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Narratives of 'woundedness' in applications for clinical psychology training.

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CHAPTER 1: Introduction

1.1 Brief overview and rationale

Selection committees for clinical psychology training generally ask applicants to provide a self-description and an account of some key experiences that they think have shaped them as a person. In response to this, many applicants provide various accounts of personal suffering detailing traumatic events, unhappy childhoods and family relationships, and other significantly distressing hardships. This leads to the concept of "woundedness" that is understood in this research as "the emotional and psychological effects of negative and traumatic life experiences on the individual." Based on a compilation of such autobiographies, this research aimed to explore trends and patterns in applicants' narratives of woundedness. The researcher further intended to investigate the implications of these seeming patterns and trends in woundedness, according to a sample of selectors, for the therapeutic process, and for applicants' psychological training suitability for clinical masters.

The rationale for this study lay in acknowledging the crucial influence of the 'person of the therapist' for the therapeutic process. This emphasis is largely based on empirical research that advocates the non-technical aspects of the therapist's contributions as being the most influential factor in facilitating positive outcomes (Beutler, Crago & Arizmendi, 1986; Lambert, 1989, cited in Chippindall & Watts, 1999). Guy (1987) explains that it is the therapist's personality which impacts that of the patient, bringing an intimate and meaningful relationship between two individuals' intent on promoting growth and change in the patient. Thus, the import for investigating aspiring therapists and their suitability to the profession was patently clear: their personality, life experiences and interrelationships must determine, to a large extent, the effectiveness of the treatment. Despite this, we know very little about the effects of the therapist's life experiences and motivations on the psychotherapy process, and it remains a relatively neglected area of inquiry (Hayes, 2002; Fussell & Bonney, 1990; Sussman, 1992).

The researcher's approach allowed for a focused inquiry into the "person of the would-be-therapist" and in terms of the highly relevant theme of woundedness. From the researcher's reading of the literature in the field, there appeared to be considerable evidence that pointed to those in the helping-professions being drawn toward, and psychologically equipped for, a career in psychology because of their earlier difficulties (Barnett, 2007; Burton, 1972; Casement, 2006; DiCaccavo, 2002, 2006; Fussell & Bonney, 1990; Goldberg, 1993; Guy, 1987; Halewood & Tribe, 2003; Henry, Sims & Spray, 1971, cited in Farber, Manevich, Metzger & Saypol, et al., 2005; Leiper & Casares, 2000; Maeder, 1989; Miller, 1981; Norcross & Guy, 1989; Racusin, Abramowitz & Winter, 1981, cited in Farber et al., 2005; Sussman, 1992). It became prudent, therefore, to consider the emotional and psychological impact of these troubled histories on individuals seeking clinical masters training, in so far as it has bearing for themselves as future practitioners and for the therapeutic process for patients.

Previously, studies of therapists' personal experiences and motivations have been undertaken with participants being either qualified psychotherapists or in the process of (masters-level) training (e.g. Cain, 2000; DiCaccavo, 2002; Sussman, 1992; Trusty, Ng & Watts, 2005). However, as Sussman (1992) warns, this approach has drawbacks: both practising and trainee therapists may exhibit emotional difficulties due to the hardships of practice and the stressors of the training itself. Also, owing to the emphasis on self-exploration, these participants were likely to have conscious insights into the nature of their woundedness and be more sensitive in recognising and reporting difficult childhood experiences. Recently, Nikcevic, Kramolisova-Advani and Spada (2007) investigated applicants to training programmes in an attempt to eliminate these possible intervening factors. However, whereas these authors examined the *early childhood experiences* of aspiring therapists (in relation to current emotional distress) only, this study explores the *life histories* of applicants for clinical training as this relates to their providing therapy and suitability to enter the profession. As such, to the researcher's knowledge, this presents a novel approach to the topic of inquiry.

This project did not follow a specific theoretical paradigm. It was, however, underpinned by psychodynamic theory and the school of object relations[1] in particular. Object relations theories are diverse, but share several assumptions. Most relevant to this study are the following: Firstly, that the pattern of relationships with objects becomes increasingly complex with development; secondly, that early patterns of objects relations are repeated, and in some cases fixated throughout life; and thirdly, that disturbances in these relations developmentally map onto psychological disturbance (Fonagy & Target, 2003).

Lastly, clarification of terms and concepts that the researcher used throughout this study are defined in the context of the literature review, bar three: "woundedness", "wounded healer" and "merely wounded". The concept of "woundedness", as already defined, specifically pertains to the psychological effect of negative and traumatic experiences on the individual. The researcher distinguishes between the terms "wounded healer" and "merely wounded" by saying that the wounded healer has the capacity for resolution of the woundedness while the merely wounded does not. The distinction in terms of the capacity for resolution is borne out in the literature review and in the discussion of the researcher's findings.

1.2 Research method

This study follows a qualitative research design. Two sets of data were collected. The first set consisted of thirty applicants' autobiographies drawn from the archival database of applications for MA Clinical Psychology held by the University of the Witwatersrand (hereafter referred to as Wits University). The second set of data was collected through interviewing ten panel members of the Selection Committee for MA Clinical training. Interviews were semi-structured and conducted with the use of some guiding questions. The autobiographies and interviews were then transcribed, coded and analysed according to the method of thematic content analysis. Firstly, explicit data was arranged at a semantic level. A second level of analysis followed, in which descriptive categories were organised into thematic charts according to an explanatory level of

[1] McWilliams (1994) notes that the term "object relations" is unfortunate, since "object" in psychodynamic theory usually means "person". It derives from Freud's early explication of instincts as having a source, an aim, and an object – usually being a person.

analysis. The two sets of data were then placed alongside each other and an analysis of continuity and discontinuity between the sets was undertaken. Lastly, the researcher presents a theorisation of the trends and patterns of seeming woundedness and possible implications of these in relation to the reviewed literature. The position of the researcher and ethical considerations were taken into account at all levels of the research process and are fully discussed in Chapter Three.

1.3 Outline and structure of the study

This dissertation has five main sections. The first is Chapter Two of the literature review. Here, the archetypal motif of the wounded healer is presented in relation to the modern day helping-professional, particularly that of psychotherapist. Empirical and clinical literature on motivations and influences of life experiences seemingly common to psychotherapists is reviewed. This is followed by literature that addresses the topic of selection of candidates to the psychological profession. The remaining section of the literature review discusses the potential benefit and risk of therapists' woundedness for the therapy process and in terms of clinical training.

In Chapter Three, the research method employed in this research is discussed. Chapter Four presents the research results in which summaries and excerpts from the data are used to highlight the themes and patterns found in the autobiographical texts and in selectors' accounts. Chapter Five discusses these results against the backdrop of the reviewed literature.

The study is concluded in Chapter Six with a discussion of the value of having used novel data, validity of the results, implications and limitations of the study, and suggestions for future research. Included in this, is the researcher's reflection of the personal value of this work as a psychotherapist in training.

CHAPTER 2: Literature review

2.1 Introduction

It is generally accepted that when patients consult psychotherapists they are urgently seeking to be healed from emotional suffering. The therapist's overarching goal, regardless of theoretical orientation, is to reduce that person's suffering (Groesbeck, 1975). But an interesting question arises when positing the impact of the therapist's suffering on the healing of the patient. Does the therapist's own suffering, or wounding life experiences, enhance or hinder the patient's healing?

A view prevalent in the literature is that it is *necessary* for therapists to have been wounded to be able to heal, by arguing that, for healing to take place, therapists must draw upon their own woundedness. Another view suggests that the healer's woundedness could hinder the therapeutic process, owing to the inherent problems associated with this. These problematic issues centre on countertransference, loss and deprivation, unmet narcissistic needs and relational attachment. So how can these opposing views be reconciled?

2.2 The necessity of woundedness for healing

This section of the literature review presents the archetypal motif of the wounded healer, this healer's arduous journey of suffering, and relates the archetype and the journey to the modern-day helping professional, particularly that of the psychotherapist. In this, the "good fit" between the wounded healer and the competent therapist is drawn.

2.2.1 The archetype of the wounded healer

The idea of using one's own wounds and suffering in the service of helping others is an ancient practice. Images of the wounded healer permeate mythology, religion, art and history. The

archetype is found in the Greek myth of Asclepius and Chiron the Centaur[2]. The concept is also embodied in the age-old wisdom and knowledge of the shaman[3]. In these oldest myths, healers were believed to have magical powers and to have created treatments based on their own recovery from suffering and illness (Cain, 2000). In other words, it was because the wounded healer was himself afflicted that he knew the way to healing: "Acquaintance with the dark secrets of the psyche, which comes from bouts with illness and the possession of venerable symbols from myth and rite, provides the wounded healer with a visionary wisdom" (Campbell, 1968, cited in Goldberg, 1993, p. 13). This implies that wounded healers do not merely work in a technical, impersonal or strictly scientific way. Rather, they use their own journey to guide others on theirs. The theme of the personal journey provides the crucible: it is the apprenticeship essential to the developmental process of becoming a healer.

Adler (1956, cited in Groesbeck, 1975) suggests that one may go as far as to say that, "the very purpose of the wound is to make us aware of the healing power in us" (p. 138). Guggenbühl-Craig (1971) explains how this lies in the paradoxical split of the archetypal wounded healer: there is a physician in the patient and there is a patient in the physician who teaches "the healing arts" but who "himself suffers from incurable wounds" (p. 91).

The healer and the patient are two aspects of the same: each time a person becomes ill, a "healer-patient" archetype is activated and the intrapsychic or inner healer is energised. This is the healing factor in the ill and the curative factor in getting well. However, when a patient fails to get well, from an archetypal point of view, it is his inner healer that does not activate or is not functioning. The patient then looks for an outer healer or doctor. No physician, however, can be effective without the patient's inner doctor. Although "a physician can stitch up a wound...something in the patient's body and psyche must help if an ailment is to be overcome"

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[2] Chiron, half human and half horse, was abandoned at birth by his mother and never knew his father, but was "foster-fathered" by Apollo. Chiron also suffered an unhealable wound from an arrow shot in his leg, an affliction he endured his whole life. He subsequently became a great healer and mentored a number of Greek heroes, including Asclepius, the biological son of Apollo. Asclepius, whose mother was murdered by Apollo at his birth, also became a great healer under Chiron's tutelage (Groesbeck, 1975).

[3] Shamans of indigenous cultures worldwide, through an arduous journey of dismemberment and self-renewal, experience inner psychic forces and work with them to heal others (Dunne, 2000).

(Guggenbühl-Craig, 1971, p. 91). For real healing to occur, patients must get in touch with, and get help from, their inner healer.

Groesbeck (1975) explains the unconscious and complementary roles of the "healer-patient": as in Shamanism, the power of healing lies in the bridging of wellness and illness. The doctor 'takes on' the patient's wounds or illness and thus begins to experience the wounded aspect of the archetypal image – the healer who is wounded. This activates the healer's own vulnerability on a personal level. In turn, the patient 'takes on' the healing strengths of the analyst and begins to experience the healer contents of the archetypal image. This activates their own personal powers of healing and strengths – patients now actively participate in the healing process and the cure themselves.

Crucially, this dynamic healing process can only take place if physician-healers do not project their own wounds onto the patient. This presupposes that they are in touch with their wounded side and own unresolved illnesses.

Jung was first to apply the term wounded healer to therapists (Wheeler, 2007). He followed the archetypal concept in claiming that only the wounded doctor can heal and, in order to heal, the physician himself must be "deeply affected by his patients" (in Dunne, 2000, p. 92). Psychologically, therapists have to be vulnerable to their patient's illness to be of help (Sussman, 1992). From this tradition, the notion of the wounded healer refers to the *vulnerability* of the psychotherapist (Wheeler, 2007).

2.2.2 The journey of suffering: biographical and autobiographical accounts

2.2.2.1 Pre-eminent Psychologists

Biographical and autobiographical accounts of well-known analysts and therapists have suggested that their personal histories, especially those of childhood, profoundly shaped their choice of profession and clinical work (Barnett, 2007; Casement, 2006; Dryden & Spurling, 1989; Dunne, 2000; Phillips, 1988). A clear illustration of this may be found in Winnicott's

personal experience of his depressed mother and his central preoccupation as a clinician. In alluding to his seriously depressed mother who was not able to 'hold' him, Winnicott's fundamental concern is for "...the way children attempt to deal with mother's absence...in a depressed or otherwise withdrawn mood in which the quality of her attention is unreliable" (Phillips, 1988, p. 30). Freud's mother, Amalia, became unavailable in her 'unhappy state' following the death of her brother and her baby when Freud was just two years old (Breger, 2000). Jung was said to have become ill following a traumatic loss in having been temporarily separated from his mother at the age of three. Melanie Klein suffered multiple bereavements, material deprivation after the death of her father, and an unhappy marriage ending in divorce (Barnett, 2007).

What the presented examples suggest is that the life experiences of these pre-eminent analysts involved some kind of trauma, loss and/or deprivation. Parenthetically, the therapist's willingness to struggle with their patients' painful issues is, therefore, closely related to their willingness to journey in search of their own healing and their own unmet psychic needs. But this begs the question that if psychotherapists "bring unmet psychic needs to their work, why do they become therapists and not simply patients? And, for that matter, why don't all people with unmet needs (e.g., most of our clients) become therapists?" (Goldberg, 1993, p. 61). Burton (1972) makes the distinction:

> *The point is that to meliorate the distinctive problems of living, one has also to be human, and that means to have problems like everyone else. The distinction between client and therapist comes only in that the therapist works his problems through, recovers thereby a consistent and fulfilling philosophy of existence, and then offers it to others in a spirit of comradeship. We might say he shares his problems rather than broods on them.* (p. x)

The psychological implication is that, like wounded healers through the millennia, therapists have used their own wounds as a curative resource in relieving the suffering of others. Quite aptly, Sussman (1992) has termed this a "curious calling". But where does this willingness to share one's personal recovery and the ability to understand others originate?

It is argued that, for therapists, it stems from the personal journey of suffering. A common theme in the literature points to them having had troubled personal histories (Barnett, 2007; Burton, 1972; DiCaccavo, 2002; Goldberg, 1993; Guy, 1987; Sussman, 1992). From her reading of the literature in the field, Barnett (2007) suggests that the main emergent themes concerned "loss and deprivation" and "failure of carers to meet the normal narcissistic needs of childhood" (p. 259).

These headers usefully capture the presented themes in this study's review of the literature. Under "loss and deprivation" we may include experiences of physical and mental illness and disability, separations and absences, bereavement, moves, divorce, social marginalisation and family poverty. Experiences of being family nurturer, confidante, mediator and caretaker, parentification and adultification may be subsumed under the theme of "unmet narcissistic needs", emerging from specific family dynamics. Other authors similarly present themes of "childhood trauma" (Fussell & Bonney, 1990) and "emotional deprivation" (DiCaccavo, 2002). The word "trauma" is used repeatedly throughout the literature (e.g. Barnett, 2007; DiCaccavo, 2002; Farber et al., 2005; Fussell & Bonney, 1990). However, it is not clearly defined in context and seems to indiscriminately imply "negative childhood experiences" (e.g. Fussell & Bonney, 1990, p. 510). It is therefore necessary to provide a conceptual definition of what is meant by the term "trauma" as it consistently appears in this study.

According to Garland's (1999) definition, "trauma" refers to a type of psychic wounding. This meaning denotes Freud's (1920) metaphoric use of the Greek word trauma in which there is a piercing and wounding of the mind by events. This occurs as a result of an individual's existing defences against anxiety being overwhelmed by a degree of stimulation that is more than can be made sense of, or managed. However, as McWilliams (1994) notes, the term trauma, as popularly used, has lost its "catastrophic overtones" and can be heard to mean psychic discomfort or injury (p. 3). Thus, from these authors (Garland, 1999; McWilliams, 1994), references to trauma in this study include various traumatic events (excessive, unmanaged stimulation) that overwhelm the individual's existing defences and cause a range of injurious psychological effects.

2.2.2.2 Common themes in the lives of psychotherapists

In an overview of the literature, comparative studies between caring and non-caring professionals show the former report histories of trauma and emotional deprivation (DiCaccavo, 2002). In particular, psychotherapists and clinical psychologists report higher incidences of adverse experiences and emotional neglect. In addition to this, researchers have identified specific family dynamics associated with this group, with therapists typically being placed in the role of family caretaker (e.g. Burton, 1972; DiCaccavo, 2002, 2006; Fussell & Bonney, 1990). Similarly, investigation of the attachment patterns of clinical psychologists showed those in the insecurely attached group being compulsive caregivers (Leiper & Casares, 2000). Taken together, these studies imply that, at some fundamental level, therapists' histories suggest common negative childhood experiences. These have seemingly catalysed their special interest in the psychological processes of human beings and their gravitation to the profession (Sussman, 1992).

In their seminal work, Henry and colleagues (1971, cited in Farber et al., 2005) addressed the question, "Why do people become psychotherapists?" Their study represented a significant sample of psychotherapists in three North American cities. Henry and co-writers (1971, cited in Farber et al., 2005) examined multiple characteristics of these psychotherapists, including religion, culture, ethnicity and political views. They questioned therapists' motivations and initial interest in becoming therapists. The study's results showed therapists to have come from rather homogenous backgrounds (Goldberg, 1993). However, when compared to the general population, there was an over-representation of certain background characteristics. Notably, a high proportion of therapists were from traditional Jewish backgrounds and were more likely to have been of foreign origin (or their parents). Given these circumstances, Henry and colleagues (1971, cited in Farber et al., 2005) posited that many psychotherapists were psychotherapists because they felt socially marginalised and this may have led to a heightened awareness of inner events and a strong need to heal themselves and others. The results also indicated that many psychotherapists had tended to hold more liberal political views than their parents did and had intense struggles for independence from their families during the critical juncture between adolescence and early adulthood.

Farber et al. (2005) argue that Henry and colleagues' (1971) discussion of psychotherapists' commonality in terms of their family dynamics leaves us with an unclear and ambivalent sense. On the one hand the authors emphasise that therapists may have had difficult parent-child relationships, especially between mother and child. They propose that therapists had loving but dominant, aggressive, controlling and clinging mothers. On the other hand, the authors conclude that therapists tend to be members of "relatively normal families and go through normative sexual and social experiences" (p. 1011). This statement is surprising in light of the following contestation of Henry and colleagues' (1971) interpretation.

At a similar time, Burton's (1972) research supports the thesis that therapists have had troubled personal histories: for instance, all twelve therapist 'healers' in his study had suffered an early and sustained physical illness which was followed by lengthy periods of inaction and introspection. This is consistent with the notion of the shaman having journeyed through suffering and illness:

> *In some [therapists], the handicap is followed by superordinate attempts to overcome and compensate for it...and the handicap becomes the human sensitivity and the justification for unreasonable dedication and effort. The handicapped try harder to make this a nonhandicapping world*. (p. 312)

Burton (1972) makes a further connection between career choice and family roles. His study demonstrated that the majority of therapists mostly came from disrupted or disjointed families. These were families in which serious problems existed and were never resolved. In Burton's (1972) book, therapists described strong, albeit often physically or psychically absent fathers, and neglectful and indifferent, or manipulative mothers. Also, they were often from "families on the move" in that there was more than the average amount of mobility, with fathers in particular "busy making it" (p. 313). Burton (1972) posits that the future therapist had a low threshold for family pain and arguments, and "could not bind it" - for these children, growing up was a constant turmoil, "a daily solving of living problems" (pp. 17-18). At a young age they took up the role of family nurturer and assumed responsibility for the happiness of the family. In a word, the young future therapists were "healers".

Goldberg (1993) further explored the influence of therapists' family of origin. His thesis is that as children, future therapists become sensitised to the suffering and degradation of others. From Henry et al. (1971) and Burton's (1972) work he draws on commonalities in the early life of therapists, such as having had long periods of illnesses and loneliness, and parents with physical or psychological disability. He also notes that the position of the child in the family (e.g. the dominant child) is relevant to being placed in the role of family healer. Goldberg (1993) adds that, for the child nurturer, brooding and desperation are present as a result of serious expectations about having to fulfil an adult role before maturity, and guilt for letting down family members by being immature and not equipped for the task. Weighing heavily on the vulnerable psyche of the therapist-to-be, these factors serve to foster an exquisite sense of the inner life of others. This, says Goldberg (1993), is the hallmark of the therapist's calling. The author suggests that as therapists, these individuals seek to gain enlightenment into others' problems in order to better understand their own emotional difficulties.

Similarly, Alice Miller (1981) in her book, *The Drama of the Gifted Child*, highlights the theme of therapists typically growing up in stressful family environments where their emotional needs were never met. She argues that future therapists tend to have narcissistic mothers[4], whose emotional equilibrium depends on the child behaving in a particular way. The child develops "antennae" to receive and respond to his or her mother's needs, which guarantees the child a means of staying emotionally connected. This ability is later perfected and extended – they become parents to their own mothers, then of siblings, and eventually develop a "special sensitivity" to the unconscious needs of others (p. 8). Thus Miller's (1981) findings suggest that there may be a specific parent-child dynamic, involving narcissistic deprivation which fosters the development of this degree of empathy and emotional responsiveness.

Maeder (1989), too, contends that therapists are deprived of love, warmth and protection while children. Often the therapist, being the first born or only child, was "rushed through childhood too quickly...and...was obliged to become a little adult" (p. 41). Maeder (1989) suggests that the developmental impact of "adultification" is that they become their parent's carers, only

[4] By "mother" Miller (1981) refers to the person closest to the child during the first years of life. These need not be the biological mother, or even women. Fathers may also assume this role.

experiencing warmth and nurturance when giving this to them. This leaves them with the belief that hard work, selfless labour and responsibility are the only things that give them value in others' eyes. Maeder (1989) alludes to the idea that, in being emotionally deprived, the future therapist suffers a narcissistic injury. The resultant painful effect of this is that they have a chronically low sense of self-worth and a stunted ability to receive genuine love or friendship. They are lured to the profession as a way of filling their own emotional vacancy, "knowingly or unknowingly, by the position of authority, by the dependence of others, by the image of benevolence, by the promise of adulation, or by a hope of vicariously helping themselves through helping others" (p. 37).

Racusin and colleagues (1981, cited in Farber et al., 2005) used both statistical and qualitative data to look at the impact of therapists' family dynamics on career choice. These authors found that all the therapists in the sample acknowledged growing up with at least one family member who had "psychologically mediated behavioural or physical difficulties" (p. 1013). In interviews, three-quarters of the therapists reported having been the family caretaker, assuming either parenting or counselling roles. Therapists further reported having felt their primary role to be that of parenting in the form of nurturing or taking responsibility for the family functioning. As children, they felt they were chosen at an early age because of their ability to sense and satisfy the emotional needs of family members. They served as an "emotional buffer" between parents as well as siblings. As adults, these individuals felt they were prepared for a career that involved listening and perceiving the unspoken messages of others.

In investigating motivational themes relevant to becoming a therapist, Sussman (1992) drew on the basic formulation that, "Behind the wish to practice psychotherapy lies the need to cure one's own inner wounds and unresolved conflicts" (p. 19). He dialogues the results of nine semi-structured therapist interviews with the literature in the field. The author identifies a number of therapist psychological needs, including those related to libidinal and aggressive strivings, masochistic tendencies and strong narcissistic needs. Sussman (1992) notes that when "parental expectations are excessive, children...develop inflated ego-ideals and may be lured to the profession that allows for fantasies of perfection, omnipotence and grandiosity" (p. 241). The role of psychotherapist can place the individual in a unique position to receive adulation and

idealisation from their patients. Due to the perceived prestige and status associated with the profession and the power differential that is inherent in the therapeutic relationship, patients are apt to approach the therapist with an attitude that contains some measure of deference, reverence and awe. In turn, the therapist's narcissism is fostered by the patient's idealisation, similar to that of the problematic parent: "*Feed me*, he says or feels; *take care* of me; *love me*. *And in return, I will worship you*" (Shepard & Lee, 1970, cited in Sussman, 1992, p. 103). Aptly put, this iconisation of therapists by their patients has been dubbed the "pedestal syndrome". Therapists' motivations stemming from conflicts regarding emotional [object] relatedness were identified in dependency and separation needs, the wish to exercise power and control others, and reparative needs. Sussman (1992) argues that these motives and personality patterns appear to be strongly rooted in therapists' developmental pasts and dynamics of the families of origin.

Fussell and Bonney's (1990) study brought further empirical support to the thesis that therapists have troubled childhoods. These authors investigated the early childhood experiences of forty-two psychologists against a control group sample of thirty-eight physicists[5]. Their results revealed the former reporting a comparatively high incidence of childhood trauma and emotional deprivation. Psychotherapists' incidence of parental absence (assessed by aspects of death, prolonged illness, divorce and separation) easily eclipsed that of physicists. The psychotherapists also perceived their family of origin as less healthy and evaluated their 'childhood happiness' in more negative terms than physicists did. Psychotherapists perceived greater ambiguity within their families – this was experienced as unclear communication, with the consequence that the child was uncertain about the thoughts and feelings of other family members. Also, as children, psychotherapists perceived themselves as assuming a caretaking role and experiencing parent-child inversion significantly more than did physicists. Similarly, Jurkovic and Sessions (1986, cited in Farber et al., 2005) showed psychology students, as compared to engineering students, having seen themselves as family problem-solvers, confidantes and negotiators to friends and family.

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[5] One may be sceptical about this research. Physicists will probably not be able to provide lucid accounts of their early emotional experiences, whereas psychologists are. Is the research measuring lucidity regarding trauma, or the actual traumas that occur? The point here is that the former informs the latter.

In their study *Ten Therapists*, Norcross and Guy (1989) analysed the autobiographical narratives of ten prominent psychotherapists. The authors found several patterns emerging in these therapists' personal backgrounds. Therapists described their parents' marriages as falling in the range of having been 'at least functional' to 'entirely successful'. Relationships with fathers were described as having particular importance and being influential in a positive way. Therapists' relationships with mothers were described in "a less positive fashion" with some "inexplicably omitted or barely referenced" (p. 222). When mentioned, mothers were portrayed as intrusive, narcissistic, insecure, dominant and sometimes competitive. Furthermore, there seemed to be a pattern of maternal enmeshment. The authors stated that the 'mixed' results [of perceived mother-therapist relationships] suggested a considerable amount of ambivalence in these. The authors note that the majority of therapists were first born, with two being only children. Although this may not be significant in a sample size of ten therapists, it lends support to Maeder's (1989) notion that [these] therapists were adultified children, and Goldberg's (1993) thesis that the dominant child is placed in the role of family healer.

Elliot and Guy's (1993) study (cited in Farber et al., 2005) empirically supported the notion of dysfunctionality in therapists' family of origin. These authors compared female mental health professionals with female professionals in other fields. The findings revealed the former to have reported at least one childhood trauma, higher rates of sexual molestation, parental alcoholism, hospitalisation of a parent for mental illness and the death of a parent or sibling. More recently, Nikcevic and colleagues' (2007) investigation shows aspiring clinical psychology students compared to non-aspiring clinical psychology and business students, as having significantly higher rates of perceived childhood sexual abuse, neglect, and parentification experiences between the ages of fourteen and sixteen. Further results showed no significant differences in levels of current negative emotions (anxiety and depression) between the groups. The authors posit that although aspiring psychology students in this study may have resolved their early childhood traumas, associated distress may emerge during clinical training.

DiCaccavo's (2002) investigations of counselling psychologists' family experiences lends further credence to the consistently emerging theme of parentification experiences in future therapists. In a comparative study, counselling psychologists reported significantly higher parent-

role inversion or parentification experiences than art students did. DiCaccavo (2002, 2006) echoes previous authors (Miller, 1981; Sussman, 1992) in suggesting that therapists tend to have narcissistic parents, as these parents seek practical and emotional care from their children in attempting to address their own unmet childhood needs. Parentified children may, for instance, take on overt caretaker roles, or assume more covert roles by being the family confidante and mediator. As children, they are described as being 'invisible' and learn that their own needs are less important than those of others. They occupy the role of the 'good' child to avoid the anticipated loss of parents if their parents' needs are not met. In this, parentified children become adept at learning to anticipate the needs of others based on their primary way of relating to their parents. It is therefore not surprising that, in this study, psychotherapists reported greater self-efficacy in perceived personal resources and ability to relieve other's suffering than did art students. Again, it suggests that, from dysfunctional family origins, future therapists become both motivated and skilled at perceiving and responding to the needs of others.

DiCaccavo (2002) further explored the dynamics of parentification by investigating predictors of this process. The test items focused on two principal dimensions of parental behaviour toward the participants as children: the first being parental care versus rejection, and the second, parental control versus encouragement of independence. The results showed counselling psychologists to report less parental care and more parental control than did art students. Also, the results revealed that, whilst a *lack* of maternal care was related to parentification in all female participants, *greater* maternal care was related to parentification for all male participants. DiCaccavo (2002) posits that, by being more cared for by their mothers, men run the risk of feeling guilt and obligation and thus remain enmeshed in the family system. Becoming professional helpers translates into an outlet for their own resulting need to care for others.

Leiper and Casares (2000) were interested in investigating clinical psychologists' attachment patterns in light of the influence these could have on their approach to therapeutic work. Attachment is defined as, "the propensity of human beings to make strong affectional bonds to particular others" (Bowlby, 1977, p. 201). Relevant to this research are the results of Leiper and Casares' (2000) study of the relationship found between therapists' early experiences and attachment style. Although psychologists were more likely to rate themselves securely attached

than the general population, a significant proportion rated themselves as insecurely attached. Insecure psychologists scored higher on self-reliance and on angry withdrawal and they had experienced more early loss events and more unempathic parental response. Also, psychologists scored higher on compulsive care-giving than any other attachment styles. In line with Leiper and Casares' (2000) definition, this means that therapists own caregivers, for one reason or another, were unable to care for them as children but welcomed being cared for.

Contrary to this, Halewood and Tribe's (2003) study showed some trainee therapists' perceptions of their parent-child relationships as being good – having felt understood, respected and mirrored by their parents. However, on specific variables, they showed significantly more negative perceptions of these same relationships than the control group of postgraduate students did. Trainee psychologists described parent-child relationships as "withholding of the self, focus on good behaviour and a need for the child to support the parents" (p. 98). The authors interpret these seemingly contradictory results cautiously, but suggest that therapists may be reluctant to criticise parents towards whom they adopt a protective role. Ford (1963, cited in Halewood & Tribe, 2003) previously postulated that trainees entertained fantasies that their mothers had been caring and responsive, despite later awareness that this may not have been the case. Miller (1981) suggests that the repression of their histories is so complete that maintaining the illusion that they had a good childhood can be done with ease.

