown, Eastern Cape, wherein she also found the blurriness of boundaries between supervision of interns and personal psychotherapy

> Supervisors attempt to assist interns to navigate this ambiguous period. However, supervisors should take care to remain focused on the professional functioning of the intern… Many neophytes are likely to discuss their clients in relation to their feelings and personal psychotherapists may need to remain focused on developing personal insight for the intern rather than providing treatment advice for a particular client (p. 84-85).

Baird (2014) outlines similarities and differences between supervision and psychotherapy. The current study highlights that these distinctions are not clear to trainees. Jacobs (1991) states that psychotherapy relationships between supervisees and supervisors constitutes an ethical violation, due to the lack of voluntary consent and freedom of the student, which are hallmark ethical characteristics of psychotherapy. According to Jacobs, the responsibility to establish, maintain and convey these boundaries is a key task of supervision in order to uphold clear-cut ethical and professional standards. As supervisees are dependent on the supervisor's evaluation of their client work in order to qualify, they may feel uncertain of how to manage inappropriate behaviour or intense interpersonal dynamics within the supervisory relationship.

> *I know a lot of programmes discourage people from continuing psychotherapy during their masters training, because they find that it interferes with what is being taught in that particular theoretical orientation. But, I don't think it necessarily has to be that way… If you have an experienced person who is on the other couch right who is actually aware of training processes… I don't necessarily see them as mutually exclusive processes. But, I think that people can benefit from both of them… running concurrently* (Participant D4).

Participants D4, and E1 advocated that both supervision and personal psychotherapy can effectively be pursued by trainees and qualified psychologists simultaneously by different psychologists, as each context meets different needs.

To prevent or curb ethical violations, Jacobs (cited in Trotter-Mathison, Koch, Sanger, & Skovholt, 2010) investigated the personal psychotherapy-supervision overlap. She found that students can feel vulnerable in the presence of their supervisors, much as clients feel vulnerable in the presence of their psychotherapists. Rønnestad points out that much is at stake for the student as they are feeling vulnerable, yet it is in that vulnerable space, that the developmental potential of recognising one's human vulnerability helps to foster the character strength and sensitivity necessary to be a psychotherapist. As such supervisory and psychotherapy relationships, share a common characteristic in that they have an emotional intensity, unlike other relationships. Alonso (1985) depicts supervisors as "professional parents" to trainee psychotherapists. Pope, Keith-Spiegel, and Tabachnick (1986) recommend that supervisors need to intentionally and consistently investigate their countertransferential reactions to supervisees which could disrupt their working relationship. In tandem, students need to develop the capacity to investigate their own dynamics towards authority figures. Jacobs highlights that dynamics that may occur in supervision include supervisees feeling deprived, feeling compelled to please, feeling overly criticised or feeling anxious about overburdening the supervisor with their needs; she argues that these dynamics may be rooted in childhood experiences with caretakers.

> *I had some really good supervisors and I had some really difficult supervisors. I saw some very unethical things and I experienced some unethical things… one of the things… that I think would have helped me enormously is what we do with our students now, which is helping them to look at things from a systems point of view and helping them to understand context.*
>
> *And, I think I went into my internship in terms of that much too naive… and because I am quite congruent the combination of nativity and congruency- and congruency is very dangerous for someone going into the profession for the first time… it allowed me to get sucked up into processes I shouldn't have been… that whole circular process, once it kicks in if you are not aware of what is happening, you don't have the resources to become aware of what's happening. Things can go very wrong, very quickly… it ended up that I had made enemies that I didn't even realise I had made of higher-ranking people than me …*
>
> *I think personally that every training should find some way of introducing skills for the workplace. For the internship as well, not just a lecture on how to make*

sure your supervisor turns up on time. But how to read process, how to find your role in that process. And, how to understand what you are doing that is facilitating or blocking what should be happening for your own growth… - otherwise, you end up getting stuck in fighting other people's politics, instead of learning all the ropes and tricks of the trade that you should be learning (Participant D).

Jacobs (1991) advocates that explicit information and training needs to be provided to students about what clinical supervision entails in terms of supervisor and supervisee roles and responsibilities. Participant D4 verbalised that she as a trainer of masters students prioritises orientating students to the intricacies of supervision prior to entering into internship to address the "academic neglect of issues related to power abuses and boundary violations in the student-supervisory relationship" (Jacobs, 1991, p. 130). Such awareness engenders trust enabling students to seek help in the event of supervision difficulties. Pinderhughes (1989) points out that a lack of information for supervisees "about how they can cope with external systems and with victimizing structures can be a way of perpetuating their dependency and trapped position"(p. 134) and their victimisation.

It's changed because now I see the importance of it… I look back on the year, I'm like, 'Other interns have experience like since the beginning. I haven't' and I would feel like 'It's almost too little too late! Because it could have helped me a lot if I had more supervision and actual supervision since the beginning'. So, I feel like robbed of that experience... (Participant B).

In the current study, three intern psychologists, one experienced psychologist and one senior psychologist voiced during their own internship experiences of being negatively impacted by the unethical behaviour of their supervisors and how it negatively impacted their learning experiences during their training.

There's so much knowledge and so much you can learn, but then it's painted by, I don't know, the way the person is or the way, the power dynamic in their favour or it becomes a game, .. as an intern, you've got no feet to stand on and I think also that's why everybody keeps quiet because you just wish for the year to finish! Because then you're out of here and then you don't ever have to come back! And, who wants to have an internship like that? … what angers me is that people

should know better. 'Are you not an ethical person? Because then I wonder how this person is in therapy?'. It worries me, so ja (yes), it does change the experience… the way you do supervision gives me some view of the way you might be in therapy, ja (yes). Because you are you. You can't be anything else [chuckles]… I think having a mentor, somebody that you look up to in the profession, good supervision (Participant B).

I had a terrible, terrible experience in my internship year in supervision. I think supervision is a very fragile and vulnerable territory that needs to be approached in a very specific way. I had a supervisor who quickly… approached supervision as if therapy and supervision are the same… She told me she doesn't really separate the two (Participant B).

One student psychologist also voiced experiencing very problematic supervision as well as good supervision during her training at her university.

They would really engage with me and I'd paint this picture about my clients and they would really be involved with me and immersed in the stories and concerned. And, you know, they would ask me. And, they'd send me articles and they'd say, "You know what, I found this. Read up on that" and you know, really very engaged with me in the process.

And then, I had my last supervisor… I was completely traumatised… he was completely absent… not even in the room… 'Tell me when I said something wrong to a client. Comment about my process with the client; don't comment about my appearance…

I don't know how well it's monitored of who we let out as psychologists into society… It scares me to know that that person is going to have people's hearts and emotions in their hands. It worries me… I think if it's not monitored, it can be very destructive… South Africa as a culture, we're very free birds… We don't want to be monitored military-style, but I think it's sometimes necessary (Participant A).

To provide quality supervision, Falender et al. (2004) advocate that supervision needs to be recognised a distinct professional competency that requires specific training and task-specific

competencies in order to be deemed a competent supervisor of clinical work. Over the last two decades, Falender et al. (2014), and Falender (2016) have conceptualised APA guidelines for clinical supervision (2014) as well as rating scales to assist supervisors in tracking and improving their performance as supervisors. According to current guidelines within South Africa, registered psychologists need to have at least three years of clinical experience after internship prior to being in a supervisory position (HPCSA, 2009). However, currently in South Africa there is no mandatory training for psychologists on how to supervise effectively, prior to supervising trainees or registered psychologists.

4.10.4. Group Supervision During Training.

> *There's not a person sitting in every single session that can guide me or give me a blow-by-blow of what I'm doing… we sit and do like peer supervision… It (theoretical orientation) becomes a part of them… and you can see… what they're passionate about. It comes out when they speak about the case or even difficulties they are experiencing* (Participant B3).

In the current study, participants differentiated between formal supervision and informal supervision. Coren and Farber (2017), and Farber and Hazanov (2014) found that trainees access a variety of sources for assistance with their clinical work. In agreement, the interns, in the current study, spoke about the supportive function of their peers as they could identify with each other's anxieties and challenges (B1, and B2) and how supportive they found talking about cases to their peer colleagues during their internship (B3, B4, and E5). Pillay and Johnston (2011) underscore the need for peer support during the internship year as interns "identify with each other and share their difficulties, challenges and goals" (p. 79). This reflects Rogers' observation (1980/1995) that in an atmosphere of mutual caring and understanding trainees can provide learning for one another. Furthermore, senior psychologists (E4, and E5) acknowledged how critical they had found their peers' support and input while they were undergoing training decades ago.

> *Often you actually have to have supervision of some kind, even if it's just talking to some of your colleagues. But, someone can point that out for you and you go, "Oh shit! You're right, you know!" I think that certain things can be evoked in therapy and you reveal blind spots about yourself, and you learn things about yourself* (Participant B1).

Being with your colleagues because we are each other's support structure here at (psychiatric hospital). I've felt emotionally supported… that has helped me grow and get through this process. You definitely can't do it alone… we're in the same level in the hierarchy of the workplace. Maybe we're different ages, but the experience is the same… we all felt like out of place in the beginning of the year and out of depth. We were all scared about the year ahead. Most of us questioned our ability as therapists, 'Should we do this? Should we be here?' Most of us burned out or freaked out at some point [chuckles]. So, I think it's that experience where you can just relate with one another, where a consultant is immediately at a different level. So, the power dynamic comes in, but also their experience is different with years that they've been in the profession… So, there's a disconnect for me (Participant B3).

My contact with colleagues, the year in- (Tertiary Psychiatric Hospital) because we were quite a diverse group, very diverse group… mostly, from Wits but some other influences. And, we influenced each other a lot, which was absolutely great. We talked a lot, we laughed a lot. It was a delightful year at -(Tertiary Psychiatric Hospital), intense (Participant E5).

This internship is so all-consuming that if you don't also turn it into your friendship circle and your source of support, you don't really have time elsewhere to get that (Participant B7).

At the hospital, mainly I think, being a new therapist, you are so like enthusiastic and you want to learn, so you bounce-off each other's energies and you share stories of what you have seen or learned … I have built strong relationships with my peers… they are in the same boat… it feels like if you were to speak to someone else, they wouldn't really understand or they kind of forget what it felt like… I think what is making me so anxious about next year is I am sent off to a place to do Community Service where I don't know anyone… or in the prison I am going to be the only psychologist there… So, that is quite frightening for me (Participant B4).

4.10.5. Post-qualification Reading Groups or Group Supervision.

Peer consultation continues after qualification (McWilliams, n.d.; Swartz, 2007), in reading groups (C3, C4, C5, D1, and D5) or group supervision (E5). Rice (2011) points out that "therapy is a private and isolating process, making it important for psychotherapists to find nurturance, collegiality, and friendship outside the consulting room" (p. 185). Participants (D1, D5, and E5) emphasised that registered psychologists need to prioritise practicing within a network of professional support in terms of reading groups, and meeting regularly with psychologist colleagues for peer supervision to discuss cases (E4, and E5).

> *I'm not in formal supervision at the moment… but, I have got a handful- few, less than a handful of colleagues who I use as sounding boards. So, I suppose its informal peer supervision… It's a reciprocal relationship… Two of them I am very close friends with on a personal level… they are able to ask questions and comment on things with the knowledge of me- as a social or a personal sense* (Participant C7).

> *I haven't had much personal supervision myself. It's always been on almost an ad-hoc basis with colleagues, just having a few conversations. Or, being in a supervision group… I've been in a group for about 15 years now, the same group… new insights, because they are all very much in the forefront of new developments, new ways of thinking, on life also and existential issues, which is extremely helpful, just sharing. Sometimes, realising that, 'I'm not okay in this area'… essential feedback… That really needs to be ongoing. I'll never stop the group supervision… one always needs supervision… You can't just be on your own. You're not an island. You need the input, you need the other voices, the other faces, to know, 'I'm still worth something because they value what I say'. They bring something to this group, I bring something. Uhm, it just adds such value to one's work and individually, it's also personal and there's a lot of inter-personal- and actually doing the work… It's extremely, extremely helpful* (Participant E5).

> *You can use them very effectively for very specific cases and casework and ethical dilemmas… and in some ways that can become quite academic… there is*

something about thinking collectively… thinking in a group space that is very, very, for me, very beneficial… there is not that sense of aloneness, so everyone is struggling with something… you know that you have got the support of your profession. Because often times, I mean psychology can be a very competitive profession, so in the groups… there is definitely a supportive element (Participant C3).

I would have moments in therapy when I go; 'That was such a good session!' and not know why… but after I had a sense of it and also talking at the specific reading groups that I was part of… which gave me permission to say; "Shoh – this thing happened…" And, gave it a name... what happened was I had all this knowledge. And, then I experienced it, I suppose with my eyes open… And, I was able to see what a difference it would make.
… the beginning would have been the theory, then bouncing ideas off a reading group that was in line with what I was in line with, and then seeing it happening with my patients… I suppose part of it is that you have to bounce off with your peers… "Did I understand this correctly? Is this right?" And, then they say, "Ja (yes), we think so…" And, then you try… 'Does it work?' – "Oh look, what an amazing session. She feels really connected and safe and so do I. That must work." Go back to the books and that's – ja (yes) – 'That's how it works! That's so well written! That's what I did!"… So, only after you have done it a few times, then suddenly you realise that's what you can do… (Participant C4).

Input and collegial support from peers through a group format (C3, C4, and E5) of reading clinical papers or presenting cases to colleagues was regarded by post-qualification participants as very beneficial, useful and valuable for their professional identity and for their work with clients. Additionally, participants reported feeling supported by the profession during group professional activities as seeing clients is done in a private, isolated setting due to the confidential nature of therapeutic work (C5, and C7).

4.10.6. Having a Fresh Eye: Post-qualification Individual Supervision.

The struggle for me of not being in supervision is… firstly, I know I should be. So, there is this kind of superego element to it. So, if you are not, you are on the fringe, you know your work is impacted... I need to know that someone else has

my back, you know, and that's very rare to feel… I think not in a mothering way, but in a way in which they are so ready to face the dilemma with me… that's the element of supervision that I am attracted to (Participant C2).

One thing as well that I am find challenging, after Community Service and, now, having to figure it out is: 'How do I find all these things? How do I find reading groups? How do I find a supervisor?' Then in my Community Service was too far and I couldn't-, Those things, it kind of felt like a lot of pressure to make the right decision, and it was just that element of, 'Now you have to make sure that you make the right decisions and all the right things that will help you grow as a therapist'. It is obvious but the experience of it is-… It becomes a more word-of-mouth kind of thing. You ask people or, maybe, in your training you come across certain names or people and you think, 'Maybe, that person?' …
then I decided to start a practice and then it also took a while for me to get back into it, because I think part of the thinking for me was, 'Okay, maybe, I need to develop my client base, or maybe, once I get to this number of clients, I don't feel like I have enough'. And, then I realised, 'Am I ever gonna start?', or 'When is the right time?' So, it was kind of like a feeling of wanting to see what or trying to figure myself out as a therapist. So, there is kind of that battle between finding my own identity as a therapist, but then also having someone guide me (Participant C5).

Qualified early career participants (C2, C4, and C5) voiced that they did feel it was a requirement that they should be in supervision post-qualification. Psychologists need to be, *"humble enough to understand that ongoing training or supervision is a part of the journey, not a judgement that, 'You are not good-enough'"* (Participant E2).

Participant C2 highlighted that the benefits include knowing one has a supportive other in the profession and is willing to offer support to address the often conflicting and confusing nature of clinical work; the notion of 'two heads are better than one'. Participants C2 and C5 explained the dilemma of the novice professional when supervision is no longer overseen by the training context. The importance and pursuit of ongoing supervision is left at the sole discretion of the qualified professional. Within the South African context, the HPCSA recommends that

qualified professionals seek out supervision, but it is not a mandatory requirement that is monitored. Hence, not all qualified professionals attend supervision regularly.

> *To me what that says is that one is saying, 'I am perfect, I am a perfect therapist and I don't need anyone and I don't have any blind spots'… I think it is useful to have supervision, whatever form it comes in, if it is one-to-one supervision and also the kind of peer supervision groups* (Participant C5).

The conflict professionals feel, via their superego, about being given such autonomy is articulated as fears of rebellion or fear of the newfound independence and autonomy granted to them upon graduation. As such it appears that participants experienced a need to prove to themselves that they can be independent practitioners, prior to returning to experienced or senior practitioners or even elders in the profession to consult in relation to clinical work which they are solely responsible for.

> *In the internship you are already allocated supervisors, but, then in Community Service- then I had to go and find my own external supervisor… as a beginning therapist, I mean I had no question about it that it will be important for me to speak to someone who is more experienced. And, also just understanding that there are different ways to look at something and maybe I might not have considered… I look at it as the way of monitoring my own development, or actually a way of continuing that professional development, because I can think I am doing a fantastic job. And that is great! But there might be cases where it is more difficult than others. I think it is also good to have a fresh eye and someone who is more experienced to maybe lead me into a different direction.*
> *… in the Community Service… I think there was a bit of a block and I didn't know which way to go. But, she suggested something and then it was one of those Aha! - moments, when I tried it. And, I saw that, 'Okay, that is what I was missing'. I think it is with cases like that,… I think stick a lot more… there was something I really didn't see or didn't consider. And, then when I implemented it I thought, 'This is really helpful, and this is a good way of thinking about it'* (Participant C5).

Participant A3 recalled how she had been exposed to and plans to adopt the view of her mentor in terms of career-long regular supervision and personal psychotherapy being a vital investment:

> *That drive, it's that ambition to always better and grow and learn. And, she taught me that personal therapy and supervision is… a mandatory investment in yourself and in your client. And, I think that's what key! That's what counts the most, because going to supervision and going to personal therapy is helping your client and if it's helping your client, it's helping your practice… she would go to personal therapy and supervision once a week. So, it was two hours a week where she was growing and learning and changing.*

Some qualified participants (C3, C4, D5, E2, and E4) prioritised attending regular post-qualification formal individual supervision with a senior colleague. Participants valued that their supervisors were now self-chosen.

> *To go for supervision is essential as well… I don't think one can ever stop getting input, whether you formally go to supervision or whether you consult a colleague. But, I actually like the formal supervision… I grow so much, I learn so much… I think (one gains) perspective on a few things… sometimes when you're in the process, you do not always have enough objectivity to sense where to go... sometimes one just doesn't know what to do… it really, really helps and sometimes you miss things… they point it out* (Participant D5).

> *I think clinical psychologists should all be in supervision [chuckles] at a regular basis. Whether it's for their clients or whether that's just to confirm that they are on the right track, seriously… it's very easy to just continue with what you are doing* (Participant E4).

> *Supervision as a practicing therapist, I think has been interesting because I have started off in a specific supervision, and like a sponge – just sucking up everything! And, over the last eighteen months or so, I have realised that, 'I will listen to the supervisor, but I won't always agree'…*

It did feel like a growth stage because in some ways it felt like my supervisor didn't grow. So, I was getting the same advice and the same guidance, but he wasn't necessarily hearing me change. And, that I needed different guidance. Or, that I wasn't going to be the sponge anymore, and just do what was told… I was going to take bits and pieces of what he suggested and make it my own. I had to be – give myself permission to do that and believe in myself…
– but, the supervisor wasn't always like, "All hail the supervisor!"… actually, they had some valid points but I was the therapist in the room, and I knew my patient. He or she didn't… 'I'm going to decide what I need from you… Everything that is said is valuable. But, it might not be pertinent to what I need… And, maybe, something that you say, in six months' time – I will suddenly go; "Oh, okay, yes… Now, that is helpful."' So, it wasn't helpful then, when maybe the supervisor thought that at that point it was a helpful thing.
I had to develop; the mental shift was I had to learn to trust myself to when I was going to use the information. And, whether it was relevant to that client or maybe somewhere in my mind I thought, 'Actually, that's more relevant to a different situation, and that's something I hadn't thought about!' I get to decide… And, then I have to be held accountable by the supervisor anyway. But, I have to be able to say, "I took what you said, and I thought about it this way, and I would rather say it this way at this time." And, I suppose the other part of the shift is that I don't now go away and do it. In supervision, I will now say, "Ja (yes), but I don't want to say it like that. That's your voice not mine. I would say it like this..." And, to be more present… Rather than just 'new', and, 'I don't know anything and I wish you were holding my hand all the time'… [laughs]
(Participant C5).

Qualified participants (C3, and C5) voiced their need for collaborative supervision. Participant C3, stated he prefers supervision wherein the supervisor is *"ready to forfeit their knowledge"* and wherein input related to clinical work is formulated by "*a suggestion that is born out of the two of us"* through discussing the particular case, in the light of self-states, together.

My ideal supervision would be: I would want to walk away from that supervision feeling like someone really understood me. And, that can only happen when the supervisor does not impose their theory on me or doesn't give me a suggestion that comes from them. It would have to be a suggestion that is born out of the two of us and it is exactly the same in relational therapy…

So, the supervisor needs to be ready to forfeit their knowledge. Remember, because I am not asking them for their knowledge, I am asking them to help me access states in myself that are currently limiting my ability to work effectively with a patient…it can be, "You know this part about your history is interfering with this"… It's a very fine line, but I know that I would want my supervisor to comment on me, but in a way that directly relates to my work with the patients… but, it's not about the client, it's because the client isn't separate from me … so whichever client I bring, I am actually not talking about the client in the supervision… I am actually always bringing a self-state that I am not aware of in the moment that is directly related to my work with the client.… the supervisor will help me access the self-state that is currently being activated by this client… it is not just countertransference; it's not just what the patient evokes in me, it's what I bring to the table.

… So, I would bring that dilemma… the ideal supervisor would then help me understand not what the patient is trying to do to me, 'But what part in myself is now evoked that I am- that I cannot shift my intellectuality with her? What self-state is that? And, why does it come up with her?' And, that's not what a therapist will do, a therapist will help me explain, explore more about that, once I am more clear on that self-state. And, then possibly the only way my supervisor will know how to tackle this issue is by exploring the same dilemma in themselves. So, do they themselves feel that they have to be intellectual with me?

Participant C3 articulated a specific model of supervision, namely, a relational psychoanalytical model of supervision related to the supervisor and supervisee together discussing the self-states of the psychotherapist that were elicited during the session with a specific client. Participant C3 admitted that this form of supervision is walking a *"very fine line"* between personal psychotherapy and supervision wherein supervising the person of the

psychotherapist is seen as imperative as the psychotherapist is understood as very much part of the process of the client's psychotherapy.

Participants (A3, and D4) articulated the high monetary cost of supervision and ongoing professional development whether through specialised courses or supervision of casework within the South African context. Limited finances may be a silent reason as to why many qualified professionals delay or do not access supervision or participate in learning opportunities on a weekly nor monthly basis.

> *Vital… My problem though with it is costs, and I know we say that psychologists make a lot of money etc. But, it isn't always the case. And, if we don't find a way to make it more accessible for more practitioners I think that we might end up failing ourselves. We might end up creating a void into which nobody can step – because, you know, there isn't enough provision for people to do supervision* (Participant D4).

4.10.7. Supervising Qualified Psychotherapists.

I do a lot of individual supervision of professionals (Participant E5).

Participant E2 found that supervising other psychotherapists, results in the supervisor being, "*really forced to be on your toes. You not only grow in a unique process with a supervisee, but also have continuous exposure to the profession with new doors opening. You learn with your supervisee"*. Participant E2 relayed, *"The biggest lessons are the ethical dilemmas"*. As such "*the most difficult space to be in"* is when the supervisor is confronted with the level of psychopathology seen in supervision (of the supervisee). Participant E2 prioritised the selection process of masters training programme and, yet, it's *"a very thin line"* when encountering the wounding as *"there are benefits, but also the downfall"*.

Experienced psychologist Participant D1 when supervising students and talking about psychotherapy through with them found that "*the picture becomes clearer and clearer"* of what psychotherapy and psychology entails and how in the process of clarification one's intuition becomes stronger. Senior psychotherapists (E3, and E5), specifically, spoke about how when they are supervising psychotherapists they are also learning simultaneously. As such, a good teacher is an eternal student.

> *Supervision is part of the learning process and [chuckles], as you supervise, it's not only your supervisee that learns from you. As you teach, you also learn*

(Participant E3).

4.11. Mentoring as Inspirational Watching Over

As opposed to supervision which priortises client's progress in psychotherapy, mentoring keeps a holistic picture of the fledging professional in mind. By definition, the self-chosen or assigned mentor or magic helper (Drake, 1992) focuses on the psychotherapist in their entirety in terms of holding both the personal developmental trajectory and the professional development trajectory in order to encourage the integration of these two trajectories within the individual psychotherapist. Participants relayed experiences of being mentored before and during their career as a trainee psychologist.

Prior to being selected for masters training, participants shared being informally mentored by extended family members who were psychologists who exposed them to the career of psychology (A5), informally by lecturers during undergraduate and honours postgraduate years (B1, C1, and D4), and during training or practicing as registered counsellors (A3, and B2).

> *In my registered counsellor years, I was mentored by a wonderful, wonderful clinical psychologist. She has since emmigrated to Australia and I have very much adopted her kind of style of therapy* (Participant A3).

> *Even before I started the masters course, there were people that influenced me… with the theology I always knew that I never wanted to preach or become a pastor… one of my mentors there, said that he thinks I am very good with therapy and, maybe, that's an avenue that I should explore. And, he helped me to start to explore that part of me…*
> *my uncle is an educational psychologist… So, getting a lot of feedback from him, talking with him helped me a lot as well… He said that he thinks that I would be a good therapist and that he can see that my personality will fit with being a therapist… that was really like a boost for me* (Participant A5).

> *I think mentors make a massive difference in terms of sticking with it almost. It's a very long road* (Participant B1).

> *When I started my first year at university,… I found a mentor and I didn't know it at the time, but Professor S.… He had the most amazing stories to tell and he*

always had time for students… what for me was the most amazing thing about him was that here was this old Afrikaner Oomie…
he spent his time when he was in the military working on, basically, looking at resilience and ways of assisting black communities to become healthy, mentally healthy. Not the idea of imposing the Apartheid mentality on people, but, actually finding ways in which clinics could offer better services… he was there at the coalface. And, he understood a lot about Black cultures… and he asked questions and he never felt embarrassed to ask the questions, or to mispronounce words in Zulu or anything ...[laughing].
He wasn't young and he wasn't hip. And, he wasn't an all-powerful psychoanalyst… yet, he was probably the best published. His students adored him, and he had the type of intellectual love for academia that just-, it brought out the best in you intellectually. And, I learned that I didn't have to be a particular type of psychologist… or psychotherapist in order to make an impact… he worked with people from all walks of life even though he was not supposed to. He tried to understand people from all different cultures, even though it was considered taboo… when I was in my honours year,… we were writing a proposal and we could choose anything in Social Psychology and he encouraged me to take a look at my own culture (Participant D4).

So, as I studied, my love for psychology grew from as a result of M (lecturer). So, I started then following up, but then I did my honours… I was a Police Officer for two years and the criminology and the psychology, it actually- even my salary was adjusted because I had this module, so I felt I was in the right place… after that I didn't enjoy the hierarchical, authoritative- because I thought my opinion helps. And, when you are a Constable, your opinion does not count! So, I felt stifled… I resigned and went to join S. And, that's where I met this other psychologist who was working with S. Then my love for psychology was renewed… I started applying into the masters programme(s)' (Participant C1).

I think she's very relatable, you know, and she's very honest… she never tried to sugarcoat things for me, but she was always very containing… we drank tea together, like, 'Tea is just getting you through life' [laughing]… in her office she had like a jar of sweets, like, 'Eating will get you through the profession'. … although, I did feel like she was my supervisor, I never felt like I couldn't go to her. She had an open-door policy. So, I really liked that about her.

… afterwards, like, I had a very analytic supervisor who like, if you got there like two minutes before, you had to wait outside. Only start at seven and then finish at exactly the same time. And, there's no drinking during supervision. There's no like eating… Which was also helpful, but, and really helpful.

So, that's why I suppose it's difficult to say… S's warmth and her openness was just awesome… She is very persistent… and also a part of that also resonated in me because I also, especially working with the parents. Sometimes, you just want to make them a cup of tea and give them some cake and chat. But, they go through so much that sometimes you just want to be real with them, you know. "Sometimes the process and the realness it's hard for you"… then I'm like, 'What's happening inside of me that wants to nurture them?' (Participant B2).

As trainees in a masters programme, participants spoke about being informally or formally mentored by supervisors/trainers (D4, and E3), or informally by their personal psychotherapists (A3).

One of my trainers B- shaped the therapist that I am today because I really looked up to her, and C-… I thought he was a very refined therapist and I was looking up to both of them… the way they held the space… somebody that you also look up to because without that reference, you don't have anything to build your skills on… A role model in any career is very important (Participant E3).

There have been a couple of other people that have been very influential... but also they are mainly psychotherapists as well. And, hearing how they understand and formulate and learning specifically from them about what compassion looks like… They were not afraid to if-, for example, a kind word, was required and they felt moved to do so, it would come. It was not just about… taking the high

road and taking the one-up position… if it was necessary to stop and allow silence to continue, and they were moved to do so, then they would. And, that for me is also compassion, is acknowledging the need for a break, acknowledging that some things are just too hard to say out loud (Participant D4).

I learnt from my involvement with her as a therapist is, you know, HPCSA puts rules there for a reason… I understand that we as therapists have to have boundaries with our clients. And, I don't know if it's because I'm a student psychologist and she almost knows that she's mentoring me because I'm learning from her. Yes, I'm doing personal therapy, but I'm still learning how she's doing things (Participant A3).

Trainees who were trained systemically also spoke about their course programme formally assigning them mentors to facilitate their personal and professional growth as psychologists (A10).

We have gotten appointed mentors last year and I wasn't really sure exactly what was the point of that… mentoring was a space where I could sit and reflect on what's going on in my world… I experienced it as a very flexible process … It's somewhere in-between supervision ...[laughing] and therapy… it's less formal than supervision and therapy, but it's not a social kind of meeting with your lecturer… neither is it an academic conversation… And, it's not fully-fledged psychotherapy… So, I know where it is, but I just, putting that into words is a bit- ...[laughing] (Participant A10).

As a senior psychotherapist, Participant E2 felt that a mentor or teacher was critical for one's ongoing development and that it need not necessarily be one's trainer or supervisor during training. He linked this to Buddhism where initiates are always asked, "Who is your teacher?"

My mentor or teacher taught me to become silent. To live and treasure my introversion. Through working with my archetypal images or inner figures I experienced learning beyond words (Participant E2).

4.12. Advanced Development

During later phases of development, participants exhibited an embracing of their transformation. The qualified psychotherapist now leaves the intense and, yet, safe incubation of the training environment to embark upon independent practice as an autonomous professional

with all new challenges and rewards inherent in offering society the potentially healing properties of psychotherapy.

A number of the main developmental experiences and aspects of qualified participants were a continuation of what participants began within their training years, namely, embracing the complexity of therapeutic work and distilling clients' problems, holding the success of psychotherapy lightly and not becoming undone at perceived therapeutic failures as well as accepting one's mistakes along the journey as a psychotherapist.

Other threads that are unique to the qualified psychologist, namely, desired but expensive continued professional trainings, essential self-care to ward off burnout, and a deeper integration of one's personal and professional selves into a comfortable mandorla-like overlap will be explored.

4.12.1. Distilling the Process.

> *Kind of both. I think I'm aware of the complexity, but I almost consciously simplify it so that I can deal with it. Complexity is there but… I have to simplify. I'm good at that* (Participant E5).

Participants, across developmental phases, emphasised that psychotherapy remains complex by virtue of human beings and their dynamics being so complex (A1, A2, A5, A7, B2, B6, C6, and D3) and therefore working with each client remains a unique, complex endeavour.

> *I'm stuck between a rock and a hard place… I don't want it to be become simple because a person shouldn't be simple. A person is a complex individual… I think sometimes people become complacent and it does become like that and I mean I can't speak for myself yet. Who knows, maybe I'll become that stagnating therapist, but I think I don't want it to be simple ever… maybe less anxiety. I think at my stage of development, I still feel anxiety, like butterflies in my tummy when you still get a client… the more experienced therapists, should I say, don't feel that anxiety so much anymore… Like you walk in there and you go, 'Okay right, let's sit down and work!' now* (Participant A2).

> *Definitely, not simple, it's very complex. Understanding human dynamics is something I don't think humans will ever fully understand. Every person is unique and every person has had different dynamics in their lives… being okay with the*

fact that I don't know myself yet, I think… if I'm still learning things about myself… then how can I expect to know everything, to know everything about everybody else? It's not reasonable to expect that… I still learn things about myself every day, through clients, through family, through whatever (Participant B5).

It is actually becoming more complex for me. And, it is just because you can't have a remedy and think, 'Okay, this is how I am going to do therapy', because every person that walks through that door, is an individual person who is unique, you know, is totally different. So, you can't just be the same for every single person [laughing]… (Participant B6).

I think people are complex… And, realising that they might come for a simple problem, but it is seldom so simple. So, as you start working with the people, we unfold and discover the complexities of the simple issue… let me try and think of something real: the child looks like- there are concentration issues and the teachers are complaining… So, naturally, you think, 'Ahh, need to do an assessment!' and in the intake you realise that, 'There is, you know, dad is referred to as maybe being a bit scary for the child'. So, the key thing looks like it is concentration and attention, basically, meaning ADHD, but as you discover, it is actually the emotional side of things… whereas initially… you might have thought, 'Oh well, let's do an assessment and let's, you know, whip down the diagnosis and send off to the paediatrician'… I do find that with experience, I suppose, you realise it is more complex (Participant C6).

Rousmaniere (2017) speaks about how inexperienced psychotherapists defend against complexity through experiential avoidance. In that, young psychotherapists reach for quick solutions in order not to feel overwhelmed by the complex problems clients present them with. Indeed, like Hercules, with his club and golden sword, young psychotherapists need to become equipped with therapeutic skills and strategies in order to feel strong enough to take on the Hydra-like complexity of the problems they are confronted with and be prepared to labour and fight a long, arduous battle to assist clients (Waterfield & Waterfield, 2012).

However, trainee participants reported that their capacity to not be overly anxious, frightened or overwhelmed (A3, and B4) by the complexity lessened. Their capacity to allow, hold, and incorporate the complexity (A2, A3, and A5) improved over time the more they did client work. Trainees learnt not to feel undone when caught offguard or surprised (A7, and A8) but rather developed a malleability to adjust to novel situations (A3, and A8).

> *It's sort of becoming a lot more simple to me because I think I can classify things, initially, … I kind of tend to see the big bear and then eventually as I start working through this, it gets a lot easier but that's a pattern throughout my life. I'd rather see things, worst-case scenario first and know what I'm up against. I don't like being caught unaware!*
>
> *… recently, I'm becoming more comfortable with being caught unaware of how tough things are. It's still difficult, but I'm getting there. The working through things is definitely easier… especially the more I read, the more I make sense of it. It gets less complex, complicated* (Participant A3).

As such student psychologists become aware that they need to expect surprises and that no amount of preparation can protect one from the unpredicatablity of therapeutic processes. Participants also found that they no longer saw psychotherapy as offering clients quick solutions, remedies or instaneous interventions (B7, and C6). Strategies of trainees and early career psychologists to manage the complexity included reading (A3, B2, and B6), individual and peer supervision and to forego pushing a client's concerns into rigid diagnostic categories or labelling practices (A6, B5, C2, C3, and C6).

> *My defence is to go and like rationalise and read up on everything, and just, you know, try and find out about the latest courses… journal articles. And, I know that is my way of coping. But, I must say, what really helps with the complexity of therapy is working at the hospital where I have 12 other interns… speaking to them and like hearing their opinions, and you know, that sort of just normalise it for you, that they are also finding it complex* (Participant B6).

> *From what I've experienced from therapists, which I deemed to be good… I would feel that one really needs to be able to look below and beyond the diagnosis, and below the behaviour and understand, and, that's difficult* (Participant C2).

Participants spoke about how they felt as they saw more clients they were able to make more sense (A3) of what was presented to them, unfold and discover (C6) to hold it (A4, B7, C3, and E2) and to work through complexity (A3) with clients. Years of reflective experience led to a high tolerance for ambiguity or "grey areas" (C1) and learning to sit with the discomfort of uncertainty. Participants, across developmental levels, acknowledged that as they learnt more they realised how much they did not know (A7, and E4) and that new aspects are inherently complex prior to becoming simple through assimilation processes (A10).

> *Oh, it's become much more complex. The more you know, the more you know you don't know… Of course, some things comes easier… but, the older you get and … the more experienced you get… it is more complex for me… you know so much more and you are also more aware of the importance of what you are doing and the impact that you do have on people's lives* (Participant E4).

This parallels Skovholt's finding (2012) that the larger the circle of knowing grows, in tandem the circle of not-knowing enlarges, as such the field of psychotherapy is ever-stretching the bounds of human beings' knowledge of the human condition. Such continual grasping for knowledge (A1, A4, and B5) keeps practitioners on their toes which inherently ward off unfounded confidence (A7, and B2), complacency (A2), or becoming too laidback or blasé (E5), stagnant (A2), or super-comfortable (B3).

> *It's not either-or… it is complex so the more I learn, or the new aspects that I learn is initially complex… The new techniques and strategies and how to implement them makes it complex for me. But, once I become comfortable with it, it becomes more simple. So, it becomes… in the background and you use yourself… So, every time you go in a new dynamic, it shifts from complex to simple; to learning something new about it and it becomes more complex* (Participant A10).

> *I cannot say that, 'Therapy will go in this way', and you cannot say that, 'I am going to get this problem', or, 'I'm going to get this client that brings in this type of problem'. So, you'll never know who's coming to your sessions. So, somehow it's complex because you have to be flexible, and to be able to accommodate whoever comes to your office for help… it's getting more and more complex, and in, a way because I won't have the one-way mirror all the time* (Participant A8).

I don't think there's anything simple about therapy… I don't think you'll ever be super-comfortable and there'll be no anxiety and you'll know like what you'll be doing… [sighs]. No, it's more complex and even the fact that I got my own personal therapy is my extra layer that I need to deal with. So, now that is even more complex because if I go on a Monday evening… how can it not influence my Tuesday. So, then I'm trying to sit with the person and it's now their stuff and my stuff … So, it's very confusing (Participant B3).

Then the certainty comes and the comfort, the danger is to become blasé. I try not to become blasé. That's why I still read and do workshops… One is never there, there's not really an end point where you can say, 'Now I've achieved, now I know it all. Now, I can sit back and relax. Never. You still always need a little anxiety, just to keep you alert and aware of what is happening. You can't be blasé. It was a gradual process… It wasn't like steps… it's a gradual but a comfortable, wonderfully rewarding journey (Participant E5).

Intern psychologists are testing out whether psychotherapy, their years of training and their own therapeutic performance in reality can benefit many clients. Trainees asked themselves a number of questions (A1, A10, B1, B2, B7, and D3) regarding the efficacy of their therapeutic work and disclosed experiencing feelings of self-doubt in their abilities and self-questioning their skills to actually succeed at helping psychotherapy clients (B1, B5, B6, and B7); as such a stance of self-questioning takes root.

Initially, it was, 'Am I doing the right thing?' Uh, you question yourself a lot… the basic ability to just be with a stranger, for sixty minutes. If you can't do that, if you don't have the comfortability in you to do that; how in hell do you want therapy?... And, that was very quickly for me something that I had to learn. Not to hear and try and rescue, not to hear and try and do things, or think in my head, 'What do we need to talk about next?' Then you have your five minute silence, then you say; "Alright, what about this?' … the typical intern thing of practicing therapy in front of a mirror, you know: 'I don't really know what to do next'. But, moving all the way through training as the years go by (Participant D3).

The internship year involves a constant process of self-exploration for trainees (Baird, 2014).

> *I think that the ability to self-monitor is one of the most difficult aspects of this job. It's hard to know sometimes if you're doing well, and I think that's one of the most challenging things* (Participant B1).

> *I think because I'm my own worst critic, I obviously do a lot of self-reflection… I do take work home even though it's just in my head and I would reflect about the day or what happened…* (Participant B3).

Trainees also expressed anticipatory fear of how they will manage the complexity of psychotherapy without their supervisor at hand (A8) or near-hand (B4).

> *I have grown a lot, but I think there is still a lot of scope for growth and I know I am going to be doing quite a bit of that next year. So, at the moment I would find myself with a client, and I would still perhaps think, 'Okay, I am only going to see this child for a few sessions for psychodynamic work, it's going to be a little bit harder. Should I do a bit more narrative?'... my decisions are still a little bit unclear at times, 'Where should I be going with this'… I do think next year those kind of decisions and processes are going to become a bit more simpler, because they are going to have so much more focus and clarity…* (Participant A1).

From an international perspective, Orlinsky et al. (2001) argue that exposure to clients in direct clinical experience should start early in training and be integrated with studying of the knowledge base of psychology. Early work with clients ought not to be confined to so-called simple or straightforward cases, but needs to include trainee exposure to challenging presenting concerns in order to learn to work with the likely strains and ruptures in therapeutic alliances with psychotherapy clients (Andrews, 2001; Lambert & Hawkins, 2001). In the current study, participants spoke about seeing complex cases during their training years and beyond. Due to the high levels of trauma and limited mental health services and resources in South Africa, trainees are exposed to complex cases immediately when embarking upon casework, usually in the first three months of masters training, under the direct supervision of qualified psychologists (Eagle, 2005; Eagle, Haynes, & Long, 2007; Kottler & Swartz, 2004).

> *I feel very much in an in-between space. So, I think while on one hand, it feels that there's been almost a movement towards simplicity in terms of just being present*

and holding and just being in the space and putting less pressure on myself to solve or fix or get to a certain point. So, in that sense I guess, and almost having more confidence in myself as a tool, in my presence as the tool, in my natural empathic responses… I guess it feels like it's becoming more simple.
But, I think more complex in the sense of with… all the self-doubt, all the: 'Is this good enough?'… 'When is therapy working?'. The kind of questions that I wasn't focused on previously, because the focus previously was all about trying to apply a specific technique. Now, the questions are more about: How do we see change? When do we know it's happening? When do we know a process needs to end? So, in that sense, it feels it's become more complex (Participant B7).

I think it is becoming more complex for me actually. I think in the beginning it becomes a lot simpler, because you would think like, 'Oh, well I am growing and you're learning new things, and it will fall into place'. But, there is still time, I mean, I am a total different therapist to how I was in the beginning of this year or last year. And yet, you still sometimes sit in the chair with a patient or a client and you think, 'What the hell am I doing?'... It is like, 'Am I doing the right thing? Am I actually helping?'…
I don't actually feel ready to go and just like, go into private practice… you don't have that supervision anymore. It is quite scary… when you are at varsity (university), and the training I had, you thought, 'Oh there will be a few modalities'… then you go out, and you research and there is all these different courses. And, the world is changing and like, there is so many things! It actually sometimes feels quite overwhelming (Participant B6).

Trainees admitted to initially having a shallow understanding of psychotherapy or underestimating (A5, A10, B1, and B2) how difficult it is to do therapeutic work. Their initial image of therapeutic work was based only upon advice-giving (C1), their exposure to basic helping skills or thinking all they needed to learn was the models and techniques and by doing this application would be easily accomplished, without knowing about the nuances of psychotherapy nor the individuality of clients (B2, and B7). Over time, trainees spoke about

being able to see more complexity as they became more adept at conducting psychotherapy processes, and 'seeing process' (A4, A10, and B2).

In the current study, trainees (A5, B2, and B4) realised how difficult self-directed learning and self-evaluation of their performance as a psychotherapist was as marks (grades) were no longer the prized form of feedback or reassurance.

> *One of my biggest challenges has been rating my performance. It was much easier for me in the past, because you would write an exam and you would get your 75+ and, 'No, I got my distinction. So, I did well'. And, there aren't marks anymore. So, that falls away… That has been a challenge for me, about 'How do I rate my successes? and how, you know, 'Do I see where my shortfalls are?'* (Participant B4).

> *As an intern, you feel vulnerable and you feel so insecure. Like, you always think you're doing something wrong or, 'Am I doing it right?'… at least with masters even when you present a patient, they mark you… you get a distinction, you're like, "Whoo! whoo!"…. (In internship) no one told you anything. You don't know if you're doing okay* (Participant B2).

Yet as a trainer (E3), the ability to self-assess one's work as a psychotherapist is vital. Therefore during masters, trainers prioritise modelling to trainees how to elicit feedback and learn from feedback processes in the moment with clients.

> *You get a fresh perspective from the students… They don't only give feedback to me… It gives them an opportunity to pace themselves and to draw reference in terms of how much they have learnt from that. Because some of them may not even be aware, 'This is what I have learnt in this class' but if somebody says it, then it makes more sense to them and that's where you see the 'a-ha' experiences… It gives them an opportunity to crystallise the information… I'll never trade that for anything else* (Participant E3).

During training, trainees' feelings of self-doubt can "swell to untenable proportions by the pressures of trainings" (Karter, 2002, p. 4). Appreciating the complexity (A1) and not resorting to over-simplifying or becoming complacent (A2, and C2) was seen as a necessary, humble approach to succeed as a psychotherapist (B2, C2, and E4). Participants also spoke about

becoming more comfortable working with *"stuckness"* in psychotherapy (A6, A10, B5, and B7) and being more open to "stuffing up" in order to learn through difficulty (C3). Over time psychotherapists learnt to utilise supervision, without self-derision, to assist with feeling stuck with clients (A6, A10, C3, and D2).

> *What makes a good therapist is ability to embrace stuckness in therapy… if they meet an impasse in therapy... I've seen so many cases where you turn to, like, different techniques to change the stuckness, "Okay we're going to go do something else"..… think to yourself, 'But, why are you doing that? Not to the benefit of that person sitting in front of you… you're doing it for your own… to give yourself some closure as a therapist, to make sure that you're doing a good job!'… Sometimes you just need to recognise that and say, "Look, we're stuck, why do you think this may be?"… admit it* (Participant B5).

As such, trainees voiced that they have begun to embrace the paradox that the less they try to get things right the more likely they will get better at conducting psychotherapy. However, the ability to hone in on key features, create a focus, define how to intervene was seen as becoming easier to do as time with client work increased. As such a greater clarity of how to work occurs for participants, which in this sense makes psychotherapy simpler (A1, A5, and E2) and easier to manage (A5, and E5).

> *I think it's like a double-edged sword. It definitely becomes more complex because of the more knowledge that you gain… like just having play therapy with a child… As a new therapist you won't think anything of something. So, for instance, I've seen a pattern with depressed children. They don't play. They get ready. 'We are going to make a Lego boat'. And, then they'll take all the Lego out to make a Lego boat. And, then they'll leave it. And, then they'll be like, "Actually, to make this Lego boat, I think we need to make some cookies". And, then they'll go to the oven and take all the stuff out.., they just can't play! And, it's almost like they can't let go. They have to be in charge! They have to be in control…*
>
> *it becomes more complex because of your understanding. I don't think it ever becomes simple. I really feel like if I ever feel, 'I know what's going on here, I've got this', and, then I can go and be in trouble… every new patient is someone*

new… I think in the beginning… you listen and you reflect… give them (it) back and you say it in a nice way and they leave. That's simple… the more you develop, the more you understand, the more you read, the more you think, the more you develop- the more complex (Participant B2).

I think I allow the complexity now… I think at first the goal was always to just make it as simple as possible to try… that idea of protectionism, bring it down to its simplest form and then you can tackle it, right.
But, I think the wonderful complexity of psychotherapy is actually what you look for now. Because it actually then reflects what it means to be a human being. And, if you keep trying to reduce people's experiences to something very simple, it feels to me as though I robbing them of something incredibly rich. I am saying to them, 'No, you know what your life is too complicated in a bad way, and therefore you need to undo, undo, undo, undo' And, that isn't necessarily so. People's lives can be wonderfully complicated in a good way, sometimes with negative consequences. But, it is for them to be able to unpack that.
… I envision that in developing as a therapist and also next year in my internship, I would hone in a lot more on particular theories, and in that way it would make the application of it simpler. I do think it will be more in-depth though… be more robust and quite rewarding for me. And, I hope that in that, there will be some kind of efficiency that will come and that clients will then benefit from… I can almost envision then really immersing myself in psychodynamic theory to the extent that… it informs my therapy so much and gives such clear guidance, and in that I can say it will become simpler… one can almost argue for either one… (Participant A1).

It becomes more complex for me as a therapist. I always thought that its simple and that you just sit and talk about emotions. But, this two years have taught me that's not what it's about… Humans in themselves are very complex and especially in systems theory you learn about complexity … I feel that, as I go along there would be just more factors that I would become aware of that can

influence a client and I need to take note of all of that… you learn how to make order of the complex. To place, to make it manageable for yourself… last year, when we worked at Soshanguve (township north of Pretoria) at the school doing just basic counselling it was very simple and easy to do and just a reflection of emotions. And then, this year starting with the psychotherapy clinic, it became more complex because I think as you grow as a therapist, you also have to incorporate that complexity… having the reflecting team watching you… (Participant A5).

I think therapy will become I think more complex,… I like to believe it will be easier with the years of experience that you have, but it becomes complex in the sense that with experience, - then there comes that sense of assuming or kind of readily knowing or from what you've experienced and maybe trying to push that into your client-… I think it will be that difficult if you have had years or if you've seen certain disorders or, you know, multiple times… but being able to see it uniquely to this particular client and appreciating its uniqueness in that client's life (Participant A6).

The ever-unexpected nature (B3, and E3) of psychotherapy kept participants on their toes, as they realised that despite preparation, they can never fully anticipate what they will be confronted with by the client in session (A7). Participants spoke of "*surprises*" and being confronted with the ever-new.

I think your experience can help you… equip to a certain extent, but the thing about working with people is that there'll always be surprises. There's always be that moment where you're like "I haven't seen this before, I haven't dealt with this before"… people are so different. I mean you can't say, 'You've experienced it all, and you've seen it all' (Participant A7).

Definitely, my view of the therapy has changed. A lot of people, and for myself, I used to see therapy as me giving you, the client, certain advice about the problems that you present. So that's changed… it's more about me sort of helping you to see various perspectives that you hadn't seen with regards to interaction

with other people. But also giving you that environment where you can grow, can allow yourself to go through certain emotions without any form of judgment…
I see it started changing when I was in my honours year. That's when I really got to see the bigger picture, that therapy is more than just a person sitting here saying, "My husband beats me!" and me saying, "Okay well, get divorce papers and leave that person"… So, for me going through that honours process up until now, it sort of taught me to see the grey areas and to see other areas where we hadn't really challenged ourselves to look at it because it's just so difficult. 'It's easier to see you as a victim and him as a perpetrator, instead of the other way around', or even looking at it beyond that… life is more complex than giving people advice for their problems, because it's not always that easy and it doesn't work like that (Participant C1).

It's definitely become more complex… I think it will never become more simple. I think as I go on it will become more and more complex. Just because I am allowing myself to be influenced more and more by each patient… I don't have this strong need anymore to diagnose my patient or to perform or do things. And, because of that I am allowing myself-, I am more comfortable being influenced by them. If it means stuffing up or if it means going through a difficult period with them or if it means you know making a huge error… I am open to going through the motions with them… And, that is always complex because I am not in the position of treating them according to this label (Participant C3).

I think the more you learn, the more you know and the more you start to pick up things that you didn't see before. So, it just increasingly becomes more and more complex [laughs]. But, you get comfortable being what the context would be and you can hold more… Where before you could maybe only hold one or two things, now you can sit with a whole lot of elements –…
I've learned that I can, like, sit with a lot of things going on in my mind and I can still function…to hold their boxes… I'm able to do that and then look at the theory… to multi-task … they may say one sentence and you pick up something

that they haven't said… And, then you start thinking how does this link to what they've said in the previous session and then some theory pops up… and then, some non-verbal things… it's many things all at once (Participant A4).

More complex, I would say. I feel like my style hasn't changed very much. But, the way I think about things has, and my ability to link things together… I guess techniques and things like that I've added… I feel like today, I work harder in therapy… because I'm more capable of working harder… like more tools in the toolbox… you are better able to uncover underlying processes, then there's more processes to deal with, whereas before, maybe, you were working more on a surface level than you would like to admit… no matter at what point in your therapeutic thing that you're in, you always think, 'You're like getting into it' you know. Because it's an exhilarating kind of experience therapy.
It can be tiring, but it's also challenging and exciting. And, I think it feels that way no matter how many skills you have, because it's kind of like an 'ignorance is bliss' thing. Only in retrospect can you see, 'Oh, I was a bit shallow'… In the moment it's like, 'Yeah, we're getting into it' kind of thing (Participant B1).

For senior psychotherapists, despite decades of seeing clients, the challenging nature (E3) of therapeutic work did not necessarily disappear. To complicate the question of psychotherapist development further is the reality that psychotherapists are not an isolated variable in their work. "Expertise is unnecessarily treated as an acontextual psychotherapist factor, when performance in the conduct of psychotherapy is not only an individual trait but also an emergent feature of the psychotherapy interaction" (Norcross & Karpiak, 2017, p. 68). Another key facet is for the psychotherapist to develop a vigiliance to assess the impact of an intervention towards a specific client and to be able to adjust in light of the impact. This has been likened to highly successful comedians who continuosly read their audience of that particular gig and not solely rely on their prepared material to be successful in real-time.

I don't think a great therapist is an absolute. I think the clients help to co-produce a great therapist in a particular therapy or a particular session… I think it is an interactional thing… of course, there are great therapists like Whitaker, Andolfi and so on, who have a lot of experience. One can see them working very richly

with a lot of people. But, even they sometimes look very mediocre… take the typical demonstration tapes of great therapists working, then if you know these people, you have to go to the producer of these tapes and say, "Show me the pieces that you cut out, that you censored out… on the cutting floor… Therapists are also co-produced by clients and vice versa, because therapists are influenced as much by clients as they influence clients (Participant E1).

As Participant E1 pointed out, in the current study, often it is the client that contributes to the psychotherapist looking good or demonstrating skill and finesse in the therapeutic encounter. Clients, in essence, can facilitate psychotherapists performing expertly. Laitilia (2009) employs a spatial metaphor to conceptualise expertise in particularly the field of family psychotherapy outlining vertical and horizontal expertise. Vertical expertise can be defined as "the cumulative individual storage, in the person of the psychotherapist, of knowledge and skills" (p. 240). Whereas, horizontal expertise draws upon "the resources of all the participants in the therapy situation rather than relying exclusively on the skills of an expert therapist" (p. 240).

These challenges compelled qualified participants to draw on their wide repertoire of skills harnessed over the years:

I would see it more, not as complex- because what makes something complex, it's when you don't have the skill to manage that- but, if your skills reservoir, it's broad enough to contain the situation… but, I can talk about challenging… you can never get into a therapeutic space fully prepared or knowing exactly what you're going to encounter. So, in that way, it puts in a situation where you have to deal with issues as they come. So, I can never say, "I've got, you know, a well worked-out formula for the client's problem"… and, that puts you on your toes all the time… You have to be quite awake and accurate in your analysis. And, it's not something that anyone who passes, like, will be able to do. And, that's what cuts a therapist above the rest… It's your ability to hit the nodal point. And, you don't just hit the nodal point (Participant E3).

Metacognitive monitoring of ongoing actions within therapeutic consultations is an advanced skill. Senior participants spoke of distilling the complexity to have a handle on what was being presented by clients needing to be addressed (E5), and also reframing the

psychotherapist's role in addressing the client's problems (E1, and E4), in order for the psychotherapist not to become immobilised.

> *It's the art of changing the interaction, how we interact with another. That for me sums up what psychotherapy is all about, because the reason why we experience discomfort… pain is interaction-driven… and interaction is based on communication* (Participant E3).

> *It is probably very complex, but, you know, what I try to do with students… I train all these choreographers and say, "It's not your responsibility to change people. You cannot change a dog… But you can create a context for the situation in which the dog can choose to behave differently. That's your job"* (Participant E1).

4.12.2. Learning From Patients.

> *It's an ongoing process of refinement… my favourite slogan also is that, "your clients are your teachers". So, we continuously learn from our clients. So we can never say we've arrived as therapists because your clients will continuously teach you. You can never tell me that you've seen two identical patients presenting the same issues and interacting the same way to you. So, each and every client brings a new dimension of learning to you as a therapist* (Participant E3).

> *I've got a lot of respect for my patients… because I think it's the hard option to take, ja (yes), I think there's many, many easier options… just going to the GP (General Practitioner) and getting medicine, or just ignoring it, or just taking it out on someone else … I think it's difficult to want to address this, to want to talk about it, to want to understand this… I just value it so much when people walk in and they've come for this now … and, they're willing to start a bit of a process* (Participant C2).

Kottler and Carlson (2015) in their collated book, *The client who changed me: Stories of therapist personal transformation,* speak of how psychotherapists developed as a result of experiences with a particular client.

> *I think my patients are my main reviewers, obviously. They are the ones that give me the feedback… one of the big things is: Do they stay in therapy?… How do*

they stay? But, not based on a compliance element, obviously I would look for that. But, do they stay? Do they change in relation to me? Because, I never know if they change on the outside. You know, I can take their word for it, but, I am never there. So, I can never see what's happening on the outside. But, how do they evolve with me and how do we evolve together?... What about our being together changes? (Participant C3).