Attachment theorists (Halpern, 2003) offer an interpretation from a different perspective. Halpern's (2003) paper proposes that the Adult Attachment Interview (AAI) be used as an empirical basis for selectors when evaluating candidates' suitability. From this perspective, an interviewee who tends to dismiss or derogate his/her life experiences and presents his/her parents in positive terms (and/or idealises them), but is rarely able to support this with examples, is indicative of a "Dismissive" attachment pattern. According to the AAI, this adult category corresponds to the "Avoidant" child category. Children with avoidant attachment patterns experience caregivers as unresponsive to their needs and develop internal working models of "self" as being unwanted and others as being rejecting (Ainsworth, Blehar, Waters & Wall, 1978, cited in Trusty et al., 2005). It suggests that the trainees in Halewood and Tribe's (2003) study, though professing good parent-child relationships, were likely to be more anxiously than

securely attached. From this perspective, Leiper and Casares' (2000) findings appear valid – a significant portion of clinical psychologists may be insecurely attached and compulsive caregivers.

In a recent study, Barnett (2007) interviewed nine psychoanalysts and psychodynamic psychotherapists[6]. The results showed each therapist to have suffered some form of significant interpersonal loss before the age of twenty years, although only in one instance was this through death. It was usually the loss or absence of fathers which led to the subsequent emotional loss of mothers, most often to depression. This finding challenged Norcross and Guy's (1989) study, which found therapists' fathers to be positively influential and prominent. Therapists appeared to have had families that were constantly on the move and felt they dared not attach to anyone lest they be uprooted. This would support Burton's (1972) finding of therapists coming from "families on the move", and Casement's (2006) personal description of how seventeen moves in as many years left him showing more attachment to places than people because of having experienced the latter as "unreliable".

Accounts of being sent to boarding school and living away from home were associated by therapists with feelings of abandonment (Barnett, 2007). A recurring theme of unmet dependency needs and resulting separation difficulties were expressed by seven of the nine therapists in the study. For example, some therapists describe various experiences of mothers being heavily dependent on them as children and as a result, felt pushed into premature independence. Again, themes of isolation and loneliness as well as the future therapist taking the role of confidante in childhood emerged. Therapists in this study reported having early feelings of shame in various experiences. These included parental disapproval and limitations, difficulties adapting to changes of environment, early trauma, family illness, secrets and poverty. Barnett (2007) posits that therapists' need to care for others were closely linked to feelings of shame and insecurity and that this may lead to patterns of self-sacrifice and the need to be idealised by their patients.

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[6] The sample size in this (Barnett, 2007) and other presented studies (e.g. Burton, 1972; Norcross & Guy, 1989; Sussman, 1992) are small. One would need to be cautious, therefore, about making generalisations on the basis of them.

2.2.2.3 “Goodness-of-fit”

It has been argued that, as a result of possessing the personality characteristics and functional motivators for the role of psychotherapist, these individuals experience a professional “goodness-of-fit” with their own inner processes and dynamics (Guy, 1987). It is consistently evident in the literature thus far that many therapists-to-be suffer negative and traumatic childhood experiences. It speaks of them having felt deprived, lonely, isolated, sad, shamed or hurt in their childhood. It points to them having been drawn toward, and psychologically equipped for, a career in psychology because of these painful experiences. In summary, the literature suggests that they gravitate toward a career in psychology for the following reasons:

Firstly, they have already developed the skills necessary to work with the psychological demands of others. They enter into helping professions as adults because this represents an extension of their childhood roles and they are already equipped for this (Barnett, 2007; Burton, 1972; DiCaccavo, 2002, 2006; Fussell & Bonney, 1990; Goldberg, 1993; Leiper & Casares, 2000; Maeder, 1989; Miller, 1981; Norcross & Guy, 1989; Racusin, et al., 1981, cited in Farber et al., 2005). In some, a motivating factor may be the wish to be a ‘better parent’ than the therapist had experienced (Casement, 2006).

Secondly, in the role of psychotherapist the individual is vicariously able to deal with his/her own projected distress by healing his/her patients (Henry et al, 1971, cited in Farber et al., 2005; Maeder, 1989; Goldberg, 1993; Sussman, 1992). By caring for the patient individuals can care for themselves at a distance, both exposing themselves to emotional distress while defending against direct personal recognition of losses (Blumenstein, 1986; Bowlby, 1980; Burton, 1994, cited in DiCaccavo, 2002; Fussell & Bonney, 1990).

A third motivating factor may be therapists’ wish to fulfil needs for closeness and intimacy that were not met in childhood (Dryden & Spurling, 1989). The practice of psychotherapy may afford them the opportunity for human contact without long-term commitment, thereby avoiding loneliness (Barnett, 2007). Storr (1990) posited that because of therapists’ “early difficulties in mixing” they have chosen a structured situation in which convention and rules govern the space

and in which "intimacy is of necessity one-sided" (p. 182). However, although the therapeutic relationship is often intimate, the nature of this unidirectional intimacy has constraints for therapists, as they are generally trained to avoid disclosing their feelings and reactions to patients. This may mean that when they feel disturbed by their patients, they are unlikely to attend to their own discomfort or pain (Sussman, 1995). Perhaps this too is a perpetuation of their internalised childhood role: while therapists care for the needs of others, their own needs remain unmet, just as they were not met in childhood.

A corollary of this discussion is that because there is a "good fit" between wounded healers and the competent therapist, we would expect the selection process for clinical training to favour wounded healers.

2.2.3 Selection of candidates

Selectors are the "gatekeepers" for the psychological profession; they bear the onus of evaluating an applicant as suitable or not suitable for clinical training. Ultimately, the selector's evaluation of a candidate's suitability reflects his/her perception of who is suitable to be a practising psychotherapist. Parenthetically, the choice of the suitable candidate suggests two things. Firstly, selectors hold perceptions of what the suitable versus unsuitable potential therapist looks like and secondly, that they have a way of distinguishing these.

This section of the literature review presents the argument that selectors evaluate the suitable candidate as necessarily having had experiences of early conflict and trauma and having mastered these to some extent. In other words, it suggests that selectors, either explicitly or implicitly, use the concept of the wounded healer to make their choice. This is reflected in the criteria used in the selection process, which displays a bias toward woundedness in candidates, as well a bias against "normality". The presented literature also suggests that selectors rely upon their countertransference and intuition when assessing candidates, with the goal of seeking out potential wounded healers.

2.2.2.1 Selectors' bias toward woundedness

From the presented literature it may be reasonable to propose that a candidate's woundedness bears a positive influence on selectors' impressions in deciding their suitability. It is either assumed (Chippindall & Watts, 1999) or overtly acknowledged as a necessary criterion for selection and clinical training (Coltart, 1993; Heimann, 1968; Mander, 2004). This strongly suggests that selectors use the concept of the wounded healer to make their choice among those applying.

As in this research project, Chippindall and Watts's (1999) study was undertaken at Wits University, which is a psychodynamically-orientated training institute. The authors aimed to identify selectors' pre-eminent assumptions regarding the admission of candidates to the MA (Clin. Psych.) programme. The results of the study showed participants' emphasis on candidates' capacity for empathic engagement and flexibility being linked to experiences and mastery of early trauma or conflict. Underlying the argument for the importance of trauma is the assumption that the potential for becoming a therapist arises from the experience of personal suffering. This allows the therapist access to intense and primitive emotions through 'empathic regression', which is required to grasp and fully understand the patient's experience. It is clear that participant selectors in this study acknowledged the need for mastery of early conflicts in the development of a potential therapist. Mastery was said to enable the therapist to feel safe enough to let go of defences and experiment with a variety of psychic and bodily experiences (Paolino, 1982, cited in Chippindall & Watts, 1999). The findings of this study are supported by Sussman (1992), who sees therapeutic potential arising from the experience and mastery of early conflict and trauma. What may be inferred from Chippindall and Watts's (1999) study is that selectors see healing potential necessarily arising, not merely from personal suffering, but in having worked through this. This suggests that selectors use the concept of the wounded healer rather than mere woundedness, to make their choice.

In Heimann's (1968) classic paper, the notion of the wounded healer is alluded to in evaluating candidates for psychoanalytic training. The author states that the candidate need not be an

"extraordinary personality" and need no more attributes than the normal human decencies (p. 536). She follows this with a remark made by a colleague which struck her in its simplicity:

> *After all, no matter how sophisticated our concepts of ego psychology have become, what we really expect in a psychoanalytic candidate is that he should have a good heart and that he should have gone through some suffering without denying it.* (p. 537)

Mander (2004) works on Heimann's (1968) assumption that the would-be therapist need not be an extraordinary personality, but posits that he or she needs to be able to learn from experience and have three indispensible requirements - empathy, intuition and the capacity for thinking. Clearly, a capacity for thinking applies to any profession. However, in this context, it pertains particularly to Bion's (1993) theory of thinking that is an exemplar of the "reverie" mothers can provide for their infants when they are experiencing anxiety. That is, therapists must have the capacity to take on their patients' projections, to hold both their patients and their own anxiety without becoming overwhelmed by it, and to *keep on thinking* in this process. As such, therapists are able to hand back patients' unconscious projections to them in a now tolerable form, allowing them to make sense of these because of having been understood and made sense of by a "thinking other".

Drawing on Heimann (1968), Mander (2004) argues that the candidate has to have suffered without denying it. In this, she acknowledges that she applies the concept of the wounded healer to establish an applicant's suitability for the therapeutic task ahead. The would-be therapist necessarily has to have suffered but also has to have a capacity for reflection in not denying it. As they will be later required to do with patients, candidates must have been able to make their own experience and suffering meaningful by thinking about and making sense of it.

Mander (2004) argues that the wish to help is rooted in an experience of suffering and so looks to link the "wound with the wish" in evaluating candidates - she looks for the helper in the patient and the patient in the helper (p. 166). This idea follows Guggenbühl-Craig's (1971) concept of the paradox of the archetypal wounded healer whereby there is a physician in the patient and a

patient in the physician. For Mander (2004), locating the patient in the helper allows the individual to make conscious the unconscious mechanisms connecting "the helper with the helped". She posits that the candidate will thus be able to make good contact with their childhood, and therapeutic activity will no longer be the acting out of unfinished business, but a way in which they can use themselves creatively.

From the studies of Chippindall and Watts (1999) and Mander (2004), it may be argued that selectors see woundedness as a necessary condition for suitability and, in this, they seek the woundedness of the candidate for the benefit of the therapeutic process. Storr (1990) similarly proposed that as long as therapists are aware of how their own psychopathology has contributed to their choice of profession, it can be used in a constructive way in helping patients. Wheeler's (2002) study further presents the idea of using candidates' woundedness for the benefit of the patient. She proposes that if one accepts the research evidence that therapists have their own unique psychopathology that has driven them to helping others, rather than seeing it as a problem for analysis or therapy to 'iron out', this psychopathology could be harnessed to help their patients.

2.2.2.2 Selector's bias against normality

Although the literature suggests that the medical profession is wary of wounded healers in their ranks (Cain, 2000), this review suggests that the psychotherapeutic community is [at least] equally wary of seemingly "unwounded" candidates in its ranks. It is largely accepted that it is candidates' own unique psychopathology that has driven them to helping others (Barnett, 2007; Burton, 1972; Casement, 2006; DiCaccavo, 2002, 2006; Fussell & Bonney, 1990; Goldberg, 1993; Guy, 1987; Halewood & Tribe, 2003; Henry et al., 1971, cited in Farber et al., 2005; Leiper & Casares, 2000; Maeder, 1989; Miller, 1981; Norcross & Guy, 1989; Racusin et al., 1981, cited in Farber et al, 2005; Sussman, 1992). This, and the potential to help others, is borne in experiences of suffering (Neumann, 1959). Conversely, without experiences of suffering, the candidate will have no access to a curative source, nor meet this healing power (Adler, 1956, cited in Groesbeck, 1975). As Coltart (1993) says, an applicant's suitability is strengthened if

they themselves are already wounded by life, and thus 'normal' candidates are unlikely to be accepted for psychodynamic therapy training.

Wheeler (2002) raises a concern around candidates who seem "too good to be true": her worry is that there is something "so awful" in these candidates' lives "that they cannot recognize it or even articulate it" (p. 435). An assumption here may be that it is too good to be true that nothing awful happened, because everyone has had some difficulty somewhere. Other authors have expressed concern around the candidate who appears normal. Coltart (1993) provides a caricature of "normal" as someone who is conventional, likeable but genuine, has defences that are tough but work for him, ego strength, and does not suffer much. Normal people have no interest in introspection, may deny their unconscious mind, and have limited emotional range – they are not burdened with emotional swings, impulses, symptoms or over-dependence on others.

Coltart's (1993) caricature appears incomprehensible in alluding to normality as the absence of symptoms or suffering because this is considered inevitable in the course of normal development. Psychoanalytic concepts of normality are various, but in the light of this study on woundedness owing to early conflict and trauma, the following view seems relevant. According to Hartmann (Sadock & Sadock, 2003), the concept of "normality" is described in terms of "autonomous ego functions" (p. 17). These functions are psychological capacities (such as perception, intuition, learning and intelligence), present at birth and largely free from the ego's inner psychic conflicts. They represent the person's potential for normality; that is the degree which the ego can adapt to reality and be autonomous. Hartmann argues that these psychological capacities and autonomous ego functions help to explain why some people lead relatively normal lives in the presence of extraordinary experiential traumas.

Years earlier, Tolentino and Zapparoli (1968) had stated that normality was considered a negative aspect for selection, and Eisendorfer (1959) emphasised that a candidate's inability to dispense with a façade of normality was a worrying sign in that it indicated a lack of sensitivity, emotional awareness and was often a cover up for chronic pathology. Coltart (1993) has proposed that "a 'normal' person is unlikely to be a gifted therapist is almost an *idée recue* in our

strange world" (p. 7). The most gifted therapists are not always the most stable characters. This ties to Burton's (1972) commentary of renowned and gifted therapists in saying, "The lives of therapists from Freud, Jung and Sullivan onwards convince me that most therapists experience themselves as closer to the shoals of psychosis than other people do" (p. 20). The authors' consensus here seems to be that selectors should be wary of those candidates who seem too emotionally 'undisturbed'.

2.2.2.3 Selectors distinguish between potential wounded healers and those merely wounded

Debbanés (in Traub-Werner, 2007) points to the confusion arising from the difficulty of selectors when defining what they are looking for in a candidate, and those stemming from the 'fusions', "The training analyst's unconscious comes into play in selection and training; the analyst's unconscious intersects with the unconscious of the candidate and the unconscious group dynamics of institutions" (pp. 314-315).

Traditionally, countertransference is the term used to describe the therapist's emotional reactions to the patient (Lemma, 2003). In this context, it implies that, as in the countertransference dynamic of the therapeutic setting (Ivey, 1999), there is a complex unconscious phenomenon in the communicative field of the selection process that is co-created by the candidate and selector as well as the group dynamic [selection panel] of the training institution. Mander's (2004) study provides a case in point: she notes that in order to check if the would-be therapist's wish to help is prompted by a healthy desire or immature narcissism, interviewers will use their countertransference to test the strength of candidates' projections, defences, resistance and anxiety. This suggests that selectors are using their countertransference to distinguish between the wounded healer and the merely wounded candidate.

Moreover, Mander (2004) adds that in attempting to ensure that the candidate is a 'safe bet', selectors will have to use their intuition and make links in the would-be therapist's life story, which contains clues to unresolved conflicts, developmental blocks and potential breakdown in crisis. Parenthetically, this means that, along with the transference - countertransference

dynamic, intuition is used by selectors as a "tool" in assessing candidates' suitability, by distinguishing between merely wounded candidates and potential wounded healers.

2.2.3 Necessity revisited

The deep empathy of wounded healers for the pain in others comes from having personally experienced their own pain and suffering. Their resultant wounds inform and sensitise them to the suffering of others (Goldberg, 1993; Guy, 1987; Hayes, 2002; Sussman, 1992). Hayes (2002) explains, "Sensitive, empathic listening can probably take place *only* if the words spoken by one speaker are invested with private meanings by the other" (p. 95). The therapist's own woundedness is critically important in providing a point of reference and an internal place with which to connect with the patient. In short, the wounded healer's own personal experience opens up the possibility of deep empathic understanding and connection.

This kind of empathic understanding is commonly considered to be a valuable therapeutic asset**.** In Lafferty, Beutler and Crago's (1989) study, empathy was found to be the most important variable to discriminate between more and less effective therapists (Chippindall & Watts, 1999). Researchers have historically devoted a great deal of attention to empathy in counselling (Trusty et al., 2005). The crucial importance of this comes from the person-centred approach of Rogers (1975). The task of empathic understanding demands a high degree of sensitivity and only by people who are secure enough in their own identity to move into another's world without being overwhelmed by it.

The journey of suffering thus shapes the wounded healer into the curative therapist by gifting him/her with the ability to empathise with the patient. Indeed, Neumann (1959) stated that "only a wounded man can be a healer... he carries within him a regenerative force capable of bringing forth a cure not only for himself but also for the community" (p. 186). These views are consistent with the essence of the meaning of the wounded healer motif. They are reflected in the selection process when assessing candidates for clinical training.

2.3 The risk of the therapist's woundedness

This section of the literature review presents the view that the healer's woundedness could hinder the therapeutic process. The inherent problems associated with woundedness will be explored in the concerns around countertransference, loss and deprivation, unmet narcissistic needs and relational attachment. These issues will also be considered in relation to difficulties that may arise for the therapist during training and later in practice.

It stands to reason that, in the light of their negative and traumatic histories, selectors would exercise caution in allowing wounded healers to enter the profession of psychology. It remains prudent, therefore, to consider the developmental impact of childhood deprivations and unmet psychic needs on the 'person of the therapist'. This deserves further scrutiny in so far as the therapist's emotional difficulties could interfere seriously with his/her capacity to function effectively in the clinical setting. It has been acknowledged that the therapist's personality is the primary tool and the instrument of change in the practice of psychotherapy. Crucially, it is the therapist's personality which will impact that of the patient (Guy, 1987) and comprise the most influential factor in facilitating positive therapeutic outcomes (Beutler et al., 1986; Lambert, 1989, cited in Chippindall & Watts, 1999).

This is further compounded by Weinberger's (1993) investigation of common [effective therapeutic] factors that found therapists' competence or expertness with the "lowest levels of emotional disturbance" being positively correlated with the best outcomes (p. 51). In the words of Hans Strupp (1959, cited in Wheeler, 2002), "In the absence of a favourable emotional matrix, no amount of expert technique could shift the psychodynamic balance in the direction of therapeutic growth" (p. 434). Specifically, there is concern that wounded healers will struggle with issues around countertransference, loss and deprivation, unmet narcissistic needs, and relational attachment. However, it may be argued that all these concerns can be addressed in that wounded healers acknowledge their own wounds and in having worked to resolve them, gained heightened self-awareness and knowledge, to the benefit of their patients.

2.3.1 Countertransference

One of the main concerns of the mental health profession is that of transference-countertransference issues faced by wounded healers in their work as psychotherapists (Cain, 2000). Transference refers to the patient's tendency to displace earlier childhood feelings, object relations and attitudes onto the current therapeutic relationship. Countertransference refers to all the therapist's emotional reactions to the patient (Lemma, 2003). In Freud's time, therapists regarded these emotional reactions as a manifestation of their "blind spots" – primarily a sign of unresolved conflicts in the therapist. Later, Heimann (1950) offered a broader conception of countertransference that shifted the viewpoint from seeing it as something that interferes with technique to a means of understanding the patient's unconscious communications. The therapist's emotional response to their patient is a technical tool, not a hindrance (Lemma, 2003). But this can only take place if therapists withdraw their projections and this presupposes that, like the archetypal wounded healer, they are in touch with their own wounded side. Furthermore, this requires that therapists be vigilant in monitoring their own projections as the interaction between therapist and patient evolves and is determined by unconscious forces operating in both. For instance, therapists who do not feel competent or are concerned about damaging their patients tend to have patients who break off treatment (Vaslamatzis, Markidis & Katsouyanni, 1989, cited in Lemma, 2003).

These findings illustrate that countertransference is a complex unconscious phenomenon co-created by both the patient and therapist in the communicative field of the therapeutic setting. As Ivey (1999) states, transference and countertransference, although conceptually distinct, "are fused components in an intersubjective field in which patients unconsciously dramatise their transference illusions and compel therapists to relive elements of the patients' childhood histories and internal objects relations by means of counter-transference evocations" (p. 63). Clearly, if the therapist's own unresolved issues are (re)activated in the therapeutic setting and get in the way of helping the patient, Freud's initial meaning of countertransference as an impediment remains. The implication of this in relation to wounded healers suggests that, in reworking the hurts of their own traumatic childhood histories and emotionally deprived objects relations, they may be particularly vulnerable to therapist-induced countertransference issues and an

unconscious tendency to use their patients for the gratification of their own neurotic needs (as suggested by Freud). This is of concern and puts the motif of the wounded healer under the microscope for careful scrutiny.

Cain (2000) investigated the countertransference issues of psychotherapists with histories of emotional struggle and mental illness. These diagnoses included mood disorders, various personality disorders and chronic schizophrenia. Participants' accounts of the negative impacts of the countertransference included discomfort, anxiety, frustration and reminders of difficult times. Some expressed that their own feelings of depression, vulnerability and isolation may have impinged on their patients. However, in spite of the negative impacts, all participants stated that their own histories of mental illness experience and countertransference helped them with their patients. They reported that their histories inspired and informed their clinical work, greatly increased their empathy with patients as well as building their own trust and faith in recovery. With regards to the challenges of countertransference, therapists felt they were "not scared of sitting with them… [and were used to]…having to deal with difficult feelings" (p. 26). They ultimately valued learning about themselves, which resulted in emotional and professional growth and confirms Maeder's (1989) assertion that, in tending to personal wounds, therapists confront their own problems and ultimately gain self-knowledge.

Hayes (2002), too, proposes that the wounded healer's countertransference, if judiciously used, is a potentially powerful benefit to the patient. The author emphasises that this requires that "I check my arousal level to try to determine if my issues are sufficiently resolved...be able to recognise important distinctions between her experience and my own, between her emotions and mine, between her needs now and mine then" (p. 98). Hayes (2002) argues that in allowing himself to re-experience affect connected with his own personal events, and the source and intensity of those feelings, he is able to use his countertransference to gain cues of the patient's experience. This implies that the wounded therapist's countertransference affect becomes a curative resource in providing deeper understanding of the patient and guidance to their work.

Sedgwick (1994, cited in Wheeler, 2007) links countertransference with the capacity to be wounded. He tentatively uses the term "neurotic-countertransference" and explains:

> *The more personalised the countertransference can become, the greater the potential utility and healing. Or in Jungian terms: for wounded healer work to be healing, the analyst has to be really wounded by the patient, the deeper the better*. (pp. 248-249)

In short, in having dealt with difficult feelings, wounded healers may be less inclined to deny or distort their own wounds and use their countertransference affect to help patients (as suggested by Heimann, 1950).

2.3.2 Loss and deprivation

Storr (1990) stated that therapists who had suffered loss, rejection and loneliness and are prone to depression may resist challenging patients or making interpretations for fear of provoking an angry response or losing them. Barnett (2007) argued that the resultant effects of early loss can lead to difficulties in respect of intimacy, dependency and separation in the therapy process. If therapists' own dependency needs were not met in childhood, they may fear dependent feelings emerging in their patients or, conversely, foster these feelings in the patient in an attempt to heal their own insecurities. A strong maternal identification on the part of the therapist may result in difficulties separating from the patient. This may impede the therapy process in that there needs to be separation between the therapist and patient, just as between mother and child. The therapist needs to be able to think *about* the patient and not only *with* the patient and the patient needs to be afforded separation in order for growth to occur. From Barnett's (2007) study, themes of abandonment suggest that therapists may have difficulties in making attachments for fear of loss. Therapists' underlying grief, together with anger and frustration, may result in the temptation to break boundaries or, instead, in inflexibility and the tendency to intellectualise their patients' problems.

There seems to be a gap in the literature that specifically addresses the theme of the therapist's personal experiences of trauma for the therapeutic process – the "catastrophic overtones" (McWilliams, 1994) of histories of sexual and physical abuse, for instance. A literature search suggests a possible research trend in investigating the impact of the patient's trauma on the therapist, that is, of secondary or vicarious traumatisation (Collins & Long, 2003; Black & Rhys,

2004, cited in Wheeler, 2007; Hudnall Stamm, Varra, Pearlman & Giller, 2002). Nonetheless, what seems to emerge from these studies is that there is an increased risk of traumatisation to therapists if they themselves have a personal history of trauma. Wheeler (2007) cites the work of Black and Ryhs (2004) who use the term "contra-identification" to describe the way in which a therapist, who identifies with the negative experiences of the patient, will try to dissociate from these characteristics.

One way of addressing these concerns is to argue that the more therapists are able to identify with trauma, the more empathic they will be. However, the sceptic will argue that the more involved wounded healers become in their patients' trauma, the more distressed and caught up in their patients' experience they will become (Black & Ryhs, 2004, cited in Wheeler, 2007). The literature suggests that, in order to protect helpers from developing prolonged psychological difficulties themselves, they require external supports. For instance, Wheeler (2007) stresses the critical role of the supervisor in identifying and breaking the cycle of therapist traumatisation. Hudnall Stamm and co-workers (2002) advocate supportive resources such as training and peer and professional consultation.

There is an argument that suggests that the most protective factor for *all* therapists working with trauma comes from a combination of resources – from outside and within themselves. These have been identified as "hardiness" and "social support" (Collins & Long, 2003). Hardiness is characterised by feelings of control, commitment and perceiving change as challenge. King, King, Fairbank and Adams (1998, cited in Collins & Long, 2003) speak of "resilience". By definition, this refers to those who can readily recover from negative experience (Oxford Dictionary, 1988). The essence of the meaning of the wounded healer is thus congruent with the idea of having "resiliency", defined as "power of recovery" (Oxford English Dictionary, 2009). In short, in having dealt with their own history of trauma, wounded healers may be resilient as therapists. They have the capacity to feel at a deep level and be most real and vulnerable with their patients. Crucially, in such difficult work, wounded healers' unique qualities may have much to contribute to the therapeutic endeavour.

2.3.3 Unmet narcissistic needs

From the literature, therapists describe experiences of having been family nurturers, confidantes, mediators and caretakers, parentified and adultified children. It may be important at this point to clarify these seemingly interchangeable concepts. Maeder's (1989) concept "little adult" [adultification] resembles Fussell and Bonney's (1990) definition of the "caretaker role" as "a concern of the child for the well-being of all family members, extending the sense of responsibility for parents to a similar feeling for the entire family" (p. 510). However, "parent-child role inversion" or "parentification" differs by definition in that it refers particularly to a subjective distortion of the parent-child relationship. In this, the [actual] parents perceive their partners or even children as if they were their parents and the parents assume the role of the children. (Boszormenyi-Nagy & Spark, 1973, cited in DiCaccavo, 2002, 2006). Nonetheless, despite these differences, all such cases are commonly seen as a failure of the parents to recognise and meet the child's normal narcissistic needs.

The term "narcissism" was inspired by Ovid's myth of Narcissus in *Metamorphoses* (AD 8, cited in Halewood & Tribe, 2003). According to the legend, a young Greek man falls in love with his reflection; a reflection which is perfect. The disowned part, the "shadow" of his inner self, his pain and his history remained out of sight and therefore, hidden from him. Psychically speaking, they are 'cut off' and out of his conscious awareness (Barnett, 2007). Narcissism is an extremely complex phenomenon, but in terms of psychological functioning it traditionally refers to "the state of self-directed libido, or, in other words, a concentration of psychological interest upon the self" (Sussman, 1992, p. 99). This definition portrays narcissistic individuals as excessively self-absorbed, hence the popular reference to "self-love". However, underlying the grandiose portrayal of great ambition, highly unrealistic goals and an intolerance of failures and imperfections, are issues of personal self-esteem and the need to overcome a diffuse identity. Such an individual is a "prisoner of his aspirations, his needs, and his harsh criticism" and requires constant reassurance, admiration and love to bolster his/her self-esteem (Nemiah, 1961, cited in Sussman, 1992, p. 109).

Miller (1981) argued that the legend of Narcissus actually tells us the tragedy of the loss of self. In describing the psychic climate of these children, the author makes it clear that they have a primary need to be acknowledged, affirmed and respected for who they really are at any given time. In an atmosphere of respect and tolerance for his feelings, the child in the phase of separation-individuation will be able to give up symbiosis with his mother and move towards autonomy and individuation. However, this requires that the parent experienced a similar emotional climate as a child. If this is not the case, then the deprived parent(s) will, in turn, look for what their parents did not give them – the presence of someone who is completely aware of them and will take them seriously. Their *own children* become the substitute gratification. For the young child, being completely dependent on his parents for his very survival, he does all he can to avoid losing them. He develops into something his mother needs. In this way he saves himself in securing his mother or father's love, but this nevertheless prevents him from being himself. In this exploitative relationship, the framework in which the child could experience his feelings and emotions is missing. The natural needs appropriate to the child's age "cannot be integrated, so they are repressed or split off" (p. 30). Miller's (1981) theory here is compatible with the idea of a "narcissistic injury", occurring as a result of caregivers failing to respond to or validate their child's spontaneity and "true self", resulting in the subsequent development of a "false self".

Winnicott's (1960) model of the "false self" suggests that it functions to hide the "true self". According to this theory, its aetiology lies in the first stage of object-relations. The "true self" presents in the infant's occasional spontaneous and instinctual gestures. The good-enough-mother meets these omnipotent gestures and repeatedly makes some sense of them. Through the mother's response, the infant's "true self" begins to have an experience that meets with the external object world and so is strengthened. However, in failing to meet and respond to the infant appropriately the not good-enough-mother substitutes the infant's omnipotent gestures with her own. In practice the infant lives, but lives falsely; he defends his "true self" from exploitation and the threat of annihilation by compliantly relating to the caregiver's gestures as if they were his own. For Winnicott this lies at the root of the "false self" structure. He adds that a "false self" may fit in very well with the family pattern, and can very easily be mistaken for health. But, says Winnicott (1965/1975), it implies instability and a liability to breakdown.