I get my clients to share back with me how they are feeling about the therapy… the client's feedback is important… And, your referral bases... My practice grows based on people's previous experience. So, new clients come to you and they say, "Oh, I was referred by-", and it's an old client. So, that's a monitoring thing for me… because I work in a small community then I bump into somebody and they say, "Ahh, I believe you are doing such great work in town!"… They don't talk specifically about somebody, but they refer to my work. So, that also gives me some kind of indication on how am I doing.
And, my processes that I have with clients also give me an indication of, 'How many one, once-off sessions am I having as opposed to how many therapeutic processes am I having?'… And, a therapeutic process could be four sessions… and you can recognise it as being a process, and it's not four sessions where no rapport was developed and it was just cut off…
… I do sometimes negotiate rates when I see that this client really needs this process but resources are very limited, in which case I allow them a special rate… I try and encourage a process to develop, as opposed to a once or two, 'This is my rate', once-off. Because then I am ineffective anyway. What can you do in one session?… (Participant C6).

I rely on peer supervision or peer feedback and my supervisor's feedback… 'Am I stuck and what am I doing in therapy?'… And, then also my sense of myself, you know, 'How am I feeling in this process?" I think that also helps me to determine if we are making progress, if I am not comfortable: 'Why am I not comfortable?'

Or, 'What is making me feel stuck like?'… and usually when I am frustrated it's because I am stuck. So, that's how I gauge myself.
I rely a lot on the client… they usually let you know, it may not be overtly, but they let you, know, if things are going well, if you are making progress… when they are enthusiastic, when they are committed to the process, when they are excited to come back and say, "You know, this is what's been going on or this is the change that I have noticed", so feedback… when I find them being a bit guarded, a bit resistant, I know that I am touching something that's quite important, so that tells me that I am making progress. So, when they are too comfortable I think that's when I start worrying ...[laughing]. 'Why are they so comfortable you know?'… it could be because they are making progress and they are more comfortable, or it could be that we are not touching on the right things and so they are stuck in that homeostasis?' So, I think that is an indication for me (Participant A10).

I think working with clients and seeing how they respond to you as a therapist, that's a big learning school for me. Telling me, "But this works, this doesn't work" (Participant A5).

I rely on the clients' reactions to things I say and how I come across. And, how I interpret or, you know, make meaning of how they come across to me (Participant C7).

It's difficult, because- I can build rapport and I can build a good therapeutic relationship; that for me is my success… People tell me you know, "Wow. This was great."… there is a standard question or two that I ask somewhere within the therapeutic space …"So what were your thoughts on our previous session?" So, I build-in that as a monitoring question.... To see you know, did they take anything? Was it bad?... I test their perception… It's not about me… And, then I end my therapy sessions, … by asking the question, "So, how was this session for you today?" … we can go through a whole range of stuff within sixty minutes, but at the end of the day, I need to gauge if this sixty minutes was worthwhile for the

person sitting there… That is my check and balance to see whether the person is benefiting. How they are reading. It's also a chance for me, if there is any misperception or…that we have missed somewhere, somehow, each other. To clarify things… People will easily tell you, they will quickly tell you… "Ja, (Yes) it's been good" or, "Well, this session was okay, it wasn't great." Or you know, "I feel better," or whatever reflection they give (Participant D3).

Participants prioritised learning from their patients how to be better psychotherapists (E1, and E4). Participant D3 shared how he prioritised doing "verbal check-ins" (Rousmaniere, 2017, p. 120) with clients during each session to guage how psychotherapy was progressing.

At first, I always thought that there would be that phone call ten years down the line, and people saying, 'Oh, you had such a great impact on my life, etc', and so forth. And, then I realised that you know actually most of the time they leave thinking, 'Oh, my gosh, what a bitch!' ... [laughing]. Not always, but, sometimes, I think, 'Wow, how come she didn't help me? She just gave me a bunch of questions, that I now have in my head and, and that is not fair', and, you know, maybe later on they realise, 'Ahhh, okay, I have my 'aha' moment, and, therefore this is what happened'… I have gotten one of those calls. About two years down, after therapy ended, I got a call from a patient who said, 'I don't know if you remember me, but, this is what's happened since I stopped therapy'… she just wanted to let me know how much better her life had been (Participant D4).

Sometimes, you'll do six months of therapy at - (Tertiary Psychiatric Hospital) and then your internship (rotation in a specific unit) is over and then you leave them behind. And, you've laid a foundation, but you never got to see the building… you're left feeling like maybe you did nothing. I think that's one of the challenges of this job, this feeling of helplessness that can come when you don't see the progress… you want to see very obvious progress. You want them to come next week looking happy… taking better care of themselves. You want to hear that they've got a job, whatever the hell it is! You just want to feel like you've made a difference. And, sometimes it's not like that (Participant B1).

> *Ja (yes), definitely. There is a bit of that uncertainty as to-, it is not like you can complete a survey afterwards, and say, 'Why, didn't you come back? Is it A, B or C?* (Yet)*… it was a workshop on private practice and they were saying, 'If you want to be successful, and it is a business you need to know what you are not doing right'… But, I found it a bit challenging, because I would find it a bit uncomfortable, if I was the patient or client, and someone was saying, 'Rate my service'… I think it changes the space from a therapeutic space, now, like a marketing thing… I think the challenge is then to say, '… that does not feel right for me', and not to do it; because now I think, 'Okay, I need to chase'. If it doesn't feel right, if it is not congruent then don't do it, is the way I like to do things* (Participant C5).

Participants (B1, C5, and D4) reflected how more often than not psychotherapists do not know whether psychotherapy was helpful for clients in their ongoing daily lives. Feedback from former clients is limited but does sometimes occurs which enables psychotherapists to assess the long-term outcomes or impact of their therapeutic work with clients. Rousimaniere (2017) mentions following up with clients after six months via email, in order to see how psychotherapy has impacted the client's life going forward. O'Shaughnessy et al., (2017), highlight the written feedback of clients to guage client outcomes, as they argue, similarly to participants in the current study, ultimately it is the client's opinion and improvement that counts as to whether a psychotherapist is effective or not. After all, "if our clients and communities are not becoming better, stronger, and more adjusted as a result of our work, then, we ask, what is the point?" (O'Shaughnessy et al., 2017, p. 93). Notably, Rogers when reflecting on the aspects that influenced his development most as a psychotherapist he found clients were his greatest teachers which parallels international research (Orlinsky & Rønnestad, 2005):

> The gold mine… staggers me … I feel that if I subtracted from my work the learnings I have gained from deep relationships with clients and group participants, I would be nothing (Rogers, 1980/1995, p. 62).

In the current study, Participant E1 voiced that his teachers were patients with severe chronic psychiatric disorders such as Schizophrenia and Alcohol Use Disorder.

> *People ask me, you know, sometimes who are my teachers?… I'm always tempted to say, "The schizophrenics. The alcoholics"… Because these are people who*

know something about life, but who don't want to let on that they know something about life…

Schizophrenics are almost immobilized by the complexities of life which they don't feel they can deal with, but they see it all…They're crazy, but they're not stupid…

Alcoholics, on the other hand, tell you a lot about- they know a lot about manipulation, power relationships, ah, and how they, for example, are being affected by it. They see a lot of that, but they don't let on. I mean, schizophrenics talk their crazy language, schizophrenese… or they communicate through their hallucinations or delusions. But, these are great teachers. And, if I have never met schizophrenics and alcoholics, I would have been much poorer for it, as a therapist. So, it's difficult, these are difficult customers. It's difficult work and it's sometimes scary work, but it's very rewarding in terms of your own definition of what they teach you (Participant E1).

I've learnt valuable lessons from various clients. Positive experiences as well as negative experiences; experiences that I'm proud of and some experiences that I thought I should have done it in a different way. But, I think the importance is to keep on reflecting on what you are doing. But yes, there are clients that stand out for me, from which I've learnt a lot. Not always successful therapy, but from which I've learnt (Participant E4).

4.12.3. Ever-shifting Sands: 'Success' and 'Failure' in Psychotherapy.

As the success of psychotherapy relies upon the establishment and quality of the therapeutic relationship (Horvath, Del, Re, Fluckiger, & Symonds, 2011) and not merely skills and techniques, failure is difficult to conceptualise as indicated by participants (C3, and E1) the client(s) and psychotherapist need to be a 'good fit' or make a 'good match'. Rousimaniere (2017) highlights that fundamentally expertise is gained primarily through enhancing the psychotherapist's facilitative interpersonal or relational skills first and foremost before focusing on skills tied to a specific theoretical orientation or model. Rousimaniere advocates that psychotherapists need to invest time in becoming consciously aware of their "interior state" or "internal experiences" (p. 128) during a session. Attunment is defined by Rousmaniere as "noticing what you *see* the client doing, what you *hear* from the client, and what you *feel*

internally while sitting with the client" (2017, p. 130). Rogers (1980/1995) speaks of how the psychophysiological flow that happens between two people is used to check in with the feelings of the psychotherapist. He points out that this "togetherness" that the psychotherapist shares with the client is "a trial and error exploration" (p. 145).

Qualified early career psychotherapists (C2, C5, and C6) spoke of being more comfortable with clients. A level of ease and self-confidence was also evident in terms of being accepting of having a personal style of being a psychotherapist (C5) as opposed to trying to follow or emulate the book religiously. As such allowing themselves to live out their own interpretation of what a psychotherapist can be. This sense of autonomy also includes not feeling one has to help everyone and be good at everything and thus referring to colleagues is done without feelings of self-criticism (C5, C7, and E4).

> *I know my areas where I do not enjoy working at all. And, I made the decision several years ago not to go down those roads* (Participant C7).

Going into independent practice is not merely a threshold crossing, but a critical point of development. As interns approached the end of their internship or at the completion of the Community Service year (as is the case for clinical psychologists) new anxieties surfaced of, 'Can I make it out there?' Private practice is an independent, yet unprotected environment. As Participant C5 indicated suddenly the psychotherapist is autonomous and solely responsible for their growth and the quality of their psychological services. Senior psychologists (E2, and E5) empathised with the anxiety-provoking nature of launching into private practice.

Young guns (Londono-McConnell & Matthews, 2013) or newly qualified professionals are open to various opportunities in the field. Parham (1992) outlines key struggles that young psychotherapists grapple with, which include financial issues. The business aspects of being a health professional is not focused upon during coursework at the university. This may be due to Psychology being situated in the Faculty of Humanities or Faculty of Health Sciences, where business acumen is not taught. Being confronted with having to make a living from helping others in distress, was found to be challenging for trainees and graduates entering the profession (Geffen, 2013; Viljoen, et al., 1999; Walfish & Barnett, 2008), due to lack of prior exposure to business skills (A3, B1, C5, and C7).

> *It's a really, really difficult thing because you want to help people, and I think it would be even more problematic in like a private practice where people are*

paying you. I think that would increase the anxiety or the guilt feeling even more… at the end of the day, psychotherapy is almost like a services rendered type of thing. There's a business exchange in there… but it feels awkward that this service doesn't come with a guarantee… That's my own internal thing that I need to work through, that guilt feeling of 'there needs to be progress. You need to see change. I need to be helping you'… You can rush people, you can be prescriptive, you can introduce techniques that aren't indicated… this intense need to feel like, 'I'm fixing you', can be very problematic. So, it's something you need to be hyper-aware of (Participant B1).

Going into private practice, we are not taught business or private practice business. So, there is that thing of having to figure it out for yourself … I don't think we are trained to balance the two, or in-depth on how to run a practice. I remember having one lecture on that and at the time not thinking about it. … private practice it is a business, but at the same time: 'How much?' I wouldn't feel good about focusing on only the business aspect of it. It doesn't sound like good business sense, but, at the same time, it is not a business with an object, it is business with people… I am consciously self-aware of: Some of the decisions I make may not always make good business sense, but they fit. For example, if someone calls and says, 'They want this and they want it in that number of sessions', I could easily say, 'Yes, I can do that for you of course!', But, if it is not the way that I usually I do therapy and it is not the way that I work-… So, not saying, 'yes', just because that is money (Participant C5).

When a trainee transitions from training to independent practice after writing the HPCSA board examination, newly registered psychologists have been found to often experience a dramatic increase in autonomy which can elicit feelings of excitement and yet disorientation. Psychotherapists can draw upon the principles of deliberate practice (Ericsson, 2006) as a rudder to guide their professional growth and development through the often turbulent waters of the early career years and beyond. In the current study, network-building (E4) was deemed paramount to enjoy longevity in the profession. Participant C4 found going to a self-chosen supervisor invaluable and like-minded peers in a reading group.

Participant C2 spoke of embracing error and how she has fostered self-acceptance as opposed to self-blame and self-flagellation. Intern psychologists spoke of how they have needed to come to terms with being imperfect in their work with clients (B1, B2, and B5).

> *I have learnt that it's okay to be vulnerable… and to be open to emotion… Whereas, before I thought to be a therapist was to sit up straight, and have your hair done nicely, and to be put together, and to-, you know, be all fine… that's not what it is to be a therapist* (Participant B2).

According to Ericsson (2004), and Pachman, Sweller, and Kalyuga (2013) trainees need to deliberately practice their skills to improve their performance in areas of weakness otherwise they may be stuck at an arrested development stage which prevents psychotherapists from moving to higher levels of performance. The criteria of success for psychotherapy is difficult to pin down as aspects that influence the effectiveness of psychotherapy are by no means constant.

> *The self-monitoring I think can be challenging. But, I try to when I look at my list of patients, I try to really think about: 'How I am feeling about the work? Where is it going and what is happening?'… because I think it is easy to just have this session and, 'Oh, it is already the next session'. That happens, and then I try to say, 'Okay, I need to think about this person a bit more'. But, I think the supervision helps with that because it sort of forces it* (Participant C5).

> *I think for me the ultimate marker of a successful therapy will be when I can-, when my patient catches a glimpse of my rotten potato. And, that can happen in many ways, it does not have to be disclosed… they can see that my readiness to sit with their intensity, to work through their shit, came from a place inside myself... That they can see the humanness in the therapist too… but usually only towards the end of the therapy… 'Would they be ready to see it? Will I be ready to show it'… it can mean the patient at the end of five years gaining an awareness that all that the therapist has struggled with me and for me and through me has come from their own place of woundedness, maybe.* (Participant C3).

Participant C5 reflected that she explicitly prioritised time to evaluate each client's progress and also time to evaluate how she is feeling about her work currently. She felt scheduling time to evaluate the work whether through personal reflection or supervision became necessary to ensure that one did not become absorbed in doing work without reflecting on the

therapeutic work. Setting aside time to consciously assess one's work with "an intense focus on assessing client outcomes" is a key activity of deliberate practice to improving clinical effectiveness advocated by Rousmaniere (2017, p. 27).

> *I think it is challenging, because I could say in those moments I think I understood or where I see the client's progress. That I think is how I monitor the success. If I think that there is something happening, then that makes me feel like I am being useful. The failures are challenging because there is something that I might think, 'Oh, that feels like a failure!', Like when someone does not come back and you don't know why. But, then I have to think about it and think, 'Maybe, it might just be because-… I don't think it's also a milestone to reach. I think you reach it and then sometimes you move away from it again and then you reach it again… depending on what's going in your personal life, in your professional life, in your academic life. Because I think we all kind of continue the training process… You will oscillate* (Participant A3).

> *I'm not a person who holds people in therapy for ten, twenty, fifty sessions... You engage in therapy for as long as you want to engage in it, for as long as you can benefit from it. After that you are wasting your time, your money, your everything* (Participant D3).

> *I always feel failure is (an) early termination, I always feel bad about that… 'I could have and should have?, perhaps?, and couldn't I have done this and this?', But, I've come to learn that, you know, also to respect the patient's decision, and that it's not just me and what I have done. I'm not the all-powerful… they've got free will, and, let them go if they need to go at a certain point* (Participant C2).

Rousmaniere (2017) believes that therapeutic failure acts as a necessary impetus for psychotherapists to improve their competencies. Failure or one's "uncomfortable learning edges" (p. 155), is a gift as it spurs on the psychotherapist to acquire the ability to practice well in order to achieve their highest potentional as a psychotherapist. Gallway speaks of the "inner game" which refers to an individual's capacity to forego immediate gratification and rather demonstrate a willingness to work and a desire to excel (Bloom, 1985).

Failure has lost its potency or its meaning almost to me, I don't actually even understand or use the word anymore… I mean, in the same way that society understands, because to be human is to fail. To be human is to be vulnerable… So, for me, I'm not driven by, 'Oh, is this success or is this failure or what?'… even if they come for two sessions or so-, I'm giving them an experience that they have not had before and then if they terminate, it- it's not necessarily failure, but I do feel bad about that, ja (yes). That's the closest that it comes… but, I don't see failure in the traditional way anymore (Participant C2).

Failure doesn't speak to me very well, in the sense that people come to me, we have four sessions, their problem hasn't been solved. They didn't get what they came for in the first place, they go away… That has to do with non-fit rather than failure… Ah, non-fit in the relationship between myself and them…
but, the interesting thing about if you want to use the term 'failure' one of the interesting things about that which looks like an immediate failure can become a long-term solution. So, sometimes people are pissed off and they leave and then six months later –… They improve, they report back to you, or you see them in a different context and, you know. Something in that context might not have been me… sometimes people go to therapists and that's enough of a punctuation for them to look again, without the therapist doing much or being useful… Bateson always said, "In relationships it's the <u>difference</u> that makes the difference"… Sometimes going to a therapist is that difference which emphasises the nature of the-, or the intensity of the problem which is enough to kickstart a recalibration between them… Therefore we shouldn't be grandiose about how great we are. Sometimes, we're just a marker on the road for the client, for the couple
(Participant E1).

Participants pointed out that failure is often an unhelpful concept as it is difficult to conceptualise. For often psychotherapists are not necessarily confronted with failure but rather a mismatch between the individual psychotherapist and the client (C3, and E1). In fact, 'failures' may be valuable information as to where the therapeutic process is. For example, the process is

currently experiencing stagnation (E2) or the success or benefit may only resonate for clients after the psychotherapy has concluded (E1).

> *Stagnation is still information for you. It also tells you where your client is… So, I don't see it necessarily as a bad thing and I don't see it as a function of my own input or practice as a clinician. But, I see it as feedback, that my client is saying to me, "I can't move". Then it calls for me to investigate or explore the context around stagnation… stagnation is interaction also, looked at from another point of view. It says to you your client cannot move and what is the communication value of that… I don't look at what the client does not have. I look at what informs the stagnation* (Participant E3).

Realistically, participants also pointed out that psychotherapy is not a pancaea for all problems. Therefore psychotherapy and the psychotherapist's contribution should also not be over-estimated. Many factors, ultimately, influence the resolution of clients' difficulties (E1) and psychotherapists need to be cautious so as not to fall into the trap of becoming grandiose seeing oneself as needing to be omnipotent or God (C2, and E2). "A therapist must remember that life is not a problem that can be solved" (Keeney & Keeney, 2012, p. 10). Qualified therapists were careful not to oversimplify therapeutic processes in an either-or category of success or failure, but rather spent time figuring out which aspects contributed to an effective therapeutic process, with the awareness that they were not omnipotent.

> *I also look at… how is my interaction impacting on my client and how is my client impacting on me? And, that informs the shared space between me and my client. In other words, I'm not the only one who is responsible for that and the client is not the only one who is responsible for that* (Participant E3).

Trainees reported having to become self-aware of how their expectations of the therapeutic process could be at times unrealistic in terms of external constraints. For example, less than suitable setting, or limited time (B1, B2, and B5), and/or patient role fatigue or the depleted inner resources of the patient or unintentionally self-serving in terms of needing the client to become better in order to prop up one's self-esteem as a psychotherapist or to confirm for the psychotherapist that psychotherapy indeed works (B1, and B5). Acknowledging the limitations or 'ceiling' of psychotherapy and that psychotherapy is unable to magically cure or fix people in distress is a hard pill for trainees to swallow as it challenges their hope and

idealism about the benefits of psychotherapy. Yet at the same time a certain level of hope needs to be held onto in order not to sway to the other extreme of becoming demoralised. As such trainees are in a process of achieving a balanced view of what psychotherapy can and cannot achieve for individuals and society at large.

> *I think a big part of being a therapist is avoiding projecting that onto your client. I had to recognise that I felt unhappy if a client left unhappy… I caught myself almost trying to cheer them up in the last two minutes before they left the door… I know that it comes from my own personal people-pleasing nature, the idea that I've caused unhappiness or made someone unhappy is uncomfortable for me. So, I had to recognise I was so in my own need and not their need. There's nothing worse than if you're miserable and someone is trying to cheer you up, and you don't want to be cheered up. It's horrible, a horrific experience for anyone, so definitely the wrong thing to do… it's this idea that what does it look like to be successful? Someone gets better. But, sometimes people are going to get worse before they get better, and sometimes it's going to take years for people to get better.*
>
> *… the other big lessons at Unisa, which was almost a turning point as well, actually, was the idea that sometimes there's a ceiling on how much you can do… that's hard to deal with as well. Not forcing people to be something that you want them to be, to satisfy your own need to see progress. Because some people, all you can do is contain them* (Participant B1).

> *I had to realise that it wasn't at all beneficial for that person, and you could effectively cause even further damage, or you're just wasting your time, just so that you can get closure… you do it for process notes… then ten sessions down the line you realise you're still on that same problem, and then you think, 'Well I did this, why didn't it work?' Because you were stuck and you didn't need to do that. If you'd just embraced it then! And, that's when the realness as a therapist is starting to come out again, to say, "Look, you know I'm feeling very stuck at the moment! I don't know what to say?"… Then, I think you tend to go a little bit further with that* (Participant B5).

Trainees spoke about themselves learning from experienced psychotherapists to address this expectation in themselves as psychotherapists and directly with their clients.

> *It's important to also alert people to that, kind of almost psychoeducate people about what is it that you can expect from therapy… I would want to do that with a degree of finesse so that the client does not run. But also that this isn't like a big golden, 'I-am-going-to fix-you' promise. Because, I think and what I have seen, a lot of clients come in and they go, "I want an answer. I want you to tell me what to do, or how to fix this, or what's next".*
>
> *So, I would hope that I could describe just a realistic image of what is that is going to happen in the process and that it's okay… that is something that my personal therapist did really well. So, it has been a learning curve… it is related to the values of therapy, because in a sense it is quite a transparent process. But, isn't it also ethical to do that? Because, unfortunately, if people do have a very strong preconceived notion and it isn't what therapy is, they are just going to be disappointed… there is something about, 'This is what you are going to get and this is what you are not going to get. If you want people to tell you what to do, and give you steps go to a coach, you know. It's very different work'* (Participant A1).

In light of the slipperiness of determining the 'success' and 'failure' of psychotherapy participants learnt over time not to take on full responsibility for the success or failure of therapeutic processes (A3, C6, and E4). But rather to construct psychotherapy as a co-endeavour between the client and themselves which is voluntary for both parties (C2, and E1) and wherein psychotherapist and client are co-responsible for outcomes (A6, C3, C6, D2, E1, E3, and E4).

> *I think it also depends because, you know, I can see someone for six sessions…- the most minor symptom- has now gone. Or it doesn't even have to be gone, it's just that they have found a space to honour the symptom…*
>
> *From my perspective, I don't plan the patient, so, I generally see failure as something that happened between us that we either were too blind to see or we did not have enough time to figure out what was going on between us… I really believe that the patient should have the space to say that to you, if they feel they don't fit with you. And, more importantly, that the therapist has the space to tell*

patients in the beginning that there is something in their relationship that might not be the best for the patient… A lot relies on what happens between you and the patient in terms of working out whether or not this is going to work, (or) whether this has been effective… (Participant C3).

I have always shared that with my clients that I can only do so much and there is a greater portion sitting with them. So, I can't take complete responsibility for the therapy, I only see them fifty minutes every second week, because that's how my practice is run at the moment. So, I don't have that much power over them… in order to make their… therapy effective in such a short span (Participant C6).

The responsibility can sometimes be overwhelming. That is tiring, this responsibility. I need to remind myself over and over again, 'It's not my life, it's the patient's life as well' (Participant E4).

4.13. Embracing the Pothole-filled Journey

To travel hopefully is a better thing than to arrive, and the true success is the labour – Robert Louis Stevenson (1881).

Knowledge rests not upon truth alone, but upon error also – Carl Jung (1933)

Participants (B1, D2, E2, and E4) found that being a psychotherapist involved having to manage making mistakes in one's work and working with 'stuckness' in psychotherapy (A5, A6, A10, B1, B5, and D2) or not being the right or perfect psychotherapist for every person. Trainee psychologists (A10, and B1) when they started to loosen their expectation of getting everything right started to experience more freedom to relate to and 'be oneself' with their clients (Baird, 2014).

Congruence to me is very important in therapy and funny enough, appropriate failure… if you are a perfect therapist, we have a problem because you can't be perfect all the time. And, if you are trying to be perfect, then you're definitely going to miss things (Participant A2).

I think part of it is just recognising that not everyone is always ready… You know sometimes people need time. Sometimes people need to resist- they need that. I think the lack of progress is something you have to be okay with.

It's easy for me to imagine because I'm really bad at DIY, so I've got plenty of stuff and things that don't work the way they are supposed to… you have to be okay with not always being the right tool. But, being the best tool that you can be, because you're not perfect. If you ever think you're perfect you're doing yourself a huge disservice… I think it's just about being you, and being genuine and being there and present.
I think getting caught in the techniques and the theory, you lose yourself as a person. I think the bad therapist is the therapist who thinks that they one hundred percent knows what they're doing. I think you have to be okay with the chaos and all of that. You have to be able to sift things out, and you have to be okay with being frustrated… feeling despair. You have to own those emotions and recognise them. And, use them if you can. I think being a therapist is a long journey of being imperfect (Participant B1).

But, therapists will be trained, "If you are in a maze you have got to find the right solutions… let's get you as quickly as possible to the centre so that we can solve your problems and then we can get out of here" … therapists don't like being stuck. …"Oh shit! You know, what now?... This is not going like it should be going!" I get stuck a lot of times in therapy and I just go, "Oops!" And, they look at me and I go, "Oh, well". And, I mean I am not embarrassed about it … Ja (yes), they see you as a professional and like this all-inspiring person, 'You are going to solve my problems', and I mean, if I could do that! ... Psychology would be a walk in the park. I can go write three books now and I would be a millionaire for the rest of my life. Not a chance (Participant D2).

Accept the mistakes you make along the road… A good therapist is someone who makes mistakes and questions themselves on the road (Participant E2).

I do make mistakes and I also regret certain things that I've done. Fortunately, not major harm. But, now looking back, or should I see a client after five or years when they come and ask for a follow-up appointment and you reflect, you realise

> *then is that, 'I haven't considered certain aspects in the person's context or personality. You could have dealt with it in a different way'* (Participant E4).

> *My personal development was towards not being so afraid, so holding back, so defended against the world, including my clients. But personally, yes, there is also a growth and it's so wonderful… to now feel at home with myself. I'm not so self-critical. I am critical but not that self-critical. I don't hold myself back, and that is personally and professionally* (Participant E5).

Participant E2 advocated that through self-reflection the psychotherapist can, "*take that crisis and transform. Like an onion – peel another layer to get to the centre* (Participant E2). Senior psychotherapists or the seasoned sages have found themselves relying upon their internal expertise, as such "their own body of knowledge that they rely on much more heavily in their work" (Londono-McConnell & Matthews, 2013, p. 4). Here, Colman speaks of deep integration generating clinical wisdom,

> that comes from long hours of practice but practice alone does not necessarily make perfect; there also has to be a spark that comes from the inner depths of an artist (2013, p. 203).

Participants (E1 and E4) spoke of being vigiliant in terms of keeping their therapies alive and vital to ward off boredom, and to keep the therapeutic process in a state of movement. In addition, new trainees were depicted as re-energising seasoned sages to stay on top of the latest developments in the field. Senior psychotherapists also voiced that they enjoyed teaching younger psychotherapists (E1, E3, and E5).

Skovholt and Rønnestad (1993, 1995, 2003a) identified the senior level of psychotherapists at 25 years or more. However this might need to be reconsidered as there is a difference between senior psychotherapists who have practiced 25 to 35 years and those who have practiced 35 years or more. It is not necessarily the years that describe the stage, but rather the noticeable shift in how one works as a psychotherapist prior to finally no longer seeing a client in a chair (the end point of one's career as a psychotherapist). Orlinsky (2014) speaks of seasoned psychotherapists (15-25 years) and senior psychotherapists (25-50 years). Rogers (1980/1995) identified adult seniority as an over 65-years old marker, which parallels adult developmental theories where one is considered now retired from their professional career and free to pursue other interests. However, psychotherapists do not necessarily retire from their

career as a psychotherapist at the conventional point of retirement, but they do become highly selective of how they wish to use their energies therapeutically (E1, and E5). Rogers points out there is physical deterioration of one self that one needs to contend with, and yet one does pursue new enterprises within the broad field of psychotherapy to bring about fulfilment. The current study found that psychotherapists' continued professional development becomes highly selective or channeled into key interests and contributions after specifically 35 years of practice.

4.14. Personal-professional Overlaps

Gibson et al. (2014) highlight that professional development of the psychotherapist is constituted of both intrapersonal and interpersonal aspects. According to Baker (2002), a thin, but, essential boundary needs to be drawn between the psychotherapist's personal and professional self. She acknowledges that the psychotherapist's personal life is a foundational structure that holds one's professional self and therefore plays a critical role in a psychotherapist's work with clients. With this in mind, psychotherapists need to regard self-care and "professional replenishment" as part of their duty or "life-long commitment" to their work (Klein et al., 2011, p. 299).

> *I personally don't think that you can separate the two. I think that you as a therapist you start to see things in a different light, and you start to understand things differently. But, when you take that home with you-, I think the only way- you've got to learn to do it is bracketing… And, that's something I still struggle with, because you deal with it your whole day and then you go home. And, then something happens and you're like, 'Uh-oh, that just didn't happen like that, there's something more to that?' … that ability to switch off I haven't learnt yet. I'm still in the process of learning that, because you know when you're in an analytic relationship… then you can work off that transference…, it's very different if … you're just in a more romantic relationship with someone or whatever, you can't see things the same way, but it's incredibly difficult* (Participant B5).

> *The use of your self in therapy is something that I believe in very strongly. And, you cannot be two separate people…your personal being and your professional being shouldn't be so distinct and so far apart from each other that*

you have got to consciously alternate between the two, … when you are developing inside then you are developing your own congruence. When you are learning more about yourself those are things that also assist you in therapy…
I use personal lives and personal being… So, for me personal life is more social… Who you are, when you are not working eight to five. You know, who you are with your family, with your friends… And personal being is more with yourself. Who you are as a person… so your personal being is used a lot more in therapy.
… you are going to have influences in your personal life, you are going to have stresses, you are going to have your own morals, your own ethics, your own frameworks that you abide by your culture, your religion. Although it is important, it shouldn't intrude in therapy to the extent that it blocks you as a therapist where you start imposing on to the client (Participant A10).

Who you are as a person, needs to be who you are as a professional. Obviously, there is professional boundaries and ethics. That is so important but you cannot, for me; you cannot distinguish between D3 the therapist and D3 the person, because D3 the person will be the person sitting with you in therapy… So much of you is in therapy (Participant D3).

My sister said something a lot more like understanding and calm I suppose?... it can also be difficult because you can't-, even though you're trying to be a normal person… people don't always take you as a normal person.
So, my husband will always say like if we're in a fight, "I'm not your patient! So, don't talk to me like that!" "But, I'm not trying to talk to you like my patient".
So, it's almost like a part of you that is a therapist, but is always a therapist…
You can't switch it off and switch it on. Although you do try and you are, like you're not always, but you know what I mean. That is who you are. You can't always separate the two.
Like my sister's a marketing manager for - (international cosmetic company).
So, when I do see her, she'll like, maybe, comment on my eyebrows or say like,

"What lipgloss you're wearing?" If she hugs someone she'll say, "Are you wearing this fragrance?" So, she's not trying to be the marketing manager, but it just happens. She's just-, she knows what fragrance you're wearing. She'll comment on your lipgloss, she is just that. Because that's who she is. So, I think it's almost like saying with me, 'It's just who I am' (Participant B2).

Rogers (1951) was acutely aware that the personal-professional journey of psychotherapists together with other actualising individuals has repercussions across a person's life, 'I altered therefore my world changed'. Yet, Rogers (cited in Anderson, 2001b, p. 347) believed that personal growth needs to be integrated with one's career as he emphasised "the importance of congruence in all life roles and relationships".

I remember working at the Teddy Bear Clinic (for Abused Children in Johannesburg, Gauteng) in my Honours year and like just being so traumatised by everything that I heard and seen… my supervisor said to me, "When you study psychology, the pathways of your brain change. The way you view the world actually changes the structure of your brain. And, you almost wish that you didn't know because you start to learn and see the rawness, the realness of human nature. And, you can never go back because you know now." And, it is like that.

… you see people like walking through life, just being so naïve. Like for instance, my husband, he doesn't have to explore every feeling that he gets… If I'm having an off-day, I wonder why, 'What's happening?' Thinking about myself. He's just like, you know, go through life and it's great. And, almost sometimes I envy that… I am able to switch it off, but every day you are at work and you-, it's a different way of being. You're thinking about things, you have an interaction with that person and you write process notes and think about it. You make understanding (Participant B2).

It's a very specialised field, and just as I don't know what a chemical engineer does day to day, I don't think socially or, even my family has to really understand all the complexities of it… I have said to my husband, "Like, if we ever go to a restaurant and there is a client like, I am going to tell you that we can't go in.

Like, I would rather want to go to another restaurant". And, he understands a bit of it. But, I don't think he understands like [laughing] psychodynamic depth of it all, of people having access to you and your private life …
I have gone through a lot of my own personal development, but I cannot share it with other people in the broader sense… I think in terms of my future I will integrate a bit more… (Participant A1).

It was condensed… I come from – (distant city)… when I go back now people are like,"Wow, you have grown". Very intensified and very quick… I felt unnatural at stages compared to where others are at in my life… I think I just sounded more mature and more at ease with myself (Participant B6).

I think becoming a psychologist helped me be more real and more anxious. [laughs]. I'm not sure if the anxiety is more than it was before or if I'm just more aware of it… I don't think you can get away from anxiety. I think when you have got people that come to you with certain issues, or personal dilemmas or struggles or hurt; I think even on a very spiritual level there's something happening (Participant C6).

Dimidjian (1982) examined the personal-professional lives of female American psychotherapists in their thirties with four to 12 years of years of practice who spent at least half their time doing psychotherapeutic work. Adams pointed out that women are more prone to get caught in the compassion trap due to expectations around their relational ties; this trap is said to inhibit their professional growth in the helping professions. Dimidjian (1982) through detailed timelines being described during ongoing interviews with each participant, identified four areas of concern verbalised by female psychotherapists in their thirties: one's relational tie to a significant other, a focus on professional training, growth, commitments and achievement, focus on those she nurtured or wished to nurture and lastly a focus on her own internal feelings, sensations, and personal growth. She found that in their early thirities, five of the six participants entered personal psychotherapy to consolidate their sense of personal identity. All participants in Dimidjian's study voiced that as women they experienced "pulls toward relational and work involvements as difficult to define and delimit realistically" (1982, p. 38) with the task of setting boundaries as an ongoing challenge.

I do also feel that just as you're not necessarily a chartered accountant at a braai on a Saturday afternoon, you shouldn't be a psychologist at a braai on a Saturday afternoon with friends. I do feel that part of the self-care process is tapping out every now and then. Is not being constantly aware, is letting go, is not thinking about transference, countertransference [chuckles] and all the other therapeutic tools we use…

I was raised in a household where my father definitely was different at home than he is at work, and I think I've had a very good example. You can't treat your children like clients or your husband like a client. You can't treat friends like clients. You'll alienate them. It's not your position (Participant A2).

4.14.1. Going Back Home as an Official Psychotherapist.

Trainees reported that family-of-origin issues became affected and their family system underwent alterations due to the perturbation that training creates in the relational systems in which the trainees inhabit.

My father never believed in therapy up until when his sister passed away and even went to therapy and then finally completely bought into this whole process. So, we had a joke when I got into my masters that I should start psychoanalysing my family members. And, I didn't, and I was very acutely aware of that, but we had a joke around it... (Participant A2).

I feel like I can sit in therapy and then that is that and go home again. But, the personal development has impacted me and has impacted my relationships and how I view things differently … I used to be very, very close to my mom, like really, extremely close, to the detriment of her relationship with my dad. And, it is so interesting how when I engaged in my own therapy and worked through a lot of my own childhood things, our relationships started- shifted and shifted… to the extent now where I would say I am more healthily distanced from her. And, her and my dad's relationship have increased in happiness or satisfaction in a way. So, it's interesting to me how my own personal development has also impacted my family (Participant A1).

4.14.2. Redefining Friendships.

Strain was also reported as being experienced by trainees in their friendships as their training programme created limited free time to socialise with friends. Trainees also reported that friends reacted negatively to trainees becoming psychologists. Some friends accused participants of psychoanalysing them (A1, C7, and E4), others were reportedly offended that participants were now as professional psychologists reluctant to fulfil their previous role of unofficial psychotherapist or confidante that they had previously fulfilled in their relationships.

> *People do not really know what to expect of me, you know. When you introduce yourself to someone, and they say, "What do you do?" and you say you are a psychologist, people kind of take two steps back and they are so fearful of judgement or that you can read their mind [laughing]* (Participant A1).

> *Sometimes you fall into that pattern with your friend. You don't respond like a normal friend anymore when a friend comes and talks to you about an issue. You can't. Suddenly, it's like if you're a chartered accountant and someone talks to you about finance, you switch over… I don't think you'll ever go back to reacting exactly how a friend should react to a friend of yours breaking up…*
> *You do bring in elements... it becomes part of who you are and I think if you are in the right space and you are in the right occupation, then that's something that sits quite comfortably with you. I do, however, feel that it's important to be aware of that and make sure that you don't over-therapise your friends or your family, but I also have found that with the knowledge, you can maybe kind of support them in a different way* (Participant A2).

Trainees reported figuring out the boundaries of assisting friends emotionally as a friend and not as a psychotherapist were difficult to decipher. During their training. participants reported having embarked upon redefining friendships and in the process losing or terminating unfulfilling relationships (A2, B1, B2, and C7). Similarly, in interviewing six Canadian psychotherapists in their thirties about their personal lives, Kennedy and Black (2010) found that participants reported that due to their training that they were more mindfully selective in choosing which relationships to invest their personal energy into, as such maintaining "meaningful and satisfying relationships while letting go more of superficial or one-sided relationships" (p. 430).

I lost a lot of friends... I used to have a very big friendship circle. Because I don't share their views anymore and we don't feel the same way about things anymore. And, I just didn't have the energy to kind of talk about it with everybody. And, also the fact that you were also never available. Some of them just got tired of inviting and me saying, "I cannot attend a party or a braai"… that was quite difficult. But, I carry that now…
I think if a masters is something that you place great value on, then that's something you're going to have to make peace with. You are going to have friends that are not going to understand what you go through, and also a lot of what you go through would awaken things in them that they don't like, and that's not your problem… Most of the friends I have left are also therapists or are children of therapists. So, they kind of get what we've gone through (Participant A2).

Friendships definitely changed over the years. If I look back ten years ago… it's changed dramatically and a large portion of my friends now are therapists themselves… those relationships that I maintained over the years, 'just because you are friends' kind of left and dissipated (Participant C7).

When I am with my friends, they all want to talk about psychology or ask me questions about that. And, I have to put- place boundaries sometimes there and say, when we are at a braai, that, "No, let's talk about rugby or something else," and not about the psychology or what's going on…
Previously, when they had a problem, I would try to solve it for them, help them. And being in this course, I noticed that it is not always my place to solve the problems for them… some of my friends actually rebelled against ...[laughing] that boundary that I placed there and they couldn't understand that I didn't want to talk or didn't want to help anymore in the way I did before. So, that was difficult. There was definitely a time of adjustment, that needed to take place… in training Systems you become aware of your positon in your friendships and your family so I became aware that I always had the position of being a

comforter… you also realise the whole thing about triangles and that you are not necessarily helping someone if you are the middle person…
some friendships that I was close with, definitely are not the same… I just think it's because people have a rigid view of who you are… then comes training and you start changing and your views start changing. So, it influences your friendships… it did place a strain on some of my relationships (Participant A5).

If you go to a dinner and there's tension between someone, you can feel it. You can see it. You can, if someone's really angry at like the Checkers (supermarket)… you can feel that… like also every time there's road rage, if someone goes in front of me and pulls back… often it feels so like unsettled and awful! And, then I wonder what- I mean obviously something inside of me also doesn't like being shouted at or sworn at, but also like feeling, 'Why is this person so angry? What happened?' Like, 'Why are they like that?' I wonder what's going on. But, like a normal person who's not a therapist would just be like, 'Well, it happened', and carry on… I think you become aware and it becomes sharp, and also like being aware, being able to manage it (Participant B2).

What intrigues me… got me more interested is that when I talk to people about you know, like a social conversation: "And, what you do?", "I am studying psychology." I think what fascinates me is seeing myself in the way they respond. So, they think exactly the way I thought… 'Oh, it's quite a nice job you sit for an hour and talk to somebody and you get paid for it!'… it's not that at all! There is so much of the work that goes behind the scenes, there is so much of digging deeper and knowing exactly (Participant A10).

Participant A1 voiced that she was still in a process of figuring out the impact of her burgeoning professional identity on her friendships, but thought that her introversion easily suited the profession in terms of its requirements of confidentiality and privacy.

It has impacted different areas of my relationships and then socially, I am uncertain still about how that has impacted… I have actually always been a very introverted person, so the profession suits me in that way that I don't need to sit

with a lot of people and talk about my work or about what I do, or how great things are going at work or not at work (Participant A1).

Trainees by virtue of their training found themselves challenging their friends in terms of racial (B1) and sexual orientation discrimination (A2, and B2).

*We were-, just had a braai having a few drinks and he said, you know, like "If my son was gay, I would like kill him!" or whatever. But, then I was like, "Why? So, then he was like, "Because in the bible it's a sin". And, then I was like, "What? And, then there was this like huge debat*e... *And, like a very Afrikaans man, and like, 'Dah, dah, dah, dah'. And, then it was over and we left it. … four days later he SMS'ed my husband… "I just want to say like I wanted to apologise to (B2) if I offended her in any way and it's not my intention. It sounded like she really gave me a lot of stuff to think about"… And, I did think, 'He's only ever known NG Church. He's only ever known that what the bible says is what it is… no one has actually challenged that'… then he was able to-, he started to think like, 'Hey, maybe there's something else or maybe there's-?" So, maybe it can be thought… that willingness to be open about it* (Participant B2).

Trainee participants (A5, A10, B1, B2, and B3) relayed that during the process of becoming a psychologist, personal relationships were significantly altered or terminated. The impact of relational loss was attributed to the lack of others' support or understanding and the time pressures of the programme. It is as if the psychotherapist is taken out of their society of family and friends as they know it, on a non-literal level, and comes back altered. During the masters training programme, as 'the internal landscape' shifts in the trainee the repercussions are felt and, in turn, impact the external world of relational ties of trainees.

4.14.3. "I Am Not Your Patient": Interpersonal Challenges with Partners.

Specifically, trainees also spoke about how their professionalisation impacted their relationship with their intimate partners.

I hate that it takes so much energy that when I get home, there's nothing left for myself or anybody. So, I feel a lot of the time like a shell… I definitely neglected relationships, especially, my romantic relationship with my partner… he gets it to some extent, but there's been lots of fights… he wants the old (B3) back. And, I

don't know where she is or what she looks like [chuckles]… the person he fell in love with eight years ago and this person is not the same… It's years of-, it's maturing, it's growing up, it's entering the workforce, becoming a therapist, going to your own therapy, going through a masters (Participant B3).

My husband… has done a little bit of like personal work… he realises now that that is part and parcel of our relationship even. So, when things have gone a bit rocky, he was quite open to go, "Yes, let's go to a couple's counsellor or couples therapy". Where perhaps before if I hadn't engaged in this profession that would not have come so naturally (Participant A1).

I have found with my husband… from the beginning, I have let him into what I'm learning. And, I'll be like, "You won't believe this! Oh my word, look at this! Look, Melanie Klein said- And, you can see it there, there and there!" We play around with ideas and we have numerous jokes about it and he'll be like, "Are you making reparation right now [laughs]?"… it's fun now, because we can speak about it and he's also almost educated. And, it's almost like I brought him along in the journey. And, sometimes I'll get this frantic phone call from work, "You won't believe-, I just experienced what you said to me, Babe! Here, in this workspace and I understand it now".
Numerous of my colleagues did not do that and they experienced a great disconnect- because you as a therapist suddenly, if you previously had a problem at home with homosexuality and now based on what you've learnt, you were quite open to it, you have to bridge that gap… If you don't bring your family and friends along and help them and teach them and support them as well, then they will never reach that position with you. And suddenly, you find yourself on one side of the cliff and them on the other side of the cliff and there's no bridge to connect you again (Participant A2).

When we were in the first year of my training, we were in Psychodynamic Psychotherapy… then the lecturer told us, "Nothing happens by accident.

Nothing. But everything has a purpose". So, I'm like, "Wow, can you agree?", like, you know. And, my husband was my boyfriend at the time, and he said, "Do you want to come to watch rugby with us at Loftus Stadium?" So I'm like, "That will be amazing!" So, he bought a ticket and then he was like, "Ha! I didn't buy you a ticket. I forgot." Then I was like, "Nothing happens by accident. You didn't forget. Unconsciously, you don't want me there! Why did you invite me?" Like, I had this huge fight with him.

And, then I told my lecturer in the class… "This is what happened". And, he was like, "You're not in a process with him. You're not in your office. You don't have the boundaries. You don't have everything. You can't interpret his behaviour. You know what I mean? You have to know, he's not your patient… So, many other things are happening in that relationship. You can't do that. You can't interpret his behaviour like you would a patient. It's not the same thing". He's like, "To interpret a patient's behavior, you need certain, you know, this is what time it starts, how it ends, this is-, there's a frame. There's no frame in a relationship". And, that was such a high moment for me. I was like, 'Wow!'.

… in normal relationships, I will think about it and I'll be like, 'I wonder why you?'… And, I will still think it and I will still make up my own mind. But, I won't voice it (Participant B2).

Trainees (A1, A2, B1, B2, B3, and B5) voiced how their partners noticed the changes and how they needed to reflect on how not to place their partners into the patient role or to engage in what could be perceived as the critical gaze (Foucault, 1963). However, this is appeared to be a co-dynamic as their partner or friends also reportedly voiced the societal expectation or assumption that they will now be analysed or their minds will be read or they are being pathologised or can access 'free psychotherapy' from participants. Psychology has been invested with power (Satir, 1987). Some of that power is real -beneficial and harmful- and yet on the other hand other aspects of that power is merely mythical and stigmatising.

I think therapy is also a constant push-and-pull between power and being completely powerless and vulnerable. And, ironically, the moment you've achieved that complete sense of vulnerability, you are almost in complete power.

And, it's a difficult concept. But, I'm still kind of mulling it in my mind, but I'm figuring it out (Participant A2).

A psychologist-as-partner in a sense can be constructed as 'a threatening object' in relationships. In South Africa, Hall (2004) investigated how the training to be a psychologist can impact the personal relationships of the trainee.

Remember, we are therapists in the first place. When I trained as a mediator, a year or two ago, I found it extremely difficult. I had to ask for extra sessions because it was so difficult for me to step out of the therapist role into that of a mediator, and to not be a therapist in the mediating role… it has an impact on your personality, and your personality has an impact on your therapy. It's a dual role. But yes, that becomes your lens,.. people that you meet, they would ask and then they hear that you're a psychologist. I say, 'If you analyse now…', of course, you'll say, "No!" but, of course, you do analyse them. I try my best not to label people if I'm not in therapy [chuckles], if I'm not doing therapy. But, yes, how can you miss that? (Participant E4).

4.14.4. Boundary-making with Loved Ones.

Psychotherapists instituting their own process of boundary-making or role clarification with significant others can be particularly disconcerting especially if one fulfilled the role of confidante and fixer in one's family or friendships prior to undergoing training to be a psychologist. Qualified participants (C1, C6, C7, D3, and E4) also voiced the awareness that being a psychologist becomes a core identity that is evident across contexts especially in terms of ethics and values. However, over time one also learns to place being a psychologist in the background when relating to others in other relational contexts in order to avoid negatively impacting one's personal relationships and oneself.

Oh, it's integrated... I find it difficult to separate the two because I work in a small community. I have got to be constantly aware of where I am personally, because people see me out there as a professional and not as a person…
So, on a personal level that has been difficult for me… I am restricted to very specific places where I can just let the guards go down and just be me… that is basically at home or with very, very close friends... personally and professionally

you are going to maintain the same kind of values, respect… you are going to carry them through… (Participant C6).

I think as much as it's a profession; being a psychologist is who we become. I don't think we can always separate them out… I'm not an accountant who can put my calculator down, work with numbers and when I leave here I'm not calculating numbers. When I am having a conversation with you, that valcro that doesn't leave you… you are always a psychologist… Definitely, a different type of career… it's not necessarily about taking cases home, but more about the skills or the abilities that I have acquired in myself as a person…
How I look at things has changed over the years… for example; sitting in a social circle; you see things differently. And, I can't necessarily be, you know, the superficial or mindless content conversationalist. It's difficult to shut off my mind… To seeing process or understanding process… I have become a lot better at not giving it too much attention… several years ago, I would sit and think and work out what's happening and you know, add the psychology, the terminology to it. 'What's happening here?' And, I eventually, you can't do that. You have to separate and have some kind of personal life. Otherwise, you will go crazy. So, I have gotten much better…
But, it can also be useful. I mean if you see conflict brewing amongst a social group … I can step out or try and defuse it. When it's necessary … I don't think you can always put things aside… I definitely can't.
One thing that doesn't leave me is people's awareness of me being a psychologist. So, when you are having a very difficult conversation with a partner or a family member or a close friend… They would say either; "You're a psychologist. You should know."…Or; "Don't psychoanalyse me"… I feel at times you have got to justify when you are just being the person, commenting on how angry I am because of whatever… But, the psychology never leaves you. Even if it's not me bringing it into the picture… so, it's very difficult (Participant C7).

I have a rhythm, a pattern, I do it every day. After my last client, I would sit, I would make tea for half an hour… Either on my own or I would sit-, I'm in a luxury position to work with a psychiatrist. We work separately, but in the same building. We would sometimes just talk about cases, because I think we trust and respect each other… and how challenging certain cases, uh, would be. And, that is very helpful! And, then really ready to leave your practice and just to be a wife or a mother again, or a sister again.

But, that is something that I'm very aware of, because over the years, you gather some wisdom… to know where the boundary is: 'I'm the sister, I'm not therapist'… my sister would ask me for help that is more professional and then I would say, "As a psychologist, I try my best to stay…, a psychologist would approach it in this way, but as your sister, I would also confirm this"… I try to acknowledge the different roles. But, yes, it is not that easy because you re-process all the time. Things can become very challenging (Participant E4).

Participant E4 felt that one cannot do away with one's lens, the way one makes sense of people or the world, or automatically leave one's psychotherapist identity at their practice. But, rather over time one learns to make conscious decisions about being a psychologist and yet also being a partner, parent, adult child, sibling, and friend. For example, she has implemented a transitional time so that she can navigate the identity shift over thresholds and to avoid over-contaminating her family responsibilities and family life with client work. As such, actively instituting "cleansing rituals" (Baird, 2014, p. 139) of the emotional intensity after seeing clients. She also spoke about verbally defining her position and role with others, when pressurised to be a psychologist outside the frame or formalised context of being a psychologist with a patient.

Charlemange-Odle, Harmon, and Maltby (2014) interviewed 11 British clinical psychologists regarding their experiences of personal distress. Charlemange-Odle et al. (2014) found that participants reported not wanting to go to work, multiple accumulated stressors which included financial difficulties, illness of partner, bereavement and the birth of a child. In a similar vein, senior psychotherapists in Norway reported that being a psychotherapist is difficult (Råbu, Moltu, Binder, & McLeod, 2016). The psychotherapists saw their experiences with clients as both enriching and stressful. "Exposure to aggregated human suffering was experienced as a strain" (p. 743). Being exposed to this cumulative human suffering can lead to existential

demoralisation and disillusionment (Watkins Jr, 2012). Charlemange-Odle et al. (2014) found that British clinical psychologists speak about the necessity of a "work-life balance" (p. 247). Theoretically, Kramen-Kahn and Hansen (1997), and Stevanovic and Rupert (2004) understand such boundary-making as a Career-Sustaining Behaviour (CSB). After all, the ability to achieve a balance between work and play is considered to be a quality that develops with maturity (Maslow, 1968). In response over the decades of their practice, Norwegian psychotherapists consciously prioritised self-care strategies (Råbu et al., 2016). Similarly, to the current study where participants highlighted managing daily transitioning times between their professional life and personal life, Råbu et al. (2016) found that senior therapists also prioritised managing the transitions between their 'parallel lives'.

4.15. Learning to Care for the Self

Skovholt (2001) highlights that the task of helping professionals is to work out how to balance caring for others with caring for self. After all, psychotherapists use themselves as the agent in therapeutic change. Dlugos and Friedlander (2001) interviewed passionately committed psychotherapists who spoke of needing to consciously balance their personal life with their professional life and to make time for non-work activities. They held the belief that "insufficent attention to nonprofessional life negatively affects their performance as a therapist" (p. 300). Baker (2003), and Maslach (1982), Kristiansen (2007), Skovholt, Grier, and Hanson (2001), and Skovholt and Trotter-Mathison (2011) put forth that psychologists need to investigate key ways to curb burnout and maintain professional vitality and resiliency.

Participants, across the spectrum, emphasised the risk of seeing too many clients (A3, B4, D2, and E4) and needing to be diligent about limiting their client hours. Qualified psychologists voiced how they deliberately maintained a manageable caseload (C4, D4, and E4), despite pressures, in order to prevent burnout or negatively impacting their service to clients. In the current study, participants spoke about diversifying what professional activities they were involved in, for example, teaching/training or supervising, attending workshops and varying the types of clients one saw in terms of presenting problem or modality (C4, E4, and E5).

> *Seven patients in a day will finish you off…[laughs]. Seven is like my limit. I have had eight, and you push through… But, you are absolutely shattered by the end of it… I can't work full-time – eight patients a day. It would make me a bad therapist. But, I can work Monday, Wednesday, Friday- full day. And, then*

mornings and evening Tuesdays and Thursdays with a gap in the middle. And, that's fine… I am not going home at eight o'clock at night and doing admin and resenting them for taking up my day when actually I have created that reality… and, then you abscond responsibility because someone has come to take your time. But, you have sold that time… so, you have to find the balance before the people come into your room… Now, I refuse to work on a Saturday… because I am not a better therapist for it (Participant C4).

We are at risk. Remember, I'm in the very fortunate position to be in private practice and to be at the university. So, I don't need to see 10 clients a day. The clients that I see are more a bonus because I earn my basic salary from the university. So, I can choose how many clients I see… I do see too many clients. But yes, I'm glad I'm not in full-time practice because I don't know how on earth you do it, because the demand is so high! And now, especially with these changes in terms of registration, with the strictness in terms of registration categories, is that counselling and educational psychologists would phone and ask to take their clients over and so the demand is increasing…
In terms of burnout, I think if you do not take good care-, because I think that is part of my sanity, to stay healthy, is that I have the luxury to do other things as well, and train and be in training. Because being at the university allows us the opportunity to attend workshops in time off (Participant E4).

I'm not an emergency therapist. I'm not someone who is on call 24/7. It's not part of how I work. I cannot do that… I have known a few of them (therapists) who've actually committed suicide because they couldn't go without. They answered the cellphone every time. They were always on call, they were always in an emergency room. It didn't work out for them. No, there's breakdown, there's suicide. It's not the way to go. Self-care is important (Participant E5).

Being in a shadowland makes you want to exit; have a fantasy of opening a guesthouse instead (Participant E2).

Participants acknowledged that being a psychotherapist can, if one is not consciously putting in time to pursue relaxation and quality time with their significant others and friends, lead to becoming isolated (B4, B7, C5, and C6), and being at risk for burnout or exhaustion (A2, A6, C4, E4, and E5). Furthermore, participants acknowledged that psychotherapists can become depleted, drained (A3, C2, C4, C5, and D4), depressed, despondent (D4, E2, and E5), or even be at risk of committing suicide (E5). Participants also highlighted the need for psychotherapists to have a life outside of helping people by actively pursuing 'down-time' with friends and family at home (E4), going on holiday (C7, and E5), having a braai (South African barbeque), going to dinner with friends (A5, and C6), pursuing hobbies (C7), or other recreational activities (C7). Such pursuits assisted in preventing participants being overwhelmed or becoming blunted or jaded (B1) by the level of psychiatric co-morbidity and trauma that clients often present with in South Africa.

> *I am a firm believer that psychologists need to take time out regularly through the year… you have a good break where you are away from whatever work you are doing. And, you can just be human and just be fine and be normal. Go and do photography or run or holiday* (Participant C7).

To prevent self-isolation (B7) in the profession of psychology by the confidential nature of therapeutic work, senior psychologists (E4, and E5) relayed how important it is to establish a professional network of trusted colleagues for referral needs, professional growth or guidance, as well as selecting congenial colleagues that one can personally connect with for support.