Halewood and Tribe's (2003) empirical study highlights possible difficulties faced by trainee psychologists with narcissistic issues. The results showed a significantly higher degree of narcissistic injury among trainee psychology students than the control group of postgraduate students. Trainee psychologists scored higher on items such as restriction of emotional affect, lack of understanding of self, and presence of a 'false self', as well as the need for mirroring and understanding, problems with setting boundaries, grandiosity, depression and perfectionism. The authors concluded that these results suggest the common presence of narcissistic injury among trainee psychologists. In light of the fact that all the trainees had already attended forty hours of personal therapy, these results were a cause for concern.

The authors' (Halewood & Tribe, 2003) review of the literature described several problems the narcissistically injured would-be therapist may encounter in training. Parentified trainee therapists may hold the belief that they are loved for what they *do* and not for who they *are*. Their concern with perfectionism may become increasingly problematic as the work demands escalate. Also, as the process of becoming a therapist involves feelings of doubt and uncertainty, trainees may suffer injury to their self-esteem and self-image when they feel they are floundering. Those who need a concrete form of achievement may be left feeling very frustrated. In addition, Halewood and Tribe (2003) warn that, when therapists fail to satisfy their narcissistic needs but are exceeding their own capacities, there may be an increased risk of burnout. These symptoms include anxiety, depression, exhaustion, irritability, emotional detachment, cynicism, boredom, and a desire to withdraw from patients (Guy, 1987).

Psychodynamic therapy involves managing difficult countertransference feelings stirred up by the provocative nature of the transference and patient projections. These may be internalised by trainee therapists and leave them worried about being good enough (Glickhauf-Hughes & Mehlman, 1995; Mollon, 1989, cited in Halewood & Tribe, 2003). In particular, trainee therapists with narcissistic issues may suffer from the "imposter phenomenon" due to the presence of the "false self" (Langford & Clance, 1993). Imposters often attribute their achievements to personal charm and the ability to read others' expectations, rather than to ability based on their real selves. Glickhauf-Hughes and Mehlman (1995) note the paradox, "The very qualities that may enable an individual to...excel as a therapist may make being a therapist

difficult" (p. 218). This may be taken to read that therapists are exquisitely sensitive to their unspoken messages, to the benefit of the patient, but it comes at a personal cost to therapists.

Glickhauf-Hughes and Mehlman (1995) further note that narcissistically injured therapists risk turning to their patients to meet their emotional needs in the same way their parents did to them as children. Halewood and Tribe (2003) describe the problems that may emerge as a consequence of this:

> *First, the therapist may infantilize their client...By unconsciously attempting to rescue clients, counsellors are assuming a dominant role, thereby allowing their clients less independence. Second, counsellors may project their own needs onto clients, thus misunderstanding the client. Finally, the counsellor may subtly discourage the client's negative countertransference by directing it to outside targets, or may be reluctant to challenge the client for fear of breaking the narcissistic collusion*. (pp. 92-93)

DiCaccavo (2006) raises the concern of parentified therapists working with parentified patients. The "false self" that the parentified patient is likely to present in therapy is likely to be the good child: eager to please and, in some cases, care for the therapist. Keenly attuned to the needs of others, the parentified patient may try to please the therapist. For instance, he/she may attempt to become someone who the therapist dreamed of being; that is, someone who does not have to help others to stay in relationship and can respond to his/her own needs outside the restriction of others. Reeves (1999, cited in DiCaccavo, 2006) likewise argues that therapists who have not worked through their own parentification may be limited to intellectually re-parenting the "child" before them. Defended against their own sense of loss and "...with no practised authentic emotional voice of their own, therapists are at risk of inserting their own unarticulated feelings into a client's articulated emotional suffering" (p. 475). Furthermore, as a result of poor experiences of containment in their own family histories, therapists may be unable to provide the high level of containment that the parentified patient may need. For trainee therapists who have not explored their own parentification, the danger that they will go on compulsively caring for patients without asking for more help or support, is quite likely (DiCaccavo, 2006).

In this, the authors (Halewood & Tribe, 2003; Reeves, 1999, cited in DiCaccavo, 2006) highlight the important issue of the psychotherapist's own resolution. Therapists need to develop self-awareness lest they obstruct the patient's progress or, worse, that they would use patients to satisfy their own narcissistic needs. Parentified children, in particular, need to acquire an understanding of their role within their family of origin. Understanding how their boundaries were not respected and how they were unable to set limits when they were children, may improve their ability to do so with their patients and interpersonal relationships. The authors conclude that therapeutic work could be affected if trainees fail to examine their own narcissism.

In a similar vein, Barnett (2007) asks what the "shadow" side of therapists wanting to help others is and what negative effect that might have in a therapist's work if not brought to consciousness. She links this to unmet narcissistic needs of childhood and warns that these may be omnipresent, persisting "unconsciously, into adulthood, resulting in characteristics of intolerance for failure, grandiosity and cravings for love and attention" (p. 267). Barnett (2007) states that a therapist's early feeling of shame may lead to self-sacrificing patterns and a need to become idealised parent-figures to patients. This resembles Sussman's (1992) idea that, as a result of parental narcissism, therapists unconsciously desire to be placed on a "pedestal" by their patients. In this, therapists may overvalue themselves and project all that is bad onto their patients (Barnett, 2007). They may have particular difficulty working with a negative transference and accept all that is projected on them without challenge, thought or interpretation.

Barnett further (2007) discusses narcissistically injured therapists' issues around control, selfless giving and the need to be needed. She posits that the need to be needed is closely linked to feelings of shame and insecurity – therapists may become self-sacrificing so as not to lose patients just as they needed to put the needs of their parents first in order to feel secure. Therapists who were "watchful" as children may find it difficult to challenge or tolerate patients' expressions of anger - they may just be too 'nice' for any real change to occur. Guilty feelings in not having been "good enough" [possibly a carry-over from not having been able to meet the undue expectations of family members as suggested by Goldberg (1993)], along with a need for reparation (Searles, 1966/1999, cited in Barnett, 2007), may also lead to a desire to heal.

Therapists' defences of feeling important and omnipotent may hide a sense of their own vulnerability (Barnett, 2007).

In Wheeler's (2007) paper, *The supervisor's dilemma*, she notes that supervisors "...have an important role to play in recognising and attending to the wounds of the healer" (p. 255). She quotes Wosket (1999) who posited that therapists' self-deception, seen in grandiosity or feelings of inflated self-importance, may mask feelings of worthlessness and the fear of failure. In her discussion of narcissistic reactions, McWilliams (1994) makes a useful point. She notes that psychotherapy training programmes are notorious for taking seemingly successful, autonomous adults and making them feel like incompetent children. They become opinionated, boastful, run hypercritical commentaries and idealise mentors. But, as Wheeler (2007) says, the problem occurs in the therapeutic setting when the therapist's drive for success is about enhancing his/her own sense of self-worth, when the therapist's needs consistently take precedence over those of the patient or when they significantly interfere with the therapist's capacity to maintain a therapeutic stance. For instance, an interpretation that serves the therapist's narcissistic aims in needing to feel wise and omniscient may not ultimately be helpful for the patient (Sussman, 1992).

Therapists with narcissistic issues may also struggle with not having the answers or solutions for the patient. Bion (1967a, cited in Grotstein, 2000) spoke of the importance of the therapist needing to be able to *be* with the patient, "without memory, desire or understanding" (p. 687). Bion's rationale for abandoning (really suspending) memory, desire, understanding and preconception is for the analyst to be open to the unexpected from the analysand's unconscious. That is, he must not project into them. Therapists must have the capacity to bear not knowing and for sitting with doubt. This does not mean that they cannot know or that there are no answers, but to tolerate not knowing without trying to fill the analytic space with sense. In the therapeutic process, for instance, the hasty answer may be the therapist's quest for an assurance that he is not going to be surprised. As such, the pursuit of "memory, desire and understanding" intrudes into the analytic space and obstructs the process.

Supervision may be a further area of difficulty. Therapists in training need to be open to feedback from supervisors and to learn from them (Wheeler, 2002). Learning requires that one be able to bear that the other has something to give. For these trainees, it may be unbearable to 'take' from the competent, insightful and understanding supervisor. Furthermore, if the supervisor evokes envy in the trainee, then their capacity to think about, process or link the feedback may be thwarted. Trainees may feel a need to be a step ahead of the supervisor, saying "you're right" but with no intention of thinking about what is said.

The presented literature points to therapists with narcissistic injury suffering a profound lack of confidence in their actions and feelings in training and clinical practice. Feelings such as self-doubt, shame and a lack of self-worth may evoke defences of grandiosity, omnipotence and the need for control. Miller (1981) contends that behind the grandiosity constantly lurks depression, as grandiosity is the defence against depression, and depression is the defence against the pain over the loss of self. These individuals may struggle in clinical training and practice with being open to supervision, maintaining a therapeutic stance and working in the transference, particularly the negative transference. Furthermore, there is the possibility that because of the tendency toward perfectionism and self-abnegation, therapists may suffer burnout. In having learnt from an early age to be attuned to the needs of others, therapists have difficulty in attending to their own needs and this potentially compromises their ability to protect themselves from harm (Sussman, 1995).

However, some narcissistic aspects of wounded healers may be beneficial to the patient after all: the heightened awareness of inner events (Henry et al., 1971, cited in Farber et al., 2005), the exquisite sensitivity or antennae (Goldberg, 1993; Miller, 1981) that is traced to their early childhoods and family dynamics. It has been argued that sensitivity is an essential part of the psychotherapist's personality in relating to their patient's experiences (Storr, 1990). Also, in these individuals' tendency to be over-anxious to please and highly sensitive to what may be upsetting to others, they may be adept in making initial contact with patients who may begin by being hostile or suspicious. Furthermore, therapists brought up with early experiences of ambiguity may develop another therapeutic skill in being able to tolerate ambiguity, as patients present perplexing and confusing life events (Fussell & Bonney, 1990). Storr (1990) proposes

that the knowledge of what it is like to feel insulted and injured extends their range of compassion with those they feel might have been rejected like themselves.

2.3.4 Relational attachments

Previous studies suggest that individuals with secure attachment styles are less preoccupied with their own needs and have the greatest potential to provide these high levels of empathic caregiving (Lopez, 1995; 1987; Pistole, 1989, 1999; Pistole & Watkins, 1995, cited in Trusty et al., 2005). What may be inferred from these studies is that more effective therapists have a high level of empathy because they had good attachments with their earlier caregivers (Lafferty et al., 1989, cited in Chippindall & Watts, 1999).

Attachment theory emphasises the formative influence of real experiences with caregivers and the central role of relationships in our lives (Halpern, 2003). At the heart of this theory is the concept of a "secure base" which is provided by parents sensitively responding to their child's distress – as a result, the child feels secure enough to explore his environment. Although attachment theorists have considered caregivers and infants, and not therapists and their patients, it has been argued that the intrinsic qualities to parental caregiving may be important for the competent therapist (Main, 1995; Fonagy, 2001, Slade, 1999, cited in Halpern, 2003). The idea is that a security of attachment as a result of a secure base lies at the core of the successful analyst. The literature indicates that the therapist's ability to form a warm and supportive relationship is important in the formation of the therapeutic alliance (Orlinsky, Grawe & Parks, Roth & Fonagy, 1996, cited in Black, Hardy, Turpin & Parry, 2005).

Black and colleagues' (2005) study found a positive relationship between therapists with a secure attachment style reporting better therapeutic alliances with their patients and therapists with higher levels of insecure attachment reporting poorer general therapeutic alliance. Some support was found for therapists with insecure attachments having more problems providing therapy. The authors propose that because of their need for approval, therapists with insecure attachments may be setting perfectionistic targets (Anderson & Perri, 2000) and be less able to

manage when they encounter problems in therapy. However, other related studies may challenge these findings.

In a recent study, Trusty and colleagues (2005) investigated influences of adult attachment on emotional empathy in masters-level counselling students. Emotional empathy is conceptualised as "an emotional response to another person's emotion (feeling another person's feeling)" (p. 66). The researchers' results showed that the most effective counsellor trainees perceive their parents' relationships and parent-child interactions more negatively than less effective trainees did. This is consistent with studies that suggest negative perceptions of the family of origin are related to higher levels of counselling skill (Watts, Trusty, Canada & Harvill, 1995; Wilcoxon, Walker & Hovestadt, 1989, cited in Trusty et al., 2005). In Wolgien and Croady's (1997) study, participants attributed some portion of their counselling effectiveness to their ability to deal with the distress in their family of origin. Furthermore, trainees who were high in anxiety and low in avoidance had the highest levels of emotional empathy (Trusty et al., 2005). The authors posit that counsellor trainees who do not avoid their own issues and who are highly aware of their own emotions and vulnerabilities (anxiety) would be more attuned to the emotions and vulnerabilities of others. These studies support the concept of the wounded healer whereby effective counsellors are not inclined to deny or distort their own wounds. In line with this is Storr's (1990) thesis that the capacity for empathy is connected with "a relative absence of repression" (p.173).

It is evident that researchers associate the quality of therapists' early and adult attachments with their ability to provide therapy. However, the presented and referenced studies (in Black et al., 2005; Trusty et al., 2005) appear contradictory in their findings. They do not offer a comprehensible conclusion as to whether therapists with secure or insecure attachment styles are better therapists. With closer scrutiny, it appears that these studies argue for different types of attachment being associated with different features of therapeutic effectiveness. In other words, Black et al. (2005) posit that therapists with secure attachment styles report better general *therapeutic alliance,* whereas Trusty et al. (2005) argue that therapists who hold a negative perception of their families of origin are more skilled and *emotionally empathic* as therapists. These concepts are distinct and need to be considered as such and in relation to the study's claims. Bordin (1979, cited in McLeod, 2003) offers a conceptualisation of the therapeutic or

working alliance as comprising three features: an agreement on goals, an assignment of tasks and the development of a bond. It is clear that these features are interconnected and reciprocal and that the therapeutic bond would be closely related to the therapeutic relationship and good attachment capacities (as suggested by Orlinsky et al., 1996, cited in Black et al., 2005).

However, in support of Trusty and colleagues' (2005) study, empirical evidence shows that emotional empathy is positively associated with the therapeutic alliance (Grace, Kivlighan & Knuce, 1995, cited in Trusty et al., 2005). In addition to this, empathy is shown to be the *most* important variable discriminating between more and less effective therapists (Lafferty et al., 1989, cited in Chippindall & Watts, 1999). In the context of Trusty and colleagues' (2005) study, it follows that insecurely attached therapists are more able to be empathic towards their patients in having personally experienced negative parental relationships and child-parent interactions or, as Hayes (2002) puts it, an internal point of reference. Taken together, Trusty and colleagues' (2005) findings appear valid – insecurely attached counsellors with the lowest levels of avoidance (as argued by Storr, 1990) and the highest levels of empathy, may be the most effective therapists.

2.3.5 Risk revisited

Studies have shown that therapists are often able to use their countertransference beneficially for the therapeutic task. Experiences of loss, deprivation and unmet narcissistic needs equip the therapist with heightened levels of sensitivity in relating to their patients, in tolerating ambiguity and in experiencing compassion for others. Finally, therapists who tend to have insecure attachments and low levels of avoidance, have been shown as the most effective counsellors as they have high levels of empathic understanding, which is invaluable to their patients.

However, some critics are still not satisfied. The question of the therapist's personal pathology takes on significance in the selection of candidates. Ellis (1972, cited in Sussman, 1992) has warned that individuals who enter the mental health profession tend to have emotional disturbances. There is support that emotional disturbance in the therapist is antitherapeutic and potentially damaging to patients (Fisher & Greenberg, 1977, cited in Sussman, 1992).

Conversely, therapists' emotional health facilitates treatment outcome (Beutler, Machado & Neufeldt, 1994, cited in Wheeler, 2002; Weinberger, 1993), with qualities such as therapists' self-confidence, well-being and psychological adjustment positively related to patients' outcome (Frank, 1973). Thus, there is concern that the woundedness of candidates would introduce their own psychopathology into the therapeutic environment. This concern extends to both the patient and the would-be therapist and perhaps justifies the bias *against* woundedness in candidates.

Indeed, the candidate will be required to 'survive' the hazards of clinical training (Coltart, 1993; Guy, 1987; Sussman, 1992). The road to becoming a professional psychotherapist is typically a long and arduous journey. The process is frequently characterised by severe life stresses due to changes in work, finances, living conditions and social relationships. In addition, the training is fraught with a good deal of anxiety, ambiguity and doubt that arise largely out of the focus of the training programme which interacts with the personality of the individual (Guy, 1987). Though this would be expected to be difficult for any candidate, it may be especially challenging for the wounded candidate.

Unfortunately, the difficulties do not end here. At the end of training, the therapist is still anxious, prone to uncertainty and depression and maximally aware of just how unpractised and little they know (Coltart, 1993). On graduating, the newly qualified psychotherapist is often faced with physical and psychic isolation of practice and the often slow, uncertain therapeutic outcome of his effort (Sussman, 1992). Indeed, there is substantial evidence that indicates that the practice of psychotherapy is not only a "curious calling" but a "perilous" one (Sussman, 1992, 1995) in posing significant danger to therapists. This includes a high incidence of mental illness, substance abuse, sexual acting-out, stress, burnout and suicide. In addition, it can have a negative impact on marriage, parent-child relationships, friendships and social life. Again, by their very nature and inability to attend to their own needs, wounded healers are particularly vulnerable, which selectors need to consider.

Nevertheless, although these are strong concerns, they speak to the merely wounded and not to the wounded candidate who has worked through and resolved issues. For, as Wheeler (2002) says, it is not the fact that the candidate *has* suffered traumatic experiences but rather *how* they

have dealt with it that is important in determining suitability. Wounded healers acknowledge their inner conflicts and work to resolve them, thereby transforming their personal suffering and mastery into a direct resource and curative power.

But what does it mean for the therapist to resolve inner conflicts? The understanding of "inner conflicts" comes from Freud. Firstly, the human mind, (seen as three regions of the id, ego, and superego) are almost constantly in conflict with one another; and secondly, the importance of the unconscious means that much of the individual's behaviour is under the control of forces that he or she may not consciously be aware of (McLeod, 2003). In "working through" this inner conflict, the goal of treatment is to bring to the patient's conscious attention the unconscious steps that led to the emotional conflict, as well as the resolution of the contending feelings or parts of the self (Polansky, 1991).

By definition, the word "resolve" means to solve or settle problems and doubts, etcetera (Oxford Dictionary, 1988). This is not what is meant in psychological terms: "resolution" here is that, in bringing the contents of the unconscious to light, the more mature and realistic parts of the personality will choose more appropriate ways of handling matters (Polansky, 1991). In line with this is Coltart's (1993) suggestion that, post-analysis, therapists will realise that, though they may still have a capacity for anxiety, depression and confusion, they have learnt different ways of handling these. The author adds that in this, "we have learned different ways of staying with 'it', whatever 'it' is, and working through to a better place" (p. 41). In short, through resolution, therapists will feel better themselves and more able for the therapeutic task.

Also important is the consideration of the emotional maturity and stability of the therapist, given that this will facilitate the therapeutic process of their patients. It is largely self-evident that therapists must possess a level of wholeness and personal integration to enable them to serve as guides to those in search of psychological healing. The motif of the wounded healer clarifies this point by suggesting that, in having worked through their suffering and having achieved a sense of resolution, validity and credence is given to their ministrations (Goldberg, 1993).

It is apparent from the presented literature that the wounded healers' subjective experience, both beneficial and problematic, has complex implications for the psychotherapy process and outcome, largely because of the tendency of those wounded to project their woundedness onto their patients and perform unconscious enactments around this. The personal qualities associated with woundedness may, however, aid them in better understanding their patients, in tolerating ambiguity, increasing their level of compassion and building the therapeutic relationship. Necessarily, their woundedness may be the very vulnerability that is a source of a curative power in facilitating patients' progress (as argued by Adler, 1956; Campbell, 1968, cited in Goldberg, 1993; Groesbeck, 1975; Jung, 1951, cited in Wheeler, 2007; Neumann, 1959). Most emphasised is the wounded healer's capacity for empathic understanding (Hayes, 2002; Trusty et al., 2005).

But contrary findings challenge this claim. According to proponents of attachment theory, individuals with secure attachment styles and sense of identity would be more empathically skilled than those with less secure attachment styles (Lopez, 1995; Pistole, 1999; Pistole & Watkins, 1995, cited in Trusty et al., 2005) and would have better general therapeutic alliances with patients (Black et al., 2005). In this regard, wounded attachments are a liability rather than an asset.

However, there is consistent agreement among authors regarding the importance of partial resolution of childhood wounds. Or as Jung (in Dunne, 2000) stressed, "The wounded physician...cannot heal beyond the extent to which he himself has healed" (p. 92). And it may be that herein lies the prospective value of wounded healers versus the inherent danger of being merely wounded. Wounded healers are guided by their wounds in having achieved a sense of resolution, whereas the unresolved wounded healer may be blinded by their own issues. Whereas the latter aims to rework *their* early hurts and disappointments through the psychotherapeutic process, the former is less preoccupied with their own needs, is sensitised to the suffering of *others* and is capable of deep empathic understanding, which is crucial to positive therapeutic outcomes. Indeed, being a "resolved-wounded-healer" is an essential requisite for being a good therapist.

Finally, in resolution, wounded healers hold the emotional capacity to manage the tasks involved in clinical training and practice. In having endured and worked through their own arduous journey, “resolved-wounded-healers” embody a resilience that the merely wounded (without resolution) and “normal” are likely to be without.

CHAPTER 3: Research Method and Procedure

3.1 Aims of the research

This research aimed, firstly, to explore trends and patterns in applicants' narratives of woundedness. Secondly, the researcher intended to explore the implications of these seeming patterns and trends in woundedness, according to selectors, for the therapeutic process. Thirdly, the researcher aimed to explore the implications of these seeming patterns and trends in woundedness for selectors evaluating clinical masters applicants' suitability for psychological training.

3.2 Research questions

1. What patterns or trends of personal negative or traumatic experiences are evident in applicants' narratives of woundedness?

2. Which patterns or trends of woundedness does a sample of selectors recognise as salient (whether positively or negatively) in applicants' narratives when applying for clinical training?

3. What are the implications of woundedness, according to a sample of selectors, for the therapeutic process?

4. What specific features and qualities of applicants' narratives of woundedness impress upon selectors' perceptions of suitability versus unsuitability for clinical training?

Subsidiary questions:

- Do selectors see woundedness as necessary for selection suitability?
- How do selectors perceive the distinction between candidates who are potential wounded healers and those who are merely wounded?

3.3 Research design

The choice to use a qualitative research method (thematic content analysis of documents and interview transcripts) was driven by the exploratory nature of the research aims. Questions posed to selectors involved exploring their responses, impressions, opinions and understandings of woundedness in terms of the specific context of clinical psychology masters selections and applicants' suitability to conduct a psychotherapeutic process. Inquiry into applicants' woundedness required immersion in details and specifics of applicants' autobiographical texts to discover categories, patterns and interrelationships, as well as the meanings they and selectors attached to them. Also important to this study's aims was to provide an understanding of woundedness from the subjective perspective of its participants. Questions related to woundedness are intimately associated with issues of subjectivity in how applicants and selectors construct meanings of woundedness from ideas, values, intentions and self-understandings of their own (Terre Blanche & Durrheim, 1999).

Qualitative research distinguishes itself as being committed to an "emic" or insider's view, providing in-depth or "thick" descriptions and understandings of actions and events. It has an idiographic focus in attempting to understand and describe these actions in terms of the actor's own unique beliefs, history and context (Babbie & Mouton, 2004). Therefore, a qualitative approach with an intensive study of particular cases from a limited sample was best suited to develop an adequate account of the phenomenon.

3.4 Sample

As per the aims of the research, there were two sets of data required for the investigation.

3.4.1 Autobiographies

The first set of data consisted of personal documents *viz.* the autobiographical narratives of applicants applying for clinical psychological training at Wits University. This portion of the document [hereafter referred to as autobiography] was between one and two pages in length, and

consisted of applicants' stated interest in clinical psychology and brief autobiographical accounts relevant to their interest in clinical psychology. The autobiographies were the units of analysis, not the individual authors themselves. However, for the purposes of attaining a sample of these personal documents, the researcher was required to select a sample of the individual writers. Applicants were asked to provide permission for the researcher to use this selected *portion of the document* only (see Appendix A).

The first aim of the research was to investigate themes and patterns of woundedness. This required a sampling method that ensured that these documents illustrated the desired criteria of woundedness. This necessitated a non-probability, purposive method of sampling whereby the autobiographical elements of woundedness could be handpicked for the sample. Traditionally, this relies on the basis of the researcher's expert judgment (Terre Blanche & Durrheim, 1999). In this study, however, it was the researcher's supervisor who was permitted access to the database of previous applicants for clinical psychological training and therefore had to make the selection on the researcher's behalf. The supervisor used his experience and discretion in the purposive selection of a sample of individual writers' documents. Documents were drawn on the basis that they illustrated the characteristic of woundedness in the writers having made explicit statements of negative and traumatic life experiences in their autobiographical narratives.

Research authors (e.g. Babbie & Mouton, 2004; Creswell, Hanson, Clark Plano & Morales, 2007) suggest five units as the minimum sample size for a qualitative project. In light of this recommendation, the achieved sample size of thirty autobiographies may be considered large for a masters-level research project. However, the researcher aimed for this number for the following reasons: One, more protocols would provide a greater range and coverage of different cases (Terre Blanche & Durrheim, 1999); two, the gathering of autobiographical data did not require lengthy periods of collection; and three, a larger sample size would improve the representability of the sample population (Babbie & Mouton, 2004).

In total, sixty [past] applicants were contacted via email and thirty writers gave their written consent for the researcher using their autobiographies in the study.

3.4.2 Selectors

The second data set in this study was that collected from a limited sample of Wits University clinical psychology selection panel members. These comprised members of the clinical psychology masters team and internship hospital staff. The interview material obtained from the individual selection panel members comprised the second data set. Here, a sample of participants was purposefully drawn from a pool of selection panel members for clinical psychology training. The purposive sampling method ensured that respondents were particularly informative on the topic of therapists' life histories and could provide meaningful information about the implication of these for the therapeutic process and the selection of candidates for clinical training.

The criterion for inclusion as participants was that that they were currently, or had recently been, members of a Wits University clinical masters selection panel. All participants were clinical psychologists and had sat on the selection panel on at least two occasions previously. The racial composition of the sample consisted of eight white selectors and two black selectors. All the participants were female, reflecting the demographics of psychotherapists in Johannesburg, which is predominantly white and female.

When considering sample size in terms of in-depth interviews, Terre Blanche and Durrheim (1999) recommend between six and eight sources if drawn from a homogenous sample. Although this sample would be considered homogenous, it was felt that a larger number of cases would cover a greater range of selectors' impressions and generate richer information for the topic of inquiry. In addition, as all the participants were locally situated, this was easily attainable. All ten interviews were obtained by third party referral (the co-ordinator of the Wits University clinical masters selection committee furnished the researcher with a list of its members), and thus this was also a convenience sample.

The information sheet was extended to thirteen selectors in total and ten selectors agreed to participate in the study. Reasons for declining the invitation included lack of availability (2 selectors) and lack of experience as a selector (1 selector).

3.4.3 Subsample (autobiographic protocols)

There was a further subsample that needed to be considered in this study, *viz.* the small sample of autobiographical exemplars handed to participants for evaluation prior to their being interviewed (see Appendices K1-K6). The rationale for providing selectors with this material sample was that it would support the research aims. That is, with the familiarisation and illustration of actual life history exemplars, the protocols may focus and elicit selectors' impressions of themes of woundedness with the implications of these being reflected in their ranking of candidates as suitable or unsuitable for clinical training. In addition, the provision of a standard subsample meant that selectors' impressions of, and implications for, the *same* candidates could be analysed for continuity and discontinuity between selectors. Furthermore, it was decided that including a small number of deviant protocols, depicting narratives of "unwoundedness" (i.e. no explicit or implied statements of negative and traumatic experiences) in the subsample would be valuable in exploring the implications of selectors' impressions more fully. For instance, this was considered useful in addressing subsidiary research questions of whether selectors see woundedness as necessary for selection suitability.

In line with this, the subsample was stratified into two categories and consisted of six protocols: The first, four protocols of woundedness (*viz.* explicit statements of negative and traumatic experiences), and the second, two protocols of unwoundedness (*viz*. no explicit or implied statements of negative and traumatic experiences).

In the first, the researcher employed thematic content analysis to search for themes of woundedness (explicit statements of negative and traumatic experiences) across the entire set of applicants' autobiographies (see Table 1). Based on this analysis, a quota sample of autobiographies was drawn that represented predominant themes of woundedness of the larger data set. However, as Terre Blanche and Durrheim (1999) warn, the researcher's selection of protocols based on the most predominant themes of woundedness (at this stage of the analysis), introduces the risk of subsample bias. In lieu of this, the researcher explicitly stated to the selector-readers that the subsample was an illustration of possible themes, rather than inclusive of all themes.

For the second sub-category of protocols representing unwoundedness, the supervisor again purposively selected a sample of two writers from the database of previous applicants for clinical psychological training. These documents were selected by the supervisor, solely on the basis that they illustrated the criteria of unwoundedness in there being no explicit statements or implied statements of negative and traumatic life experiences in the autobiographical narrative (see Table 2).

3.5 Data collection

Data triangulation was obtained as the researcher collected data from two different sources (autobiography writers and selectors) and in two different ways (personal documents and interviews). According to Babbie and Mouton (2004), the use of personal documents (especially life stories) is valuable in facilitating new exploration of theories and hypotheses of apparently resolved issues. In this case, autobiographies of actual experience presented novel data to explore existing theories of woundedness and the ongoing concern of potential therapists being wounded healers. More specific to the topic of candidate selection internationally, clinical training institutions have long stressed the special value of autobiographies. Calder (1968) explains that:

> *Subjective data transpiring from his mode of expression, his emphasis put on certain facts or circumstances, etc.…are extremely useful as it provides an indication of important aspects of the applicant's personality...and...experience has shown us that (autobiographies) provide deeper information regarding the applicant's personality…a test which is more analytical than any other.* (p. 540)

Essentially, the life history has the potential of providing data that overt interactions with subjective experience (e.g. interviews) are incapable of providing.