> *You need to stay in contact with the larger community of psychology as well. I don't think any psychologist should work in isolation. Not only that, you need the support system in terms of colleagues and psychiatrists. But, also in terms of yourself, who can you contact and who can you trust* (Participant E4).

> *The self-care is very important… I understand why they say psychotherapists are very high on the list of people that burnout very quickly, and I've experienced that twice before. Not on a very deep scale, but where I was definitely close to that tipping scale* (Participant A3).

Despite the real risks, participants voiced how *"rewarding"* (A1, C2, E1, and E5), *"fascinating"* (D3), *"lovely"* (E4), *"wonderful"* (E4, and E5), and *"meaningful"* (A2, and E5)

they found their work as a psychotherapist. Similarly, Yalom (2017) regards psychotherapy as life-affirming. Being a psychotherapist was seen as a *"privilege"* (A4) and to journey with clients a lifelong gift:

> *It's going to bed at night and realising you have made a difference today. I always say to people, "When you're 80 years old and you sit on the stoep (porch) with your little… blankets and you think back on your life and you think, 'Have I made a difference or have I made a helluva lot of money? Which of the two resonates with you?' I want to sit on the stoep (porch) and think, 'I made a difference to people's lives!'* (Participant A2).

> *For me the whole process, it's been so much more than just theoretical training. … it's really been like a gift to me, as a person because at the end of the day, I've been privileged enough to be trained in this profession, so I get to do something I love for the rest of my life… the way it has developed me both professionally and personally… it's something that I'll always walk away being so grateful for… humbled by.... I think you should always hold close to your heart because it's such a special experience, that not everyone gets to have* (Participant A4).

> *It becomes a meaningful journey that never has to end. That's what's wonderful about being a therapist you don't have to step down until your brain gives in. You can actually do the work* (Participant E5).

4.16. Sharpening the Saw: Continuing Professional Development.

> *If your passion is strong enough, you are always hungry in this profession* (Participant E2).

The notion of 'never having arrived' was voiced by participants across the spectrum (B7, C7, D3, and E3) this resonates with Jennings and Skovholt's findings (2004, 2016) and Nel and Fouché's phenomenological study of a South African student psychologist who voiced that a psychologist is always in "a process of 'I am becoming'" (2017, p. 4). Competence is not a static state that is awarded once and for all when registering as a psychologist. Rather competence is best understood as a habit that continually requires self-reflection and personal development on the part of psychotherapists in the spirit of lifelong learning. Importantly, ongoing development

as a psychotherapist cannot be accomplished if professional development is divorced from personal development.

> *A person cannot have enough training… if you have that notion that you have arrived, you haven't seen anything yet… As a psychologist you need lifelong learning because skills can get dull. You might find yourself having 'arrived' or you might all of a sudden deal with burnout or kinds of weird processes yourself. And then, to know that: 'Hold on, I'm not adding any value to this person's life at present because I am not what I am supposed to be'* (Participant D3).

> *I've never stopped being trained and attending workshops. Even before the CPD system came in… it's not for 30 years that we have to… there wasn't CPD training in the beginning, not officially. You got a certificate but it was more for tax reduction [chuckles]… in the beginning, especially in Bloemfontein, it is a small community of psychologists. So, we formed a very strong, dynamic group and we would go for training and we would invite people to come and to train. And, I'm very happy for that. And, that pattern never changed for me. I realised how important it is to be in contact with other psychologists… to talk about new developments: "What is new? What can we add to our therapy to make it even richer? Are there any techniques? What about theoretical development?"* (Participant E4).

> *It's very important as a therapist to become flexible… you might have 30 years of practice, but still be at the first level of practice because you haven't moved beyond that. If you're not willing to be shaped as a therapist, you can have 50 certificates, but those certificates will not help to experience or anything, because it's just a showcasing of the number of years and the accolades* (Participant E3).

The rationale of formalised, ongoing professional development is rooted in the widespread belief and ethical obligation that there is an ongoing need for each psychotherapist to maintain a certain standard of practice and develop further expertise and knowledge beyond qualification. The perishability of training can be counteracted by training trainees to develop the ability to "reflect-in-action" (Schon, 1987) and cultivate the ethos of active learning to stand them in good stead throughout their career (Bootzin & Ruggill, 1988).

CPD as a formalised and monitored activity by the HPCSA has only been introduced in South Africa within the last two decades (Viljoen et al., 1999). The ongoing accruement of CPD to enhance therapeutic competency is the primary responsibility of each practitioner. CPD activities need to be pursued according to their usefulness and relevance to each practitioner's work. Each practitioner needs to demonstrate a level of serious commitment towards further study and training courses as the field remains ever-changing (Wilkins, 1997). Their individualised CPD plan needs to be structured, cohesive and demonstrate conscious intent to improve one's skills and evidence of skills having been improved through additional training.

However, Wilkins (1997) points out that a lack of clarity exists regarding the nature of ongoing development and the quantity deemed suitable annually. He differentiates between active CPD activities and passive CPD activities and this categorisation needs to be considered when monitoring of CPD activities is undertaken by professional bodies. Rousmaniere et al. (2017) point out that passive learning CPD activities provide topical information to psychotherapists, but has "questionable impact on actual skill development" (p. 5). Thus passive-format CPD, arguably, does not achieve its outcome of ensuring the welfare of clients.

> *Now these days, a lot of these CPD workshops are so disappointing. I would sit there for three days and at the end, leave and only think, 'This was a nice muffin because there was nothing that I don't know', and I'm not arrogant by saying that… I would look at the invitations or the advertisements of these CPD workshops… and I would see… -we need social workers and I have good relationships with social workers- but as soon as I see that they and teachers and the dominees (ministers) and everybody, they are invited, then I realised, 'Oosh, now I'm just going to earn CPD points, because the level is much more in general and it is not in-depth and it is not taking us any further: 'Most of us know exactly what is going on here, but it was good to hear it again'. But, how many times should I hear the same thing over and over and over again?'*
>
> *… but, there are workshops, for example, the – (senior psychologist) workshops. They are to the point… if you look at the topics, it is in-depth explanation and discussion of specific topics. It's not as in-general… Ah, of course, you need an introduction, but on a level that you think about …*

for the younger people because they need the experience and also they need the community of psychologists, which we have at these workshops, which is of value… but, I think the important thing is that there should be levels of CPD training… an introductory course, a middle course and then advanced course, and I think we should grade the CPD workshops (Participant E4).

It's actually very essential. We cannot stop reading and attending conferences and opening ourselves to different avenues… I am a provider of CPD and every year, I do four or five workshops in various areas. So, I have to read and keep up-to-date and I'm interested in that. And, I've done a lot on different therapeutic domains- not really techniques. I don't like the word, but therapeutic approaches. So, every time, I'm influenced by what I am doing, what I'm reading and what I'm teaching. I learn through teaching. I've always been a teacher… I was a lecturer and professor… I was a teacher for a long time, ja (yes) but, I always did clinical work… When I retired from university, I carried on with private practice. But, I miss the students, I miss the teaching. So, I created a venue for myself, yes, where I can now teach… that's meaningful to me, not to keep it to myself but to share it and to get input from others…

… some of the workshops that I have attended were magnificent… I think of Nancy McWilliams and people like her that they got out. I learnt a tremendous amount from that. I knew her books but the contact with her, meeting with her, getting a sense from her, meant a lot (Participant E5).

During training, novices are carefully guided and socialised into how psychotherapy works and through a number of processes (observation, supervision, consultation, and practice) learn to meet professional expectations and immerse themselves in becoming "native speakers" in the professional culture of psychotherapists in terms of values, attitudes cognitive skills and strategies (Gibson, et al., 2010). Along the developmental trajectory, Gibson, et al. (2010) speak of qualified psychotherapists articulating a greater sense of fit within the profession, being involved in the professional community, and taking hold of their responsibility to the profession. Gibson et al. found that when this sense of belonging occurs psychotherapists are known to now

rely upon themselves for motivation and validation to sustain themselves for the course of their careers.

Wilkins (1997) concludes "the art of undertaking 'enough' professional and personal development is to be able to explain convincingly why you did what you did, how you did it and how as a result of it your practice is different or you are different" (1997, p. 18). In this light, personal reflection needs to be undertaken by psychotherapists to identify their professional aims and interest, to also evaluate what they have experienced in practice to date and from this basis develop areas for professional growth. Henderson et al. (2007) highlight that is necessary for psychotherapists to identify the "fuel" that lights their "internal fire" within the profession in order to be passionate about one's therapeutic work. Wilkins presents a strong case that such reflection may benefit from input from a peer or mentor to assist the practitioner in formulating their unique professional developmental plan.

Monitoring professional growth can be achieved by maintaining a professional log, processing recordings of client work especially within a supervisory context where specific, constructive feedback can be sought (Wilkins, 1997). Participants in the current study highlighted the benefit of reviewing the video-recordings of their client sessions in order to enhance their therapeutic performance with the same client and other clients. Monitoring personal development can occur through keeping a personal log or diary or journal. Herein, introspection may include reflection on personal blind spots that may be impacting on work with specific clients. Such written reflections may instigate or inform the personal psychotherapy that professionals decide to undertake (Wilkins, 1997).

Cost includes the price of the learning activity and the cost incurred of not earning while attending learning activities (A1, and A2). In addition, the cost of travelling to training is also in need of consideration as many specialised or advanced trainings often only occur within the major cities in South Africa. However, participants (C1, and E2) voiced the danger of not sharpening the saw.

> *I think there is a relationship between personal development and my skills as a therapist. And so, if what I have learnt at M1 was only my guiding principle, I doubt I would be where I am. Because M1 is just a basic foundation, and I need to continually build on myself. So, I improve myself going to conferences…therapy… doing meditation, learning about Eastern therapy… -doing my own PhD- so, that*

I see that as personal development-. And, as a result of learning, it translates into how I do therapy. And, it also brings awareness to myself that, "No, I am able to see where I am lacking, as the therapist…
during the Psyssa conference, I picked up there are so many therapy styles and therapeutic skills and assessments that I was not aware of, and I need to be abreast with that. So, 'If I'm not going to conferences and seeing what's out there, how can I help my patients?'… If you are only going to use what you have been taught, and you are not willing to learn, then you are doing disservice to your customers" (Participant C1).

4.17. Conclusion

From a stance of cumulative experience, as emphasised by Orlinsky (2014), and Orlinsky and Rønnestad (2005), and Skovholt and Rønnestad (2003) the participants from different vantage points shared how they had developed since they began their work as psychotherapists. Five sub-samples tapped into the experiences of participants at different phases of their career: those just starting to see clients in their first year of masters training, interns, the first years after qualification (5-7 years after writing the board examination), experienced psychotherapists (a decade or more of seeing clients) and senior psychotherapists (two decades or more of seeing clients). Level of competencies of trainees as compared to qualified professionals was discussed tentatively, in the findings of the current study in relation to other studies of psychotherapist development in South Africa and across the world. The final chapter of this thesis, Chapter Five, will endeavour to cover the significance of the overall findings of the current study to the profession of psychology in terms of psychotherapist development and psychotherapy. Furthermore, the concluding chapter will discuss the limitations of the current study as well as the contribution of the study in terms providing recommendations for psychotherapist development of clinical and counselling psychologists in South Africa and suggest future research directions in the research field of psychotherapist development studies.

CHAPTER FIVE: CONCLUSION

5.1. Introduction

The final chapter of this thesis summarises the overall findings of the current study in an attempt to outline possible implications for the profession of psychology in terms of psychotherapist development and psychotherapy. In line with qualitative studies, the self-reflexivity required in this particular study will be summarised in order to provide transparency of the research process. The limitations of the current study as well as the recommendations for psychotherapist development of clinical and counselling psychologists in South Africa in light of the findings will be detailed. Lastly, future research directions in the research field of psychotherapist development studies will be outlined to ensure that interogating psychotherapist development remains a priority of the profession of psychology within South Africa in light of international trends and to contribute to broader international research studies being undertaken.

5.2. The Relevance of Psychotherapy in Contemporary Society

Mental health issues rank third in relation to the burden of disease in South Africa, and approximately one in six citizens are likely to experience a depressive, anxiety or substance use-related disorder during the current year (Herman et al., 2009). The public health sector serves 84% of the population in South Africa (Britnell, 2015). Approximately, only 465 psychiatrists, and 6408 psychologists, trained in psychotherapy, practice in South Africa meeting the mental health needs of a population of 56 million (Gillis, 2012; HPCSA, 2017; www.sasop.co.za). Emsley (2011) reports that 167 psychiatrists work in the government sector, however only 4% work exclusively in rural areas. According to the results of the World Health Organisation Assessment Instrument for Mental Health Systems (WHO-AIMS, 2007) within South Africa 0.28 psychiatrists and 0.32 psychologists per 100 000 are registered to meet the mental health needs of the population. A staggering 75% of individuals with mental disorders in South Africa do not receive mental health services (Williams et al., 2008). Freeman (cited in Tromp, Dolley, Laganparsad, & Govender, 2014) states that 85% of psychologists are in private practice servicing 14% of the population.

Individuals with severe mental disorders have often accessed both Western and African healing systems (Muelelwa, Sodi, & Maake, 1998). About 20% of individuals with mental health concerrns seek help from traditional healers and spiritual leaders. Stigma and discrimination

against people living with mental illness has been exacerbated by some traditional explanatory beliefs, holding a disability grant and being unemployed (Egbe, Brooke-Sumner, Kathree, Selohilwe, Thornicroft, & Petersen, 2014; Lund, Peterson, Kleintjes, & Bhana, 2012). Which can lead to non-compliance with treatment recommendations and contribute to defaulting and patients' social isolation from others. In some contexts within South Africa, improved links between community members and individuals with mental health concerrns has reduced stigma (Kakuma et al., 2010; Lund et al., 2012).

Internationally and within mostly urban parts of South Africa, psychotherapy has become more accessible and people in distress seeking psychological assistance are enjoying an unprecedented reduction of stigma ((Kakuma et al., 2010). Internationally, celebrities such as Prince Harry, Pink, Pope Francis, Catherine Zeta Jones and Halle Berry amongst others have spoken out about the benefits of seeking specifically psychotherapy, in an attempt to squelch public stigma surrounding mental health issues (Chang, 2017; Wolton, 2017).

Though psychology is not new to South Africa, the professions of clinical and counselling psychology together with the training programmes to become a qualified psychologist have only been formalised in the last four decades within the country (Bantjies et al., 2016; Pillay et al., 2013). Pillay (2016) voices that confronting the current state of the discipline over two decades into democracy and contemplating its future must remain a "critical exercise" (p. 149). Contextually, though each individual's story is confidential, the South African profession of psychology need not be shrouded in secrecy. What psychotherapy can offer an individual, family or group should be publicised across multimedia, and psychoeducation of the public and advocacy should be a priority of all qualified psychologists (Pillay et al., 2013).

The visibility of the psychology profession and allied professions could be improved especially in light of the current mental health crisis (Lund, 2016). For example, the Life Healthcare Esidimeni Disaster in Gauteng where more than 143 deaths of mentally ill, indigent patients occurred in 2016-2017 as a result of being hastily deinstitionalised by the Gauteng Department of Health from government paid healthcare facilities to cheaper, yet notably poorly resourced and unregistered non-governmental organisations without extensive involvement or assessment by mental health experts, highlights the urgent need to turn around mental health services (Makgoba, 2017; Tau, 2017). From the perspective of psychiatry, Stein (cited by Farham, 2017) points out this was "death by maladministration" (p. 277). The South African

Society of Psychiatry (SASOP) released a media statement which indicated that mental health services in the country are in an "appalling state" (SASOP, 2017, p. 1). Grobler (2017) in light of the Life Esidemini Disaster in Gauteng and strained mental health services in the Eastern Cape states, "we are in fact regressing evermore into a state of defectiveness… our hands are tied by cutbacks and bureaucracy and empty promises" (p. 4). Janse van Rensburg (cited in SASOP, 2017) cautions "the failure to provide accessible mental health care will only entrench the pervasive stigma and discrimination of the mentally ill in South Africa" (pp. 1-2). From the perspective of clinical psychology, Pillay (2017, p. 143) voices that "ideal conditions" for community-based care for chronic mentally ill patients does not exist in South Africa, and thus "deinstitutionalisation *en masse*" is not the most responsible intervention but rather is indicative of the South African government not prioritising mental health care intiatives that are based on international evidence and instituting effective planning mechanisms in a deliberative manner. This preventable tragedy serves as an urgent impetus to improve and monitor the quality of mental health services countrywide.

Ongoing advocacy to protect patients' rights and address patients' mental health needs should not necessarily be solely left for non-governmental organisations to shoulder, such as the South African Depression and Anxiety Group (SADAG) or The Cape Mental Health Society. In collaboration, the government, professional bodies and civil society need to prioritise mental health treatment within the South African context (Ahmed & Pillay, 2004; Lund, Peterson, Kleintjes, & Bhana, 2012; Rock & Hamber, 1994). For example, internationally, the Anna Freud National Centre for Children and Families, based in London, is a key partner in the UK's nationwide Heads Together campaign (2016) to reduce stigma of mental health issues as well as having recently launched the Talking Mental Health campaign (2017) within the British school context with the declaration, "You're never too young to talk mental health", which is in stark contrast to the historically entrenched British societal custom of the stiff upper lip in the face of adversity.

Cook, Biyanova, Elhai, and Schnurr (2010) point out that the composition of the American workforce that offers mental health services or psychotherapy to clients in distress has widened to include not only psychiatrists, psychoanalysts and psychologists but extends to include social workers, psychiatric nurses, marriage and family psychotherapists as well as addiction and pastoral counsellors. Though the current study specifically limited its sample

within the South African context to interviewing clinical and counselling psychologists who provide psychotherapy, it is important to keep in mind that they work in an environment where other professionals or lay workers also may offer counselling, psychotherapy or life coaching whether it is recognised legally or not in South Africa. The blurring of professional boundaries also creates an urgent impetus for psychologists to offer psychotherapy that is credible and at a level of competency that demonstrates notable skill for their clients' benefit.

The current study on psychotherapist development is relevant for the current mental health context in South Africa. As it is only through richly understanding what constitutes an effective psychotherapist that quality psychotherapy services can be implemented to serve the mental health needs of the country's population.

5.3. Self-reflexivity

Boden, Kenway, and Epstein (2005), and Ortlipp (2008) point out that qualitative research is a messy and muddling process that only looks clear in the final phase when written up as a report of the research. To counteract a pristine notion of qualitative research undertakings I used a reflective journal to sort through the messiness and, yet, convey the research process as it authentically occurred.

Finlay (2002) concedes that when a researcher commits to self-reflexivity, one agrees to step into "muddy ambiguity" (p. 209). Yet, she highlights that self-reflexivity holds the potential not merely to show how the researcher has influenced or impinged upon the research undertaken but how the researcher's self can be transformational for the research itself.

In terms of epistemological reflexivity (King & Horrocks, 2010) the choices I made reflect many of my own assumptions about knowledge creation and research (Mauther & Doucet, 2003). I believe a number is only a reference point as the authentic story behind the number is where the richness lies. A family cannot have 2.2 children rather we need to look at what accounts for the variance between the one-child family, the three-child family and so forth, which implies multiple realities and contradictions. The gold mine of transformational knowledge is found in qualitative undertakings informed by an epistemology such as social constructionism.

One of the key decisions of this study was the decision to undertake a research design of a qualitative study, where interviews would be the data-gathering method. I personally value the individual's voice and thus felt that one needs to hear "the voices from the field" as such the

"defining moments" of psychotherapists as they journeyed along their professional-personal paths (Trotter Mathison, Koch, Sanger, & Skovholt, 2010) in order to begin to understand how psychotherapist development occurs across the career of a clinical or counselling psychologist within the uniqueness of the South African context.

As a qualitative researcher, I cannot guarantee that the viewpoints shared by participants are true or valid, nor can the methods I employed be regarded as offering absolute accuracy or validity, as is the claim made by quantitative researchers. In stark contrast, qualitative research does not assume it can offer absolute assurance to the reader, rather the value deeply rooted in humility, out of respect for multiple subjectivities, that a qualitative researcher can offer the reader is *transparency* in terms of how the research was conducted and how the researcher's unique eye saw the meanings behind the text (MacNaughton, 2001). As emphasised by Paré and Sutherland, "we cannot escape our subjectivity" (2012, p. 180).

My self-reflexivity includes many of the facets highlighted by Finlay (2002, 2003), and King and Horrocks (2010). In light of self-reflexive practice I needed to be transparent about my identity as it informs the current research endeavour (Morrow, 2005). Firstly, I am, like the research participants, a South African clinical psychologist who practices in South Africa, seeing a wide of range of clients for psychotherapy, albeit in part-time private practice. I was trained in South Africa and currently teach and supervise psychotherapy of clinical masters students at Unisa. As such I am located simultaneously in the very population I am investigating (Mauther & Doucet, 2003).

Being an 'insider' had many advantages as firstly, I felt personally invested in my research. Secondly, I was familiar with the jargon used and some of the terrain the participants transversed, which proved exceptionally helpful in terms of following their train of thought and articulating follow-up questions to check and deepen the sharing within the interview. Thirdly, I am used to interviewing people about their experiences in a conversational manner and thus felt at ease with the data-gathering method. As confirmed by Nelson et al. (2013) "from their training as practitioners, counselor researchers possess skills such as empathic responding; multicultural awareness, knowledge, and skills; and the ability to be reflexive. We believe these skills guide counselor researchers and help in their awareness of how qualitative interviewing might impact their participants" (p. 2). Additionally, in light of their relationship-building skills psychotherapist researchers offer the opportunity for participants to feel empowered or validated

from the interview that aims to be a meaningful conversation about their experiences (Nelson et al., 2013).

Qualitative research and family psychotherapy both make use of postmodern thinking (Anderson, 1997) and draw from social constructionist perspectives (Haene, 2010), which is well-suited to the current study which is situated within a social constructionist epistemology.

> For each of the ways that being an insider researcher enhances the depth and breadth of understanding a population that may not be accessible to a nonnative scientist, questions about objectivity, reflexivity, and authenticity of a research project are raised because perhaps one knows too much or is too close to the project and may be too similar to those being studied (Kanuha, 2000, p. 444).

Part of my self-reflexivity includes personal aspects of this research process. At many points my own personal journey of becoming a psychotherapist became constellated. As Jung (1954, p. 256) observes,

> the shamanistic techniques in themselves often cause the medicine-man a good deal of discomfort, if not actual pain. At all events, the 'making of a medicine-man' involves, in many parts of the world, so much agony of body and soul that permanent psychic injuries may result.

Ortlipp (2008) outlines the advantages of maintaining a journal to address our "baggage" and "issues" as individuals who are invested in their research endeavours (p. 698). After all, Ortlipp (2008) points out it is the researcher's baggage that led them to choose a particular topic and to their chosen ways of finding the answers they sought. A researcher's baggage can be seen as the researcher's personal experiences, feelings, and opinions about the topic under scrutiny and as influencing what is focused on when analysing and interpreting the collected data.

From a social constructionist viewpoint, Gergen (2015, p. 63), encourages social science researchers to choose research projects where they are motivated by their values and to relinquish the empiricist idea of a researcher keeping a "dispassionate distance" from the topic at hand, as all research findings reflect the world as it has been constructed by people. Nothing in the world or reality/realities is independent of an individual's perspective or lens. As researchers we cannot claim to be outside of ourselves or the "dominant discourses" of society (Gergen, 2015, p. 63).

Without a doubt, I have an intense closeness to the current research undertaken as psychology has been the journey of my professional life for nearly two decades. Studying and practicing psychology and specifically in the domain of psychotherapy is not merely my office job- quarantined off- as for better or worse it infiltrates my personal life with both richness and at times a level of distress. Furthermore, in interviewing colleagues, I could not claim to leave my own experiences as a psychotherapist at the door (Gergen, 2015). To try sanitise this research with distance or objectivity would be an unconvincing falsity as most psychotherapists will acknowledge neatness does not represent the realness of life and throughout this research process I have been challenged, inspired and affirmed in my choice of profession as seen in my journal extracts (See Appendix B).

However, the disadvantages of being an insider cannot be overlooked as the psychotherapist-researcher can take for granted that interviewing is like breathing. However to be effective in interviewing within a research context it is vital that the researcher engages with participants as experts of their own experiences (Roulston, de Marrais, & Lewis, 2003). Furthermore, researchers need to be vigilant in examining their own histories, assumptions, and values while also recognising that their position will continue to carry contradictions (Kanuha, 2000). Corbin Dwyer and Buckle (2009) critique the dichotomy of insider/outsider arguing that in a sense a designated insider is still simultaneously an outsider to that specific individual's experiences despite having obvious commonalities. To hold the complexity, Corbin Dwyer, and Buckle (2009) speak of the "space between" the researcher and the interviewee as the main priority as opposed to resorting to the insider/outsider split.

> It is restrictive to lock into a notion that emphasizes either/or, one or the other, you are in or you are out. Rather, a dialectical approach allows the preservation of the complexity of similarities and differences (Corbin Dwyer & Buckle, 2009, p. 60).

King and Horrocks (2010, p. 20) accurately assert that from a social constructionist epistemological standpoint the researcher is a "co-producer of knowledge" with the participants.

Similarly to Ortlipp (2008) my reflective journal writing provided me with an inquiry space to articulate various possibilities for the conceptual frameworks for analysis of the data. I saw that South African clinical and counselling psychologists tend to conceptualise their development as a psychotherapist as an overarching three-period process namely: Before I

became a psychologist, becoming a psychotherapist through rigorous masters training and the finale of being a psychotherapist in the world. I almost found myself developing a mantra "before, becoming, being a psychotherapist." After months of reciting this mantra, as I waded through transcripts, I recalled the literary device of the three-act play having relevance to psychotherapy. Indeed, I had remembered reading *The Creative Therapist* (2009) by Bradford Keeney during 2011 and being inspired that a literary device could potentially shift clients in psychotherapy.

I have used self-reflexivity in an attempt to highlight how meanings have been constructed from the data and, in a sense, were not found in a wholesale way. Other people may have similar or different interpretations of the interview data gathered by myself (Mauther & Doucet, 2003).

5.4. Overall Findings

The purpose of the current study was to tap into South African clinical and counselling psychologists' descriptions of the main developmental aspects that they personally felt have made them the psychotherapists that they are in light of their career to date.

5.4.1. Psychotherapists' Key Developmental Experiences.

Jewels from the ash heap. The investigation of psychotherapists' key developmental experiences started off by exploring the personal reasons of participants for choosing to become psychologists who practice psychotherapy. In the current study, the idea of wounded healer was evident across the careerspan of participants interviewed. Many participants disclosed childhood family trauma, and as a result being cast in the role of confidante or unofficial psychotherapist as a child. Such close encounters with suffering predisposed participants unconsciously to pursue the career of psychology due to their capacity for empathy and altruistic values. Kerenyi (1959, p. 99) speaks of "the knowledge of a wound in which the healer forever partakes". Additionally, trainee and qualified participants both reported from a young age being a source of advice, understanding or succorance to those in need and being known as having feeling or compassion for vulnerable others (physically or mentally ill or distressed parents and peers in need).

"The therapist's woundedness is a double-edged sword: it can be either a strength or a weakness… Therapists need to realize their own personal weaknesses and how their own woundedness affects their work." (Owen, 1992, p. 75). Norcross and Farber (2005) indicate that through self-reflection psychotherapists start to understand the deeper reasons for deciding to

become psychotherapists. Trainee psychologists and one experienced psychologist drew inspiration from television portrayals of psychotherapy and forensic profiling, which sparked their interest in psychology as a career.

In the current study, participants retrospectively made sense of why they pursued the career of a psychologist. This self-understanding of their motivations for wanting to be a psychotherapist started to unfold by attending personal psychotherapy before and during training, being exposed to learning about family dynamics, and through years of practice which instigated deep self-reflection.

Selecting the X-factor. Hill et al. (2013) advise that selectors need to consider which students would be best to train as psychotherapists to achieve a sense of which candidates would be best-suited to the profession. Undergraduate and honours lecturers may wish to reflect with psychology students or applicants to masters programmes about their motivations for wanting to be psychologists, formative life experiences, role in family dynamics, values, prior helping exposure in terms of volunteerism, strengths and challenges in themselves in relation to assuming a psychotherapist identity, career expectations of being a psychologist, and problems they foresee in practicing psychotherapy.

From the publically available selection process documents of 17 programmes (of 10 universities), analysed in the current study, the most agreed upon qualities looked for by selectors in applicants were: academic ability, research ability, communication skills, cultural sensitivity or awareness, maturity, emotional maturity and stability, flexibility, and initiative. The overlap of what selectors from different universities are looking for in psychologists raises the question of whether South Africa could benefit from a clearinghouse for applicants to streamline our selection processes which may benefit our training programmes, or at least to implement Louw and Fouché's (2001) recommendation of establishing a taskforce to institute national selection criteria that are available to all applicants countrywide to uphold the value of transparency and to contribute to an understanding of a prototypical South African psychologist in terms of adherence to certain competency expectations or benchmarking. Further studies are indicated in terms of investigating which qualities need to be inherent in applicants and which qualities can be inculcated or fostered through training programmes.

The sample of the current study not only covered universities' training of psychologists that has previously been investigated, but participants offered a preliminary glimpse of

previously under-researched regions or masters programmes of psychotherapists' experiences who were trained at UFS, UJ, NWU, Medunsa (now SMU), Pearson Institute of Higher Education, and UKZN.

Managing Hydra-like casework. Participants, at all levels of development, reported that psychotherapy holds both complex and easy aspects as one develops as a psychotherapist. Overall, therapeutic work was seen by most participants as increasing in complexity as the participants saw more clients over the months and years due to being able to see more in the therapeutic process and due to increasing comfort levels with being a psychotherapist over the years. Trainees admitted to initially having a shallow understanding of psychotherapy or underestimating how difficult it is to do psychotherapeutic work. Trainees reported that over time they became more comfortable working with "stuckness" in psychotherapy. Intern psychologists spoke of being confronted with being imperfect and needing to manage inevitable mistakes when conducting psychotherapy. Senior psychologists highlighted how mistakes increased one's self-awareness along the developmental journey.

Participants felt that some aspects of therapeutic work became easier in terms of relating to clients in a warm, engaged manner or making sense of what clients were bringing and therefore aspects of one's therapeutic skill-set could now occupy the background, or be implemented without conscious intention. However, this did not amount to psychotherapy becoming simple in terms of being straightforwardly obvious for even those who had seen clients for two to four decades. Experienced and senior psychologists spoke of now implementing their own interpretation of psychotherapy and being a psychotherapist. Appreciating the complexity and not resorting to over-simplifying or becoming complacent was seen as a necessary, humble approach to succeed as a psychotherapist.

In light of their therapeutic work, participants found that they gauged their therapeutic success with clients by means of a few tell-tale indicators, but ultimate success remained unguaranteed or not easily provable as psychotherapy was regarded by participants as involving numerous complexities that cannot always be controlled or predicted. Failure, as voiced by qualified professionals, was seen as an unhelpful way to assess psychotherapy as a number of reasons explain perceived unfinished proccesses. Trainees invested much energy in wrestling with ideas as to what psychotherapy can and cannot achieve. Verbal client feedback during the therapeutic process was deemed essential by participants across the developmental levels, to

evaluate whether the client was benefiting from the process. Rousmaniere et al. (2017) have found that feedback systems or practice-based evidence in terms of tracking and examining outcome data session by session, helps to prevent failing cases, however they are unable to lead to development of expertise for psychotherapists. As such psychotherapists can identify that something is wrong however the skills to improve are still lacking. Consequently, the field of psychotherapy is in desperate need of a model for psychotherapist skill advancement, hence Rousmaniere et al. (2017) turning to deliberate practice methods for inspiration for lifelong learning.

Specifically, for trainee participants, anxiety proved to lessen as a trainee saw more and more clients during internship. However, this anxiety reportedly resurfaces when the trainee is no longer in training environments and needs to succeed with directly paying clients in private practice. Some senior psychotherapists pitched the anxiety of private practice as lasting six years before settling into a personal rhythm.

The phase of elders' wisdom. A unique finding in terms of levels or a model of psychotherapeutic development was found in the current study that of seeing clients for more than 40 years. Within the South African context, society identifies elders as a source of wisdom who offer their knowledge and experience to support and influence those who are now in positions of responsibility or authority, positions that they once occupied during their career. Elders endeavour to promote the shared interests of the profession especially to ensure its longevity and well-being in the future (www.theelders.org). After all, Hartman and Zimberoff (2009) note that, "the hero's journey never really ends. For the true hero continues to hear and heed the soul's call to reach new heights and depths of authentic living" (p. 38).

Two senior participants in the current study, possibly introduce a new phase of development in psychotherapist development – the phase of elders – as their years of practicing psychotherapy amounts to more than four decades of seeing clients. This finding is worth studying in greater detail in South Africa and further afield in light of longer lifespans and the nature of our profession and, of course, the legacy of psychotherapy's founders who practiced well into their eighties. What became clear is how the participants who have worked with clients for four decades continued to be actively consulted by psychotherapists for supervision and training, and, notably, by experienced and senior psychotherapists for complicated casework and

to assist them in how they are now carrying the baton of training and supervising the new generation of psychotherapists.

The findings of the current study show that it is of value to specifically set about exploring 'grandparent' involvement and the continuing professional development of 'third-generation' psychotherapists in the field. Although elders in the profession may have retired from some previous involvements in the field or reduced their working hours, participants spoke of actively pursuing key or selective interests in the field including seeing clients for psychotherapy and younger colleagues for casework consultations. They reported that being a psychotherapist continued to energise and imbue them with Life's meaning, as such "the continuing stimulation of younger minds and younger lifestyles" (Rogers, 1980/1995, p. 63). Across career levels, participants voiced how rewarding they found their work as a psychotherapist.

5.4.2. Aspects Utilised to Enhance Psychotherapeutic Development.

The current study also set out to explore and describe what South African trainee and qualified South African psychologists make use of to enhance their psychotherapeutic development. As is similar to international studies participants reported that a number of factors "fed" and continue "to feed" their professional development as psychotherapists (Rogers, 1980/1995 p. 61). In the current study, participants felt particularly personal psychotherapy, peer supervision, and specific lecturers or mentors helped them to take hold of a model of working therapeutically. The aids or resources that assisted participants in developing as psychotherapists are summarised in Figure 1 below so as to provide a 'snapshot' of how South African psychologists enhance their psychotherapeutic development throughout their career.

Personal psychotherapy. Of the 34 participants interviewed 28 voiced having attended individual personal psychotherapy. Participants, in the current study, strongly voiced how personal psychotherapy had enhanced their empathy for their clients' struggles. Thus personal psychotherapy was seen as essential by most participants. This may be linked to the theoretical orientation of psychoanalytic therapy or psychodynamic therapy being valued by many participants. However, this is not necessarily the case as systemically-trained psychotherapists interviewed in the current study also attended individual psychotherapy during their training.

Supervision. Live group supervision during session, utilising a one-way mirror, recording equipment and call-in phone equipment, with real clients was found to be initially nerve-

wracking for student psychologists. But after experiencing the benefit of supportive feedback from their peers and supervisor in the reflecting team, systemically-trained trainees found live supervision to be incredibly valuable. Intern psychologists of various theoretical orientations reported feeling that video presentations to a hospital-based panel of psychologists though valuable could be done in a more supportive manner.

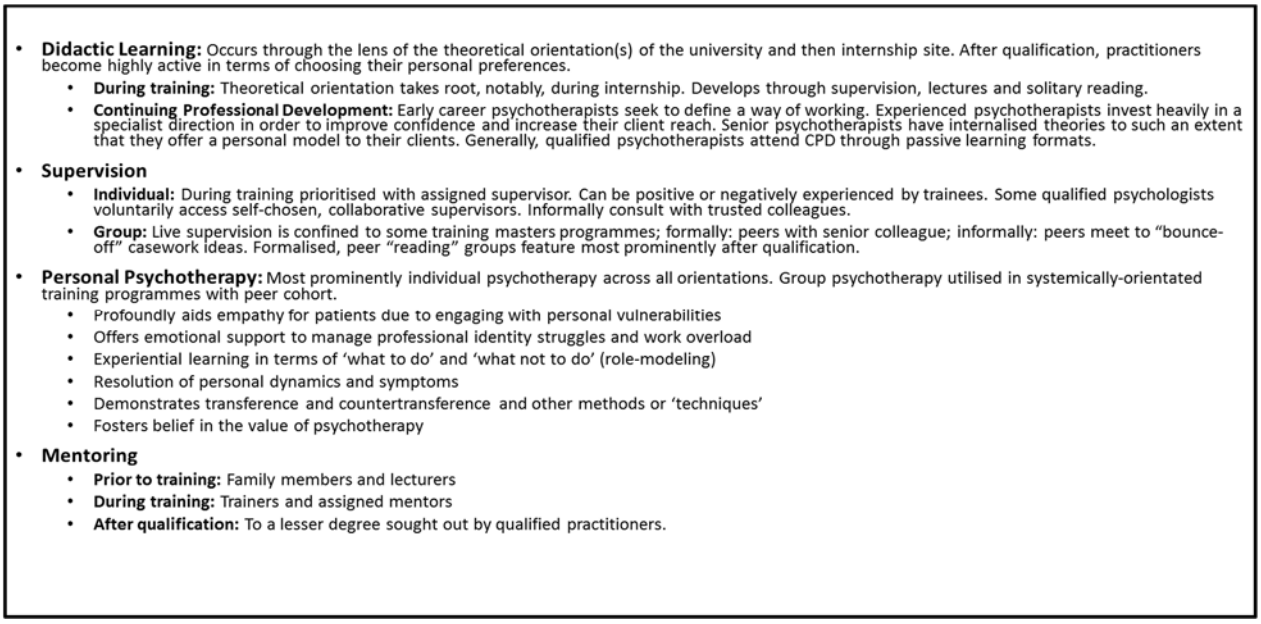

Figure 1: Aids utilised for trainee and qualified psychologists' development as psychotherapists.

It is recommended that live supervision of clients with a reflecting team and one-way mirror simulations be considered as a compulsory CPD activity for qualified professionals, in light of deliberate practice research which values procedural knowledge over theoretical knowledge alone. This could also contribute to universities or government hospitals hosting CPD activities, at more reasonable costs. The cycle of excellence (Rousmaniere et al., 2017) could easily be adopted as a training model for trainees and already qualified psychologists as it specifically addresses the unique needs of trainees to achieve competency as well as providing a route of deliberate practice for qualified psychotherapists to meet their need to work towards a level of expertise (Rousmaniere, et al., 2017).

Participants, across career levels, emphasised that individual supervision could be improved particularly during psychologists' internship year. The findings indicate that supervision was very good in some instances and appalling in others. Participants reported negative training experiences where their assigned supervisor was unethical or was disinterested

in supervising their cases during scheduled supervision sessions. The current study also prominently showed that there is a notable blurring of boundaries between supervision and personal psychotherapy, particularly, of intern psychologists with both positive and negative outcomes.

Participants provided a broad array of options that met their supervision needs. Informal conversations with a trusted peer colleague regarding cases was utilised by a number of trainees and qualified participants. Qualified professionals also made use of formal group peer supervision and reading groups which accrue CPD points and felt that the support alongside new knowledge gained in the group setting was experienced as a worthwhile endeavour. Formal individual supervision with a more senior colleague remained an option, however it was not as utilised as the peer context by registered participants in this particular study. Early career psychologists voiced that individual supervision when pursued was valuable as the supervisor was now self-chosen and a collaborative process with the supervisor was sought. It is recommended that formal individual supervision should acquire a certain portion of CPD points per annum, to ensure actual casework of qualified practitioners has undergone a level of scrutiny.

Identification with a theoretical guru or internationally-recognised niche. Both trainee and qualified psychologists highlighted how they had benefitted from being taught psychotherapy from a key person(s). The person was recognised by the participant as an active psychotherapist who demonstrated to them how to be in the room with clients.

Findings in the current study make a case for training programmes to deliberately limit the number of theoretical orientations or therapeutic models that trainees are initially exposed to. This was deemed to be necessary by trainee and qualified participants who felt that as one embarks upon seeing clients daily, feeling strong in one theoretical framework boosted their self-confidence. In the current study, the sample consisted of participants who had been trained in one main theoretical orientation or epistemology, namely, three participants in a psychoanalytic orientation, and 10 participants in systemic orientation, whereas 11 participants trained integratively. However, all trainees in the current study who had trained integratively though appreciating the diversity (theoretical breadth) voiced a strong personal preference and, yet, an openness to incorporation of other theoretical ideas as adjuncts or of secondary importance. It is recommended that the development of a strong preference in terms of theoretical orientation needs to be explored further within areas in South Africa where psychoanalytic thinking is not

predominant. More detailed studies need to be carried out in the milieu of the Free State, Eastern Cape, and North-West provinces. For it appears that internship sites hold considerable influence in moulding the theoretical orientation of initially integrative model student trainees.

Qualified professionals spoke of embarking on a further journey of seeking additional, often internationally recognised training in specific therapeutic interventions (a niche), and benefiting from being taught and identifying with a founder of a therapeutic model. Specifically, those at the experienced and senior levels of psychotherapeutic development drew on their personal interests and how it could potentially link to psychotherapy which resulted in a deep integration of personal knowledge and professional knowledge amounting to a personal model when reaching seniority in their career.

Within the USA, the Delphi poll predicting psychotherapy in 2020 (Norcross, Pfund, & Prochaska, 2013) forecasted that orientations set to increase include mindfulness, CBT, integrative, multicultural, Motivational Interviewing, Dialectical Behaviour Therapy (DBT), eclectic, and exposure psychotherapies. By contrast, transactional analysis, Adlerian therapy, Jungian therapy, and classical psychoanalysis were expected to decline.

Within South Africa, in contrast to Norcross et al's (2013) prediction, Jungian therapy (Analytical Psychology) and psychoanalysis, as well as psychoanalytic group therapy in terms of the Centre for Group Analytic Studies (www.cgas.co.za), are now enjoying established training institutes, outside of universities (Bantjies, 2016; Swartz, 2007). However, due to legal requirements such training programmes are accessible only to already qualified psychologists or psychiatrists.

Similarly to international trends, DBT, specialised CBT and Mindfulness have been embraced by South African psychologists. DBT and Cognitive Behaviour Therapy for Eating Disorders (CBT-E) is used at the Tara H Moross Centre Hospital, in Johannesburg. Motivational Interviewing is taught at SU Faculty of Medicine. Additionally, in partnership with the Institute for Mindfulness South Africa, SU also offers a qualification in Mindfulness-Based Interventions accessible to the Western Cape province. Such theoretical niches suggest that different universities linked to public hospitals are explicitly benchmarking their psychotherapeutic services in relation to international standards. Inspired by international hubs of psychotherapy services which are being consistently researched by practice-research networks, South Africa is likely to have both public and private psychotherapy centres of excellence, of various theoretical

persuasions, in the near-future.

5.4.3. Professional and Personal Issues Affecting Psychotherapists' Development.

High-risk context. Participants, across the developmental spectrum, recalled times where they had felt burnt out by the sheer magnitude of the therapeutic work they were doing. The accumulative stress led them to consciously implement self-care strategies within their daily lives. Self-care of psychotherapists was voiced by participants as a neglected subject during training. Participants felt that self-care strategies should explicitly be taught and prioritised during training and that even possibly self-care activities or retreats should be prioritised as a monitored CPD activity. Qualified participants spoke of learning to regulate their caseload and prioritising rejuvenating activities in their personal life. Senior participants valued diversifying their practice activities to ward off burnout and keep their interest in their career alive.

Under pressure to deliver. Against the economic backdrop of managed care, participants across the developmental spectrum, voiced feeling under immense pressure to conduct successful psychotherapy within a limited number of sessions (often less than ten sessions). Participants verbalised that they found themselves having to consider the applicability of their theoretical orientation and/or best psychotherapy treatment options in light of financial constraints. This was a difficult dilemma for participants to reconcile especially when confronted with the high levels of intractable (co-morbid and chronic) conditions in South Africa. A similar sentiment is expressed by Smith (2014), who asserts "the traditional autonomy of the professional has been eroded and our judgement about the treatment needs of our patients is no longer privileged. All too often we have to motivate our treatment decisions and justify our recommendations" (p. 48-49).

Balancing on a tightrope. Participants spoke of consciously implementing boundaries between their personal and professional lives, yet this remained an ongoing challenge as the boundaries needed to be clear, but remain flexible. Trainee psychologists spoke of how their development as a psychologist altered their friendships and led to interpersonal conflict with their partners that needed to go through a process of resolution. Future South African or international studies may benefit from interviewing spouses or partners of trainees and qualified psychologists, to in a sense find out in greater detail what is their lived experience of being in an close or intimate relationship with a trainee or registered psychologist who conducts

psychotherapy. Such a study could offer new perspectives on how psychologists can best manage their personal lives in relation to their confidential professional work.

5.5. Limitations of the Current Study

Initially, it was my intention as a researcher to conduct a mixed methods study involving a nationwide quantitative survey and qualitative interviews (See Appendix D), however due to recruitment challenges this proved currently impossible. A larger sample would likely enable the implementation of a quantitative study using the results of the DPCCQ. A national survey would be meaningful in terms of providing a 'broad snapshot' of South African psychotherapists.

Of the 16 universities who train psychologists in South Africa, 11 universities' graduates feature in the current study. Future studies would therefore need to particularly focus on psychologists that were trained at universitities situated in KwaZulu-Natal (particularly the University of Zululand), the Western Cape (UCT, SU, and UWC) and in the Eastern Cape (particularly RU and Fort Hare University) provinces of South Africa. Notwithstanding, more graduates from each university in the country could provide alternative psychotherapist development stories.

The current study tended to draw participants who currently see clients in two major cities: Johannesburg or Pretoria (29 participants) within Gauteng. Others included: two participants in Bloemfontein within the Free State, one participant in Stellenbosch and one participant in Paarl, within the Western Cape, and one participant in rural Eastern Cape.

However, it must be noted that South African psychologists do not necessarily practice where they were initially trained. With this in mind, university training programmes need to ensure that they are training students to be a 'South African psychologist' to serve mental health users across the country in diverse contexts.

5.6. Implications for Practice

5.6.1. A Sought-after Career: Improving Selection Processes.

Participants voiced that selection processes for becoming a clinical or counselling psychologist are very competitive as limited places are available in each clinical or counselling psychology programme (Cooper, 2014; Rock & Hamber, 1994). This constraint led to some participants voicing how they spent years doing community work in terms of lay counselling (Pillay et al., 2013) to improve their standing in selection processes and applying more than once to a number of universities each year within the country. Of the participants who trained within

the last decade (23 participants), six of them initially were trained as HPCSA registered counsellors and one was training to be a HPCSA psychometrist prior to studying masters. Thus, unlike the experienced and senior participants, many younger participants came to training already having experienced being a lay or registered counsellor. This may have implications for training content in the future, as prior experiences may be helpful in terms of trainees having a head start, or in contrast some processes or skills are, possibly, best 'unlearnt' by trainees who fulfilled such lay roles previously in order to be an effective psychologist which is a higher level of specialisation.

"Psychology created the professional but failed to develop and encourage the appropriate job market and employment opportunities" (Pillay, 2016, p. 149). The cap on trainee spaces in masters training programmes of clinical or counselling psychologists is understood as due to the current scarce number of internship sites available at universities and government hospitals as well as the broader market not being able to sustain the livelihood of an influx of qualified clinical or counselling psychologists where psychotherapy being made available by the national Department of Health is currently not a sufficiently recognised priority to the extent that is needed to meet the extensive demand for mental health services in a resource-strapped South Africa (Pillay, 2017; Rock & Hamber, 1994; Young, Bantjes, & Kagee, 2016). Government services in terms of salaried psychologists providing psychotherapy to mental health users is over-burdened with cutbacks in terms of posts and deterioriating conditions within the health sector (Grobler, 2017; Lund et al., 2012). Internationally, McFall (2006) points out that "education and health care are intertwined tightly. Our education and training ideally should be driven by the needs of the health-care system; the quality of our health-care system, in turn, depends on the validity of our education and training" (p. 22).

Pillay et al. (2013), and Pillay and Kramers (2003) state that the psychologist training offered by South African universities is of a generally high standard as compared to international standards. South African psychologists are highly sought after by the Commonwealth English-speaking countries (e.g., Australia, Canada, New Zealand and the UK). Pillay (2016) states that South African psychologists' training programmes "compare very favourably to equivalent professional training programmes elsewhere in the world" (p. 152). There is broad unofficial consensus nationally about the general criteria of trainees when examining the selection criteria made available to applicants and their referees, as previously found by Louw and Fouché (2001).

In light of government policies, quotas in terms of ethnicity and language feature in selecting psychologists to redress the historical imbalance in the profession of psychology within South Africa due to Apartheid and colonialism (Eagle, Haynes, & Long, 2007; Pillay, 2016; Rock & Hamber, 1994). Since the advent of democracy, in 1994, the profession is in the process of ensuring that professional psychologists represent the entire population and address the needs of all South Africans with nuanced cultural competence (Gibson et al., 2001; Kriegler, 1993; Pillay & Kramers-Olen, 2013; Ruane, 2010). Highly competitive selection processes for psychologist training programmes are not confined to the South African milieu as indicated by research in the UK, Canada and the USA (McFall, 2006; Wood & Nattel, 2017).

In South Africa, selection processes have become streamlined in the Western Cape province with the three universities within the region prioritising exactly the same selection criteria in terms of applicants' reference letters. However, the selection processes across South Africa vary according to the theoretical orientation of the university's training programme(s). The rationale of selection panels is to observe whether the candidate and the course are a 'good fit'. For example, psychoanalytic courses prioritise the individual applicants being interviewed by two trainers simultaneously, whereas systemic courses prioritise applicants interacting with other applicants in a group setting with a trainer facilitator while other trainers, with the consent of applicants, observe their interactions, potentially behind the one-way mirror. Participants, in the current study, felt that how applicants actually interact with people needs to be directly observed by trainers. Out of the 16 universities offering psychologist training, only NMU (then NMMU) makes additional use of psychometric testing of personality to assess the suitability of short-listed candidates for masters training (Hurter, 2009; Lunt, 2005; Smit, 2010).

5.6.2. Enhancing Training of Trainee Psychologists as Psychotherapists.

Managing the plethora of theoretical orientations. Personal choice in theoretical orientation was valued by registered practioners, trainers and supervisors in South Africa and deemed contextually relevant for diverse clients. However, it is worthwhile for curriculum developers at universities to contemplate the value of providing trainees in-depth training in only one theoretical orientation or model for psychotherapy for the first six months of the first year of masters. Such theoretical focus potentially could offer grounding to anxious students, as found in the current study, who are just starting to see clients, prior to incorporating other theoretical orientations, models or ways of working with psychotherapy clients.

However, Owen cautions "therapists who are only versed in one theoretical model may be limited in their ability to produce alternative hypotheses about what is happening in clients' lives" (1992, p. 69). Yet, by internship, trainee participants in the current study reported they were situated in various therapeutic milieus where they actively sought out alternative ways of working from peers, and felt they could at this stage of their development benefit from being exposed to alternative rich theoretical formulations that were not available at their specific universities. Participants, across levels of development, voiced that they needed to implement short-term psychotherapy due to the constraints of managed care which led to many participants with less than two decades of experience finding this adjustment to real-world practice rather challenging. Furthermore, trainees should be equipped to provide both short-term and long-term psychotherapy interventions in order to effectively meet the needs of diverse clients (Pillay et al., 2013; Smith, 2014).

The value of personal psychotherapy or groupwork. The extensive advantages of trainees and qualified psychologists undertaking individual personal psychotherapy prior, during and after training has been described by the participants in the current study. International standards vary in terms of how many hours of personal psychotherapy need to be undertaken by trainees. However, internationally, what is apparent is that personal psychotherapy is no longer only mandated by psychoanalytic training institutes or courses, and a minimum of 40 hours of personal psychotherapy/self-experience is instituted by law in some European countries, regardless of the theoretical orientation of the students. Within the South African context, the cost of 40 hours of mandated personal psychotherapy would burden the student with an additional cost (approximately R34 200 in 2017, in light of medical aid/insurance rates) which amounts to the equivalent of another year of tuition. However, without personal psychotherapy the self-awareness required of the trainee cannot be fostered easily.

Group processes with training peers during university coursework years and hospital-based self-experiential workshops during internship training was valued by participants who had experienced such processes. Groupwork has been used effectively to foster self-awareness and the ability of the trainee to read process as voiced by both systemically-orientated trainees and senior psychotherapists within the current study. After all, family psychotherapist Harlene Anderson (2001), in reflecting on training psychotherapists with her colleague Harry Goolishian, points out: "We could not teach a person how to be a psychotherapist but we could provide an

experience in which they could learn to be one" (p. 357)

Enhancing the training curriculum with standardised modules or seminars. Internationally, the mystique surrounding how a psychotherapist develops has begun to fall away, in that two transitional workshops have been introduced for psychologist trainees to explicitly reflect on major transitional points in their career so far. At University College London (UCL), UK, the first transitional workshop embedded in their training programme is seen as an opportunity for trainees to reflect on their own processes from shifting from a beginner student to an advanced student (www.ucl.ac.uk). Herein, a particular focus has been how trainees utilise their supervisory space. The second transitional workshop is attended by trainees that are about to step into being renumerated practioners. The reflective space of the second workshop encourages trainees to explore how they are going to perform effectively at their internship placement in light of personal and professional challenges when the structure of the university training programme dissolves.

Another standard module or seminar series, needs to be developed at a national level, that explicitly focuses upon the professional, legal and ethical issues including the HPCSA standards of conduct, which a psychologist needs to know and to understand in order to uphold the credibility of the profession of psychology and not to bring it into disrepute in the eyes of those who are entrusted into its care. Such seminars can provide trainees with an understanding of the professional and organisational contexts within which psychologists practice in South Africa as well as teasing out the ethics of relationality and what it means to relate to those who are Other (MacCallum Sullivan & Goldenberg, 2015), which forms the core of the psychotherapy endeavour. Being a psychologist involves the integration of personal and professional ethics without which effective ethical and reflective therapeutic practice is difficult to achieve (www.ucl.ac.uk). Developing an ethical compass is an ongoing task and additional seminars need to foster reflective ethical practice of trainees over time in terms of the complexity of ethical dilemmas that psychologists are confronted with in various contexts (Slack & Wassenaar, 1999).

Within the current study, two trainee participants voiced how their development enhanced their advocacy against racial and sexual orientation discrimination in society. Ahmed and Pillay (2004) advocate that psychology as a discipline must be self-reflexive and challenge dominant discourses and practices in a way where social justice is a "permanent agenda" (p.

650). A module or seminar series, embedded within masters programmes, more explicitly exploring oppressive discourses and diversity in relation to sexuality discrimination, referred to as Gender and Sexual Diversity training (McGeorge & Stone Carlson, 2011; Owen-Pugh & Baines, 2013), sexism (Baird, Szymanski, & Ruebelt, 2007; Brown, 2005; Juntunen, Atkinson, Reyes, & Gutierrez, 1994; Kannan & Levitt, 2009), racism (Carolissen, 2008; Espery, 2017; Kleintjies & Swartz, 1996; Stevens, 2001; Wood & Nattel, 2017), ethnocentrism, colonialism (Espery, 2017; Wood & Nattel, 2017), classism, social inequality (Pillay et al., 2013), ableism (Axelman & Kashani, 2009; Olkin, 1999; Swartz, 2010), and ageism appears to be vital in order for psychotherapists to serve the needs of the entire population of South Africa. Such a module can equip trainees with a keen understanding of accessibility challenges to mental health resources within the country as well as the ability to critically analyse the suitability of mental health services in light of clients' needs and perspectives.

Diversity seminars and training have been prioritised in international psychology programmes, for example, UCL trainees in the Doctorate of Clinical Psychology (DClinPsy.) programme attend Difference and Diversity trainings in order to equip burgeoning professionals "with the knowledge and skills to function as clinicians who are sensitive to disadvantage and discrimination… flexible and critical in the application of psychological approaches to very diverse clients and communities" (www.ucl.ac.uk). Similarly, DClinPsy. trainees at the University of East London in England attend workshops for example, 'Decolonising White Psychology' to facilitate awareness of racial identity and anti-racism conversations (Wood & Nattel, 2017), and how race is understood in therapeutic consultations (Esprey, 2017). Whiteness and white privilege as a concern of the discipline of psychology is not confined to the post-Apartheid context of South Africa (Eagle et al., 2007; Green, Sonn, & Matesbula, 2007). Wood and Nattel (2017) show that Whiteness, Eurocentricity, and religious discrimination practices, especially in relation to Islam, has become a central concern of training programmes in England, which shows a need for anti-racism and inclusion sensitivity being incorporated in psychology training and practice worldwide.

In-depth formal case presentations as a national requirement are recommended for trainees during both coursework and internship years, as case presentation skills need to develop over time. Within South Africa, in-depth case presentations, potentially, take place before a panel of trainers during oral examination, during group peer supervision, at case presentation

events at university clinics or at psychologist in-depth ward rounds at hospitals. Internationally, case conferences are attended by all trainees and are also open to supervisors to showcase contemporary topics, and its translation into psychotherapy with clients.