The second way the researcher gathered data was through the method of interviewing participants. This supported the goal of conducting an in-depth investigation of selectors' impressions of woundedness and the related meanings they attached to these when assessing an applicant's psychological training suitability. The interviews were conducted after the

compilation and analysis of autobiographies had been completed by the researcher and placed alongside the data. This allowed for the further analysis of continuity and discontinuity between the researcher's findings and selection panel members and between selectors themselves. This also improved the chances of the researcher maintaining objectivity and achieving valid and reliable results (Breakwell, 1995). In line with the qualitative paradigm, compatibility between the researcher's findings and selectors' impressions would give credibility or believability to the study's findings; likewise, a core of "sameness" would lend dependability to these. Also, the information collected from selectors provided an objective "check" to the researcher's findings, which reduced the possibility of researcher bias and helped promote the confirmability of the findings (Babbie & Mouton, 2004).

3.5.1 Collection of personal documents

The researcher first approached the Dean of Humanities of Wits University for consent for the researcher's supervisor to be allowed access to the [past] applicant database for the purpose of the research. Having obtained the Dean's written consent, the collection of autobiographical data was undertaken by the supervisor on the researcher's behalf.

The supervisor contacted the writers of the autobiographical sample set (drawn from the archives of past applicants for clinical psychology training) via email to invite them to participate in the study. The electronically attached subject information letter (see Appendix A) gave a brief description of the purpose of the study and explained how the data would be used. Applicants were requested to explicitly state their consent to the supervisor for the researcher to include their autobiography in the data. Informed consent to participate in this study was thus attained by respondent's written agreement via email. An applicant's non-response to the invitation to participate in the study was understood as a refusal to participate and was upheld by the researcher and supervisor. (As discussed later, ethical principals were observed in upholding writers' confidentiality and anonymity).

The supervisor photocopied the original autobiographical documents of consenting participants. Before the photocopied autobiographies were handed to the researcher, they were censored by

the supervisor. In practice, this entailed the supervisor concealing all writers' biographical information and any other identifying information appearing in the autobiographical text. On receiving the censored autobiographies, the researcher typed the handwritten scripts verbatim and inserted **** in the place of deleted information voids. According to the methods of thematic content analysis, the full sample of autobiographies was analysed (see research results section, Table 1) and the subsample compiled (see Table 2). At this stage of the collection process, the researcher was ready to gather the interview data.

3.5.2 Interviews

On request, the co-ordinator of the selection committee for MA clinical psychology training at Wits University furnished the researcher with a list of its members who currently sit or had recently sat on the panel. Following this, the researcher made telephonic contact with these members and explained that she was conducting a research project and requested their permission for the information letter be posted to them in this regard. Potential participants provided the researcher with their email addresses and the subject information letter (see Appendix B) was electronically posted. In this letter, the purpose of the research, expected duration and procedures were explained. Participants were informed that the researcher aimed to investigate themes and patterns in the earlier experiences of those seeking a career in clinical psychology. However, the theme of woundedness was not explicitly stated as it was felt that this would potentially direct and/or constrain the exploratory nature of the investigation. Rather, the researcher would listen for spontaneously emerging themes of woundedness and explore these in selectors' impressions and implications for candidates' suitability for clinical training.

The researcher followed up the posting by telephoning committee members one week later. Arrangements were made with members consenting to participate in the study to hand the exemplar sample of autobiographies to them, along with the attached instruction sheet (see Appendix D). The exemplars were hand delivered by the researcher to the participants. Follow-up appointments for the individual interview were made.

Semi-structured interviews were chosen as the method of data collection. Respondents were encouraged to talk freely of their experience and impressions of the autobiographies they had read and this yielded rich and nuanced data. In line with the unstructured design of the interview, the researcher had not prepared fixed questions, but established a general direction and guide for the conversation in terms of the autobiographical material and the selectors' perceptions of this (Breakwell, 1995). The interview schedule was derived from the literature relating to wounded healers and their suitability to the profession of psychotherapy, as well as Chippindall and Watts's (1999) study (see Appendix E). The questions were designed to elicit both descriptive and interpretive answers, asking for examples of potential issues selectors had identified, as well as the implications of these. The use of these open-ended questions proved valuable in allowing for participants' understandings and insights of the phenomenon of woundedness to emerge in as much detail as possible. The researcher also found probes useful in gaining more depth and pursuing specific topics raised by respondents, such as "What would that mean for a candidate?" and "In what way could that influence the therapy process?"

Ten selector participants were interviewed and the interviews were held at times and locations convenient for the participants. In all cases, participants elected to hold the interviews in their offices during working hours. This allowed for confidentiality and promoted participant comfort. The interviews lasted between fifty-five and sixty minutes. As recommended by Breakwell (1995), the researcher's interview design included an opening explanation for the interview and an opportunity on conclusion for participants to raise any doubts or queries they might have had about the interview. In the first interview, the participant stated that she would have liked the researcher to have made it more explicit that the interview would be based on the exemplar of protocols. Thereafter, the researcher clearly emphasised the purpose of the exemplar to the remaining participants when handing them the material. After the first two interviews were held and transcribed, they were discussed with the research supervisor. It was decided that the interview schedule was appropriate and no alterations were made.

3.6 Data analysis

The dual purpose of this study was to describe and understand trends and patterns in the content of applicants' narratives and selection panel members' interview transcripts. Thus, it was the *content* of the qualitative data that was of interest in the process of analysis. Thematic content analysis seemed best suited to this purpose as it reflects the search for themes across a data set on the basis of content to find repeated patterns of meaning (Braun and Clarke, 2006; Simons, Lalhlean & Squire, 2008). Furthermore, thematic analysis essentially provides a useful tool for identifying, analysing and reporting patterns within the data according to themes. It minimally organises and describes the data in rich detail and frequently goes beyond this by allowing interpretation of various aspects of the research topic (Braun & Clarke, 2006). Hence, the applicability of thematic content analysis was in line with the aims of the research.

3.6.1 Steps in the analysis

In practice, thematic analysis involves a constant moving back and forth as needed, through a number of phases. The process of reduction and extraction in this study was influenced by a number of accepted procedural steps. Braun and Clarke (2006) outline six steps for using thematic content analysis to analyse data and Terre Blanche and Durrheim (1999) identify five steps to guide the analysis. However, as these authors (Braun & Clarke, 2006; Terre Blanche & Durrheim, 1999) caution, interpretive analysis rarely proceeds in a step-wise manner and may be less linear in reality. The transcripts were analysed by using a combination of these two approaches in this study.

Step 1: Familiarisation/immersion (Braun & Clarke, 2006; Terre Blanche & Durrheim, 1999).
Before the data was collected, the researcher familiarised herself with the research topic by reading literature in the field and brainstorming ideas with the supervisor and peers. From this, and the verbatim transcription of the taped and handwritten data, ideas and theories began to form. However, as this analysis was primarily data-driven rather than theory-driven, the researcher attempted to avoid theoretical preconceptions at this stage. The researcher read and re-

read the data in an active way, searching for trends and patterns present. Initial ideas and markings for coding were noted and brainstormed.

Step 2: Generating initial codes (Braun & Clarke, 2006).

Initial codes were generated from the most basic elements of the raw data. These identified a feature of the extract data at the semantic level of mostly *explicit* statements – for example "death in family" or "alcoholic father". These codes identified particular features of, but were not limited to, the data set that pertained to the phenomenon of woundedness. Care was taken to code extracts inclusively by keeping a little of the surrounding data for context. A comprehensive list of the different codes was compiled and coloured markers were used to highlight potential patterns.

Step 3: Inducing themes (Braun & Clarke, 2006; Terre Blanche & Durrheim, 1999).

Themes were, for the most part, identified inductively from the bottom-up – the researcher attempted to work out what organising principles naturally underlay the material without fitting them into preconceived categories. However, to some extent, this process did include a top-down or deductive approach as the researcher was also alerted to common themes that had been identified in previous research. At this stage, themes were labelled in the terminology of participants and then collated at a broader level into potential themes. For instance, "boarding school" and "constant moves" combined to form an overarching theme of "physical moves". The keyness of a theme was evaluated in searching across the data set to find repeated patterns of meaning *and* in relation to the overall research question. For example, "physical moves" captured an important aspect of the writer's sense of woundedness or personal suffering. From this level, the researcher searched for meaningful relationships between codes, between themes and between different levels of themes (i.e. main overarching themes and sub-themes within them).

Step 4: Elaboration (Braun & Clarke, 2006; Terre Blanche & Durrheim, 1999).

Once the researcher had devised a set of candidate themes, they were closely explored and refined. Candidate themes were reviewed for internal homogeneity within themes and external heterogeneity between themes. In practice, this involved firstly a review, at the level of coded

data, to see if data extracts fitted and cohered within each theme and, secondly, a review of the entire data set to ascertain whether the individual themes were identifiably distinct and valid. Once it was established that the candidate themes captured the contours of the coded data, they were transposed onto a thematic map which reflected the meanings evident in the data set as a whole. This was an organic process and the data was repeatedly coded, elaborated and recoded until no new thematic elements appeared.

Step 5: Defining and naming themes (Braun & Clarke, 2006).
This stage of the analysis progressed to the researcher defining and naming themes – the attempt to capture the essence of what each theme was about and how these fitted into the broader overall story that the data was telling. Again, themes were reviewed for significance and validity across the data set. As part of the refinement, large and complex themes were hierarchically structured into sub-themes. For instance, the overarching theme of "countertransference" [evocations] also contained the sub-themes of "defences" and "over-identification".

Step 6: Interpretation and reporting (Braun & Clarke, 2006; Terre Blanche & Durrheim, 1999).
Here, the researcher moved beyond description of the data towards interpretation and the argument of the study. This involved collating an interpretation of the findings and a written account of the phenomenon; and theorising the significance of the patterns and their broader meanings and implications in relation to the reviewed literature. In this final stage of the analysis, the researcher reflected on how her personal role and involvement may have coloured the process of collecting and interpreting the data.

3.7 The position and reflexivity of the researcher

In accordance with qualitative methodology, it is the researcher who is the "primary instrument for both collecting and analysing the data" (Terre Blanche & Durrheim, 1999, p. 126). And as Parker (1994) states, like any method where the researcher is an overt participant through all the phases of the process, "it is worth considering the 'position of the researcher', both with reference to the definition of the problem to be studied and with regard to the way the researcher

interacts with the material…" (p. 13). These points highlight the need to address the issue of researcher bias in this study.

During the period of this study, the researcher was a trainee clinical psychologist. It was therefore prudent to address the possibility of researcher bias from the onset. To begin with, the researcher undertook to be as self-conscious of her preconceptions, feelings and attitudes to the research data and process as possible. Quite soon into the process, the researcher became aware of her own sense of woundedness being evoked in reading the literature and autobiographies. During interviews, in particular, the researcher's own desire to learn more about her personal woundedness may have meant that she was directive and leading at times. In addition, many of the selectors that were interviewed were known by the researcher as they had been teachers and/or selectors for her clinical training. This positioned the selectors as experts to the researcher and not just in relation to the topic of inquiry. In this, it is possible that the researcher felt intimidated at times and could have been reluctant to probe or question selectors' answers. To counter this, the researcher used a memo and attempted to record and analyse all emotions, motivations and opinions influencing her decisions and interpretations made during the research process. This created a disciplined approach in which the researcher would openly reflect on concerns regarding the possibility of being biased toward the data by her own personal experiences. The researcher's subjectivity was further contained by being supervised by a senior psychologist throughout this process. The researcher and supervisor met at each stage of the process and regularly discussed the supervisee's position in relation to the study.

3.8 Validity

Guba and Lincoln (1981) suggest eight procedures to ensure good qualitative research practice: prolonged engagement, persistent observation, peer debriefing, triangulation, referential materials, thick description, an audit trail and reflexivity.

In this study, peer review and reflexivity was used as an external check in the form of research supervision. Also, the thick description of interviews and the audit process undertaken by the researcher formed accountability for all the steps, decisions and reasons informing them. In

addition to this, the research design of complementing the autobiographical data with interview data and the use of self-reflexive memos, reduced the chances of researcher bias and helped to attain valid and reliable results. In practice it promotes "...the use of multiple perspectives to check one's own position against" (Kelly, 1999, p. 430) and can help the researcher "to 'home in' on a correct understanding of the phenomenon by approaching it from different angles" (Terre Blanche & Durrheim, 1999, p. 128). In this study, data triangulation facilitated the analysis of continuity and discontinuity between the researcher's findings and selection panel members, and between selectors themselves (Breakwell, 1995).

3.9 Ethical Considerations

The data corpus of this study consisted of two data sets drawn from two sample populations. Therefore, ethical research practice needed to be considered and undertaken for each. The ethical guidelines stated in the code of conduct for psychological research by the Professional Board of Psychology (2002) were followed.

Firstly, the Dean of Humanities of Wits University gave written consent for the researcher's supervisor to access the [past] applicant database for the purpose of the research. Also, a research clearance certificate was granted by the Human Research Ethics Committee (non-medical) - protocol number HO70706.

3.9.1 Applicants' autobiographies

Although the sample of applicants selected for this study would not be classified as a "vulnerable population", the subject material they shared was of a sensitive nature. In attempting to ensure that this did not elicit undue distress for participants and in upholding ethical research practice, the following ethical considerations were taken.

The applicant participants for this study volunteered themselves and were not offered any inducements for participation. The subject information letter sent to applicants informed them of the purpose of the study and what participation would entail. Potential participants were advised

that there would be no advantage or disadvantage to them in agreeing, or not agreeing, to participate in the study. In addition to this, it was explicitly stated that, in the event of past applicants intending to re-apply for future admission to clinical psychology training at Wits University, they would not be advantaged or disadvantaged in any way in agreeing or declining participation. An applicant's non-response to the invitation to participate in the study was understood as a refusal to participate and was upheld by the researcher and the supervisor. The information letter extended an invitation to participants to withdraw from the study at any time if they so wished. Potential participants were also provided with the supervisor's contact details in the event they required further information. The results of the study were offered to respondents on request (see Appendix A).

The applicants' confidentiality was assured through the role of the supervisor. The supervisor's role included the selection of writers from the archival database, approaching writers via email on the researcher's behalf and obtaining applicants' written consent via email. Thereafter, the supervisor undertook to photocopy the relevant portion of the application proxy, to delete all writers' identifying information from the photocopied document and to return the original autobiographical document to the archival database from which it was drawn. The supervisor further ensured applicants' anonymity to the researcher by censoring all participants' identifying details in the autobiographies prior to handing these to the researcher (at the supervisor's discretion, all identifying information was deleted in the document).

Participant applicants were assured that no identifying information would be included in the research report or any publication arising from the research. Participants were made aware of the researcher's intention to use direct quotations from the interviews for the purposes of illustration, validation of argument and analysis. The quotes selected in the final report were selected in a way that attempted to ensure that no participant applicant could be individually identified. The gathered data [photocopied autobiographies] will be destroyed by the researcher after examination of the research report. They will be kept in a safe place until such time.

3.9.2 Selectors

The selectors interviewed for this study volunteered themselves and were not offered any inducements for participation. At the start of the interview, an invitation to withdraw from the study at any time was extended, as well as the assurance that they could choose not to answer any particular interview questions. The subject information letter was received by participants prior to the interview and advised potential participants that there would be no advantage or disadvantage to them in agreeing, or not agreeing, to participate. The purpose of the study was stated in the information letter and respondents were informed of what participation would entail (see Appendix B). This was again clearly stated prior to the interview in the covering letter attached to the subsample of autobiographies (see Appendix D).

Confidentiality was ensured by concealing and censoring any potentially identifying information of the participant selectors. They were assured that no identifying information would be included in the research report or any publication arising from the research. Participants were made aware of the researcher's intention to use direct quotations from the interviews for the purposes of illustration, validation of argument and analysis. The quotes selected in the final report were selected in a way that attempted to ensure that no participant could be individually identified. Consent for the study was obtained prior to the interview being held as well as consent to tape record the interview (see Appendices C.1 and C.2). No selector participant objected to the recording of the interview. The gathered data [transcripts and audio tapes] will be destroyed after examination of the research report. They will be kept in a safe place until such time.

The researcher provided contact details to all participants in the event they required further information and the results of the study were offered to respondents on request.

CHAPTER 4: Research Results

4.1 Introduction

This chapter is presented in four sections. In the first section, the presentation of the major themes and patterns of woundedness found across the autobiographical texts are explored, described and analysed. Secondly, the selectors' accounts of recognised salient themes and patterns of woundedness in applicants' narratives are explored, described and analysed. Integrated into this section is a presentation, according to selectors' accounts, of the implications of woundedness on the therapy process and for clinical training. Thirdly, on the basis of the set of protocols (Appendices K1-K6) each of the selector's impressions of applicants' suitability versus unsuitability for clinical training will be explored separately. Lastly, the individual findings are compared in terms of continuities and discontinuities between selectors' accounts and the researcher's findings and between selectors themselves. Summaries and excerpts from the data are used to highlight the themes and trends found in the autobiographical texts and selectors' accounts. A summary of findings is presented for each section of analysis according to collated themes and patterns.

4.2 Presentation of autobiographical findings

The presented themes and patterns are data-driven and limited to *explicit* statements made by the writers. Individual autobiographies are denoted by 'K' from cases 1 through to 30. The initial categories that arose from these accounts have been divided into three broad areas: "Trauma, loss and deprivation", "Perceptions of childhood experiences in family" and "The emotional and psychological effects of life events and childhood experiences in family" which have then been refined and explored (see Table 1).

4.2.1 Trauma, loss and deprivation

This category is divided into themes that emerge from applicants' accounts of "death", "illness", "physical moves" and "crime trauma". Overall, every applicant, bar two (K6 and K10), report having at least one negative and/or traumatic experience during the course of their lives.

4.2.3.1 Death

Approximately one-third of all applicants report having lost someone close to them through death. In no instances, however, does the death occur during the period of early childhood; that is, applicants only report having lost a significant person in adolescence or adulthood. The apparent themes here are loss and separation:

> *My last year of primary school was very difficult...during this year my grandfather also died of cancer* (K13); *My father...suddenly passed away when I was 17...when he died I was devastated. My mother passed away when I was 24* (K14); *...losing my Ouma unexpectedly... [age 16]* (K17); *Traumatic experiences, was the loss of my son at 9 months* (K18); *[My matric year] ...was a particularly hard year for me as my boyfriend at the time committed suicide* (K21); *At 15 my best friend died in a car crash... [and later] a close friend died of AIDS* (K22); *...while I was in Std 7, my father died after a long illness...and my maternal grandmother died [5 years later]* (K23); *My twin brother died from lack of oxygen... [at birth] ... [and later] the death of my grandmother...* (K24); *Unfortunately my husband passed away five months after our wedding (Gun-shot)* (K25); *My father passed away as a result of a stroke...and my housemate...died from an asthma attack... [and] my mother died [5 years later]* (K26); *[During] university...I was involved in a car accident in which a close friend was killed...my brother, who was also my best friend...developed meningitis...he has hospitalised for 10 days before dying...* (K27).

4.2.3.2 Illness

In half of applicants' autobiographies, the theme of having endured illness and/or physical or psychological disturbance, in either family members or themselves, is presented. In these accounts, mental illness and/or some form of substance abuse predominates and are more often located in family members:

> *My father was an alcoholic, so life with him was never easy. [I had] anxiety and panic attacks...as a child* (K1); *...the experiences I have had with my family...specifically pertains to the development of psychosomatic illness on reactions to severe and prolonged stress as I have witnessed. [And] I have witnessed my sister attempt suicide* (K2); *I sought comfort in...drugs/alcohol* (K3); *I am hospitalised with **** ... My four-year old zest for life is split off from me* (K9); *I have two older sisters who are both mentally ill... At a very young age I had a spinal dislocation, for which I wore a brace until the age of 14, after which I went for an operation* (K11); *I was sent to see a psychologist...and told I had dyslexia...I have very little memory of this time* (K13); *My father had been an alcoholic for many years* (K14); *My university years were very intense, and dark at times...I was quite depressed* (K19); *...my mother was diagnosed with a disabling disease* (K20); *my father died after a long illness...my mother was diagnosed with **** and was eventually diagnosed with cancer* (K23); *...my grandmother...had been diagnosed with schizophrenia when I was very young and spent most of her remaining years at **** Psychiatric Hospital* (K24); *...my mother was diagnosed with breast cancer...* (K26); *...I was involved in a car accident... I sustained injuries that prevented me from returning to university... [and later] I experienced constant pain due to my earlier injuries* (K27); *...My dad's subsequent, massive heart attack; my youngest brother's alcohol abuse* (K28); *... [I observed] from extended family alcohol abuse...drug abuse...* (K29); *...my parents were involved in a car crash in which many people died...they were in hospital...* (K30).

4.2.3.3 Physical moves

One-third of applicants report having emigrated, physically relocated and/or been separated from their family during childhood. The themes here are instability and adjustment and separation difficulties:

> *I went to boarding school in another province…I found the distance from home difficult* (K3); *I emigrated...when I was eighteen months old...we had to relocate frequently...my school work and emotional stability began to suffer* (K4); *I was living in **** for 5 years...after which I went to **** to live with my aunt, while my parents remained.... I moved to ****** (K11); *...during my grade 5 year, both my parents decided that it would be best for me and my sister to go to **** Girls School in **** [province]... [later] my mother moved to ****** (K12); *...we moved 18 times in 22 years...this has made my marriage and shooting roots even more important to me* (K14); *My life...has been a long and winding road with much globe trotting.[And] My childhood consisted of many moves* (K15); *...before I began Nursery school we moved to **** ...we had to move around a lot...[in Standard 6] I decided to go to Boarding School...to avoid the family problems, moving houses...* (K17); *I...moved to **** (country) with my parents at the age of 9... This was an adjustment that I found quite difficult at the time* (K21); *...my family moved to **** (country)...I was twelve years old at the time and anxious about leaving my friends and dog behind...It was a stressful time for all of us...* (K24); *The first few years of my life were spent moving around from place to place... Having lived in 5 different countries by the time I was 7...* (K27).

4.2.3.4 Crime trauma

Approximately one-third of applicants describe various accounts of having been physically assaulted, sexually abused, hijacked, robbed and, in one case, an applicant's spouse was murdered. These experiences are mostly described by applicants as "traumatic" and associated with feelings of anxiety, pain, guilt, humiliation, resentment and fear:

From a young age I was sexually abused by a family member... (K1); *I am reminded of the pain I felt when I was nine years old...A relative was very inappropriate with me...* (K4); *...my father was verbally and physically abusive...* (K5); *...I had to face the daunting task of dealing with the sexual misconduct of a highly respected teacher...* (K8); *The armed robbery was traumatic because it was the first time I faced life and death... (*K17); *Traumatic experiences, was the...sexual molestation of my daughter at 10 years...* (K18); *...my sister and I were hijacked – I later developed an intense fear of the dark...* (K20); *...A series of robberies...the severe beating of my pet...we were left with nothing* (K22); *...my husband passed away five months after our wedding (Gun-shot)...* (K25); *the decision to leave **** Job was made after I was hijacked. It was a traumatic experience...* (K26); *My near-death experience in a hijacking encounter...* (K28).

4.2.2 Perceptions of childhood experiences in family

Childhood relationships with family members are explored within this category and themes are described that emerge from the subcategories of "family relationships and dynamics" and "role in the family".

Applicants' accounts of their childhoods suggest that they hold negative, positive or ambivalent perceptions of these. Of all the applicants who describe their childhoods (23 of 30), approximately half appear to hold predominantly negative perceptions. The remaining half is made up of those holding positive perceptions and a few describe ambivalent perceptions.

Negative perceptions: Eleven applicants describe negative perceptions of their childhood experiences in terms of problem families and life circumstances. These are predominantly attributed to family relational difficulties and associated with feelings of anxiety and instability:

My parent's marriage was never a happy one…they were divorced…my mother was unaware and my father generally absent (K1); my family system was an enmeshed one…my sister attempt[ed] suicide…a result of poor communication…the problem continued (K2; …an authoritarian family system…growing up as a child can only be

described in one word – fear…constant conflicts…my father was verbally and physically abusive (K5);…my mother, speaking as if I'm not there…my siblings avoid me...my parents separated (K9);…growing up in an environment where I have always been exposed to people with mental difficulties…my parents are also elderly (K11);…my parents troubled marriage…there was much instability in my life [and] family problems (K15); I…grew up without my father…life offered our family many challenges…my mother sacrificed a life of love and care for herself (K16); …my parents got divorced…we had to move around a lot…my father became very distant…my older sister had her child unexpectedly… (K17); We were raised in a poor and reconstructed family of uneducated parents who struggled on a daily basis to bring food on the table…these were not favourable conditions for a child to develop well… (K25); There was much conflict with my parents who became extremely overprotective...who disapproved of the relationship with my partner as he was of a different religion (K27);...being brought up in an unstable, conflicted home environment...my divorced parents [and within the extended family] ...alcohol abuse, violent spouses, drug abuse, teenage pregnancy... (K29).

Positive perceptions: These are described by seven applicants mostly in relation to family systems and/or relationships within these. The predominant theme is of "close family" systems, followed by "happy childhood" and "stable home":

[A]...small nuclear family [in which] I enjoyed a happy childhood (K3); *...a stable home [and] normal childhood* (K13); *...a close family...all...provide support for each other* (K18); *…my childhood and adolescence were predominantly happy and 'normal'* (K22); *...close relationships and bonds within my immediate family* (K24); *...my home environment was stable, being blessed with parents who remained loving and married...* (K26); *...a very close knit family and communication was always important to us...* (K30).

Ambivalent perceptions: There is indication that some individuals hold an unclear and/or ambivalent sense of their childhood experiences in their family. This is illustrated by five

applicants who made both positive and negative statements of their childhood experiences, and/or in relation to their parental figures:

> *Being part of such a small family has made my life both a happy and a plagued one* (K4); *My childhood...was a happy one...I [had]...a very close loving family, but at the same time they put a lot of pressure on me to succeed academically [and] to end it (relationship with girlfriend)* (K7); *My parents although strict are supportive… [but following a trauma] my family did not address my feelings* (K8); *I grew up in a happy and carefree childhood…my parents got divorced…I felt pressure from my family* (K12); *My childhood [was] a rather ambivalent one…we moved 18 times in 22 years…I had a reasonably successful childhood…my father was a passionate and intelligent man…he had been an alcoholic for many years...* (K14).

4.2.2.1 Family relationships and dynamics

In all applicants' accounts providing positive perceptions of childhood experiences in their family, there are no descriptions of mothers or fathers as individuals and there is no mention of their personal relationship with either parent. In only one case (K30), the parents are described as supportive of their children and as "strong, independent and self-sufficient people." In this case, the applicant describes a once-off "unique experience" of having adopted the "adult" role following a traumatic event, "...to take a decision for my parents because they were incapable of doing it for themselves."

From applicants presenting negative and ambivalent perceptions of childhood experiences in their family, half of these individuals (8 of 16) provide some description of their mothers and/or fathers or their relationship with them. These applicants refer to mothers and fathers as frequently as each other; however, both parents are more often described in a negative than a positive light. From some applicants' accounts (K4, K14, K5, K16) a pattern emerges of applicants portraying a positive depiction of their mothers, portraying a negative image of their fathers or omitting any account of them. And vice-versa, some applicants depict a positive father

image and depict their mothers more negatively or do not mention them. The following summary and excerpts illustrate these rather complex and mixed results.

One applicant describes a mother who was “unaware” of the applicant’s trauma as a child (K1), while another (K9) alludes to having been “invisible” to her mother in, “my mother speaking, as if I’m not here.” Other descriptions allude to mothers having endured hardship and been self-sacrificing as a result of the father’s “domination and abuse” (K5) or “absence” (K16). One applicant (K2) negatively describes the mother’s relationship with a family member by, “...my sisters attempted suicide...a result of poor communication between herself and my mother”, while for another applicant (K14), the mother-child relationship was “just good enough.” Two applicants refer to feeling guilty in relation to their mothers: “Guilt was used as a weapon...” to make the child do her mother’s bidding (K15) and, for (K16), “The guilt, sometimes associated to her [mother] altruism and sacrifice, that I am left feeling...I need to make up for her missed opportunities.”

Two applicants describe their fathers in positive terms, “My dad, a humble **** by trade worked very hard...” (K4) and “My father was a passionate and intelligent man...” (K14). However, in the former, it is due to the father’s being so hard working that the family has to “relocate frequently” and there is no mention of the mother in this account. In the latter case, the father is described as, “an alcoholic for many years” who is positively influential in that “... [he] subtly shifted my wishes...to more constructive thinking” while the mother-child relationship is “just good enough.” Three applicants describe their fathers as having been “absent” (K1, K16) or “distant” (K17). One applicant (K5) describes his/her father as “a powerful and dominating figure ... [who] was verbally and physically abusive” and that the “dramatic changes” his/her father makes over the years “[are] due to my mother’s resilience and dedication to her marriage and her family.”

Parents’ marital relations are described variously by applicants as having been loving (K26) and long-term (K20) or dysfunctional, with problem marriages being the predominant theme. These problem parent relationships are represented, again, by half of the applicants (8 of 16) holding negative or ambivalent perceptions of childhood experiences in their family:

My parent's marriage was never a happy one and they were divorced after many years (K1); *My parents divorced recently although it was expected* (K2); *...I was witness to constant conflicts...my mother endured much pain...my father was...abusive* (K5); *My parents separated shortly after this...I blame myself* (K9); *...my parents got divorced... [it] was hard on me* (K12); *...my parents [had a] troubled marriage. As far back as I can remember they fought...* (K15); *...my parents got divorced and this was a beginning of a life where we had to move around a lot...* (K17); *...I experienced desensitisation of observing...(at first hand) divorced parents* (K29).