A further recommendation is the possibility of a registered practitioner also presenting a key facet of psychotherapy at case presentation events, in order to bridge the chasm that often unnecessarily exists between training institutions and practitioners not working within institutions such as universities and hospitals. Being privy to the casework of a practicing practitioner is likely to provide trainees exposure to a wider spectrum of role models within the profession of psychology, such as non-governmental, grassroot, corporate, private practice, law enforcement/forensic/psycho-legal or war-torn/refugee contexts (Bantjies et al., 2016; Young et al., 2016). Such a feedback loop of practitioners informing trainees and the training context can assist in creating an ongoing awareness of contemporary trends that are impacting psychotherapy contextually. For example, clients' use of technology/social media in their relationships and also how technology is used to mediate the psychotherapist-client relationship. In addition, such links can assist trainees in witnessing and developing their responsibility towards the professional community and public. After all, the development of one's professional identity begins during training and not at graduation (Gibson et al., 2010).

Internationally, trainees nearing the end of their university coursework are encouraged to participate in elective seminars or workshops. Here trainees, in consultation with trainers, are encouraged to demonstrate proactivity in their own learning, and display increasing levels of autonomy by organising their own continuing learning needs with speakers (www.ucl.ac.uk). The topics can be likely concerned with specialist client populations or settings or offer advanced teaching on topics covered earlier during the masters programme. Such elective seminars inculcate similar principles of CPD, whereby practitioners need to learn to take ownership of their own learning early on in their career to bode well for their professional lives in future.

Participants, across developmental levels, disclosed a level of frustration and anxiety about the ever-increasing administrative protocols that needed to be completed in order for patients to access medical funds. Participants reflected that as trainees they would have liked to have benefitted from seminars related to the economic realities of psychotherapy practice. Trainees need to be equipped to negotiate with managed care requirements in order for patients

to have access to effective treatment and in tandem for psychologists to make a livelihood, in a constrained economic market (Smith, 2014).

5.6.3. Enhancing Training of Qualified Psychologists as Psychotherapists.

Training of supervisors. The findings of the current study indicate the need for accredited training of supervisors regarding how to work with supervisees in relation specifically to their actual psychotherapy cases. Such training can outline for supervisors how to assist trainees to manage casework-related anxiety, potential impairment in supervisees as well as advising self-care strategies to supervisees (Jordaan et al., 2008), without losing their role-definition as workplace supervisors.

International research (e.g., Bernard & Goodyear, 2014) indicates that good psychotherapists do not necessarily nor automatically translate into good supervisors. This has led to accredited supervisor training in the USA and Europe being a registration body requirement in order to fulfil the role of supervisor. For example, in Denmark qualified psychologists need to undergo two years of additional training (30 hours on the theory of supervision and 40 hours of supervision on their own supervisory work), in order to qualify as supervisors on a specialist level (Jacobsen, 2011). In line with international trends, it is recommended that aspiring supervisors and supervisors attend specifically tailored training on how to effectively supervise therapeutic work (Smith, 2014) especially of trainees who are assigned their supervisors and as such cannot choose who to be supervised by.

CPD as specialised activities. Within South Africa, participants who were qualified practitioners attended CPD activities and valued the principle behind such activities. However, concern was raised regarding the choice of CPD activity being at the wide discretion of the practitioner. Rather it was recommended that guidelines be established as to what is regarded as specialist or advanced training for psychologists deemed to be a worthwhile endeavour, to ensure that the competency of psychologists remains specialised knowledge. Currently, there is little distinction between generic mental health education, and courses/trainings that are in the scope of psychology, designated only for psychologists. Possibly, the PBP of the HPCSA, who audits CPD activities, could consider a certain number of points being allocated to general or generic mental health presentations (for any mental health professionals and educators) and a certain number of points allocated to psychologist-only trainings. Additionally, attending supervision could be regarded as a compulsory CPD activity, which accrues a set number of

points, for example six points, in order to encourage practitioners to regularly obtain direct assistance for their own actual caseload.

The cost of trainings was voiced as a barrier to accessing quality ongoing professional development of participants. Currently, the cost of CPD can be estimated to be at minimum R5 000 (online training) and R9 000-R15 000 (face-to-face training) to accrue the stipulated 30 as well as five ethics, human rights or health law points per annum. It would be worthwhile to consider investigating the typical cost of CPD activities and the cost of supervision by surveying psychologists in relation to their CPD activites over the course of two years. This survey could possibly for ease of admistration be linked to the regular CPD auditing of practitioners that is implemented by the PBP of the HPCSA.

5.7. Implications for Future Research

5.7.1. The Potential of the DPCCQ.

Since 1990, survey information has been gathered in the SPR international database of more than 11 710 psychotherapists of varied professional backgrounds and theoretical orientations utilising the DPCCQ (Orlinsky & Rønnestad, 2005; Orlinsky, 2014), which has been translated into 20 languages in over 30 countries. For example, Heinonen, Lindfors, Laaksonen, and Knekt (2012) utilised the DPCCQ to investigate the professional and personal characteristics of psychotherapists conducting short-term as opposed to long-term psychotherapy. The analysis of the quantitative data provides descriptions of the demographic characteristics and, to some extent, describe and explain aspects of the experiences of psychotherapists across their career lifespan.

Since 2013, 53 online DPCCQ survey forms have been completed by South African psychotherapists in my initial hope that such information could enhance the field's understanding of psychotherapist development. Additionally, the international database has 42 paper survey forms of South African psychotherapists carried out by other researchers.

Sample sizes in previous studies, utilising the DPCCQ quantitative questionnaire, ranged from 18 nurse psychotherapists held in comparison to 34 psychiatrist psychotherapists (Kazantzis et al., 2010), a sample of 55 psychotherapists (Heinonen et al., 2012) and 538 mental health psychotherapist participants (Bae & Orlinsky, 2004). However, a sample of at least 300 psychologists would be needed to accurately reflect the population of psychologists who conduct psychotherapy in South Africa. In order for such a large-scale project to bear fruit, it is

recommended that a national survey be carried out with psychologists who practice psychotherapy by the PBP of the HPCSA with an incentive or honorarium for their time to participate in order to effectively reach all practitioners across the country as potential participants. With such information, practitioner-informed improvements in training, supervision and CPD can be made.

Recently, the PBP of the HPCSA completed a nationwide online workforce survey (2017). However, the information gathered was across all categories (clinical psychologists, counselling psychologists, educational psychologists, industrial psychologists, research psychologists, registered counsellors and psychometrists) some of which do not conduct psychotherapy. A key broad finding though was that the majority of clinical psychologists, counselling psychologists, and educational psychologists practice in Gauteng and the Western Cape provinces. Additionally, the major city Bloemfontein in the Free State province has accessible psychological services. Yet, the other six provinces in South Africa, and especially rural areas, are notably under-resourced (HPCSA, 2017). Thus, fine-grained information related to the psychotherapeutic practices of clinical psychologists, counselling psychologists, and educational psychologists needs to be specifically focused upon.

5.7.2. Other Nationwide Studies.

Another potential national research study is to link a longitudinal trainee survey across the 24 masters programme offerings to the training programme audit that the PBP, under the auspices of the HPCSA, regularly carries out at each university. Researching training programmes of psychotherapists has become a central project of the SPR internationally since 2013. In order to improve psychotherapists' performance for their career life ongoing evaluation of psychotherapist development needs to take root at the trainee level (Reese, 2017). Student and intern psychologists can be interviewed at intervals during their training to capture the experiences of training from those who are being trained as clinical and counselling psychologists within the South African context on a larger scale (Nel & Fouché, 2017).

Recently international studies (e.g., Bhola et al., 2017) have been published regarding longitudinal trainee development which has become a focus area of the SPR through the Development of Psychotherapists-Trainee Background Form (DP-TBF; Grafanaki, Elliott, Orlinsky, & the SPR Collaborative Research Network, 2010) and Process Form (DP-TPF; Orlinsky, Elliott, Grafanaki, & the SPR-CRN, 2010). Research using these measures may be

fruitful in terms of comparing South African trainees to their international counterparts in relation to psychotherapeutic competencies.

Along similar lines to the Australian psychology profession (Pachana, O'Donovan, & Helmes, 2006) greater links need to be made between South African universities who offer masters training for clinical and counselling psychologists. In addition, course co-ordinators/directors, trainers and curriculum developers across the country could be interviewed in 'cross-pollination' focus groups in order to understand how trainees are currently being trained in light of contextual similarities and differences; for ease such data-gathering could take place at the annual PsySSA national conference. As though each university has its own style of training and this should be respected and valued, the national imperative is to train a South African psychologist. One's professional identity can be understood to hold a certain national standard of training and exposure (Pillay et al., 2013) which needs to translate into transparent general compentencies as stipulated in course syllabi which can be utilised across the country and thus be easily benchmarked in relation to international standards.

5.7.3. Potential Studies on Key Aspects of Psychotherapist Development.

To understand supervision practices in more detail, a study focused on supervision exploring the choices of supervision seems warranted. Post-qualification supervision was seen as different by participants to supervision during training. Within the current study, participants also incurred significant expense to attend international trainings hosted in the major cities within South Africa or overseas to stay abreast of new developments and advancements in psychotherapy.

As indicated by the ambivalence expressed by participants in the current study related to the quality of supervision provided, the supervision of psychologists, needs to be particularly investigated nationwide. Possibly, focusing upon the supervision questions of the DPCCQ is a rather feasible study for the South African context as has already been completed in Denmark with 350 clinical psychologists of which 273 reported on being supervisors (Jacobsen, 2011). As psychologists are likely to benefit from a culture of supervision, deliberate practice activities, for example, reviewing video recordings (as utilised by a number of participants), throughout one's career in order to promote therapeutic expertise is worth being pursued.

Lastly, the current study used as one of its building blocks the idea of vertical expertise which assumes that expertise is a "developing set of personally acquired skills and competencies

as well as a cummulatively growing store of knowledge" which is undergirded by a "phase-specific development from novice to expert… culminating in the acquisition of special skills and knowledge that the layperson does not possess" (Laitila, 2009, p. 241). In that, the current study relied particularly upon the international phase model of Skovholt and Rønnestad (2003a, 2012) which investigates psychotherapists self-reporting their development. However, Laitila (2009) argues that researchers in the field of psychotherapy need to consider investigating horizontal or interactive expertise where psychotherapists together with clients and reflecting teams in psychotherapy can voice what makes psychotherapy work as a collaborative effort.

5.8. Conclusion

In sum, the current South African study afforded 34 clinical and counselling psychologists from a spectrum of therapeutic contexts within the country, the opportunity to share their overall experience and pursuit of psychotherapeutic development, spanning their personal journey in conjunction with their first contact with psychotherapy clients to their current professional-personal life and future aspirations for their development as a psychotherapist. The study examined how participants came to choose psychology as a career, how they have developed over time as a psychotherapist and how they have experienced their therapeutic work.

Chapter Five set out to contextualise the current study within the international and South African mental health context in order to situate the findings within the domain of conducting psychotherapy. In light of the current study being conducted by a clinical psychologist, the self-reflexivity process was also briefly summarised in an effort to uphold the ethic of transparency. This concluding chapter then provided the overall findings of the current study with an awareness of the limitations of the study. Lastly, this chapter in light of the findings of the current study provided recommendations for psychotherapist development of clinical and counselling psychologists who are in training or practicing within the diverse South African context to be considered. In addition, possible future research directions within the sub-field of psychotherapist development were proposed.

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Appendix A: Chronology of Articles on Psychotherapist Development in SA

Author(s)	Year	Topic	Province(s)	Participant(s)	Results/Findings
Snyders	1979	Selection	Gauteng	42 Unisa clinical psychology applicants	In-vivo interview role-plays and leaderless group discussions provide high reliability when selecting trainees.
Anema	1981	Training: Therapeutic Process	Eastern Cape	Personal account, RU	Focused on individual therapy process with adult male client which involves the therapist's self-confrontation.
Bassa and Schlebusch	1984	Practice patterns	Free State	Qualified psychologists, UFS	Survey: 15.55% of clinical psychologists active in private practice. 44.5% of clinical psychologists spent their time on psychotherapy.
Manganyi and Louw	1986	Profession challenges: attitudes regarding clinical practice and theory	Nationwide	137 clinical psychologists	Non-consensus regarding social, cultural and economic concerns.
Rock and Hamber	1994	Profession challenges	Nationwide	60 seasoned psychologists	Implement 60:40 in favour of black trainees. Consider two-year internship.

Ahrends	1995	Training: Race, multiculturalism	Western Cape	Intern clinical psychologists, UCT	In the context of experiencing the after-glow of the achievement of the 'rainbow nation', in 1994, similarities between people emphasised and differences minimised.
Pillay and Petersen	1996	Practice patterns & attitudes towards mental health policies	Nationwide	Clinical and counselling psychologists	National survey: 47,7% worked solely in private practice and only cater for 23% of the population (mainly white and middle class). 10.55% of respondents work solely in rural settings. 91.2% of respondents spoke English or Afrikaans.
Kay	1996	Training	Western Cape	Three student clinical psychologists, SU	Trainees experienced pressure to introspect, support from classmates and lecturers. Personal growth, development, and meaning in training context.
Kleintjies and Swartz	1996	Training: Race, supervision	Western Cape	Seven black clinical psychologists (qualified and trainees)	Awareness of and sensitivity to racial issues is essential in supervision.

Chippindall and Watts	1999	Selection	Gauteng	Nine selectors' ratings of six clinical psychology applicants' autobiographies, Wits	Suitable applicants exhibited a secure sense of self, capacity for libidinal investment in others, flexibility, empathy, evidence of academic ability, and mastery of early personal trauma or conflicts.
Richter and Griesel	1999	Women in psychology	Nationwide	Register of psychologists, HSRC data, and survey in 1997 of clinical and counselling psychologists.	Tracked feminisation of the profession: In 1996, there were equal numbers of registered male and female psychologists (2130 and 2125) in South Africa. By 1996, 70% of newly registered psychologists were women. In 1994, male psychologists earnt substantially more than female psychologists regardless of work sector. Needing to balance work commitments with undiminished family and domestic responsibilities may attract women to the profession.

Slack and Wassenaar	1999	Ethics	Nationwide	49 clinical psychologists offered ethical dilemma data	Breaches of confidentiality, dual relationships and payment issues were the most encountered dilemmas.
Viljoen, Beukes, and Louw	1999	Training relevance to practice	Free State	61 UFS-trained (1991-1996) qualified psychologists	Survey: 43.3% worked full-time in private practice. Another 13.3% worked part-time in private practice. 93.4% recommended training on private practice management. 94.4% spent 54.8% of their daily work hours conducting psychotherapy. Inadequate training in group therapy reported.
Peltzer	2000	Psychotherapy practiced by South African psychologists	Nationwide	Clinical and counselling psychologists	Literature review: Provided a historical and current overview of the psychology profession with psychotherapy as the focus.

Gibson, Sandenbergh, and Swartz	2001	Training: Community-orientated work	Western Cape	Trainers' perspectives on UCT-trained student clinical psychologists	Students struggle with disillusionment and feelings of incompetence in relation to community work. Recommendations: provide limited and structured, developmentally sensitive exposure to community work, build bridges between conventional psychological practice and community work, provide ongoing support for students and supervisors.
Kometsi	2001	Trainee's experiences of race	Gauteng	Published personal account	Trainee black clinical psychologist relayed incidents of race impacting clients' perspective of the psychotherapist and implications of idealisation or devaluation for the psychotherapeutic process.

Louw and Fouché	2001	Selection	Nationwide	424 questionnaires completed by university and non-university based psychologists, and selected masters students (clinical, counselling and research categories).	Selection procedures are controversial in terms of being equitable. Recommendations: Too many students selected for honours then fall by the wayside during masters selection: needs to be reduced. Lack of standardised selection criteria needs to be rectified by the committee of Heads of Departments of Psychology or a specific taskforce. Transparent masters selection criteria needs to be made available to undergraduate students.
Makena	2001	Training	Gauteng	Personal account, Unisa	Ethics of psychotherapists vicariously meeting their own needs during the client's therapy underscored the need for self-awareness to be a prioritised feature of training.

Clarke	2002	Training	Gauteng	Personal account, Unisa	Process of embracing multiple realities, self-doubt and uncertainty in order to learn as a clinical psychologist.
Jansen	2002	Training	Gauteng	Six clinical psychology trainees & two trainers, Unisa	Trainees felt challenged to integrate the theories of postmodernism, systemic therapy and African traditional healing when assisting clients in an open-air community therapy clinic.
Kaschula	2002	Selection	Eastern Cape	RU applicants	Enjoyed self-reflective questions of the Narrative Therapy approach to selection process, however the critical gaze still remained as examining their performance.
Prentice	2002	Training	Gauteng	Various vantage points: three women clients, himself and five newly qualified psychologists from five universities reflecting on their coursework years	The choreography that occurs between the trainer, trainee and training context had far-reaching implications for the quality of psychologist developed.

Kühn	2003	Internship	Gauteng	Four intern clinical psychologists, UP	Experienced apprehension, stress and fatigue which led to eliciting mainly support from family and friends. Supervision was valued. At the end of internship, feelings of accomplishment were highlighted.
Lloyd	2003	Training	Gauteng	19 trainees, Unisa (eight first year masters students, six second year masters students, and five intern clinical psychologists)	Double bind experiences of implicit and explicit learning contexts of training exacerbated confusion and powerlessness in trainees.
Richards	2003	Training	Gauteng	Personal account (autoethnography), Unisa	Confronted with the 'unstructuredness' of the systemic-orientated training context at first, however subsequently valued the differentiation processes inherent in training.

Small	2003	Training	Gauteng	Personal account, Unisa	Confronted with inherent paradoxes e.g. complexity of managing different roles within the same person, as such supervisor who is a therapist.
Ahmed and Pillay	2004	Profession challenges	Nationwide	N/A	*Commentary:* Psychology as a profession needs to be transformed to be relevant to all South African citizens. Psychology needs to engage with poverty without dismissing it as a social, non-psychological problem. Inaccessibility to services and language barriers. Government services on average see patients for less than two sessions. Need to interrogate training policies and practices including curriculum content to ensure more black psychologists can access training and services are relevant to all citizens.

Eagle	2004	Training: Culture	Gauteng	Trainer's perspective of training clinical psychologists, as well as her interviews with six fellow Wits clinical psychology trainers: Black (4), white (2); Female (5), male (1). Trainers had trained at Wits (3), Rhodes (2), UWC (1), and the author had trained at the former University of Natal (now UKZN).	Culture is a slippery, loaded and multifaceted construct viewed as a product of lived experience. Race and poverty in South Africa is linked up with culture which aroused painful feelings. Recommendations to enhance cultural sensitivity: Exposure to different lived experiences, diversity of training cohort, investigating suitability of theory, becoming aware of bias in case presentations, advocating political sensitivity and being cognisant of underlying historical and current power dynamics.
Hall	2004	Training: Impact upon personal relationships	Gauteng	Five intern clinical psychologists, UP	Isolated from personal relationships, emotional overload, an awareness of personal unmet needs prompting renegotiation of existing relationships.

Kottler and Swartz	2004	Training	Western Cape	Two senior trainers' perspectives on trainees' development by reviewing UCT student clinical psychologists' weekly feedback over three years.	Training as a 'rite of passage' especially during the first year of masters includes: trainee's separation from others, a fluid and marginal state between student and professional identity, reintegration back into society as a fully-fledged professional after training.
Mayekiso, Strydom, Jithoo, and Katz	2004	Selection		Applicants at eight universities (1994-2004)	Trend of prioritising race or African language proficiency as a key selection criterion.

Viljoen	2004	Self-care		Newly qualified psychologists	Therapists question at some point whether or not they possess what it takes to perform therapy e.g. self-doubt. Therapists' beliefs shape the way in which clients are dealt with. Complaints lead to therapist vulnerability and burnout. The need to remain resilient and flexible is overwhelming for young therapists, although important and therefore peer supervision was prioritised. Directly paid services in private practice is experienced as a stressful dynamic. Limited validation is available in therapeutic contexts for therapists. Ill-prepared in training for harsh judgements of society in relation to therapeutic work.

Dlamini	2005	Training	Gauteng	Personal account, Unisa	Managing reductionistic, diagnostic practices in light of being trained systemically, proved to be challenging.
Eagle	2005	Supervision	Gauteng	Student clinical psychologists, Wits	Utilising the Wits trauma model through a lens of cultural sensitivity, trainees needed to assist patients with severe trauma. Found supervising trainees' severe trauma cases challenging due to vicarious trauma. Trainees report a 'loss of innocence' in supervision. Recommendations included supervision providing containment.
Haumann	2005	Personal psychotherapy	Western Cape	Eight qualified psychodynamic psychotherapists	From a relational and intersubjective theoretical orientation, the notion of the wounded healer featured and informed participants choosing to enter the profession and benefitting from personal therapy.

Lunt	2005	Selection	Eastern Cape	Clinical counselling psychology applicants, NMMU	Administered Minnesota Multiphasic Personality Inventory (MMPI-2) on interview stage applicants to masters programme to assess emotional stability and personality dynamics.

Meese	2005	Training	Gauteng	Nine student clinical psychologists, UP	Participants' retrospective collective and subjective experiences of genograms & family sculpting in experiential family therapy module. Trainees felt overwhelmed as both observer and observed, from a third-person perspective. Awareness of process results in a loss of spontaneity and initial debilitation. Reflexive reconstruction of self occurs due to access of family dynamics and exposure to complexity of systems which ultimately facilitates integration, repair and resolution.
Naidoo	2005	Training	Eastern Cape	Personal account of counselling psychology trainee, NMMU	Trainee therapist challenged to use their personal self within psychotherapy.

Human	2006	Training	Gauteng	Six student counselling psychologists, UP (1999-2000)	Through adventure-based learning (ropes course) trainees' professional development and personal development enhanced by experiential knowledge of how boundaries, anxiety, roles, cohesion and trust occurs and influences interpersonal relationships.

Pillay and Harvey	2006	Community Service	Nationwide	52 Community Service clinical psychologists surveyed.	Lack of resources and clarity regarding Community Service psychologists' role within the healthcare system. More than half the respondents were not proficient in the primary language spoken by their patients. Nearly three-quarters of respondents accessed supervision. 90% confirmed the importance of Community Service and that their confidence levels improved during the year.
Rohleder, Miller, and Smith	2006	Community Service	Western Cape	Personal reflections of three Community Service clinical psychologists within Correctional Services	Lack of personal safety, appropriate supervision and institutional support in Correctional Services placements.

Van Wyk & Naidoo	2006	Internship	Western Cape	Published personal account, SU	Description of the psychological needs of a rural disadvantaged community and reflected on challenges of being an intern counselling psychologist in a peri-urban community clinic as part of the Jamestown Community Project.
Carruthers	2007	Ecosystemic context of therapy	Gauteng	Conversations with five qualified psychologists, a psychotherapy process with a client and a case study from the media informed exploration of the system of discourses.	Globally, psychology in flux as discourses shift e.g. to being less deficit-orientated, the rise of consumerism. Additionally, social contexts were found to impact the perceptions and abilities of psychotherapists.

Eagle, Haynes, and Long	2007	Training: Race, poverty	Gauteng	Student clinical psychologists, Wits	Examined learning processes of trainees at a community clinic Entailed interfacing with the 'unfamiliar'. Supervisory reverie helped students convert raw sensory data into reflective practice. Students experienced personal anxieties as well as context-related anxieties of persecution or annihilation, narcissistic injury and contamination.
Jordaan, Spangenberg, Watson, and Fouché	2007	Emotional stress and coping strategies	Nationwide	238 clinical and counselling psychologists	56.3% above average anxiety levels, while 54.2% were mildly depressed. Coping strategies included: self-blame, denial, self-distraction, and substance use, amongst others. Participants experienced difficulty managing stress.

Brown	2008	Internship	Gauteng	Trainer's perspective on internship training, Weskoppies Psychiatric Hospital, Pretoria	Systemic tensions impacted therapeutic encounters with inpatients within 'total institutions' such as government psychiatric hospitals
Carolissen	2008	Race	Western Cape	Multi-levelled analysis: 1. Survey of SU, UCT, UWC, combined with interviews with a community psychology lecturer in each department. 2. Survey of all psychology honours students in the Western Cape. 3. Survey of perceptions about community psychology amongst senior psychologists. 4. 27 senior psychologists in three focus groups about community psychology and professional identity.	Identity representation is important in transforming the discipline of psychology in contemporary South Africa yet race is an area of silence. Community psychology is constructed as psychology for black people: who delivers services and who the clients are. Thus parameters of inclusion and exclusion for community psychology and psychology, as a whole.

Nair	2008	Therapeutic process: Culture/race	Western Cape	19 intern clinical psychologists, SU, UCT, UWC	Participants reported their own experiences related to their racial identities and difficulties experienced in cross-racial therapeutic dyads as race is regarded as a 'painful construct'. High 'cost' incurred when race not recognised in therapy. All trainees felt training in multicultural competencies was lacking.

Gentz and Durrheim	2009	Expertise and governmentality	KwaZulu-Natal	70 psychologists across all categories graduating from UKZN (1993-2003/4)	Questionnaires: 118 problems identified by participants in daily work context: clinical syndromes, public health issues, socioeconomic problems, adjustment problems, labour problems, problems defined by trigger only e.g. sexual abuse, professional issues e.g. non-payment for services. Participants voiced how they were confronted with social deprivation addressed through traditional individual therapy interventions which remains problematic when faced with structural poverty and inequality.
Hurter	2009	Selection	Eastern Cape	247 NMMU applicants	Interviewed applicants were emotionally stable and well-adjusted as confirmed by psychometric testing.

Nabal	2009	Training: Ethics	Gauteng	Personal account, UP	After an armed robbery, trainee challenged to incorporate her personal values into her understanding of people to restore her faith in people to effectively work from a relational ethics base.
De Lange	2010	Experienced psychologists: Private practice	Not indicated	Seven qualified psychologists (10-20 years in practice). Counselling (4), clinical (2), and educational (1) psychologists.	Fortigenic perspective adopted to explore experienced psychologists' experiences in full-time private practice. Stresses included: private practice being a business, marketing ability, unpredictability of income, unpaid leave and sick leave, secondary trauma. Positive aspects included: resiliency, flexible hours, autonomy.

Laidlaw	2010	Comparing stages of development	Eastern Cape	Five interns & six qualified psychologists for more than seven years, NMMU (9) RU (2)	Personally wounding events and early helper role attracted participants to the profession. Theoretical orientation(s) influential, but clients' needs prioritised. A strong therapeutic relationship seen as vital. Professional growth involved personal therapy, 'unforgettable cases', group supervision; and post-qualification workshops. Interns reported dissolution of naivety, reduced anxiety, greater flexibility, decreased inappropriate responsibility for clients' progress, and negotiation of personal and professional lives. Established psychologists voiced increased confidence, yet some anxiety fostered humility.

McGregor	2010	Training	KwaZulu-Natal	Eight student psychologists, UKZN	Together with Skovholt and Rønnestad (2003) model of psychotherapist development, Interpersonal Process Recall (IPR) was employed following the first interview with a role-play client. Anxiety was evident due to fear of being evaluated Carving out a professional identity is filled with fear and critical feedback can create further anxiety. Positive coping strategies of self-talk assisted trainees whereas negative coping strategies of reverting to rigid structured processes escalated anxiety leading to poor self-efficacy.
Smit	2010	Selection	Eastern Cape	44 NMMU applicants	ENFP, INTP and ISFJ most common personality types successfully selected for training.

Swartz	2010	Careerspan of an individual's personal-professional development	Western Cape	Personal account	Memoir of being an able-bodied clinical psychologist, the son of a man with club foot, the husband of a wife with a disability and a disability researcher.
Collocott	2011	Scope of practice: Counselling Psychology	Western Cape	Survey with 72 honours students. Of the masters programmes six of 25 clinical and two of three counselling student psychologists agreed to be interviewed. Interviews with course conveners of UCT, UWC and US were also conducted.	Course conveners identified clinical psychologists as working in hospitals with severe pathologies whereas counselling psychologists work with problems of living. Clinical psychologists perceived as having a higher status. Private practice blurs boundaries between specialties. Recommendation: Equip students with scope of practice information.

Gerber and Hoelson	2011	Training: Curiosity and managing uncertainty	North-West, Eastern Cape, Gauteng	Mixed-methods exploratory descriptive design: Quantitative data collected with Curiosity and Exploratory Inventory (n=50), and qualitative interviews to tap uncertainty as a psychologist (6). Participants from NWU, NMMU and UJ.	Moderate to high levels of curiosity reported by trainees. Actively sought new information and frequently searched for growth opportunities. To cope participants utilised supervision, peer support, self-enhancement strategies e.g. personal therapy, theoretical knowledge, learning from practical experiences, positive cognitive appraisals and self-care. Training contexts need to facilitate trainees' perceptions and emotions that lead to greater curiosity and exploration.