4.2.2.2 Role in the family

In all of the accounts in which applicants present a positive or ambivalent perception of their family of origin, there is no indication that the writers saw themselves as having fulfilled any particular role in their family of origin. Accounts of childhood roles emerge only from applicants who present a negative perception of their childhoods. In the context of illness, poverty and problem families, six applicants describe adopting the role of mediator, caregiver and/or parentified child:

I have dealt with many issues in my family...these are too many to mention. I took up the role of peacemaker and parental role within the family... (K2); *Feeling as if I filled the position of mediator and remaining silent, I would hear each of them vent how they felt about each other* (K5); *...in an unstable, conflicted home environment, I assumed the responsibility of being the mediator, rationally contributing to the daily crisis by being "family diary".* (K29); *...there was much instability in my life. I am the oldest...and therefore I took on much responsibility that followed me for years to com*e (K15); *...without my father... [my mother was] forced to work overtime a lot, to earn extra income, meant that I often cared for my younger brother* (K16); *My younger brother and I - who continue to live at home – have become the main caregivers for my mother during her illness* (K23).

4.2.3 Emotional and psychological effects of life events and experiences in family

Applicants' accounts of the emotional and psychological effects of their life events and experiences in their families of origin are explored within this category. In this, applicants' perceptions of themselves, as they relate to these events and experiences, are explored.

4.2.3.1 Life events: negative and traumatic experiences

The following excerpts suggest many applicants perceive their life events and family experiences to have had significant emotional and psychological effect on them. Sixteen applicants emphasise that these experiences have had a "life-changing" psychological impact. In line with the definition of trauma used in this study (derived from Garland, 1999; McWilliams, 1994), these experiences may be considered to have been of an intensity that overwhelmed these individuals' existing defences and caused psychic wounding or injury by having a painful, discomforting or distressing psychological effect on them. Drawn from applicants' accounts (previously represented in categories "trauma, loss and deprivation" and "perceptions of childhood experiences in family") the theme of "wounding" is illustrated by the following:

> *From a young age I was sexually abused by a family member... I believe the abuse was a major contributing factor in the separation and panic attacks I had as a child* (K1); *I am reminded of the pain I felt when I was nine years old. It was that year I grew up. A relative was very inappropriate with me... [and later] I began to work on issues like open disclosure, feelings of inadequacy, as well as guilt and humiliation* (K4); *...my father was verbally and physically abusive... in some ways I felt I was forced to grow up too quickly and emotions of resentment grew with each passing day* (K5); *The pain of losing her, regret at my decision and betrayal I felt towards my parents along with the trauma...left me at the lowest point of my life...it was also the most defining moment of my life* (K7); *...I had to face the daunting task of dealing with the sexual misconduct of a highly respected teacher...I became my own therapist, dealing with the hurt, anger, and shame and moving past it* (K8); *I am hospitalised... [and] become the object of medical scrutiny... I learn that my life is in the hands of others - they make decisions for me and*

cause me pain without my consent (K9); *Ever since I needed a psychologist in grade 10 to help me work through my parents' divorce, I knew that being a psychologist was what I wanted to do* (K12); *The armed robbery was traumatic because it was the first time I faced life and death...* (K17); *Traumatic experiences, was the loss of my son at 9 months and the sexual molestation of my daughter at 10 years...I have become a stronger person with more insight and empathy for others* (K18); *...my sister and I were hijacked – I believe the experience had not affected me but I later developed an intense fear of the dark...* (K20); *...a series of traumas that left me reeling for a while. A series of robberies...the severe beating of my pet...we were left with nothing. The company that I worked for at the time went insolvent... I was married in February. I lost 3 friends in two years... in March this year, I filed for divorce!* (K22); *...my husband passed away five months after our wedding (Gun-shot)... This was the major challenge in my life that has led me develop <u>more</u> interest in helping people...* (K25); *the decision to leave **** Job was made after I was hijacked. It was a traumatic experience but the benefit was that it drove me to assess my life, the dreams I still wanted to pursue...* (K26); *[My brother] was hospitalised...before dying. This is a loss I have not quite recovered from, and I doubt I ever will, but the pain has been lessening over the years* (K27); *...losing my family home...my dad's subsequent massive heart attack...my youngest brother's alcohol abuse...and my near-death experience in a hijacking encounter...I dealt with this and gained renewed strength and unfailing determination to answer the calling of Clinical psychology* (K28); *I only made a final decision to follow a career as a clinical psychologist after my parents were involved in a car crash in which many people died...* (K30).

4.2.3.2 Applicants' perceptions of "self"

In exploring applicants' perceptions of themselves, the following themes have emerged: "alone and insecure" and the "overcomer".

Nine applicants describe feeling "alone and insecure" during the period of childhood and/or adolescence. In most cases this feeling is directly related to family problems (K1, K5, K12, K15)

and illness (K9, K13). However, in some cases (K3, K7, K26), this is not related by the writer to any factor at all:

> *A...lonely childhood* (K1); *I frequently chose isolation over people* (K3); *...trust was a critical aspect [and] confrontation was not my game* (K5); *...I was insecure as a child, often fearing that I had no friends [and] a fairly anxious and withdrawn teenager* (K7); *...I have learnt what it's like to be "othered".....the outcast...to say nothing...my self-image crumbling* (K9); *...I felt extremely lost* (K12); *...became very shy [and] quite unassertive* (K13); *there was much instability in my life* (K15); *...as a child I was very independent.. [but] ...quite circumspect about getting socially involved...* (K26).

The dominant theme is that some of these applicants, and others, perceive themselves as "overcomers", usually later in life. In every case, these self-images are directly related by applicants to negative and traumatic experiences such as sexual abuse, family problems, loss, illness, poverty and crime trauma. Twelve applicants report that in having "survived" these difficulties, they have gained personal resources. In other words, they suggest that they developed ways of coping and certain attributes *because* of these experiences:

> *I have learnt through trauma...how to cope...I am strong and capable* (K1)*; I gained confidence and the belief I could meet any challenges that come my way* (K5); *[Being] at the lowest point of my life...[and] …it gave me far greater understanding of myself and life* (K7); *overcoming the obstacles in my life has matured me...I gained strength from the knowledge I survived* (K8)*; ...psychotherapy enabled me to transform my [trauma] experiences into personal resources* (K9); *I will continue to grow and face challenges and opportunities where ever they may present themselves* (K16); *We did not become victims, but worked through these issues as they presented themselves and I have become a stronger person* (K18); *My own pain and healing has had a profound impact...and has resulted in my compassion and empathy...[for] others* (K19); *I...learnt early to deal with the loss of loved ones [and later] I...assert my independence as a driving force and a means of survival* (K22)*; I have been able to use my coping skills which I developed as a result of the illnesses and deaths...* (K23); *I dealt with this [difficulty] and each time*

gained renewed strength and unfailing determination... (K28); *[I] adapt easily to change...becoming independent and responsible...* (K27).

4.2.4 Summary of autobiographical findings

In sum, of all the categories, "Trauma, loss and deprivation" was the most consistently represented by applicants. Except for two applicants, all reported negative or traumatic experiences during the course of their lives. The main emerging theme within this was "illness". Secondary to this, and equally represented in the autobiographies, were "death", "physical moves" and "crime trauma".

From the category "Perceptions of childhood experiences in family", "negative" perceptions were predominant and were mostly related to family relational difficulties. With regards to family relationships and dynamics, "parents' problem relationships" was the dominant theme. Accounts of childhood roles, such as family "mediator or care-giver", emerged only from applicants who presented a negative perception of their childhoods. Applicants with "negative" and "ambivalent" perceptions of childhood experiences tended to portray their parents more in a negative than a positive light. Some of these individuals depicted their parents as "good mother" and "bad father" or, vice-versa, "bad mother" and "good father".

The second dominant theme in this category was applicants' "positive" perceptions of childhood experiences in family. Family dynamics were described mostly in terms of "close family" systems and there were almost no accounts of writers' personal family relationships within these. The third, albeit minor, theme was that of applicants who appeared to hold "ambivalent" perceptions of childhood experiences in their family. Some accounts of family and parent relational difficulties were reported by these individuals.

Many applicants' depictions of their life events and childhood experiences in their family of origin suggested that these had a negative emotional and psychological effect on them. "Death" and "physical" moves were associated with themes of loss, separation and instability; "illness" was associated with physical and/or psychological disturbance; and "crime trauma" was more

often associated with traumatic psychic injury. Common "perceptions of childhood experiences in family", such as parental distance and/or absence, relational discord and divorce, produced feelings of anxiety and instability.

From "Applicants' perceptions of 'self'", some individuals describe themselves as having been "alone and insecure" as children and adolescents. These self-images were related to family problems and illness; but in some cases, were not related by the writer to any factor at all. Many, but not necessarily the same applicants, represented the dominant theme of becoming "overcomers", mostly as adults. These individuals' accounts suggested that, in having survived their life difficulties, they felt they had gained personal resources and capacities.

Thus, the dominant pattern that emerged from the autobiographical data was that several applicants felt alone and insecure as children and teenagers. Although some applicants recounted close family relationships and stable environments, applicants more often came from unstable and troubled family backgrounds. These difficulties were mostly associated with their parents' troubled marital relations. Due to problem family dynamics and life difficulties, some of these applicants adopted roles of caregiver, parent and mediator as children. Finally, almost *all* applicants experienced some kind of trauma, loss or deprivation during the course of their lives. Most often these were negative and traumatic events associated with physical or psychological injury, distress and discomfort. As adults, many applicants considered their difficult experiences to have transformed them in a positive way.

4.3 Analysis of the protocol subsample

A thematic content analysis of the protocol subsample (K1-K6) is presented according to the themes and patterns of woundedness found across the larger data set (see Table 2). These protocols represent applicant autobiographies depicting woundedness (*viz.* explicit statements of negative and traumatic experiences) and deviant protocols of unwoundedness (*viz.* no explicit or implied statements of negative and traumatic experiences).

4.3.1 Subsample of narratives of woundedness

Taken together, these protocols (K1, K2, K4 and K5) represent each of the main categories and themes of woundedness found across the autobiographical data set. That is, "Trauma, loss and deprivation" is represented by themes of "physical moves" (K4), "illness" (K1, K2) and "crime trauma" (K1, K4, K5). The category "Family relationships and dynamics" is represented by "negative" perceptions (K1, K2, K5), with the dominant theme of "parents' problem marriage" (K1, K2, K5) and thereafter, "ambivalent" perceptions (K4) of family relations. Childhood roles in the family of origin are found in the theme "mediator, caregiver and parentified child" (K2, K5). From the category "Emotional and psychological effects of life events and childhood experiences in family", themes of events being "life-changing", feeling "alone and insecure" and becoming the "overcomer" are represented (K1, K4, K5).

4.3.2 Subsample of narratives of unwoundedness

These protocols (K3, K6) represent diverse narratives of unwoundedness. K3 deviates from the previous pattern or trend by conveying a "positive" perception of childhood experiences. That is, the explicit positive statement, "I enjoyed a happy childhood" in the presence of negative and traumatic experiences. From the category "Trauma, loss and deprivation", K3 represents themes of "physical moves" and "illness" (substance abuse); and from the category "Emotional and psychological effects of life events and childhood experiences in family", the theme "alone and insecure" is represented.

Protocol K6 was selected on the basis that there are no explicit statements of negative and traumatic life experiences and, therefore, this autobiography does not appear in *any* of the categories and themes of woundedness.

4.4 Presentation of interview findings

The presented themes and patterns are data-driven and for the most part indentified inductively. However, to some extent, the analysis has included a top-down approach in extracting data and

deducing categories identified in previous research and according to the focus of this part of the research. That is, firstly, to explore which themes or patterns of woundedness are recognised by a sample of selectors as salient in applicants' narratives when applying for clinical training. Secondly, to explore what the implications of these seeming themes or patterns are, according to participants, for the therapeutic process and for evaluating candidates' suitability for clinical masters training. Participants' responses are mostly based on the applicant protocols (K1-K6), but do extend beyond these.

In attempting to present the interview findings as clearly and concisely as possible, the researcher has divided this section of results into three sub-sections: Firstly, from across the entire interview data set, the presentation of themes and patterns of woundedness identified by selectors. Secondly, the implications of these themes and patterns of woundedness are related to the therapy process and applicants' suitability for clinical training. Thirdly, the implications of selectors' impressions of applicants' seeming woundedness are represented by each participant's ranking of the "most" and "least" suitable candidates for clinical masters psychological training. Individual participants are denoted by 'P' from 1 through to 10.

4.5 Selectors' impressions of applicants' narratives of woundedness

The initial categories that arose from selectors' accounts of salient themes and patterns of woundedness in applicants' autobiographical texts have been divided into two broad areas: "Commonality among applicants" and "Calling to psychology".

4.5.1 Commonality among applicants

Selectors' perceptions of applicants' historical experiences are explored within this category and themes are described as they emerge from "Trauma, loss and deprivation" and "Childhood experiences in family". Selectors' perceptions of would-be therapists' personality dynamics are presented within this category.

4.5.1.1 Selectors' perceptions of applicants' experiences of trauma, loss and deprivation

For most selectors (P1, P2, P3, P4, P5, P6, P9) many aspiring therapists, as well as themselves, are perceived to have suffered personal trauma, loss and deprivation. For the most part these experiences are unspecified by selectors and are generally referred to as "traumatic experiences". Identified themes include "illness", "physical moves", "crime trauma" and "normal developmental difficulties":

> *People often do bring quite traumatic experiences.* (P1)

> *People give disturbed histories or you know troubled histories, difficult histories you know - hell we've all got them.* (P6)

> *Ja well I mean most of them do come with something that's gone on. It's very very rare that you will get a picture of a happy childhood - extremely rare. There's usually stuff and it's often very very bad stuff that's happened. Ja I mean some of the applicants…some of the stories are terrible.* (P2)

> *What my experience has been there are quite a few sexual abuse victims...quite a few people with a history of child sexual abuse.* (P4)

> *Ja the alcoholic parent is quite common. I mean I've read quite a few through where they've had a parent who's been an alcoholic.* (P9)

> *Ja a lot of applicants have had difficult times…I mean all of us have been through something - it doesn't have to all be as difficult as sexual abuse and all that stuff - it could be just functioning in a family or bullying or whatever.* (P9)

> *So when you get a lot of protocols on applicants, like people who've moved around a lot, very often the person who's coming needs healing.* (P3)

Two selectors argue that trauma, loss and deprivation are inherent in normal childhood development. In other words, suffering is an inevitable part of growing up:

> *[Trauma] ...can be very very subtle within very normal upbringings.* (P1)

> *I don't think that you have to have been abused or neglected…to go into that pain. But I think life itself…I mean as a baby you have to give up you know the breast. You have to give up mom, you have to give up dad, and you have to give up dependency. There's always stuff that you have to give up…Every day - not getting what you want or your sibling getting more than you or whatever it is.* (P2)

4.5.1.2 Selectors' perceptions of applicants' childhood experiences in family

Selectors' perceptions of applicants' childhood relationships with family members are explored within this category. Themes are described as they emerge from subcategories: "Family relationships and dynamics" and "Role in the family".

4.5.1.2.1 Family relationships and dynamics

For the most part, selectors perceive applicants' family relationships and dynamics from the perspective of relational attachments. Specifically, participants (P3, P4, P8, P9) emphasise the quality of applicants' early attachments with their primary objects. Derived from this is the subcategory, "Relational attachments". The dominant theme within this is that would-be therapists often have "attachment difficulties":

> *I think what sort of to me seems to run consistently through them [autobiographies] is fundamental issues with attachment. I think the attachment is something that comes out in all of them.* (P8)

Depriving, disruptive or negative childhood experiences are particularly related by selectors (P3, P4, P9) to impeding applicants' attachments; specifically, those occurring as a result of family

problems and/or frequent physical moves. Consequents of the former may be that applicants' primary attachment needs may have gone unmet and in the latter, the capacity to build and sustain social and long-term relationships may have been disrupted:

> *Because if you move around a lot the implications are invariably high turnover of attachment and breakdown of attachment because you go to school and you form a little friendship and then you move and you lose your friends. Then you go to school and form a little friendship and this goes on. And it's extremely damaging because even though you might have good primary attachments with your parents, the reality is that you do need for your own development of your identity from latency through to adolescence, an identity among your peer group. Because we know that's where you learn to problem solve, to deal with your emotions, you learn reciprocity, and you learn guilt, remorse, ethics blah blah. All of that gets disrupted. So you do come out with people who are damaged.* (P3)

> *[Moves] …impact on the developing self and the sort of the attachment stuff you know. But also in terms of people staying and sticking and working through stuff as opposed to maybe having sort of disruptions and difficulties in a sense that actually you can't resolve or 'fix' things...so people get…you have to leave that situation. That's if it's sort of stimulated by that person. But I think also in terms of childhood development if there lots of moves and changes of schools and stuff, there's a disruption in terms of peer development of relationships. You know the capacity to sort of sustain relationships over long periods of time.* (P4)

> *I mean if you're moving around a lot, your relationships are being interrupted and there must be issues around endings, sustaining relationships, things being interrupted before they've been able to go through a process - you know what I mean. So I think there's probably going to be issues around intimacy, ongoing relationships and so on.* (P9)

> *…where they've had a parent who's been an alcoholic…that child will grow up in an environment where things are unpredictable – they're scared a lot. Attachment needs*

might be thwarted. An alcoholic parent, sometimes when they're sober they're really different, and when they become alcoholic they're different. (P9)

4.5.1.2.2 Role in the family

Selectors (P2, P3, P4, P9) recognise parentification, caretaking and mediating roles as a salient theme in applicants' narratives. Problem family relationships, marital discord, illness, life struggles and/or a poor quality of parenting, are provided by participants as "typical" reasons for why children assume these roles. Selectors perceive these roles for applicants, who either explicitly stated or presented histories in which normal childhood needs were unlikely to have been met in their families. From these origins, children develop "narcissistic defences" and "narcissistic dynamics" - they become family helpers and 'fixers':

Parentification is very typical and it's usually got to do with the other typical themes of family discord, usually between the mother and the father. That's extremely typical and how that's played out - how that's affected the family. And then linked to that what can be causing that discord often is alcohol. So that comes up quite a bit more than say drugs - is alcohol. (P2)

This is a typical psychologist's history of being somebody who finds themselves a mediator or an observer of a destructive relationship in the family and wanting it to be better. And they want it to be better in their own lives and they want it to make it better in other people's lives. It's a very common dynamic - they would go out with that. (P3)

Many of them are put in the position of being mediator of some sort in their family of origin and a lot of them then wanted to work on that mediation. With some you could see they took it to a rescuer role; others were a bit more in the controlling thing. Some were sort of wounded healers themselves. Those themes ran through. And that is a theme you will see in applicants…that they get into rescuer, mediator and observer roles in their families of origin. (P3)

A lot of parentified children come up where you have parents who've been ill or very involved in work or you know have had their own struggles. So you've got children who have felt they've had to take on the role of parenting...What I mean is you often find children are parentified when there's…they have a sense that their parents aren't adequately able to control and look after them and the parents aren't the ones in charge in the family. You often find that if you have say a depressed parent, an alcoholic parent, an absent parent, a parent with a personality disorder, a parent with a drinking problem - all sorts of stuff pushes the child into that adult role because basically being in the child role, their needs aren't being met. So in an attempt to try and manage a situation where they feel quite helpless and needy, they put themselves in situations where they feel they are competent. (P4)

4.5.1.2.3 Selectors' perceptions of applicants' personality dynamics

In exploring selectors' perceptions of aspiring therapists' personality dynamics, selectors (P4, P3, P9) describe individuals who were anxious or outsiders in their social and family environments. The common theme is that these individuals were experiencing emotional difficulties in their worlds:

The other thing that comes up quite a lot as well is sort of quite high anxiety and you find that people manage it in different ways. You get the sort of...two groups. Well not just two groups but you get the anxious control freaks who want to manage and control and deny that actually they have difficulties...Then you get the others who maybe have more overt low self-esteem. Sort of also anxious but are sort of a bit less contained about it. (P4)

...he's not one of the actors in the scenario. So he's you know, he talks about the difficulties in the family and…but it sounds very much like sort of an outsider...just an outsider's perspective. (P4)

You can see that from quite early on she's not really seeing herself as part of her family. She's seeing a bit on the outside looking in and trying to sort things out and struggling.

> *[And] …she also learns something about being excluded and something about being on the outside.* (P3)

> *I think then you get a lot of people who haven't achieved and sort of felt miserable and didn't achieve in school and didn't engage and felt out and different and the odd one out*. (P9)

Two participants (P4, P7) allude to future therapists being emotionally attuned and less psychologically defended than others. The following excerpts suggest that these individuals were more psychologically "open" than others, but also quite vulnerable in this:

> *[They are]...sort of...the emotionally more in touch, more attuned [one]*. (P4)

> *There's a lot of therapists who I think do come out of difficult family circumstances who are not necessarily these happy people because they're not that defended. They're kind of open to the…their own difficult painful emotions. I think it's hard to live in the world with less defences in a sense.* (P7)

Selectors (P2, P3, P8) identify a theme of potential therapists having "bucked the system" at some point in their lives. For instance, one selector recounts the frequent occurrence of applicants having come from traditional family backgrounds in which they had to assert their own needs. Others identify the unconventional path taken by some candidates. Thus, the emergent theme is "unconventionality":

> *Probably about thirty percent of people [applicants] come from more...where there is quite a traditional set up you can put it that way. I don't know about this fear but ja you get where there's you know traditional and you do what's expected of you and then the person's had to sort of be able to assert themselves and what they want. You do get that to an extent. But I think it's probably more common in Indian families actually where there's...although you do get it all over but it's sort of my gut feel that it would be probably it's a lot of Indian families that have come where they...there are certain things*

> *expected of them and they've had to sort of assert themselves in terms of what they want. And I suppose that that does draw them into a psychology kind of career.* (P8)

> *I mean in that she hasn't just followed a conventional path you know. She has tried things out, she has experimented. So maybe she's open, maybe there's flexibility, an adaptability about her.* (P2)

> *I mean she fell off the wagon a bit on the way…and that's a very common dynamic with psychologists.* (P3)

Furthermore, based on applicant protocols (K1, K4), some selectors (P3, P4, P5) further suggest that a pattern of adult relating may be found among wounded candidates. Participants describe a pattern of dependent adult relating in which candidates may seek to escape and/or overcome their earlier difficulties:

> *She hasn't got a strong sense of herself which is why her husband is also the great healer - and that happens when you have a high turnover of moving.* (P3)

> *But it sounds like she needed her husband to sort of help her through that…her husband seems very very central and very much like a pillar of strength that she has used to sort of help her get through and work through things.* (P4)

> *Well sometimes there's this tendency to make husbands the magic wing. Like as if you know some change or whether it be...what I'm saying is maybe it's not always a good thing you know. One could say maybe she was escaping you know.* (P5)

From selectors' (P6, P7, P8) accounts, [these] applicants are perceived to have idealised their adult partner. Nonetheless, these participants tend to regard these relationships positively. Selectors depict these relationships as positively transformative for these candidates and as an encouraging sign for their capacity for attachment. The theme "healing attachments" is described below:

You know a lot of them will identify their husband or whatever as their "rock" or you know like this. And I think yes - I mean we know from sort of attachment literature or whatever - that a new, you know what I mean - a new...what did they call it...earned attachment or whatever, that your attachment style can alter in response to a good relationship. So I think that that is positive. (P8)

…very idealised that relationship…[but]…the fact that she's now found this husband…is quite a healthy healing thing. She's found a good relationship so this is hopeful. (P7)

She talks about resolution as something about meeting her husband and that being quite a transformative experience for her and allowing her some kind of solidity...Something about doing it through being open to relationships that are healthy. (P6)

4.5.2 Calling to psychology

In exploring selectors' perceptions of aspiring candidates' attraction to the field of psychology, the emergent themes are "motivation" and "goodness-of-fit". These two themes appear to be somewhat linked with previously identified themes. Applicants' motivations are seen as stemming from a desire to heal themselves and others in having suffered "trauma, loss and deprivation". The "good fit" between candidates and the role of therapist is mainly associated with "parentified, caregiving and mediating" children.

4.5.2.1 Motivation

The importance of selectors needing to ascertain applicants' motives to become psychotherapists is raised:

Just generally, it's that you are interested in knowing [why they are interested in clinical psychology] because it is a very specific field and it's not the easiest field. So why would someone want to come and do this hard work? And is it because of some seen status or are they able to…have they been able to because of their own life experiences? (P2)

The perception of almost every selector (P1, P2, P3, P4, P5, P6, P7, P8, P9) is that therapists are motivated to become therapists in order to "heal themselves" – that they are struggling with or need to work through earlier trauma in their lives:

> *I mean I think that one has to know that there is something that's brought you to this profession. It isn't just an academic choice - that there would be something that you're struggling with somewhere that makes you curious about this sort of work. [And] ...we partly choose this work to understand something about ourselves...we do directly work on our own issues.* (P1)

> *I suppose it is something also about the kinds of people who are drawn to this field. I suppose that those who have been abused, especially sexually abused, I think often are drawn into this field. And maybe it's linked to what I said earlier that it's about constantly working through. And this is a field where through your own therapy, your training, through your therapies you're going to constantly be working it through*. (P2)

> *You must remember that people who apply to do clinical psychology often apply for the wrong reasons in that you get a whole lot who want to be psychologists and you get a whole lot who want to heal themselves.* (P3)

> *I think one of the things that often comes through quite strongly are people who've had their own difficulties and their own struggles. And my sense that now in an attempt to heal themselves they're wanting to get into the healing profession*. (P4).

> *I do believe in that whole wounded healer kind of idea that people are attracted to this profession out of a sense of wanting omnipotence, wanting to be able to heal themselves, save their families - that sort of idea.* (P7)

Recognising that applicants may be primarily motivated to meet their own need to heal themselves through the role of therapist raises the concern that this could be at the expense of patients:

> *I mean I think probably every therapist is working on their own healing process or whatever. So I don't think that stands out as a big problem you know what I mean. If you're obviously...if you're sort of using it - if that's the primary thing - it becomes problematic because you get your needs met at the expense of your patient.* (P8)

4.5.2.2 "Goodness-of-fit"

Selectors (P3, P4, P7, P8, P9) appear to be well familiarised with the idea of the "good fit" between the roles of psychotherapist and parentified, mediating and caregiving children. Selectors report that "child-therapists" have been trained from an early age and becoming therapists is an extension of their childhood role. As future therapists they have become very good at reading, placating and pleasing others and denying their own needs and difficulties. They form identities of nurturer, rescuer and saviour and adopt narcissistic defences such as omnipotence and control. In this, selectors allude to the role of therapist affording these childhood healers a "good fit" with their inner dynamics and a familiar avenue through which to meet their needs:

> *This one would be extremely quick on dynamics in the room and between people because he's been trained. He's been trained to be a family therapist in his family of origin*. (P3)

> *And I think in a way becoming a therapist is an extension of that [parenting roles] - sort of wanting to parent more and more people. So I think that's one of the common themes*. (P4)

> *Parentified children have been training since they were about six to be therapists because they are extremely aware and sensitive of the 'other' - the other person's emotion, where the other person is. They become very good at reading others – 'chameleon-ing'…to others. So in that sense there is a…ja they become very good at listening and containing - containing the mother, containing the father, containing the family situation. Mom and dad are not available so they pick up parental duties of younger siblings. There's that idea I mean so…which is an interesting thing. I think that*

is…actually a dysfunctional attachment style. So it talks about being…you sit with a desire to be strong and omnipotent. You need it - it's a defence as a child like that. (P7)

Look I think sort of it's a fairly obvious thing: if you take on a parental role, peacemaker, you probably nurture. Your identity is around nurturing, looking after, taking care of; which I suppose is sort of part of the therapeutic... you know what I mean - I think people who do. (P9)

I think it's a very familiar role for them [parentified children]. It's about subverting their own needs - focusing on other people's needs. Trying to placate and please in a way, parents who didn't feel like they could look after them, so they looked after their parents in an attempt to get them to meet their own needs. So I think it's sort of a way of trying to get the parents to be the parents you need and want them to be but recognising that sort of vulnerability and that they can't. And if you just do something in a particular way it gives you power and control and maybe a sense of - in a situation where you feel quite helpless - there is something that you can do to help you get through that situation...But what you often find then is there is a denial of their own needs and a denial of their own difficulties. So you find they may struggle a lot with their own vulnerabilities. And it's easier then to focus and work on other people's vulnerabilities because then you don't have to think about your own. But also then...then you are being the good strong one. (P4)

You can get the rescuer and the person's entire identity is just rescuing…I'm always in the position of the healer or the 'fixer' which means I don't deal with my own vulnerability. The other are quite narcissistically structured people who want to be in the role of helping people because they're controlling. And it's all manipulation and orchestration and they're kind of like sculpting. And they'll come in and control this one and manipulate that and they can be brilliant therapists. But you'd be scared of them because they…their reasons for wanting to change people can be expedient and their motives can be power related. (P3)

4.5.3 Summary of selectors' impressions of applicants' narratives of woundedness

In exploring the commonality among applicants, most participants expressed the view that many aspiring therapists, as well as themselves, have personally suffered in some way. The dominant category was "Trauma, loss and deprivation" and themes were generally referred to as "traumatic experiences". Identified themes within this were "illness", "physical moves", "crime trauma" and "normal developmental difficulties". Selectors' perceptions of applicants' childhood experiences revealed common themes within their families of origin. These included problem family relationships, life difficulties, disruption and a poor quality of parenting.

Applicants' negative and traumatic childhood experiences were related by selectors to having potential emotional and psychological effects on these individuals. From the perspective of relational attachments, would-be therapists may have attachment difficulties - mostly, as a result of their primary caregivers not meeting their attachment needs or disrupted social attachments. The theme, "caregiving, mediating and parentified children", arose in relation to selectors' perceptions of applicants growing up in problem family systems. The various accounts of unmet narcissistic needs, narcissistic dynamics and defences may be subsumed by the theme "narcissistic dynamics and needs".

The theme that emerged in relation to future therapists' personality dynamics is that they tend to be "anxious" and/or "outsiders" in their social and family environments. Also, according to some participants, these individuals may be more emotionally attuned and less defended than other people. A few participants alluded to applicants being unconventional and having to assert their independence in their family of origin.

From selectors' perceptions of some applicants' later relationships were the themes "dependent adult relating" and "healing attachments". Whereas the former were associated with applicants attempting to escape and/or overcome their earlier difficulties, the latter were positively perceived as affording these individuals stability and some healing through relationship.

Participants strongly suggested that applicants' wish to heal themselves is an important "motivation" to seek psychological training. As such, this was the dominant theme in this category, followed by the "good fit" between the roles of therapist and "caregiving, mediating and parentified children".

4.6 Implications of woundedness for the therapy process and clinical training

The categories that emerge from selectors' impressions of salient themes and patterns of applicants' woundedness in relation to the therapeutic process and clinical training are divided into two areas: "Resources and strengths" and "Obstacles and limitations".

4.6.1 Resources and strengths

From the category of "Resources and strengths", the themes of "capacity for empathy", "emotional maturity", "overcoming and resilience" and "vulnerability" are depicted as potential resources stemming, for the most part, from wounding or difficult life experiences.

4.6.1.1 Capacity for empathy

Selectors note that empathic therapists are more able to resonate with patients and identify where they are 'at'. They understand their patients at a deeper level and, as one participant states, "patients feel it." For some selectors (P2, P3, P7, P9), traumatic experiences are linked to the capacity for empathy:

> *It's very courageous of her to have shared that [she was sexually abused] and to be aware that this is something pivotal. And potentially it can be that she's therefore has a capacity to empathise with other people who've been very hurt very badly and perhaps very early in their lives. So that could be a strength of hers...Empathy in all the candidates is essential. But it's that…I don't know it's being able…when somebody comes and talks to you about having dealt with something like maybe you've gone through - breast cancer - you just know where they're at. You can just go there you know.*

> *And it gives you an ability to know quite quickly and quite deeply what's going on with the person. Not necessarily that you going to interpret at those deep levels, but it helps you understand where they're at. It does give you that. So I suppose what I'm saying similarly with other things in one's life you know - if you've gone through something that a patient's gone through, it can help you to understand that person's particular pain as long as you've worked with it. [And] It does give them the ability if they've worked through it, to be able to really identify and know where someone is. And patients feel it*. (P2).
>
> *Wounded healers can be very good because they can be very empathic, they can pick up on difficulties, etcetera*. (P3)
>
> *I mean when it comes down to it, I do think people who have had similar experiences to a patient often are a great therapist for that patient because there is more empathy*. (P7)
>
> *It does give one space for resonating a little bit more when you have been through some stuff and you've had some stuff to deal with or heal than if you haven't been through stuff. (P9)*

One selector (P8) acknowledges the capacity for empathy as deriving from experiencing something difficult, but argues against the idea that empathic ability stems *only* from traumatic experience. A second selector (P1) argues more directly against a link between empathy and trauma. Both these views argue for the development of empathy within primary interpersonal relationships:

> *I do think you develop empathy from having to have worked through something difficult. Look I think empathy also is quite linked to your primary relationships: If you've had somebody who's been able to respond and read your needs and da da da. I mean that gives you a capacity for empathy. So I think you know it's not always about having to struggle. But I think possibly having to work through things that are difficult and sort of seeing parts of yourself that are difficult to accept - or of having encountered parts of*

yourself that are difficult to accept - and sort of having persevered through things does give you empathy for somebody you know. That they might be doing something that kind of you can tolerate because you understand where they're at. (P8)

I don't think there's a link between people's ability to be empathic and be in touch with suffering and the severity of their own life experience…I think that people can have developed vigilance and sensitivity and empathy based on their interpersonal relationships growing up, which would not count as trauma. In fact I think the more traumatic your experience the more possible it is that your perceptions of other people's experiences are going to be slightly distorted. So I do think the quality of empathy and sensitivity and concern are definitely qualities that are going to be useful in a clinical psychologist. I just don't think that they are more found in severely traumatised people than people who've gone through normal failings. (P1)

4.6.1.2 Emotional maturity

Some selectors (P2, P4, P8) link emotional maturity with having faced difficulties and thus a capacity for "depth". One selector argues that this is an essential requisite for would-be therapists. Conversely, emotional immaturity is associated with a lack of "depth of thought" and is perceived less favourably by selectors:

It's a lack of emotional maturity. But with that a lack of depth because you can't go deep if you don't have the emotional maturity…You can't be a therapist then. And I'm not talking about…I mean we're all growing up all the time...but you have to have been…I think its with being able to have faced painful things in one's own life and to a lesser or greater extent, but have sat with it...I mean, you know, you can only go as deep in a therapy with a patient as deep as you've gone inside yourself. (P2)

My sense is that this is probably quite a young person. I don't know if that's right but my sense is there wasn't a depth of thought from this about their experiences; which doesn't

necessarily come with age but it seemed a bit…the history of this seemed a little bit superficial. (P4)

I would really worry about this person's ability to commit you know….I would worry about their ability to take responsibility, to commit to things. It seems sort of like a quite an immature person that hasn't really processed anything. (P8)

4.6.1.3 Overcoming and resilience

Having sat with, or faced painful things in one's life, is linked by selectors (P2, P4, P5, P6, P7) to "overcoming" and a capacity to "survive" life's difficulties. In having worked through their own hardships, potential therapists gain knowledge of, and mechanisms for, dealing with difficulty that can benefit their patients:

I think it's with being able to have faced painful things in one's own life, and to lesser or greater extent, but have sat with it. And been through depression or something like that, that's been really hard. Or had to mourn or whatever it is you've had to do in your life that gives you a depth of self knowledge. That you can then help your patients to access and help them to know that no matter how painful it may be, you can survive it. How can you expect a patient to survive something really painful emotionally - to go to that dark place of survival - if you don't know in yourself that it can be survived? (P2)

I think that's important because in the process you get exposed to a lot of stuff. You get exposed to really sometimes quite hectic traumatic stuff. It can push your own buttons. You can meet people who have gone through very similar experiences to you and your capacity to survive and not slip into using destructive defences - you're going to need your defences but you know to hopefully have sort of more functional useful ones that don't undo you. But I think also for your patients to feel like you can tolerate what they've been through. Are you strong enough? Can you take it you know? (P4)

> *I think you know in some ways this is a bit of stereotype perhaps of the wounded healer. But in some ways someone who has been through very difficult stuff and has found ways to survive potentially has access to what can be difficult in other people's experiences - in a patient's experiences. And potentially has some kind of sense of surviving something and of that being quite a process sometimes.* (P6)

> *Sometimes [resilience comes] in terms of people having been pushed and had to survive and found mechanisms and ways of dealing with things. But I think it's that along with having worked through stuff.* (P4)

> *There's a sense that…ja resilience as a coming out of a hard situation...I think makes for a specific type of person - people who can get through that you know. (P7)*

> *Well for me it [resilience] would be important…Because then one can then believe anything is possible.* (P5)

Selector P4 further attributes resiliency to psychological capacities, present at birth, or a secure attachment with a primary object:

> *…a resilient baby, you know. I mean she could have been a baby who came into the world…some babies can tolerate pain and difficult things better than other babies. So she may have just have had a higher pain threshold. Or it could be because there was something very good and/or something very good that happened in a very early relationship with her mom and/or dad…you know she may have had a very good foundation - a secure attachment relationship.* (P4)

4.6.1.4 Vulnerability

Some selectors (P2, P7) make an association between candidates' "vulnerability" and woundedness in having had difficult life experiences. In terms of suitability, applicants need to be "comfortable with their own vulnerability" so they can tolerate their own and patients' pain:

> *I think your ideal therapist is somebody…Are they able to sit with vulnerability? [And] They're kind of open to the…their own difficult painful emotions. But it's the one's who are able to then have insight into what has happened to them and to be able to reclaim their own vulnerability that allows them to then, I think, be balanced enough to sit with someone else's pain.* (P7)

> *So in terms of the wounding...if they can get in touch with that woundedness and be present with you and be vulnerable and be sad or whatever it may be, and think about it with you and reflect on it, then you know they can do the work.* (P2)

However, participants (P2, P4, P7) stress that candidates should not be uncomfortable or insecure in their vulnerability, as this could be harmful to themselves and hinder the therapy process for patients. The following excerpts suggest that selectors may associate applicants appearing "too vulnerable" with a lack of resilience and resolution of their earlier difficulties:

> *…the ability to be vulnerable…in an appropriate way…not start bawling and breakdown and come undone because then they lack resilience. Then they don't have enough ego strength. They haven't done enough work and they're too fragile and they will be harmful to themselves as well as to others. Then it's also unethical to select them.* (P2)

> *I think my worry about one is how robust this person is. They've been through huge traumas, huge anxieties. This person has been through a hell of a life. It sounds like they've worked through some of these things and there is a thoughtfulness and stuff like that. But I would worry about this person's vulnerability…I would really worry about this person's strength.* (P4)

> *I mean you'd wonder how this person would deal with that kind of stuff about you know…because they seem to be quite - I mean the word I'm using is "glib" - but I suppose they treat their own vulnerability in quite a superficial dismissive way. And you wonder what they would do to patients, what they would do with the patient's vulnerability? It's kind of like, 'Oh well move along, get over it.' you know.* (P7)

4.6.2 Obstacles and limitations

Selectors' considerations of candidates' woundedness are extensive in relation to their ability to provide therapy. Participants primarily raise concern in relation to the possible impediment to therapeutic practice posed by candidates seen as psychologically unresolved and defended. The main concern in this is captured by one selector's statement that, "They're more likely to repeat their own family pattern" and past experiences (P3). Specifically, these issues centre on themes of "countertransference", "therapeutic process and frame", "narcissistic dynamics and needs", "therapeutic relationship" and "trainability", which are refined and explored.

4.6.2.1 Countertransference

The following statement made by a selector captures the challenging nature of the transference-countertransference dynamic faced by *all* therapists:

> *We all have countertransferences, but it's your capacity to think and notice, 'Hang on something's happening in me - what is it? Is something they said pushing my own personal buttons? Is it something in the process where I'm being given stuff to deal with and manage for them on an unconscious level?'* (P4)

But the main problem with therapist-induced countertransferences is, as one selector (P2) puts it, that it happens "…on an unconscious level… they're not even going to be aware [of it]." More specifically, every participant raises concern about wounded candidates' countertransference in terms of the therapy being impeded by the therapist's tendency to over-identify with the patient and the employment of defence mechanisms against woundedness:

4.6.2.1.1 Over-identification

> *So whilst you might develop some insight into the harm of early trauma that could be useful, you're very much at risk in terms of maintaining boundaries, in terms of being*

able to create a space to think about your patient and not be taken over by your own connection. (P1)

If you've gone through something that a patient's gone through, it can help you to understand that person's particular pain as long as you've worked with it. Otherwise you're going to unconsciously identify, over identify. And then you're not going to helpful, then you're going to be a friend. (P2)

One of the problems with the wounded healers is that if they get a patient with a similar wound you get an over-identification and not a proper therapy. So it all comes with tags. (P3)

I can't say exactly what this over invested in helping may be. But it is a concern that they might sort of lose themselves in other people because they you know get totally wrapped up in the other people lives and thoughts and worries and whatever. And I suppose my concern would be about the boundaries and stuff like that. If you don't have a person who…well I mean I don't have a sense of this person to hold on to - and you know they might be doing sort of difficult things in terms of over-identifying or projecting their own stuff onto people and may not be aware in terms of processes going on. (P4)

You'd wonder if this person [was] just looking for <u>too much</u> kind of healing. That it's a bit too much about them…I think unless they can get a good grip in terms of countertransference and projective identification - all that kind of stuff - when you know you identify a bit strongly with patients and it becomes about your stuff and not about theirs. I think that would be the worry here. (P7)

I suppose boundary issues are something that maybe comes out in various ways. I mean sexual abuse is a sort of one example but I suppose there are boundaries. Like the other one speaks about having an enmeshed family. I mean I suppose that sort of links with the person's own capacity for boundaries in therapy you know. Whether they're going to be able to hold the boundaries, whether their sort of boundaries are very non-permeable -

which would, I suppose, affect the attachment relationship. Or whether they're too open and sort of taking on too much of the person's stuff or over-identifying with them or sort of their ability to think about projections rather than just take them on. (P8)

4.6.2.1.2 Defences

One participant (P10) describes the possible impact of therapists' defendedness on patients: "If you're sort of quite defended about your own stuff and won't disclose and very guarded, it's going to be difficult for you to empathise with a client and sort of deal with their material when they do disclose." The mechanisms employed by candidates in defending against their own woundedness in the therapy process are mostly identified by selectors (P1, P2, P3, P5, P8, P10) as avoidance, minimisation, splitting, projection and intellectualisation:

We know that people who have had trauma that see it in very stark ways - who either avoid or minimise a trauma… I think that perhaps somebody who had a more superficial minimised understanding of something very serious in the own family may struggle with looking very seriously at these sorts of difficulties that patients would bring…that there feels like…I mean obviously we've talked about some limitations…but some sort of avoidance of much more of a messy painful experience...I think it is one of the crucial qualities - to be able to sit in a room with somebody experiencing enormous distress and be able to bear that without trying to minimise it, escape it. And that they would notice also when a patient was engaged in trying to avoid or minimise or defend against such painful messy feelings. And that if a candidate, or later a therapist, was feeling terribly uncomfortable with that space, that they wouldn't be able to offer a patient what they need. (P1)

I'm very concerned that she's cutting out - she's not telling us or she's not allowing herself to feel enough of the negative stuff. I'd be concerned about potentially a tendency to split. And as a therapist not to see some of the bad stuff because you have to sit with your patients and sit with what's painful and what wasn't okay and how horrible it was -

not in a CBT kind of positivistic psychology, 'Well look at what it's taught you.' You know, it would be very false therapy in terms of what we teach. (P2)

Well they…in terms of the therapist [doing their own healing work through the role of therapist] …I mean it would be "ideal" because they won't have to own their own stuff. "Ideal" - they can just 'fix' everyone else around them. But as a therapist then they're just going to be projecting all of their stuff onto their patients as well. And there's going to be a problem that on an unconscious level they're going to be doing this – they're not even going to be aware. And there's going to be a blurring in terms of what is their stuff and what is their patients stuff because they don't know themselves enough in order to own their own stuff. And in this work once again it's critical and almost ethical actually. (P2)

People will…if they're sitting in a situation where they're feeling inadequate - the therapist may make projections of what happened to them when they felt inadequate in their childhood. So they would assume the patient's being more critical - as their parent was - than the patient actually is. So that always happens. (P3)

This person sort of describes a slightly distant intellectual defence… But there's no description of self related to a history...Now if a person can't do those things then how are they possibly going to help somebody else do it? How are you going to get a historical interpretation? How are you going to make a link between somebody else's history and what they're doing? You know you can teach them to do that cognitively, but that's the person who sits in the room and makes an intellectual interpretation and has nothing to do with the process in the room cos they can't pick up the process in the room. So what you get is intellectual interpretations that have no relation to the material in the room. (P3)

…it kind of felt like much more intellectualised you know...I mean it's like it's in her head…but it doesn't feel like an experience - like something that she went through. And you know I'd kind of be concerned that, you know, would she be able to sit and hold

> *difficult feelings because I suppose the work does require that. And…it's more like the theory is used to just kind of try and rescue her from her actually sitting with just how difficult it is...And if you're not able to do it yourself, when patients…come, they tend to… jump, change topics or whatever - try fill the space with something that's a bit lighter. I think there's a danger of colluding with that.* (P5)

4.6.2.2 Therapeutic process and frame

P5 explains the importance of maintaining the analytic frame and therapist–patient boundaries for both the patient *and* therapist:

> *I think as a therapist you need your boundaries you know. Because I think just being a therapist is about giving you know. Like not just giving your time you know...and I think you need to be able to be in a position where you are able to say, 'This I can take, this I can't take.' Just to separate. And I think even the relationship in itself…being a therapist unfortunately…it's not the chatting friendly whatever. And I think one needs to be able to draw a line because it can only be therapeutic if you keep those…The frame - it becomes quite important to actually have a relationship that's I suppose professional. And be able to kind of separate the two.* (P5)

Selectors (P1, P6, P3) raise concerns that applicants' earlier difficulties and family dynamics may impact their ability to offer appropriate therapeutic boundaries and uphold the analytic frame. The main concern is around therapists blurring professional therapy boundaries and, particularly, by individuals from enmeshed family systems:

> *…it's very difficult when one says, 'When counselling I am often forced to confront my past and have begun my own healing.' Some people take that to mean to discuss with their clients how similar their own experiences are. And some take it to mean, 'I understand what an enormous privilege it is to work with other people because it helps me in a very private way to think about things afterwards.' One of which obviously being very appropriate, I think, and the other not being.* (P1)

She's saying that her family was enmeshed and that this was actually harmful to the family…So I'd be curious then about what that would mean for why she wants to be a therapist, which is potentially also enmeshing. Or it's at least very intimate and could quite easily become enmeshing and peacemaking. (P6)

So if we were saying that this person came from an enmeshed family system you're going to have problems with boundaries okay. You're going to have problems with over identifying with other people's roles. So patient comes in and he's suicidal. Now I've got problems with my boundaries. I want to phone and check you're alright or I let your sessions run over because you look distressed. You know that kind of thing. Not necessarily very unprofessional boundary violations, but that's your problem with enmeshment. (P3)

The other problem [with enmeshment] is you might go too fast with the therapy because if you're used to closeness and people talking quickly - you push the patient too quickly. This patient is not going to do that - this person is actually going to have a kind of intellectual discussion and then feel it getting a bit distant and then do something that in a sense recreates a crises and makes an intensity in the room. So probably they'll make a bit of provocative interpretation or something. They're more likely to repeat their own family pattern. (P3)

Applicants perceived to have a high level of dependency needs are considered likely to foster unhealthy dependency in their patients:

I think you know therapy ultimately is about sort of encouraging the person to work through dependency issues and be able to be more autonomous or individuated or something like that. And I think if you're very stuck and still being very dependent then you might struggle. You might have a tendency to keep people dependent on you. (P8)

One selector describes the possible impact on the patient's therapy for applicants who had histories of frequent physical moves: that is, when therapy becomes difficult for patients, these therapists may unconsciously repeat their earlier pattern of leave-taking:

> *But also in terms of people staying and sticking and working through stuff as opposed to maybe having sort of disruptions and difficulties in a sense that actually you can't resolve or 'fix' things...so people get…you have to leave that situation. That's if it's sort of stimulated by that person…a therapist like this might very easily collude with somebody avoiding certain topics - not thinking through things...You know maybe if somebody came to therapy and started feeling uncomfortable, not necessarily helping them think through the process. They'll say 'Yes no maybe you do need a break.'* (P4)

4.6.2.3 Narcissistic dynamics and needs

One selector (P3) states, "A person who is quite narcissistically driven…describes their family as being quite disastrous and then describes their own excellence and capacity to exceed in this marvellous superior way - which fits. Because if you have sets of parents who are not focused properly on their children because they're busy fighting and what have you, you have to grow up prematurely - and you do develop narcissistic defences which rely on your own resources." This dynamic is indentified by selectors (P2, P3, P4, P7, P8) in features of pseudo-independence, the "false self" and narcissistic strivings such as omnipotence, perfectionism, "driven-ness", a need for control and adulation. Within this, selector concerns centre on the possible impact of narcissistic defences and unmet needs on the patient in therapy:

> *I'd want to know cos she says as well that her mother taught her the value of independence. And we look at this separation stuff; we look at this abuse…So I would want to ask her about you know… 'What are potentially some of the negative things about being so independent?'* (P2)

> *...can she sit with that and that there's nothing you can do? You can't take it away, you have to just sit and feel how it feels. And how tragic it is sometimes and there's nothing*

you can do about it. And can she sit there and hold that and not escape into some kind of rescue fantasy where they can just be grateful and you know thankful and therefore not feel this stuff anymore and lock it away again? Can she access and reflect on negative emotions in areas given her childhood experiences that are still potentially sensitive for her? (P2)

That's quite a narcissistic positioning of himself…he has an over inflated assessment of what he could or perhaps what he can achieve...It's very much about him and that would also be very concerning. Because in order to be an effective therapist, you need to be able to…acknowledge you know your own limitations and what you can realistically achieve and what you can't. And what your patients can realistically achieve and what they can't. You set yourself up terribly if you think otherwise. (P2)

[The parentified role] ...and linked to that is the superego and how punitive it is. And how demanding that super ego is and how perfectionistic it is…because these therapists can then be very harsh with their patients and very demanding of their patients. And they [patients] let you down all the time and they need to be able to do that. Is there room within that to say 'Okay I realise I'm in this role and I place myself easily in this role - but can I acknowledge it?'...And if they are continuing to identify with this role, who are they wanting to heal now you know - if they've moved out of their family? (P2)

This is a person who's a little bit fascinated with control and power…and I'd be worrying about are they driven by power or motives of that kind? Also very much a cognitive appraisal of problems in that everything can be changed and altered provided you know you had the right angle and the right kind of manipulation, etcetera...You've got a very manipulative person whose motives are problematic. Their motives are power and narcissism, 'I'm important and special.' And that's a problem because they will sometimes act in the interests of their own ego and not in the interests of the patient. That is the danger and you'll see it - they'll bring you a transcript where they do a brilliantly 'show-offy' session but they've actually not really helped the patient. The session is full

of 'show-offy' bits to make them look good, but there's actually a little bit of an empathy failure in the way they've managed the patient. (P3)

…now you've got to worry about this driven quality…Patients become a project and it becomes a driven thing that you've got to deal with this issue. They persecute the patient - they push and push and push and they shouldn't. You know they can't sit with somebody who stays with an abuser. You know they just haven't got the patience for it - and ja huge problems. (P3)

What they can do is…they will be able to see a patient and talk about the patient's problems and all the rest of it. The difficulty is this person needs to be seen as competent and capable in a very profound way because they feel very inferior - because of this history. And now you get a patient who picks you out and criticises you and you're not good enough. Now this person is going to struggle in their countertransference because they're not going to be able to cope with saying, 'Look, this is this person's issue,' in quite the same way. These people do need their patients to adore them. That's going to be your primary problem. (P3)

I suppose my concern is that there might be quite a narcissistic structure - that this person may struggle with some quite strong "false self" stuff...It's like the other person isn't treated as a real person. They're there as a narcissistic extension in various ways and for the therapists to make them feel competent and in charge and in control…I worry about a narcissistic person's capacity to see the whole of the other person. You know if …if they had to get wounded by the patient, would they be able to contain that and not act out by, say, making quite a cutting interpretation or, you know, going in and sort of saying, 'Oh you think I can't do this - let me show you.' And that they would maybe have to control sort of a need to triumph and win over the situation. (P4)

[Being over invested in helping people] ...some of it can turn into sort of the rescuing stuff which can be…which definitely has some sort of narcissistic elements to it in terms

> *of wanting to be people's saviour, wanting to take them away from their difficulties and 'fix' stuff.* (P4)

The sub-theme "risk to therapist" emerges from selectors' (P4, P8) concerns of the impact on parentified candidates and the increased risk of burnout owing to a sense of over-responsibility, a failure to seek help or to look after themselves:

> *Well I think there are...you know how do you deal with your vulnerabilities and your difficulties? How do you deal with it when you have difficult feelings or feel out of your depth? Do you have a capacity to ask - to sort of turn and ask for help - or do you think you just have to soldier on alone like you always have? It's burnout. That would be a very big risk for burnout you know because of them not looking at themselves and not taking care of themselves but taking care of others, that they might take on too much but may not sort of do things to take care of themselves.* (P4)

> *I mean I suppose you know if you take that on in the therapy...first of all I mean for the therapist it can lead to burnout and that kind of thing - taking on too much [and] maybe the tendency to take on a parental role and feel all this responsibility.* (P8)

4.6.2.4 Therapeutic relationship

The primacy of the therapeutic relationship in which the therapist's personality is a crucial tool is acknowledged by selectors (P1, P2, P5, P6, P8). Participants' emphasis of this suggests that the capacity to form a professional therapeutic relationship is considered a necessary requisite for potential therapists:

> *Your primary mode of healing as a therapist is your relationship with your patient.* (P1)

> *So it's the ability to work with that stuff and stay in that kind of relationship. [And] so the relationship is primary. Everything happens through the relationship.* (P2)

I mean therapy is a relationship itself you know. (P5)

Because you're the tool as the therapist – it's you, it's your personality. (P6)

I think you know in therapy the relationship is one of the fundamental factors you know. Like there's theoretical sort of understanding, there's insights, there's that kind of thing. But I think fundamentally without a relationship the therapy is not gonna go anywhere. So the person's capacity to attach or form a sort of a deep relationship in therapy is quite fundamental. I would say that the therapist's capacity to attach is quite fundamental to their capacity for therapy - you know to be a therapist. (P8)

Selectors (P1, P2, P3, P4, P7, P8, P9) concern of candidates' woundedness, in light of their early attachment difficulties, is directly related to their capacity to build and maintain the professional therapeutic relationship described above:

Well I mean I think that we know in terms of what we do with our patients, that early trauma has usually very significant disturbing effects on interpersonal relationships…So that if you're very damaged in terms of your capacity for interpersonal relationships that's going to come out in your work as a therapist. So that actually, I would have thought that people with severe trauma and sexual abuse histories, we would be very cautious, even though that wouldn't be exclusionary - of course we wouldn't exclude somebody. But we do know that the reality, unfortunately, that for many people, it has a huge disturbance on their relationships. (P1)

But it's not to say that I wouldn't consider someone who hasn't maybe had an insecure or disrupted attachment. It's just the extent to which they are aware of the stuff and they can work with it because being aware, being conscious as opposed to being unconscious - there's a <u>huge</u> difference....how much is she still aware of [her anger with her dad] and processing it because of how it may play out in relationships with men who she perceives in some or other way as being identical to her father? (P2)

Because you've not learnt to trust your primary objects…this person is going to struggle forming relationships. (P3)

The thing I was most concerned about were sort of attachment difficulties and capacity to connect. It sounds like this person grew up in a home were they didn't feel safe. And I mean "trust" in terms of development and sort of Erikson's theories, is the first stage. And your capacity to form relationships is predicated on the capacity to trust. And if this person is still sort of negotiating and dealing with that very very early stuff, we're talking about someone who…where relationships are potentially dangerous. And I would worry about how they would connect and deal with things and work through. (P4)

...she had a sort of anxious attachments…She may want to hold onto people too much, may be a bit submissive and subservient in terms of not wanting to displease and wanting to maintain the relationship. How would she cope with separateness? So I think, you know, worrying about her maybe sort of feeling a pull to merge with people because of the boundary difficulties might be something that I would worry about. (P4)

I mean the issue of trust…It sort of puts a question mark in your head….you'd wonder what this would then bring out in her therapies, with colleagues - she's gonna have issues with colleagues. You also wonder about that in supervision. I mean how would this person react to supervision when you have to be able to take criticism? My feeling is she would idealise completely like the mother depending you know, what kind of supervisor she got. But there'd be those kinds of primitive defences in action and that would come up because she's quite threatened at times. (P7)

So this is probably somebody who has perceived, as I said, closeness, has perceived closeness as perhaps something that can be threatening. And potentially, this is somebody who's going to have a little bit of a hands off approach with clients and is going to try and maintain a type of connection that's not too deep. He will struggle with clients who are dependent. He will struggle with clients who attach very quickly - like borderline clients. He will struggle with that kind of intensity or that kind of request for

> *intensity. And I think in those times he might be more likely to put a bit of a distance which might be experienced by clients as unavailable, unempathic and all that other stuff. So I think he will have challenges with some clients who are not able to be independent and so on.* (P9)

Conversely, secure attachments are considered a positive indication for would-be therapist's ability to "do the work" and manage as clinical trainees:

> *I mean the [Adult Attachment] research wasn't done around therapists per se but in terms of being able to offer perhaps children secure attachment. But I would have thought that would overlap with people who perhaps would make better clinical trainees - people who could offer some sort of…in the same qualities that you would offer secure attachment.* (P1)

> *So if the mom was at home you know she may have had a very good foundation - a secure attachment relationship. So maybe that's what's helped her absorb a lot of the difficult stuff. And if she has that kind of strong foundation, she can do all the other work with much greater ease.* (P2)

4.6.2.5. Trainability

Selectors' (P4, P5, P6, P7, P9) concerns about applicants' vulnerability and lack of resolution are consistently related to concerns for the candidate due to the psychological demands of clinical masters training:

> *In a training program like the M1 - and ultimately I guess the M2 - but especially the M1, it can be easy to disintegrate during times of stress and so on…a lot is going to make them vulnerable in their training program because it's a lot of change. There's a lot of challenge, a lot of stress. And it's really a question of are they going to be able to deal with it?* (P9)

I mean if you were to look at the M1 [Masters first year] as it's happening, there's a lot of stuff about yourself that you recognise and like never knew kind of that it existed you know. You knew in some sort that it was there but you never thought it was, you know, that strong. And I think being surrounded by psychologists, you know, like I mean you go for supervision you know. Like you know people are able to tell you stuff about yourself that you never, you know, thought… [but] …it kind of forces you. (P5)

I suppose the other thing is that it's quite a tough course. And I mean the most resolved person in the whole wide world is going to have something touched through the process of the course. So it's not only about resolution but also about the person's kind of "in-touchedness" with themselves - so they know if something is being touched. And kind of a robustness and openness to let it in - openness to let it in without it flooding….I think if things are very unresolved it's very easy for the course to mess with stuff and that's helpful neither to the candidate nor to their patients. (P6)

Ultimately you're going through this programme, you're going to be in therapy. You're going to be in situations where you will touch with some very sore...sometimes...or some unresolved parts of your life. You've got to have some kind of a questioning about certain things in your life in order to be able to carry through that process. (P9)

Academic pressures, difficulties with supervision and the impact on patients are further recognised as potential pitfalls for wounded candidates lacking some level of resolution and in terms of their anxiety and vulnerability. During training, these factors could potentially lead to applicants becoming psychologically disorganised, over-stressed and struggling to cope with the demands of the course. Candidates portraying narcissistic personality dynamics are mostly considered problematic in relation to issues with supervision. Three selectors raise these various concerns:

[There are] the anxious control freaks who want to manage and control and deny that actually they have difficulties…put all sorts of stuff in place to try manage and control. And what you find is those are people who often struggle with the masters process

because it's constantly pushing buttons. You are in an area where a lot of the time I think people feel out of their depth. And the process of the course does often address those defences and I think sometimes it can dismantle some of them and leave people feeling quite vulnerable…the other thing I've found in terms of my experience with applicants is: the ones who are very sort of into control, often we struggle in terms of their openness to feedback, their capacity to take constructive criticism. So there's that school. Then you get the others who maybe have more overt low self-esteem. Sort of also anxious but are sort of a bit less contained about it. And what can happen there is that they can struggle to manage as the work load and everything gets sort of more and more and more sort of emotionally demanding. You find that people like that can get quite scattered and chaotic and disorganised. (P4)

My concern [is] if you've got somebody who sort of hasn't integrated or thought about stuff…. because going into the training a lot of that stuff gets challenged you know. And personally…in my own training we had three people who didn't finish…And I think for all three of them it was around sort of emotional vulnerabilities and defences. But you know I think it's telling you in terms of the process: if you've got people who go through this gruelling selection and then they still don't come out the other end or they come out maybe damaged...Ja sort of a dismantling. (P4)

I think one of my worries would be with this person is if her marriage could…cos masters has a very bad impact on people's relationships. But you know I think she seems…her husband seems very very central and very much like a pillar of strength…And if her relationship didn't survive, what would happen to her? (P4)

My experience is that narcissistic people struggle with supervision in terms of taking stuff in because in supervision you frame it in different ways, but it's basically coping with criticism. Somebody sort of saying to you 'Hmm you know let's think about what you did here.' The underlying message is that you did it wrong. And how do you sort of take the fact that actually you make mistakes - you aren't perfect? (P4)

In supervision, would she be able to allow herself to be vulnerable or trust others or take difficult feedback or bring difficult or negative stuff to supervision. I think cos she was talking a lot about the father who's actually quite a feared authoritarian...I think in her relations, it would be the supervisor or with the patient at times. (P5)

*There's something very angry about authority with this person…as a potential therapist. Well they would hardly survive internship especially if they got sent to **** ...And difficult to work in like a system with serious authority...well the politics between psychiatry, psychology. You have to take it all into account. How would this person manage with that? Have they sorted their stuff out? Could they keep their own personal stuff out of it and be professional?* (P7)

4.6.3 Summary of implications of woundedness for the therapy process and clinical training

In the first sub-section of this analysis, selectors recognised salient themes and patterns of woundedness of individuals applying for clinical psychological training. From these, wounded applicants were perceived to have acquired potential resources, strengths and capacities, but also, to pose obstacles and limitations to the therapy process and in terms of clinical training.