Pillay and Johnston	2011	Internship	Nationwide	Intern clinical psychologists in 2009. Of 150 potential participants, 83 completed the survey.	Survey: 34.9% of respondents felt adequately prepared for internship, 53% felt partly prepared. 53% considered training to be relevant and 31.3% felt training was only partly relevant. One-third had planned to emigrate. 72.3% were female interns which is similar to international trends. 89.2% found their work stimulating. 73,5% reported feeling supported in the training and 75.9 satisfied with supervision received. 75.9% had language difficulties with patients.

Cooper and Nicholas	2012	Profession overview	Nationwide	N/A	*Commentary:* For over a century South Africa has engaged with international Psychology, and its organisation is reaching maturity. Increased participation of black psychologists in leadership and research has the potential to use a transformed profession to address public concerns.
Ivey and Partington	2012	Selection	Gauteng	Ten selectors' ratings of six clinical psychology applicants' autobiographies, Wits	Woundedness processing of applicants influenced whether selected.
Ivey and Waldeck	2012	Training	Gauteng	Nine clinical psychology trainees, Wits	Eight participants endorsed mandatory trainee personal therapy.

Geffen	2013	Private practice	Western Cape	Eight Cape Metropole and one Stellenbosch clinical psychologist in private practice interviewed.	Participants spoke of taking on *pro bono* or reduced rate clients. Frequency of sessions and duration of therapeutic processes were driven by limited funds. Participants primarily saw themselves in the role of therapist, as opposed to social activist. Constructed the public sector as having limited posts, as overwhelming and not the ideal setting to conduct therapy. Private practice was seen as a business and as competitive (market phenomenon).

Human	2013	Training	Gauteng	19 student counselling psychologists, UP	Adventure-based learning (archery, obstacle course, sea kayaking, sea rafting, abseiling), as well as eight group debriefing sessions. Students reflected in writing on their adventure experience. Students' personal growth involved increased awareness; challenging of their boundaries; discovering uniqueness, creating trust and collectively establishing group cohesion.
Manganyi	2013, 2016	Careerspan of an individual's personal-professional development	Gauteng	Personal account	Memoir of being a black clinical psychologist during Apartheid and beyond, over five decades.

Padfield	2013	Community Service	Western Cape (rural)	Published personal account	Lack of privacy and space yet the claimed space provided therapeutic benefit for patients who had little private space to reflect. Inconsistency in attending sessions due to travel costs and having to reassure patients about the reliability of session time. Importance of self-care in terms of supervision and personal psychotherapy to manage isolated setting, where the ramifications of Apartheid are still acutely felt.
Pillay, Ahmed, and Bawa	2013	Profession challenges	Nationwide	N/A	*Commentary:* Slow training redress for black psychologists. Insufficient psychology internships and jobs.

Swarts	2013	Community Service	Western Cape	Published personal account of Community Service at Overberg District Municipality Provincial Hospital Complex	Challenges: Patients' inability to access the service due to limited finances and transport, burdensome work environment of nurses, lack of a multidisciplinary team, mental health care embedded within the biomedical model, lack of institutional support. Provision of resources, supervision and management within the Community Service year should be prioritised by government.
van der Merwe	2013	Training	Gauteng	Personal account (autoethnography) of clinical psychology trainee, Unisa	Self-differentiation involved two key themes for the trainee within a systemic orientated training environment, namely, individuation and the development of authentic relationships with others. Study highlights the importance of personal development of the trainee alongside professional development.

Pillay and Kramers-Olen	2014	Internship	KwaZulu-Natal	Intern clinical psychologist trends in KwaZulu-Natal (since 1981)	Examined clinical psychology intern training within the context of the country's socio-political history over the past 30 years. Since 1981 intern demographics have changed dramatically as a result of democracy.
Teixeira	2014	Internship	Eastern Cape	Three newly qualified counselling psychologists to retrospectively recall their internship of the previous year, RU.	Participants gained more confidence during internship and trusted their abilities more. Realised an imperfect therapist is likely to be valuable therapeutically, and therapist and client bear equal responsibility in the therapeutic process. Positive experiences of supervision reported. Sought congruency between their professional and personal self.

Ruane	2015	Training: Culture	Gauteng	27 participants (Eight trainers and 19 clinical or counselling psychologists) at a historically white university.	Findings indicated the need for greater diversity of trainers and selected students as well as the need to develop gender sensitivity and race cognisant workshops and journal articles related to diversity. Broadly, the research found the need for active measures to be taken to transform a historically white university's discources and practices in order to train multiculturally equipped psychologists.

Pillay	2016	Profession challenges	Nationwide	N/A	*Commentary:* During Apartheid the discipline did little to challenge injustices however now attentive to ethics and human rights, thus enjoys acclaim and has hosted international conferences in recent years. Limited government positions to service the poor. Debates regarding neuropsychology and forensic psychology being specialist-level categories. Scope of practice issues reduce access of services due to limited medical insurance reimbursement. Need to incorporate African perspectives in training nationwide. Psychology well-placed to drive public mental health initiatives within the envisioned National Health Insurance.

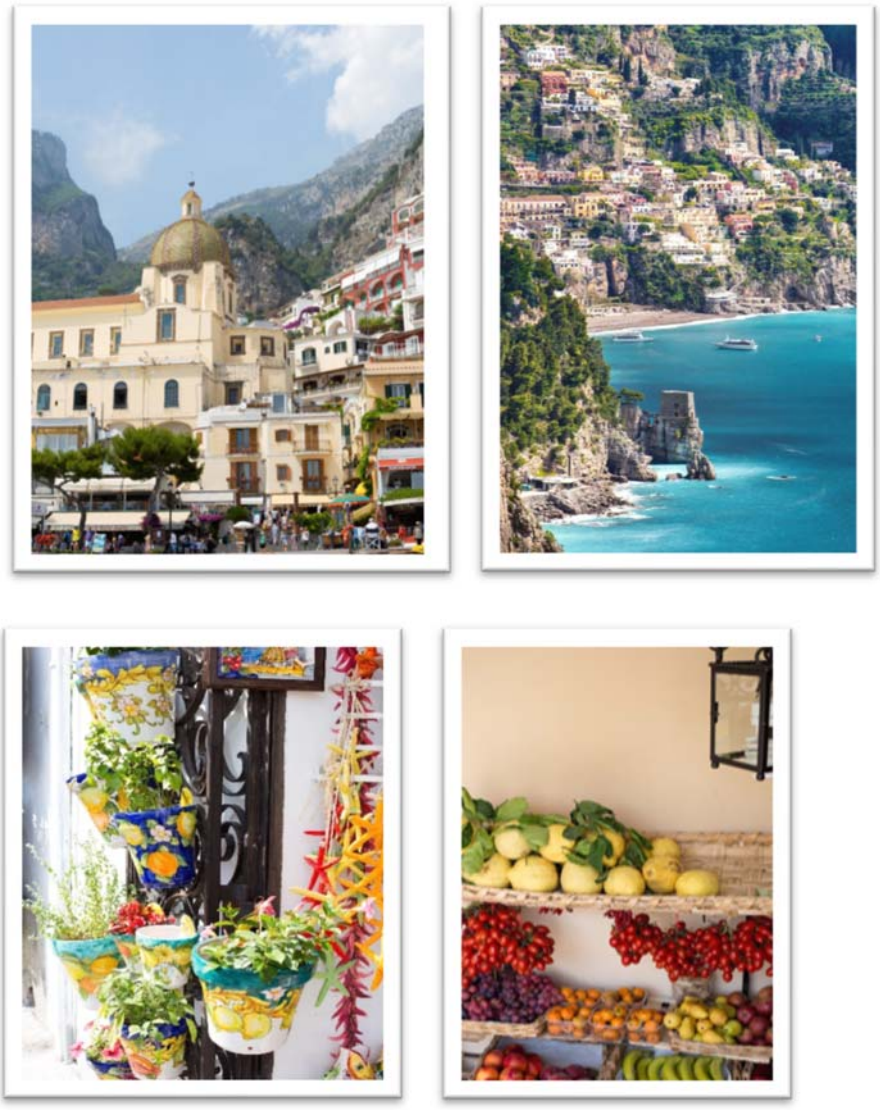
Young, Kagee, and Bantjies	2016	Profession challenges: Counselling Psychology	Nationwide	N/A	*Commentary:* Counselling psychology in South Africa will grow fully into social justice role through the provision of public money for salaried positions.
Bantjies, Kagee, and Young	2016	Status of Counselling Psychology in SA	Nationwide	N/A	*Commentary:* Counselling psychology in South Africa is negatively affected by the scope of practice debate, as a category can make a more meaningful contribution within public health, health care and education systems.
Booysen and Naidoo	2017	Selection	Western Cape	Student clinical psychologists, SU	Initially, unsuccessful applicants experienced anxiety, intense feelings of rejection and a void. Paradoxically, their previous experiences with uncertainty now creates the ability to sit with uncertainty as a trainee psychologist.

Espery	2017	Therapeutic process: Race	Gauteng	Qualified clinical psychologists: Clinical material from a 'Coloured' clinical psychologist, and author's personal account and clinical material as a white clinical psychologist.	Cross-racial therapeutic dyads are difficult to talk about from an experience-near position due to individuals' racial identities and histories being so complicated in South Africa and eliciting racialised enactments in sessions, especially as currently society is in a 'racialised moment' with the threat of destabilisation evident.

Nel and Fouché	2017	Therapist development of a student psychologist	Free State	One student clinical psychologist: three interviews with trainers and three student reflective writings, UFS, through a Positive psychology lens.	Becoming a psychologist is known to be a long and difficult journey. However continuous self-reflection enabled meaning-making. The participant felt that being a therapist is always a process of becoming. Key role-players: fellow trainees and individual supervisors enabled introspection, and together with departemental structures provided support and containment for the trainee's personal growth. Clients also were found to shape and instigate the personal growth of the trainee therapist.

Appendix B: Journal reflections

An Encounter with a Positano Sandalmaker



When writing up the findings of the current research, it dawned on me that going to therapy is like my nieces going to have sandals made by the sandalmaker in Positano. A year prior, my sister had been in Italy for business and she had these beautiful sandals made from scratch by a sandalmaker sitting by the church in the most scenic town of Positano along the Amalfi Coast.

She remembered a year later that Positano is something special, so she decided to go back with her whole family in tow… We literally only had an hour to tour the town after lunch before we had to rush back to board the ship in the port of Naples. Needless to say, my sister convinced everyone that she had enough time to find the sandalmaker to make my nieces Jackie Onasis sandals - and off they went running.

Here now, in Pretoria, South Africa thinking about how therapy is so complex, and there being no set way of doing therapy I am reminded of the Positano sandalmaker. When encountering my sister, a year previously: he measured her feet, worked out how to craft his leather, jewels and thread in a way to fit her unique feet, with the clock ticking and the world-renowned reputation of Positano sandalmakers hanging in the balance. 'Can he pull it off?' Indeed, he does! My sister then put him to the test with my nieces who are completely a whole new encounter…

Back on board the ship, (yes, we made it back to the dock in neck-breaking speed), dressing for dinner, my eldest niece, when showing off her sandals to me, declared, "Aunty, it was too difficult to choose between the sea turtle and the starfish!" – and on examining her sea-turtle-clad foot and then her starfish-clad foot I could see the dilemma she had been in and there had been no time to spare – 'Why, of course have one of each! Why, not? Who says shoes have to match?'. She then showed me how it works for her as she can change her feet over when crossing her legs depending on which sea creature she wants to show people. And, my youngest niece also takes the prize as her sandals, surprisingly, are the epitome of femininity; a glowing pink that works unusually well with her vintage-looking, heavy metal Metallica, rose-pink T-shirt.

On reflecting on this encounter, the wisdom of the Positano sandalmaker is elusive, but one can hold a glimpse of it- he figured out what he had, what the situation called for and what my nieces needed to go forward in life…

Now, in snow-capped mountainous Switzerland sit summer-jewelled sandals at the bottom of my twin sister and nieces' cupboards. Long-forgotten in the winter months, but for the living, magic-spinning knowledge that a sandalmaker in a Positano street created bespoke sandals, to make them each sparkle in their daily life whereever life may take them.

"The shoe that fits one person pinches another; there is no recipe for living that suits all cases." - Carl Jung

(Photos by Julie Gallagher, newspaper clippings of Jackie O & second photo of Positano from Pinterest).

The Sacredness of the Journey

Since starting my journey as a therapist, I have always found the stories of Prof. Rachel Naomi Remen, at the University of California, San Francisco (UCSF) School of Medicine, inspirational! She believes in the sacredness of the health professions and advocates that this needs to be shared with the next generation. I also find Remen's reflections (two quotes here) on an education compared to training an important point of discussion:

> Education is not preparation for life; education is life itself - John Dewey

> For me, the process of education is intimately related to the process of healing. The root word of education -- educare -- means to lead forth a hidden wholeness in another person. A genuine education fosters self-knowledge, self-trust, creativity and the full expression of one's unique identity. It gives people the courage to be more. Yet over the years so many health professionals have told me that they feel personally wounded by their experience of professional school and profoundly diminished by it…
>
> In a training your own way of doing something can often become irrelevant. In such a milieu students often experience their learning as a constant struggle to be good enough. Training creates a culture of relentless evaluation and judgment. In response students try to become someone different than who they are - Rachel Naomi Remen

Rabbi Abraham Joshua Heschel states, "If the body is the Temple of the Lord, then the physician is a priest who ministers to the Temple." And here, is the story that inspires the sacredness of journey of the patient and the health professional:

"Immy was a frail little girl, the only child of older parents. At three, she was only as big as the average 18-month-old. She was born with a hole in her heart and a badly formed heart valve. Only the most careful medical management had enabled her to live until she was old enough to undergo extensive surgery.

“When the time for her surgery finally came, her parents were understandably anxious. As the senior pediatric resident, I met with Immy’s parents and afterward, I took them with me to the children’s ward to examine Immy.

“Immy’s heart sounds were not good and I marveled at her endurance. As I helped her dress, I noticed a St. Christopher medal pinned to her undershirt. ‘What’s this?’ I asked her parents. Her mother told me that a relative had made a special trip to Rome to have this medal blessed and then had dipped it into the healing water at Lourdes. ‘We feel that it will protect her,’ she said.

“Immy spent the next day undergoing tests, and I saw her a couple more times. The medal had been moved from her undershirt to her hospital gown. It seemed so important to her parents that I mentioned it in passing to the cardiac surgery resident. He gave me a cynical smile. ‘To each his own,’ he said.

“I made a note to be sure to take the medal off Immy’s gown before she went into surgery. But by the time I reached the floor, Immy had been taken upstairs. The surgery lasted almost 12 hours, and things had not gone well. Immy had lost a lot of blood. She was on a respirator in the intensive care unit.

“The next day, her mother told me that Immy’s gown had been removed in the operating room and thrown into the hospital laundry. The medal was gone. Concerned, I called the surgery resident and told him what had happened.

“ ‘Perhaps you should tell the surgeon [Dr. X] who operated on her,’ I said. He began to laugh. ‘Don’t be absurd,’ he said. ‘Why would you want to bother a world-famous surgeon over something as silly as that?’

“That night I kept thinking about the lost medal and what Immy’s parents had told me about it. Around 2 a.m., I took some paper and wrote a note to Dr. X, telling him what had happened and how important the medal was to Immy’s family. I taped it to Dr. X’s office door.

“When I returned to the hospital for the evening shift, I stopped by the Intensive Care Unit to examine Immy. When I leaned over to listen to her chest, I noticed a medal pinned to her hospital gown. Turning to her parents with relief, I asked: ‘How were you able to find another one so quickly?’

“ ‘Oh, no,’ her mother said. ‘This is the one that was lost. Dr. X came in this afternoon and brought it to us.’

“The next morning, the surgery resident told me how the medal had been found. On the previous day, Dr. X had made his rounds accompanied by the young surgeons in training.

“Instead of ending his rounds at the ICU, he had taken them all to the laundry. He explained what had happened, and then he and his residents went through the laundry from the day before, looking for the gown. It took them a while, but they found it, neatly folded, with the medal still attached.

“ ‘Did Dr. X say anything when he asked you to do this?’ I asked. ‘Oh, yes,’ the resident replied. Surrounded by the sheets and towels, Dr. X told the young surgeons-in-training that the reason he was making them go through the laundry was so they would learn that it is as important for a doctor to care about the souls that are entrusted to them as it is to care about their bodies.”

(Extract from *Kitchen Table Wisdom: Stories that heal,* by Remen, 1996)

This story always reminds me to consider our clients holistically. In addition, the doctor was wise enough to understand that easing the fears of the patient’s family is also a part of one’s intervention and, notably, that honouring the soul is as important as healing a body.

Appendix C: Qualitative Interview Guide

Demographic information

Pseudonym:

Gender: **Age:**

Ethnicity:

Marital status:

Qualification:

Year of qualification:

Years practicing psychotherapy:

The Grand-tour Question:

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

Possible prompts/focus areas:

2. Out of analytic-psychodynamic, cognitive-behavioural, humanistic/existential, systemic, narrative or other, which theoretical orientations greatly influence your current therapeutic work? (Orlinsky & Rønnestad, 2005). How do you describe the theoretical orientation you work from? (Hersh & Poey, 1987; Kassan, 1996). What theoretical perspectives do you find useful or interesting? (Mullan, 1996). How did you choose a theoretical orientation? Is there anything in your personality that is reflected in or determines your choice of theory or technique? (Kassan, 1996).

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

4. Using a metaphor or image how would you describe the therapeutic process? (Duncan, 2010; McLeod, 2003, 2010; Najavits, 1993). How does therapy work? Has your view changed over time? (Kassan, 1996; Skovholt & Rønnestad, 1995). What happens when someone comes to see you? How would you describe how you do therapy? (Mullan, 1996). What is psychotherapy? How does psychotherapy heal? (Jennings & Skovholt, 2004). What are the tasks of the psychotherapist? (Kassan, 1996).

5. How would you describe yourself as a therapist, that is, your actual relational style or manner with clients? (Carlock, 2000; Hersh & Poey, 1987; McLoed, 2010, p. 163; Orlinsky & Rønnestad, 2005). What would you say is particularly "therapeutic" about you? How does the person you are impact the therapy you do? (Jennings & Skovholt, 2004). What are your core values about therapy and being a therapist? (Johns, 1996; Jennings, Sovereign, Bottorff, & Mussel, 2005). How do you think patients see you? (Kassan, 1996).

6. What qualities do you feel are necessary for a therapist to possess? What do you think are the necessary skills a therapist should learn? (Mullan, 1996). What tools do you think a therapist should acquire and how do these tools impact the identity of the therapist? (McLoed, 2010, p. 194). What is the role of the therapist? (McLoed, 2010). What kinds of people make the best therapists? (Skovholt & Rønnestad, 1995). What distinguishes a good therapist from a great therapist? If there were a recipe for making a master therapist, what ingredients would you include? (Jennings & Skovholt, 2004). What is your greatest strength or asset as a therapist? (Kassan, 1996; Ladany, Walker, Pate-Carolan, & Gray Evans, 2008). What is your greatest liability or challenge as a therapist? (Kassan, 1996; Ladany, Walker, Pate-Carolan, & Gray Evans, 2008).

7. What was your first awareness of the profession? What experiences or chance events in your background led you to choose this profession? (Kassan, 1996; Ladany, et al., 2008; McLoed, 2010, p. 20; Sussman, 1992, 1995, 2007). What early experience influenced you to become a psychotherapist? (O'Leary, 2011, p. 39).

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

    a. Should or how much psychotherapy should a psychotherapist have? What was your experience as a client? How does your experience as a client affect the way you work as a therapist? (Kassan, 1996; Smith, 2008; Sussman, 2007; Waldeck, 2011)
    b. What was your experience in supervision? Have you ever supervised other therapists? What's that like? (Kassan, 1996)

9. What do you regard as critical incidents or turning points that significantly contributed to your professional growth? (Cormier, 1988; Furr & Carroll, 2003; Howard, Inman, & Altman, 2006; Roehlke, 1988; Skovholt & McCarthy, 1988; Mullenbach & Skovholt, cited in Jennings & Skovholt, 2004).

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

11. How do you monitor your performance? How do you self-monitor your work? What self-monitoring do you engage in? (Mullan, 1996; Whitmire, 1991). How do you measure your success in your work? (Skovholt & Rønnestad, 1995). What are the criteria for success or failure in psychotherapy? (McLoed, 2010). What are the desired outcomes of therapy? (McLoed, 2010, p. 192). How do you know when you are doing a good job with a client? (Jennings & Skovholt, 2004). When are you disappointed with your work? When do you feel drained or depleted by the work? When do you feel energised and excited by the work? Do you like being a psychotherapist? What do you like best? (Kassan, 1996).

Appendix D: Request Letter for List of Registered Psychologists

1 February 2013

Mrs Adelle Taljaard

Tel: 012 338 9349
Email: adellet@hpcsa.co.za

Dear Prof. Tholene Sodi

RE: Distribution of international professional development quantitative survey to psychologists and CPD activity authorisation

I would like to ask permission of the Professional Board of Psychology for a list of registered practitioners within the discipline at all career levels. I wish to approach the population of psychotherapists within the discipline of psychology to be anonymous respondents to a professional development international online survey.

The quantitative survey is to form the first part of my doctoral study which is to investigate the professional therapeutic development of psychologists across the career lifespan ranging from registered counsellors to senior psychotherapists (25 years or more in the profession). The results of the questionnaire are then envisaged to inform the sample of subsequent qualitative interviews of practitioners at the various levels identified.

The study is to extend my Masters' research of professional development of psychotherapists within the Eastern Cape (*See* http://www.nmmu.ac.za/documents/theses/C.Laidlaw%20Treatise%202010.pdf).

Prof. David E. Orlinsky from the University of Chicago, together with Prof. Helge M. Rønnestad, University of Oslo, and the Society for Psychotherapy Research Collaborative Research Network has given me

permission to use the international Society of Psychotherapy Research's Development of Psychotherapist Common Core Questionnaire (DPCCQ; See Appendix A) which has been applied across the world *(See* www.psychotherapyresearch.org).

I also wish to ask if it is possible that completion of the questionnaire could be a CPD activity and result in the granting of CPD points for the respondents, due to their participation in furthering critical knowledge and contributing to the profession within the South African context. Such an endorsement and valuing of practitioners' time and input may likely lead to a larger sample. The online questionnaire takes approximately an hour to complete. The proposed CPD activity could also easily be linked to articles relevant to the subject matter of development of psychotherapists which are linked to the items of the survey being undertaken.

The information gathered has been shown to be highly relevant for stakeholders in the professions offering psychotherapy. The data provides profiles of practitioners at all career levels and can subsequently inform CPD activities and policy-making within the profession. Such information may be pertinent with regards to competencies, training, experience, expertise, and specialisation which can easily be compared to practitioner data across the world.

Please do not hesitate to contact me for further details. Thank you for your time and consideration.

Yours faithfully

Christine Laidlaw

University of South Africa

Tel: +27 12 429 8294

laidlc@unisa.ac.za

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Nelson Mandela Metropolitan University
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fourime@unisa.ac.za

Head of Department: Prof. Ilse Ferns
University of South Africa
Tel: +27 12 429 8256
fernsi@unisa.ac.za

Appendix E: Information Emailer

Appendix F: Information Letter

UNISA university of south africa

24th of January 2014

Dear Colleague

RE: Research Study on Psychotherapist Development of South African Clinical & Counselling Psychologists using an International Survey & Interviews

I am currently doing my thesis for a doctoral degree in psychology at the University of South Africa. This mixed methods research study aims to describe the therapeutic development of psychologists in different career phases from their own perspectives. The information will be used to gain an understanding of the professional development of psychotherapists within the profession of psychology.

South Africa currently has approximately 4500 clinical and counselling psychologists who potentially see clients for psychotherapy. However we only have limited insight into what makes a good psychotherapist and how to train and develop psychotherapists to enhance their expertise throughout their career. The current research aims to develop a model of psychotherapist development that uniquely reflects our context and yet also allows for comparison to other countries.

Phase One

I request your participation in the international DPCCQ survey which forms part of the International Study of the Development of Psychotherapists. An ongoing project developed by the Society for Psychotherapy Research Collaborative Research Network.

The online questionnaire in English will take you no longer than 50-70 minutes to complete.

Your participation is strictly voluntary, and your decision whether or not to participate will in no way affect your present or future employment/lifestyle. There are no risks associated with participating in the study. All identifying information will remain anonymous and confidential throughout the study, and the results of the survey will be reported in terms of general results and themes.

Your anonymous data will contribute to the international database of psychotherapists of the Society of Psychotherapy Research. As a result of your participation in this study the results are intended to contribute to the knowledge of the profession of psychology and specifically the professional development of psychotherapists on a national and international level. Access to findings of the current national study will be possible through a copy of the thesis being available through the libraries of the University of South Africa and articles may be published in scholarly journals aligned to the profession of psychology.

Completion and submission of the survey will be taken as indicating your informed consent to participate. Simply, click below to participate in the survey. Your participation is much appreciated!

https://www.surveymonkey.com/s/XL383PG

Phase Two:

The second phase of the research entails a qualitative interview of forty minutes in duration. Such a face-to-face interview provides an opportunity where your journey as a psychotherapist can be shared in greater detail. The recording will be transcribed and all identifying details removed in the thesis. An honorarium (R300) will be given in light of your interview time.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Thanking you for your consideration to participate in contributing to the knowledge base of our profession.

If you require additional information or have any questions pertaining to the study please do not hesitate to contact me.

Yours faithfully,

Researcher: Ms. Christine Laidlaw
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Chair of Ethics in Department of Psychology: Prof. Piet Kruger
University of South Africa
Tel: +27 12 429 6235
kruge@unisa.ac.za

Appendix G: Informed Consent

Title of the research project	A Careerspan Model of Psychotherapist Development within the South Africa Context.
Reference number	
Principal investigator	Christine Laidlaw
Address Postal Code	Department of Psychology Theo van Wijk Building Preller Street Muckleneuk Ridge Pretoria 0003
Contact telephone number	012 429 8294

A. DECLARATION BY OR ON BEHALF OF PARTICIPANT (Person legally competent to give consent on behalf of the participant)	*Initial*
I, the participant and the undersigned (full names) I.D. number Address (of participant)	

A.1 I HEREBY CONFIRM AS FOLLOWS:	
1. I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Christine Laidlaw of the Department of Psychology In the Faculty of Social Sciences of the University of South Africa.	
2. The following aspects have been explained to me, the participant: 2.1 Aim: The researcher is studying the professional development of psychotherapists tracing their development along their career paths by means of their narratives. The information will be used to gain an understanding of the professional development of psychotherapists within the profession of psychology.	
2.2. Procedures: I understand that the interviewing process will take place for approximately 40 minutes to an hour. I may refuse to answer any question and may withdraw at any point I wish. The interview will be audio-recorded and later transcribed. The transcription will be included in the appendix of the final work with all identifying remarks and my name absent. Once the transcription is complete the recordings will be deleted. Generalised feedback regarding the study's outcomes will be made available should I be interested.	
2.3 Risks: I will not remain anonymous to the researcher and promoters.	

2.4 Possible benefits: As a result of my participation in this study the research findings are intended to contribute to the knowledge of the profession of psychology and specifically the professional development of psychotherapists.	
2.5 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the researcher and promoters.	
2.6 Access to findings: A copy of the research will be placed in the library of University of South Africa. An article may be published in a journal aligned to the profession of psychology. Generalised feedback regarding the findings of the study will be provided to me and other interested participants	
2.7 Voluntary participation/refusal/discontinuation: My participation is voluntary ☐ YES ☐ NO My decision whether or not to participate will in no way affect my present or future employment/lifestyle ☐ TRUE ☐ FALSE	
3. The information above was explained to me by Christine Laidlaw in English and I am in command of this language. I was given the opportunity to ask questions and all these questions were answered satisfactorily.	
4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.	

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

Signed/confirmed at

	on		20

Signature	Signature of witness
	Full name of witness

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

Appendix H: Non-disclosure Form for Professional Transcriber

cyber transcription
Virtual Speech to Text & Copy Typing
Tax No.: 1672677158

C: 083 227 5966
F: 086 647 6813
P: PO Box 7827, Centurion, 0046
E: juliamb1@mweb.co.za

11 December 2017

To whom it may concern:

I hereby confirm that I was responsible for transcribing all audio recordings for Christine Laidlaw [Department of Psychology] at Unisa.

I, Julia Marianne Martinelli of Cyber Transcription, agree to hold any information contained in any audio recording/documents related to this study by Christine Laidlaw, in confidence, as well as regarding individuals and institutions involved in the research study.

I understand to violate this agreement would constitute a serious and unethical infringement on the informant's right to privacy.

Sincerely,

Julia M. Martinelli
Cyber Transcription Services
Unisa Supplier No: 9008144