According to selector accounts, applicants' perceived "resources and strengths" were predominantly represented by the theme "overcoming and resilience". This was followed by "capacity for empathy" and lastly, the themes "emotional maturity" and "vulnerability". Mostly, participants attributed these resources, strengths and capacities to individuals having experienced their own life difficulties. However, there was some argument against the idea that the capacity for empathy stemmed only from having personally endured traumatic experiences and there was some argument for the view that this capacity was primarily linked to good quality parenting. There was consistent agreement among participants, however, that these resources and strengths were essential therapist qualities and were of benefit to patients.

In the category "Obstacles and limitations" selector concerns of wounded applicants were extensive. The overarching concern was that these individuals' unresolved issues would play out

and interfere with their patients' therapies. The dominant theme was of applicants' "countertransference" evocations in the therapy process - over-identifying with patients and the employment of defence mechanisms against woundedness. The second dominant theme, the "therapeutic relationship", was linked to applicants' attachment difficulties and the concern that they would struggle forming and maintaining professional therapeutic relationships. Conversely, secure attachments were perceived to afford patients a better quality of therapy and benefit therapists in their work. Selectors' emphasis on the primacy of the therapeutic relationship suggested that the capacity for attachment was considered a prerequisite for potential therapists.

Equally represented by participants, the following themes were "narcissistic dynamics and needs" and "trainability". The former was identified by selectors in forms of pseudo-independence, the "false self", and narcissistic strivings. Within this, the sub-theme "risk to therapist" emerged in relation to parentified applicants and the increased danger of burnout to themselves. In the context of training, candidates portraying narcissistic dynamics were mostly considered problematic in relation to issues with supervision.

The less dominant theme was of wounded candidates impeding the "therapeutic process and frame". Concerns centred on their inability to uphold appropriate therapeutic boundaries, fostering unhealthy dependency in patients and difficulty in sustaining the therapy process. Also, although an applicant's own vulnerability was considered a resource in their being able to sit with their own and other's pain, the sub-theme theme of applicants being "too vulnerable" may be considered in terms of "obstacles and limitations" – being "too vulnerable" hinders the therapy process and, again, poses a risk to therapists themselves. This concern was further evidenced in terms of "trainability" and participants' worry that trainees who are "too vulnerable" would be psychologically at risk during clinical masters training.

Overall, the main category was "Obstacles and limitations". According to selectors' accounts, the major themes were "countertransference" evocations, "therapeutic relationship" and "narcissist dynamics and needs". By selector accounts, the only theme to be equally represented as the last, was "overcoming and resilience" in the category "Resources and strengths".

4.7 The implication of woundedness for selection

In investigating the implications of selectors' impressions of applicants' woundedness when evaluating candidates' suitability for clinical training and practice, the initial categories are "Necessity of woundedness for healing", "Distinguishing the wounded healer from those merely wounded" and "Bias against normality". These categories are refined and explored for themes and patterns below:

4.7.1 Necessity of woundedness for healing

In exploring selectors' perceptions of applicants' woundedness, the theme appears to be that woundedness is not regarded as a necessary precondition for clinical training or a predictor of becoming a good psychologist:

> *I think the idea that somebody is more suitable for clinical training because something awful has happened to them is ridiculous…I think it's a bit of a red herring to be thinking that it's the trauma that would predict whether somebody is or isn't suitable.* (P1)

> *Generally I'm not concerned with what people…I mean obviously some people have things horribly stacked against them and therefore they would have to do a lot more work, but generally its not about what they've been through. It's their ability to work with it and sit with it and acknowledge it.* (P2)

> *Some were sort of wounded healers themselves. Those themes ran through. And that is a theme you will see in applicants - not necessarily a theme that would get you in or get you out of selection.* (P3)

4.7.2 Distinguishing the wounded healer from those merely wounded

Despite selectors' statements that woundedness is not a necessary precondition for selection, the following excerpts suggests that almost all [these] selectors (P1, P2, P3, P4, P5, P6, P7, P9, P10)

look for candidates with some level of resolution and/or capacity to work through their difficulties. From this, the theme of "resolution" emerges, the main emphasis being whether or not candidates display a capacity for resolution. Participants variously attribute this capacity to psychological qualities such as insightfulness, self-awareness and self-reflectiveness, psychological mindedness, ego strength and a capacity to think about and acknowledge difficult feelings:

> *...most of it links back to the capacity to tolerate pain. The capacity ego functioning to tolerate, sit with pain. A lot of this stuff is about some or other pain*. (P2)

> *Look I think that there is a lot of very helpful research that really does clarify that what's the most useful predictor would be around people's ability to talk about trauma in a particular way, rather than whether people have had you know a traumatic experience or not. I don't think that whether you've had trauma in your life or not has got* <u>any</u> *bearing on how good a clinical psychologist you're going to be. What we know is that people who have had trauma see it in very stark ways - who either avoid or minimise a trauma…And that on the other side, people becoming very absorbed in their own trauma without being able to stay consistent, stay contained when thinking about it, are also equally not suitable..So it's the nature of the way you perceive your experiences rather than what they were.* (P1)

> *…And provided they come with some sense of 'I can survive this and I'm intact. I've got some sense of resilience, I've got these scars - everybody's got scars,' and they've got some attempt to reflect on it, you've got a workable person. Okay that's what you're looking for. It's not a question of 'Oh God, you've got a bad history – you're not coming in.' That's not the case*. (P3)

> *Definitely for me it's not much more really about how much [they have brought in the historical account] …it's not like if you've been through a lot then you can't. I think what I would be interested in is you know - are you working through it? I'm not saying*

somebody should have worked it through - it's a lot. But at the same time I think you know having insight and being able to kind of constantly work through the stuff. (P5)

A lot of psychologists come from very difficult backgrounds – often, I mean not all, but quite a few - and may be motivated by that. But that it's in how it's resolved that makes the difference for me…And I do think that people come in with a huge variety of different experiences both good and bad and often really difficult stuff. And what's important is less what happened than how it's…the process of how it's unfolded… (P6)

Ja a lot of applicants have had difficult times. But it's not necessarily the difficult times that make a good applicant; but in the presence of difficult times it's more in how self-reflective the person is and how they make sense of that. Some people have had difficult times and they're all over the place and they've held too much without really making sense of it and don't show insight – that's not a good sign. And some have had difficult times - that they've shown some kind of healing quest almost. And that's what for me… somebody who's gone through a healing process or searching for healing and perhaps looking to psychology for some healing. (P9)

This person must be able to show a genuine kind of movement or shift from what has happened. And insight in terms of how it affects them as a person - things they may have needed to change. So it's no use to say like, you know, 'I was abused so therefore I have more empathy with abused people.' or 'I was raped therefore I have more empathy with that.' It's not about that. It's being able to then…for them to make some kind of link to their own vulnerability, their own whatever it was that happened, and how they've worked with it...I think your ideal therapist is somebody…I don't think your family situation makes a difference actually. It's what they've done. Are they able to sit with vulnerability? Do they have the capacity to be strong? So I think it's both - they need to be able to do both. (P7)

Furthermore, selectors (P6, P7, P10) emphasise the necessity of some level of resolution in candidates, both for themselves and their future patients:

Wits selections I think looks for people who have done quite a lot of processing for themselves already because it's an intense enough [M1] year as it is. You don't want to now have to pick up a fragment of a person for example where the stress and the…it's too much they can't cope with it. (P7)

I think why it's important is for therapists to have at least some level of resolution - look these are training therapists so there's also a process that's going to happen along the way - but to have some resolution as a therapist I think is quite important; otherwise it's just too hard to separate out what's your patient's and what's your own. (P6)

I mean you almost kind of get bombarded with all of the trauma you know… what I get to in terms of feeling it hasn't been worked through sufficiently is that I don't get a sense of, I suppose, a quietness. Its chaotic – that's what it is – it's chaotic. I then land up having a sense that there's lots of things being unresolved and not really understanding if there has been shifts how it might have happened. I only get the sense of the announcement of the trauma and the childhood chaos...You know one isn't sure what the capacity is to then have a "reverie", around holding a chaotic person and being able to be calm in the room. (P10)

4.7.3 Bias against normality

No selector used the words "normal, normality or normalcy" in describing any of the candidates or their narratives. However, what the following participant excerpts (P1, P2, P4, P5, P8, P9) imply is that there is a questioning of applicants depicting themselves as, for instance, being happy, resolved or without having experienced previous difficulty:

With some of them there's the sense that they…there's a tilting towards a quite positive slant and positive portrayal. And then you sort of wonder about, you know, is there a tendency to split in this individual? How able are they to own the negative stuff or negative emotions and therefore how psychologically healthy are they? …And if you really feel that everything's resolved and there's nothing you have to face, then what are

you blocking out, and how much are you blocking out, and how much can you not see? So every…I mean she's clearly been through a number of difficult things, but everything she's thankful for and I just wonder about that. (P2)

You know they say 'small nuclear family' which, in my mind, you sort of conjure up feelings of closeness, whatever. That isn't the sense that I got though. And it's very difficult because you know they <u>say</u> *some things which sound quite positive but it didn't feel like it had much substance to it...Well I suppose I would sort of wonder how much they've integrated who they were you know….Were they feeling on a superficial level or maybe sort of more a "false self" level that people would accept them and so they would put up this bravado and this front? Whereas underneath, there was maybe more difficult stuff going on that they couldn't necessarily share or maybe felt they needed to deal with on their own.* (P4)

I suppose it's something of a personal nature that I often really really struggle with people who say they're fine and they don't need therapy…Like as if there's nothing there, ja. I suppose I'm always of the opinion that there's definitely something there. Like I mean - be it you know - you see yourself as minor…perhaps you minimise it. But something is there" (P5).

It sort of...there's also a sort of you know what I mean...it speaks of you know sort of like the happy ending. And that would worry me. But I just think that this...okay there's also the...you know that she's the sports captain and this and this…That there's this sort of outer 'I'm sort of doing well' and whatever, but underneath, you know, like I don't know about her emotional development. She would be very worrying to me. (P8)

On some level I do believe we're all looking for healing. Everybody looks for healing and those who are not for some reason I don't know…psychology's some sort of enterprise where - I cannot really put a finger on it - people who are not looking for healing and have had some difficult experiences in life, perhaps they are not quite there yet, perhaps they are in denial. (P9)

Two selectors raise concern regarding applicants' motives to become practicing therapists in which no history of their having experienced difficulty was provided:

> *I don't think it's a realistic reflection because why would you have somebody who was so incredibly invested and concerned about other people's pain and hurt and whatever if you hadn't had your own experience. Or unless you know…because in a way I think there is sort of the whole notion of the wounded healer that is part of things. But my sense is the way that this person presents things, I think there are covered up wounds that haven't sort of been dealt with. But I really couldn't say*. (P4)

> *I mean obviously one would be interested in the, 'I enjoyed a happy childhood.' which isn't unpacked. And obviously no links are made between why somebody who had had quite a happy time was then so rebellious. Yeah, so there's obviously some sort of contradiction in that. [And] Well I'm curious why there wouldn't be any link to the profession of psychology. There is no indication of why a person would want to come*. (P1)

4.8 The implication of woundedness in selectors' rankings of protocols

The implications of selectors' impressions of applicants' perceived woundedness or unwoundedness are presented for each participant in their ranking of candidates. The implications of woundedness is thus explored in participants' evaluation of the subsample protocols: According to the analysis, K1, K2, K4, K5 represent narratives of woundedness, and protocols K3 and K6 represent narratives of unwoundedness.

This section includes a presentation of selectors' spontaneous countertransference reactions in reading the protocols, their impressions of the subsample of protocols' representativeness and their views on candidates writing autobiographies for the purposes of being selected for the clinical masters psychology programme at Wits University.

4.8.1 Selectors' countertransference reactions

Selectors (P2, P4, P5) acknowledge their own countertransference evocation in reading applicant autobiographies. In each case, these are negative countertransference reactions. One of these is linked to the anticipated therapist-patient transference dynamic in the therapeutic setting:

> *...how I'm left feeling in terms of my own countertransference. It's like 'I really want to know more about you.' [And] if it's stuff she plays out and she's hooked just in terms of me reading this, how much of that is then going to play out on a much deeper prolonged level in relationship to her patient, where the patient may experience her as being present - seemingly there, seemingly interested - but keeping stuff from her. Patients with withholding issues would get extremely hooked by all of this.* (P2)

> *It lacks emotion and I don't connect with him. I suppose that's why I'm irritated*. (P2)

> *It doesn't feel...but it's like you know if you read I think it's the first two paragraphs that maybe just irritated me - because it was, you know, like these are the tick points that you need to be considered for masters…It doesn't sound...I sound so jaded.* (P4)

> *Unfortunately in psychology it's much more than just telling us what you are or who you think you are. You maybe telling me, but I'm maybe getting a different version really of who you are. So I kind of feel that this is not really…if anything actually it's just kind of makes me react negatively towards the applicant rather than actually see all those…ja [skills]*. (P5)

4.8.2 Selectors' impressions of autobiographies and representativeness

Overall, selectors' impressions of the sample of protocols are that they vary in terms of the applicant's narratives. There appears to be agreement that the protocols are similar and representative of protocols selectors had read in previous selection proceedings. There is no

consistent overview concerning selectors' perceptions of applicants' suitability for selection, however:

> *I guess that they're quite varied in terms of the detail they go into of people's past experiences...I think that the scripts that you've given me to read are quite similar and quite representative of the people we meet (for interviews).* (P1)

> *I thought they were probably selected as a representation of the types that we get because they are quite diverse.* (P2)

> *Well I think with a lot of them they're quite typical of the sort of protocols that I've read in terms of the selection process before. And I think one of the things that often comes through quite strongly are people who've had their own difficulties and their own struggles.* (P4)

> *[The protocols] ...I think it's I suppose it's something that's quite common*. (P5)

> *I suppose the impression that I did have was that all of them talked about their family history, particularly, except for one I think which really didn't…but I was also struck that, except for one, I didn't think that they were histories that showed or autobiographies that showed the candidates in a particularly good light*. (P6)

> *Well I thought firstly, they're quite diverse. I mean some of them look very suitable and others very not-suitable, I thought.* (P7)

> *They were dissimilar - I think they were. And then I also noticed there were sort of one or two that you could see were far more like sort of psychodynamically oriented, where there was sort of a more of focus on the self and others, where others there was more sort of a "systems" you know - they saw themselves in terms of family dynamics and that kind of thing. So I mean I suppose they you know...like just in terms of suitability, maybe they*

would be sort of you know what I mean - depending on the training or the university, certain ones would be more appropriate for certain universities and not others. (P8)

Well I didn't really find anyone I thought was a dead cert [certainty] actually. But some were definitely more insightful than others - there's no doubt about it. (P3)

A lot of them are very similar in terms of experiences that people have gone through with a level of reflexivity. They're different because some of them have gone more - you know - deeper into their experiences and others have left it more general. But ja it's very typical. (P9)

4.8.3 Applicants write the "suitable" autobiography

Selectors (P1, P3, P4, P5, P6) acknowledge that applicants may tend to 'slant' their autobiographies according to what they perceive as necessary criteria to be selected for clinical training at Wits University:

I think that in some ways people worry that if they haven't had a quite significant traumatic experience, then they are going to be prejudiced against, rather than people worrying that they're too damaged to apply. And I think that obviously different courses [universities] have different characteristics. So people apply to different courses and imagine that the selectors are looking for different things, which I think has probably got some truth in it. (P1)

I've learnt over the years that applicants feel if they're not absolutely honest they won't get in. So they often say things that they shouldn't in a first interview. So I think its part of the process. (P3)

I know when I've spoken to people applying, they've always been concerned about how much is or isn't appropriate to disclose. Do you want to disclose too much and look unboundaried or not enough and then look all guarded and defended? (P4)

I suppose if I look back to my own, there's always been that notion - do you say you know as an applicant that you've had this? And if you say, you feel like maybe you're selling yourself short. And if you don't say on the other hand, then you know you're not open – you're guarded and defended and stuff like that. (P5)

I mean often applicants try and guess what's required, what kind of thing to write…maybe they had a sense that if you talk about some of the difficulties - that's important to do. (P6)

4.8.4 Participants' ranking of candidates in terms of suitability for clinical training

This section of results is divided into two sub-sections. The first sub-section is of participants' impressions of individual applicants' suitability, presented separately for each participant in their ranking of candidates. These reflect the decision of selectors to invite or not to invite, applicants to further selection proceedings (i.e. an interview) at Wits University. The categories are "Most suitable" or "Least suitable" candidates for clinical masters psychological training. In some cases, participants express difficulty in ascribing only one candidate to these categories. The researcher notes these occasions when they occur and supports the ascription of "most" or "least" suitable candidate on the basis of the participant's rationale. The second sub-section is an overall presentation of selectors' rankings which is then analysed for major themes and patterns – what the most and least suitable candidates look like, and what distinguishes them for selection.

During these interviews, both selectors and the researcher tend to refer to candidates as being "female"; however, the gender of applicants remains unknown and the use of "she" or "her" as a generic reference to most applicants is not intended to be sexist.

Participant: P1

P1 states that a crucial quality they "…would look for most in a candidate is an ability to tolerate discomfort themselves," without trying to "defend against such painful messy feelings." Also, for this selector, "It's the nature of the way… [candidates]…perceive of…experiences rather

than what they were. [If] …the person can talk about something in a way that leaves them still remaining contained… [Because it is] the way you talk about or conceive of your experiences, traumatic or not, that's the best predictor of your ability to maintain boundaries…a secure attachment." This excerpt suggests that P1 seeks candidates who display a capacity for self-reflection (in not defending against difficult feelings) and the ability to convey a sense of their experiences without becoming overwhelmed by them.

Most suitable – K2 and K3 are ranked by this selector as the candidates most suitable for an interview. However, P1's weighting of K3 having displayed potency, autonomy and more of a locus of control than K2, suggests that K3 is the applicant most likely to be invited for an interview:

> *In Case 3 is an awareness of one's own responsibility and more of a locus of control. So that, although the person in Case 3 doesn't go into a lot of detail about the trauma, what is conveyed is more of sense of potency and responsibility by saying 'I chose rebellion over conformity' but yet recognising that was empty. That seems very important in terms of recognising choices and recognising that they may not have been the most useful, but not describing them to the fault or responsibility of others. I think that does seem, even in such a short passage, very valuable. I think that would be a valuable quality in a candidate to recognise one's choices. So although the person relates it much less to becoming a psychologist or a choice of profession, I do think that's helpful. Yes - no the person sounds more autonomous perhaps.*

P1 appears to have concern regarding K3 in that "…no links are made between why somebody, who had had quite a happy time, was then so rebellious. Yeah so there's obviously some sort of contradiction in that." Also, that there is no clear link of earlier experiences "to the profession of psychology" or motivation to be a therapist. As P1 states, "I think it's valuable to know that we partly choose this work to understand something about ourselves." However, it appears that these concerns are superseded by P1's perception that this candidate is "somebody who took personal responsibility even if they haven't quite finished working it out. That's the other thing I don't think you have to have finished the process of understanding yourself. I think you just have to be

curious about it." This latter statement suggests that, for P1, K3 lacks some psychological resolution, but that this is in process.

According to the analysis of themes, P1's account indentifies in K3's autobiography a theme of "trauma", although this is unspecified, but implicit in the selector's statement that "the person doesn't go into a lot of detail about the trauma." From "resources and strengths", emerges the theme of a candidate conveying an "external locus of control" which, P1 says, "would be a valuable quality in a candidate." The theme of selector's "personal bias" emerges in light of P1's acknowledgement that "…on a very personal level there's something powerful for me writing 'I chose something' and ja, I can imagine other people wouldn't see that, so that feels sort of more individual."

Least suitable - On the other end of the scale, K5 and K6 are ranked the least suitable applicants. However, P1's statement that K6 is "the least suitable for training" places this candidate in the lowest position of rankings. P1 alludes to K6 being avoidant and thus, representing the category of "Obstacles and limitations" and the theme of "defended":

> *Case 6 is the least acknowledging of one's personal experience. So I guess I would say that the last one was probably the least suitable for training...Particularly because somebody was asked to give an autobiographical account and they haven't and I'd be curious to know why they haven't given an autobiographical account. It isn't as if the question was, 'Write something that helps us understand why you want to be a psychologist?' This is the autobiography and clearly the person has avoided doing it.*

In summary, P1's ranking of K3 appears to reflect the personal weighting by this selector; that is, despite the perception that K3 has not displayed an understanding of their earlier difficulties, or their motivation to become a psychologist, they have conveyed a "potency [and] an awareness of one's own responsibility and more of a locus of control."

Participant: P2

For this selector, distinguishing between the suitable and unsuitable candidate lies in "the way they portray their life experience…how integrated does it come across as? How able are they to own the negative stuff or negative emotions and therefore how psychologically healthy are they?" Suitable candidates must have a "psychological mindedness and insightfulness." The stronger candidate can self-reflect and "look back on their own lives and see the link." And, "In terms of supervision – how trainable are they? They need a certain amount of openness and ability to self-reflect." Candidates also need to portray a "real" sense of "self", a capacity to tolerate pain and emotional maturity with a depth of understanding.

Most suitable - K5 is ranked by this selector as the most suitable candidate for an interview:

> *There was something very contained firstly by the way she wrote. She conveyed a real sense of where she comes from and how it shaped her. She's linked it very nicely. There's a depth of understanding. She displayed incredible insightfulness especially here where she says, 'Being brought up in authoritarian family system, I believe my social life has given me a sense of control.' So she's identified how she has internalised that controlling object relationship as well. So she's acknowledged things about herself that are difficult. She hasn't just tried to portray herself in a positive way or that she's just risen above this terrible stuff that's happened to her. She's been able to say, in a very balanced way, that, 'I can look back and I can see that I've taken in what's happened to me and that means I've also taken in stuff that's not so nice.' And that's terribly insightful. And that she has the emotional maturity to acknowledge it you know or acknowledge her resentment to her father. So [she's] in touch with those feelings...Very insightful identifying the enactment of internalised family relationships.*

P2 appears to conceive of K5's being resilient in relation to having endured and coped with "terrible stuff" and problem family dynamics: "There's…a resilience to her…that she continued to do quite well. She was high achieving which is also you know - you could ask her about well what does she think that was about. But she's resilient." When asked to expand on the capacity

for resilience, P2 attributes this to psychological capacities, present at birth and/or the possibility of a secure attachment, primarily with the mother: "She could have been a resilient baby…and/or…she may have had a very good foundation - a secure attachment relationship. So maybe that's what's helped her absorb a lot of the difficult stuff."

Still, for P2, K5 has potential relational difficulties: "She says she has difficulties in relationships today." This is a concern in relation to the candidate's ability to form and sustain a therapeutic relationship. "Now okay that [difficulty] would make you also think because you do look at quality and longevity of relationships…because the therapy relationship is a relationship…it's the ability to work with that stuff and stay in that kind of relationship." A further concern is the possible countertransference evocation in the therapy space because, "…she's clearly still angry with her dad...and where she is now today in relation to this anger...how much is she still aware of it and processing it…because of how it may play out in relationships with men who she perceives in some or other way as being identical to her father."

According to the analysis of themes, P2's account indentifies, in K5's autobiography, negative experiences within the family of origin and alludes to this having been traumatic in saying K5 had been through some "terrible stuff". "Resources and strengths" are represented in themes of "resilience" and "emotional maturity". The candidate's perceived capacity to tolerate difficult feelings, insight and psychological mindedness suggests the theme "capacity for resolution". "Obstacles and limitations" are represented in issues around "countertransference" evocations with patients. Also, P2 considers K5 to have "attachment difficulties" and links this to the possible impact on the therapy relationship. However, it may be that the following perception overrides this concern. P2 states, "However, if you look at her history again, the family did work through the stuff. And…she still sees herself as being part of a relationship." This suggests that K5 has the "ability to work with…and stay in that kind of relationship."

Least suitable - On the other end of the scale, K6 is ranked the least suitable applicant for clinical psychology training. The concern for this selector is that the applicant is presenting a "false self" or is highly defended, lacks the ability to self-reflect, and is therefore unsuitable for psychodynamic training and practice:

> *I just wrote here 'She hasn't revealed anything about herself.' You know she just tells you about her working experience. There is no <u>self</u> disclosure. So I said 'Is this a psychologist façade she thinks we're interested in?' You know is it like a context-adaptable "false self" or is she highly defended and therefore unwilling to disclose? And if she doesn't know herself or she's not comfortable with sharing of herself, she's not suited to psychodynamic training which is about self-reflection. And you expect your patients…you're going to ask them to be disclosing. And if you can't do it how can you ask them to do it?*

P2's concern of K6 being highly "defended" falls within the category of "Obstacles and limitations" in impeding the therapeutic process. The theme of "narcissistic dynamics and needs" is represented in P2's perception of the presence of psychologist façade or context-adaptable "false self". It may be interpreted that in contrast to K6, P2's sense that K5 "conveyed a real sense of where she comes from and how it shaped her. [And] …hasn't just tried to portray herself in a positive way or that she's just risen above this terrible stuff that's happened to her." presents a "real self", and that this feature further distinguishes these candidates for suitability. This statement further suggests that P2 perceives an applicant portraying having "just risen above" their difficulties as a cover-up - it suggests that the participant holds some "bias against [such] normality".

In summary, P2's ranking reflects this selector's thesis by saying that, "Generally I'm not concerned with what people…I mean obviously some people have things horribly stacked against them and therefore they would have to do a lot more work, but generally its not about what they've been through. It's their ability to work with it and sit with it and acknowledge it." It appears that this criterion is met in P2's first choice of candidate K5 who is described as having gone through "terrible stuff" but resilient, emotionally mature, insightful and able to "acknowledge things about herself that are difficult."

Participant: P3

P3 describes features and qualities in the suitable applicant: "You want an observing ego. Whether it's sophisticated or not is not interesting - the person is not trained. But you want to see that they can do those things. And it doesn't matter if people are rebellious or if they take drugs. What matters is if they get out of it, and they get out of it for the right reasons and can reflect on how they got there. [A]…putting together of how that happened." The suitable candidate needs to be psychologically minded and "make the links" in their history, in a causal way. Above all, P3 values "authenticity… [as] the most important quality" in potential therapists.

Most suitable – P3 stated that she did not find any of the applicants a "dead cert" [certainty] for clinical training. However, P3 appeared to rank K1 as most suitable for an interview invite in that this applicant was "workable… [and] this one we should try with."

> *This one, she had a history of sex abuse which she then linked to anxiety…and panic attacks…So I've taken that assumption that she was aware that she'd had something that happened in her childhood that made her an anxious person and made her feel very very insecure. So she's making links here all the way as she goes through… [She says] the [parents'] marriage wasn't happy and they got divorced. She tells us a little bit later down the line that dad was a bit of a sod and an alcoholic and blah blah blah…*

In this applicant, P3 identifies a common dynamic in terms of, "a typical psychologist's history of being somebody who finds themselves a mediator or an observer of a destructive relationship in the family and wanting it to be better. And they want it to be better in their own lives and they want it to make it better in other people lives." There is the perception that K1 may be defended in that, "She said she had the support and patience of her family. Now…if [she was referring to] her family of origin you've got a bit of splitting going on there that doesn't quite fit." However, this is further understood as the applicant "not quite managing that ambivalence yet [and] that probably need[ing] a bit of work…But If you have a history like this it's very unlikely that you wouldn't have some foibles or 'blind spots'."

K1's relational attachments are emphasised by this selector. "This was a good-enough mother despite the fact that maybe she didn't spot the abuse. [And] the therapy did make the anxiety better…she responded to a healing relationship which means her capacity for object relations is probably quite good...I think there was good-enough relationships early on with the parents." However, K1's pattern of adult relating is considered a continuation of the pattern of her 'giving over to others'. "The husband has ended up being the saviour and made things right…she's attributed all of her healing and her education to her husband…a bit idealised." This pattern is further related to K1 during clinical training. "So she'll be a very nice candidate to train because she'll listen to what everybody tells her. The trouble is - what will she do when she's on her own in private practice when there isn't somebody to tell her what to do. That will be her Achilles heel."

According to the analysis of themes, P3's account identifies in K1's narrative the following: In the category of "Trauma, loss and deprivation" are themes of "illness" in a family member with substance abuse and "crime trauma" in the candidate's account of ongoing sexual abuse. K1 is described as being in the position of "observer" to dysfunctional family relationships and dynamics in which there are marital problems. To this, the selector links the "motivation" for K1 to heal herself, her family and others, as well as a "good fit" with the role of therapist in having assumed the role of "mediator" in the family of origin. This further suggests, along with the dynamic that K1 continues 'giving over to the other', the theme "narcissistic dynamics and needs". Also, K1 displays a pattern of "dependent adult relating". P3 links this to the candidate's "trainability" and posits that this dynamic would repeat itself with supervisors. In relation to the therapy process, K1 may have "countertransference" evocations in her "blind spots" and the use of "defences" such as splitting and/or idealisation in managing her ambivalences.

Least suitable – P3 ranks applicant K3 as least suitable of all applicants to be invited for an interview:

> *The whole way that that autobiography is written is it lacks self-reflection. The person is not reflecting on what's happened…They are not particularly psychologically minded. So events happen and there isn't really a very clear understanding of how they might have*

> *followed on in a causal way, psychologically speaking... how come they had this wonderful time and suddenly became a rebel. They didn't sort of respond to that [boarding school] might have been quite painful or difficult and traumatic or anything...So I wasn't happy with that. I thought this person was terribly defended… Not reflective, not psychologically minded…there's no mentalization.*

P3 links K3's inability to self-reflect to the therapy process and the transference-countertransference dynamic. "If you can't make links in your own psychodynamics it's going to impair how you make links in others…where they're going to run into trouble is with transference and process work…And if they have a countertransference responsive patient - I don't know what they're going to do with it."

In summary, P3's ranking appears to reflect her argument that, "[It is] how they try and put it together. And provided they come with some sense of 'I can survive this and I'm intact. I've got some sense of resilience, I've got these scars - everybody's got scars' and they've got some attempt to reflect on it, you've got a workable person. Okay that's what you're looking for." This fits with P3's first choice of candidate K1, who is described having had a "bad history" but showing an attempt to reflect on these difficulties. Conversely, K3 is perceived as "terribly defended" in not responding to something that may have been "quite painful or difficult and traumatic or anything." Although this selector identifies life difficulties and potential psychological defences in both candidates, it is perhaps K1's ability to "make the links" that suggests a psychological mindedness and thus, a capacity for resolution.

Participant: P4

P4 emphasises that the most important quality that the suitable applicant portrays is, "a capacity to think about and work through feelings… For me it speaks to having thought about and worked with and tried to process and make sense of stuff...And I think you can look at it in two different ways: you can look at it in terms of Bion's capacity to think and verbalise and talk about feelings and think about feelings. But also on an intellectually academic side, a person's capacity to

express their written thoughts and stuff like that." Also, the suitable candidate needs to present themselves in a whole and balanced way.

Most suitable – P4 states that applicants K1, K2 and K4 would be invited for an interview. However, based on P4's impression that K1 is "a bit more coherent than some of the others", K1 is ranked the most suitable candidate to be invited for an interview:

> *This person has been through a hell of a life. It sounds like they've worked through some of these things and there is a thoughtfulness and stuff like that…she sounds to me like she's worked hard at stuff… [and]…has put it in a coherent way in terms of her language; a capacity to express it….it sounds more thought through...Even though it's really hectic stuff, but it sounds a bit more coherent than some of the others.*

P4's main concern with this candidate seems to be in terms of vulnerability and capacity for dealing with and working through her difficulties in light of her early history. "I would worry about this person's vulnerability... [and]…how robust this person is. They've been through huge traumas, huge anxieties I would really worry about this person's strength…with all of the stuff she's gone through, her capacity to deal and work with things."

K1's relational attachment difficulties are related to potential difficulties with the therapeutic relationship. These are perceived as "…sort of anxious attachments which would mean that she might…struggle. She may want to hold onto people too much, may be a bit submissive and subservient in terms of not wanting to displease and wanting to maintain the relationship. How would she cope with separateness?" K1's relational attachments and trauma are related to the therapeutic process and frame, as P4 states her concern of "…worrying about her…feeling a pull to merge with people because of the boundary difficulties; you've got the childhood sexual abuse… [in]…which you often find is that the parents didn't pick it up or notice. So there wasn't that sort of relationship or connection where the child was able to disclose to the parents or the parents noticed something was wrong." A further note of concern is around the centrality of K1's adult relationship in that "…her husband seems…very much like a pillar of strength…And what would happen to her relationship during the course of the course? And if her relationship didn't

survive, what would happen to her… [and]…in terms of maybe evoking sort of abandonment stuff?"

P4's perception of K1's personality dynamics is that of "a child who felt quite alone and abandoned," and in light of the ongoing sexual abuse would consider, "Is this somebody with sort of a borderline personality disorder which would be something we very commonly see with this sort of history?" However, K1's lack of primitive defences and potential for balancing the "good and the bad" is perceived as a positive indication: "She talks about this in a very non-splitting way which, for me, is positive. There isn't very much the good and the bad and the whatever. She's talking about things more in a whole way…and she puts in bad stuff about herself - she doesn't just put a glowing image or whatever….it seems quite balanced."

According to the analysis of themes, P4's account identifies in K1's narrative the following: The category of "Trauma, loss and deprivation" in ongoing sexual abuse ("crime trauma"). "Obstacles and limitations" are represented in terms of maintaining boundaries in the "therapy process and frame". From the perspective of relational attachments and therapist personality dynamics, themes of an "anxiously attached" and "lonely" child are described, as well as the theme of K1's pattern of "dependent adult relating". These relational dynamics are linked by this participant to the "therapeutic relationship" and the possibility that K1 may hold onto patients. Additionally, P4 expresses concern around this candidate being "too vulnerable", and so the theme "risk to therapist" presents itself. "Capacity for resolution" may be represented by the portrayal of this candidate's capacity to think about and express difficulties and also by the perception that she was able to present the good and the bad – 'her whole self'.

Least suitable – Selector P4 ranks applicants K3 and K6 as the least suitable of all the applicants for an interview. However, on the basis of P4's statement that K6 was "actually much worse than three", this candidate is placed in the lowest position of ranking:

> *For me this [autobiography] read like them really selling themselves as a potential therapist. They were telling you exactly what they thought you wanted to hear. But I don't get a sense of this person at all. It's like it sort of feels quite empty and a bit too*

> *controlled and contrived. And you get no sense of where does this person come from? …Where's the person you know - where's the person that doesn't want to be a therapist or is being a therapist? How this person has constructed their identity you know? And also I would be very concerned about them sort of being over invested in helping. And that was sort of a lot about…what their identity and their personality was about.*

K6's seemingly being over invested in helping is linked by P4 to the theme of "narcissistic dynamics and needs", "the rescuing stuff which…has some sort of narcissistic elements to it in terms of wanting to be people's saviour, wanting to take them away from their difficulties and 'fix' stuff. But…it's also like you are involved in other people's lives and not your own." When asked whether this candidate's apparent lack of a difficult history in their narrative is a realistic reflection, P4 replied that it is not. This is further linked to questioning the candidate's motivation to become a psychologist: "Why would you have somebody who was so incredibly invested and concerned about other people's pain and hurt and whatever if you hadn't had your own experience? Or…I think there is sort of the whole notion of the wounded healer that is part of things. But my sense is the way that this person presents things, I think there are covered up wounds that haven't sort of been dealt with."

This selector's concerns of K6 fall primarily in the category "Obstacles and limitations": "…the boundaries and stuff like that. If you don't have a person…a sense of this person to hold on to - and you know they might be doing sort of difficult things in terms of over-identifying or projecting their own stuff onto people and may not be aware in terms of processes going on. [And] …I think the concern about the countertransference also is that the person is unaware of themselves." These concerns represent the themes "defences", "countertransference" issues, and difficulty in terms of boundaries and maintaining the "therapy frame". The theme "narcissistic dynamics and needs" is linked to the rescuer role and the "motivation" of wanting to heal others.

P4 views K6's 'lack of life difficulty' as questionable and potentially as a sign of unresolved difficulties. This suggests that this participant holds some "bias against [such] normality". Furthermore, in terms of P4's own countertransference reading this narrative, the selector

describes her reaction: “It’s the first two paragraphs that maybe just irritated me…like these are the tick points that you need to be a therapist.”

In summary, P4’s first choice of candidate (K1) appears to reflect her thesis that, “I think making meaning is…it’s sort of your capacity to think about and make sense of stuff. Or start to try and make sense of yourself and then the person who you are seeing for therapy.” This fits with P4’s first choice of candidate in “her capacity to think and work with things sound[ing] promising.” This candidate is distinguished from K6, in that the candidate is perceived as not having a sense of person to hold onto and thus has an “inability to hold onto themselves and their thinking-selves.”

Participant: P5

For this selector, suitability is “…if somebody shares…it’s not [just] about sharing…because we’ve all been through…traumatic [experiences] …and I believe that [is] …one of these reasons why we are attracted to this profession… But maybe much more about you know the journey.” The stronger candidate conveys “how they have come...to process it - to work with it, what it means for them and the insight that they have…about how maybe this…has grown them and how also it may affect them in terms of the work - the population that we’re actually are supposed to deal with.”

Most suitable – K1 and K4 are ranked by this selector as the most suitable candidates for an interview; however, K4 appears to be the candidate P5 would “most likely invite.”

> *What I also kind of liked with this one was some insight…I found that she was actually insightful because I think at times we think of trauma as these big things - that it has to be sexual abuse or rape or whatever. But I think even something that may seem as not harmful as just moving away. And I suppose she’s able to talk about it as you know something that she actually had to adjust to. And what I think I also liked about her was she was able to point out both the negatives and the positives…it kind of felt like…she’s able to kind of pick…both something good and something bad...I’m just thinking in terms*

> *of being able to integrate the two you know… And being able to…say, 'I've been able to enjoy the happy times and…the difficult times.' So for me it kind of felt like she was trainable.*

For P5, the question of whether K4 is in personal therapy is considered in relation to the necessity of psychologically working through earlier difficulties and gaining self-awareness: "[I would want] to get a sense of whether she's in therapy or not. She can surely get to understand something of herself in therapy." This self-knowledge is further linked to providing therapy and the therapeutic relationship: "I think being in therapy helps you realise some of these things. I mean therapy is a relationship itself, you know. Like there's something that you would actually pick up of yourself…it just becomes important that people are in therapy."

P5's query that K4 should be in personal therapy is further linked to, "this tendency to make husbands the magic wing….One could say maybe she was escaping you know...That's why I think instead of having the husband who comes along and then things are kind of back to normal or perfect - but that one has a [therapy] space to think things through."

According to the analysis of themes, P5 identifies "physical moves" in the category "Trauma, loss and deprivation". P5 perceives K4 to have a pattern of "dependent adult relating" and a tendency to avoid or escape difficulties which falls within the theme "defences". Also, the perception that K4 portrays that, following this [relationship], "…things are kind of back to normal or perfect," suggests a premature foreclosure on psychologically working through earlier difficulties. However, K4 is perceived to have been insightful and able to integrate the good and the bad and thus suggests, the theme "capacity for resolution".

<u>Least suitable</u> - K6 is ranked the least suitable applicant to be invited for an interview:

> *I wrote there, 'It's a rehearsed version.' Like somebody's just writing a summary of some sort or what she thinks actually a good psychologist or psychologist should be…But there's nothing about who this person is. I just have no clue who actually she is…I'm not sure but I don't think this is a mistake that you just kind of write all these things written*

> *here. For me it would just be…that she's not really…giving something of herself. I would classify her as somebody as quite defended.*

In terms of this candidate having stated that they had been in therapy themselves, P5 argues "I'm not even sure why she's in therapy. Did she just wake up and kind of like, you know, 'I wanna go to therapy?' And…even though therapy is important…I would want also to explore...that because there are some candidates who…actually just go to therapy a month before the selections just so they are in therapy - almost as if it's like a uniform…just a cap that you wear and after the selections you can just put it there in your cupboard." This was further related to the candidate possibly being defended. "But ja it just makes one wonder - being in therapy and not being able to share something of yourself." P5's perception of K6 'wearing a uniform' further suggests the theme "narcissistic dynamics and needs" in the candidate presenting a context-adaptable "false self".

In reading this, P5 recognises her negative countertransference evocation and states, "Unfortunately in psychology you know it's much more than just telling us what you are or who you think you are. You maybe telling me, but I'm maybe getting a different version really of who you are. So I kind of feel that this is not really…if anything actually it's just kind of makes me react negatively towards the applicant rather than actually see all those…[skills]."

In light of the importance that this selector places on applicants being in personal therapy, K4 may not have seemed P5's most likely first choice. However, P5's ranking of K4 appears to reflect this selector's choice of a candidate that "…has insight and…able to kind of constantly work through the stuff."

Participant: P6

For P6, the suitable candidate is able to "…as much as one can - which is never perfect - but to try to integrate different senses of who you are. [And] …something about being able to put good and bad together, being able to not either idealise or denigrate…experiences." Applicants also need to convey some level of resolution in having begun their own healing work, but a lack of

foreclosure in this. The suitable candidate needs an authenticity or "realness", "some kind of 'intouched-ness' with themselves," and "a robustness and openness to let it in…without it flooding."

Most suitable – K4 is ranked by this selector as the most suitable candidate, "in comparison to the rest" of the protocols. However, she states, "There were things that I would want to explore more and I'd wonder about and have concerns about."

> *I know part of it for me was she reflected on the good and the bad. So she says 'Being part of such a small family has made my life both a happy and a plagued one.' And she talks about happy times shared with her parents and younger brother as well as the pain when she was nine years old…I think she conveys that the relative was inappropriate and that there was a transgression of some sort and that it was something she kept quite secret for a long time and couldn't really talk about. But she kind of brings in both the good and the bad. And she also makes a reflection …she makes a link between what she said earlier… [it] does convey she can make the link between confronting her past and beginning her own healing through facilitating others and thereby 'Identifying issues that I still need to work on and manage.' And you know it's hard to put your finger on sometimes, but the tone of how she writes it seems quite real to me...I don't have questions about 'Well how much have you actually confronted?' which of course is always there. Or 'Is there a problem here with you using the pain of others to deal with your own pain?' It kind of just doesn't feel like it's hugely that to me. So it's something about the tone which is more authentic - I think for me more real… [And] she doesn't actually say it's resolved. She says, 'I've had these experiences and I can feel that I...' she doesn't say this but… 'I have begun my own healing…that there is something happening.' So it's the lack of foreclosure perhaps.*

For P6, there are questions regarding K4's process of resolution:

> *I mean the way that she talks about resolution is something about meeting her husband and that being quite a transformative experience for her and allowing her some kind of*

> *solidity. She talks about 'He has been my rock' against which to deal with her more difficult feelings. So I suppose I'd explore that a little bit more as well. Maybe particularly regarding how else she has developed that or accessed that or whatever… she does seem to suggest that her relationship with her husband is quite a solid relationship….Something about doing it [resolution] through being open to relationships that are healthy.*

According to the analysis of themes, P6's account identifies "crime trauma" in K4's having experienced an inappropriate transgression by a relative. The theme "motivation" is alluded to in P6's perception of K4 having begun their own healing, and this suggests that there is some level of resolution. The theme of "capacity for resolution" is further represented in P6's perception of the candidate being self-reflective and making links between her past and present life experiences – a psychological mindedness. K4's adult relationship is seen as presenting a "healing attachment".

Least suitable – P6's ranks applicant's K3 and K6 as unsuitable for an invitation to the selection process, with K6 being the least suitable of all:

> *Case 6 who was interesting for me and its absence about…their family history or where they come from or their path or something like that… I wrote, 'Very little about self.' It's all about her credentials. I mean even the most real part of it, which I think is the last paragraph, 'The rewarding feeling of knowing that you've helped someone but you can't help everyone.' and being in therapy has helped her. But what she's also doing is saying, 'I've got all those qualities that you're looking for.' It's a very generic response. It could apply to any "ideal" applicant in a way…[And] the hypothesis is that there is a need for her to convey herself as good, as skilled, as got all the stuff that you're looking for. And that that might also be difficult if you're a therapist - that's then more about your own need to convey yourself well to someone else…It's been very un-exposing of her. There's been very little risk that she's taken in writing this perhaps. [The writer] needs to take a bit of a risk in putting out something a little bit more personal so that the selection panel can get a glimpse into who you are. Because you're the tool as the therapist – it's you,*

> *it's your personality. And if you're concealing your personality…it makes you wonder about her ability to be open and authentic…with someone else.*

This selector's concern regarding K6 appears to suggest the theme of "narcissistic dynamics and needs" in the perception that the applicant needed to portray an "ideal self". Also, that K6 is perceived as unwilling to risk revealing her personality to selectors, presents an "obstacle and limitation" to the therapeutic endeavour, in which the therapist's personality is considered crucial.

In summary, P6's first choice of candidate (K4) appears to reflect her emphasis that "I do think that people come in with a huge variety of different experiences both good and bad and often really difficult stuff. And what's important is less what happened than how it's…the process of how it's unfolded… [And] Because my belief is that a lot of psychologists come from very difficult backgrounds - often I mean not all, but quite a few - and may be motivated by that. But that it's in <u>how</u> it's resolved that makes the difference for me." Thus, is P6's first choice of candidate, K4, perceived as having had difficult experiences but conveying some level of resolution, and how this may have been facilitated. Along with this, are qualities of authenticity or "realness" and some sense of "self". This perhaps distinguishes K4 from K6 whose "lack of self", along with the portrayal of an "ideal" applicant, primarily suggest the theme of "narcissistic dynamics and needs".

Participant: P7

P7 states, that in selecting candidates, "what you're looking for…is the ability to self-reflect. Can you actually take what's happened in your life and make some kind of coherent narrative…Make sense of what's happened in your life and be able to then make choices that are not necessarily based on what's happened?" In terms of Wits selections, suitable candidates must "have done quite a lot of processing for themselves because it's an intense enough year [M1] as it is. You don't want to now have to pick up a fragment of a person…where the stress… they can't cope with it."

Most suitable – K1 was ranked by this selector as the "strongest" candidate for an interview:

> *I felt…my initial impression was like sort of a hint of narcissism…it was this bit at the end: 'I have a lot to share.' and '…yearning to share my strength with others.' She plays up her strengths quite a lot which I think you are supposed to do, but in a balanced sort of fashion. There's quite an omnipotence. It's more I suppose than the narcissism is…This idea that you know she's just been lucky and she's so grateful for all these difficult things that have happened in her life…you would think - okay no. Where is the genuine kind of angry reaction to this? [And] ...maybe it was hard living at home. She struggles to sit with her own vulnerability or to present it in a sense. So it's not very balanced…But having said all of that I'd invite her because I think she has the potential to…I mean I would want to look at the narcissism. I'd look for that and I would look for rigidity in this one in terms of those 'unalterable boundaries' and the 'unqualified love' and the tendency to idealise… [her husband] …but I mean she shared quite a lot - she risked…at the same time, did try to show how it affected her...she's showing self-awareness and insight.*

P7's further account describes the applicant's earlier trauma and features of pseudo-independence: "Her mom taught her the value of independence. Ja because mom didn't notice she was being abused so she had to be independent." And, because the mother did not notice the sexual abuse and the father was generally absent, "There was an incredible anxiety that was going on at that point and vulnerability. So how she's presented her entire paper makes sense just on that - that she's had to be strong, very together, look after herself because the parents were not around. So she's become quite parentified and the omnipotence."

According to the themes of analysis, this participant describes K1 as an "anxious" child. In the category "Trauma, loss and deprivation", the theme of "crime trauma" is identified in the ongoing sexual abuse. The theme "narcissistic dynamics and needs" is represented by P7's perception of K1's dynamics as omnipotent and "parentified". Also in the category "Family relationships and dynamics", P7 describes a poor quality and absence of parenting. This participant appears to hold a generally positive perception of K1's adult relationship and

suggests it is a "healing attachment": "Ja, very idealised that relationship," but, "the fact that she's now found this husband, who is not abusive as far as we can see, is quite a healthy healing thing. She's found a good relationship so this is hopeful." P7's question, "Where is the genuine kind of angry reaction to this?" suggests the category of "Obstacles and limitations" in mechanisms of "defence" (e.g. denial and/or repression). The theme "capacity for resolution" is represented by P7's perception that K1 displays self-awareness and insight.

Least suitable - On the other end of the ranking, K5 is considered to be the least suitable applicant to be invited for an interview:

> *There's still quite a lot of naivety in this one. There are still quite a lot of like primitive defences in a sense. She's got quite a superficial integration of what's happened in her life...it's written quite dramatically…I almost want to say histrionic but she's not histrionic…ja which makes you wonder about her ability to hold boundaries in terms of holding. Ja quite a lot of intense emotion. Would she react in an intense fashion given a difficult circumstance? I mean there's a bit of splitting and idealisation where she talks about how awful her dad was but how everything miraculously came right…it doesn't sound genuine. It sounds defended. What I think she's trying to get across here was that this is something from the past that she has learnt about…where she says 'Confrontation was not my game and if trust was broken, I'd wash my hands clean of the person.' What she's talking about, is quite a tendency to split. And she's not talking about how she addressed this, how it's changed, what's different. It's as if she has quite a superficial understanding that it's wrong - that she shouldn't be doing that in a sense. But she's not conveying it - she doesn't have a deep enough understanding I suppose...She said ja her dad 'made dramatic changes over the years due to my mother's resilience and dedication to her marriage and her family.' Now that is complete idealisation of the mother – mom's omnipotent and all rescuing here – dad's bad, mom's good. [And] She talks about it being quite painful history. Dad was physically abusive and she's like very enmeshed with the mom it sounds like.*

P7's account of K5 includes the following themes: The candidate is described as naïve and superficial and this suggests she lacks "emotional maturity" and a depth of understanding. The category "Trauma, loss and deprivation" is identified in P7's perception of "…it being quite painful history." P7's query whether "she [has] separated enough from her family?" suggests enmeshment and the theme of "problem family dynamics" and negative experiences in the family of origin. In relation to the "therapy process and frame" there was concern that the candidate would have difficulties maintaining appropriate boundaries. Furthermore, in terms of K5's "trainability" and "countertransference" evocations, the candidate's "issue of trust" poses concern: "You'd wonder what this would then bring out in her therapies? She's gonna have issues with colleagues…how would this person react to supervision when you have to be able to take criticism? My feeling is she would idealise completely like the mother depending you know, what kind of supervisor she got." K5 is considered primitively "defended": "…there'd be those kinds of primitive defences in action and that would come up because she's quite threatened at times." These features, in sum, suggest that this candidate may be "too vulnerable": "Trust…points to early issues…and together with this kind of dramatic naïve presentation with all these defences…I mean you think a little bit fragile. It would be a rough year for her."

The category "Trauma loss and deprivation" and the concern of "defences" is raised in relation to both K1 and K5. It seems in summary, however, that P7's ranking of K1 as the most suitable candidate reflects the import, for this selector, that the candidate show a "capacity for resolution"': "She's integrated quite a lot in there [the autobiography] so I think there is an ability…to self- reflect." Still, for P7, "The little bits of omnipotence - kind of you'd worry about." This concern is followed, however, by the selector's comment, "But I always think a bit of healthy omnipotence and narcissism helps being a therapist."

Participant: P8

This selector emphasises the primacy of the therapy relationship. "I think fundamentally without a relationship the therapy's not gonna go anywhere. So the person's capacity to attach or form a sort of a deep relationship in therapy is quite fundamental." And so, "[From the adult attachment interview]…attachment…is your ability to give a coherent…detailed and in depth account of

yourself." For P8, the suitable candidate also displays a capacity for insight and empathy along with warmth as "a lot of people would respond well to a warm therapist."

Most suitable – K1 and K2 are ranked by this selector as the most suitable candidates for an interview; however, it appears that K1 is the first choice overall as suggested by P8's statement, "I think she does link quite nicely this first one."

> *This person discloses about sexual abuse by a family member and she looks at the sort of dynamics around it: That her mother was…was unaware. Although the mother did seem to be aware you know but the mother was kind of absent and the father was absent. I suppose she links that to her enormous anxiety and panic attacks - sort of having to deal with things without parental support and how anxiety provoking that is. You know I think she's able to sort of indicate that she did engage in sort of drug and alcohol abuse and that was linked to her unhappiness and that she did in a way expose herself to potentially abusive relationships; that there was a lack of self-esteem, a lack of self-worth. She is now married… [and] …she might have a tendency to idealise…but she does seem to be using her current relationship in quite a positive way, which I think is quite positive. I think there might be…a bit of inconsistency because she talks about her mother being absent and her father being absent and then her father being an alcoholic. And then she sort of 'My family has taught me the morals and values.' It's sort of…a little bit of splitting in a way because she's saying what a difficult impact it had but then... but I mean that's something I'd like to explore and to see what extent she's able to hold those two aspects in her mind. I also think she discloses but there is...it's a contained disclosure. It's not sort of all out there and it is quite contained...She mentioned sexual abuse by a family member but she doesn't go into the details of how she was abused, and who it was, and sort of you know maybe details that might be inappropriate you know - that type of situation. So I think she does, she mentions it, but she doesn't sort of inappropriately divulge details and that kind of thing.*

Still, for P8, K1 has potential attachment difficulties. This is a concern in relation to the candidate's ability to form and sustain a therapeutic relationship. P8 states, "If you look at this

person and she was sexually abused and…her father was an alcoholic and absent and her mother was sort of didn't assist her or was unaware…I would imagine that she's got attachment issues you know - it comes up as separation anxiety panic attacks and that sort of thing." However, this selector further notes that K1 appears to have "the capacity to form other relationships …Like she mentions her marriage, which is sort of quite a rock for her stability… She is indicating that she seems to have formed an attachment to a partner and seems to have been able to negotiate some of the difficulties involved in a sort of an intimate adult relationship." Furthermore, the information that K1 had previously been in personal therapy is considered "positive…and again…whether you're able to stay in a therapy relationship speaks about your capacity for attachment." In addition to this, P8 had found the experience of therapy "helpful…and…containing," and had conveyed that this had "helped her deal with her anxiety." Thus, although P2 raises concerns regarding K1's early attachment difficulty, it may be that the perception that the applicant has achieved some resolution through a healing relationship, and displayed a capacity for attachment, alleviates P8's concern.

In relating K1's history to the therapy process and frame, P8 states concern that, "it's linked with the sexual abuse….boundary issues are something that maybe comes out in various ways. I mean sexual abuse…sort of links with the person's own capacity for boundaries in therapy, you know. Whether they're going to be able to hold the boundaries, whether their sort of boundaries are very non-permeable which would, I suppose, affect the attachment relationship." This is also related to potential countertransference issues and defences in the applicant: "…whether they're too open and sort of taking on too much of the persons stuff or over-identifying with them or sort of their ability to think about projections rather than just take them on."

According to the analysis of themes, P8's account indentifies in K1's autobiography an "anxious" child with a poor quality and/or a lack of parenting. The category "Trauma, loss and deprivation" is represented by themes of "crime trauma" (sexual abuse), and "illness" evidenced by the candidate's anxiety and panic attacks. From K1's potential earlier "attachment difficulty", the theme of "healing relationships" emerges and the potential to form attachments. In the category "Obstacles and limitations", there is concern that K1 employed "defences" (splitting) and would have potential boundary issues and "countertransference" evocations with patients. In

terms of "Resources and strengths", K1 portrays psychological mindedness in that "she looks at the dynamics" around her earlier trauma and makes "links" in her history. This suggests the theme "capacity for resolution".

Least suitable - K6 is ranked the least suitable applicant for an interview:

> *[They] gave away nothing about themselves. And sort of just looking at the autobiography, I think my sense would be…less suitable because they're not opening up - they don't seem to have insight. [And] I think it [attachment] is more difficult to gauge…because they don't mention anything about themselves. But I think that in itself...the autobiography would give you an idea of whether the person's able to give a sort of a detailed account of themselves. [This] person…certainly doesn't give a detailed account of themselves.*

P8's concern regarding of K6's attachments appears to be in terms of the applicant not providing a "coherent…detailed and in depth account" of herself and, in line with the tenets of the adult attachment interview, shows a poor indication for attachment. Also, the candidate did not seem to have insight and thus, the "capacity for resolution" is not indicated.

In summary, P8's ranking reflects this selector's emphasis on the candidate's capacity to form attachments. Whereas P6 has shown no, or poor, attachment ability, P1 is perceived to have the capacity to make attachments and therefore to form the essential therapy relationship.

Participant: P9

According to this selector, "a lot of applicants have had difficult times. But it's not necessarily the difficult times that make a good applicant; but in the presence of difficult times it's more in how self-reflective the person is and how they make sense of that. And that's what for me… somebody who's gone through a healing process or searching for healing and perhaps looking to psychology for some healing…So I think it depends on how they write about those difficult experiences." Candidates also need to "Be in touch with oneself… [as this] is a start for being in

touch with somebody else." P9 adds that the most important therapist quality she looks for in a candidate is "sincerity".

Most suitable – P9 states that she would invite K4 and K1 for an interview. However, based on this selector's statement that "This person [K4]...should reapply the following year", suggests that K1 is ranked by this selector as the most suitable candidate:

> *She's gone through a lot. She gave a very detailed account of what her life has been. A lot of potential… [And] She's gone through sexual abuse by a family member. Parents that largely were not aware of it. She's had to go through that; overcome separation anxiety and panic attacks. And she talks about not being a victim – you know - that kind of language. Parents getting divorced while either he or she was ill. I'm not sure why I keep saying 'she'? An alcoholic father and then the person experienced with drugs and alcohol, had lots of boyfriends - that's probably why I said 'she' - had lots of boyfriends. One of them was abusive…I mean she's saying that she's gone through a lot of things - but for me it's really the insight of how she came out of it; and the insight of how this impacted her and how this made her as a person. Ja and basically how her story has been moulded by her experience. That insight is what I think makes me want to see her and get to know more about her.*

P9 hypothesises that K1 may have various psychological difficulties in light of her family dynamic and relationships. For an applicant growing up in an unpredictable environment, "attachment needs might be thwarted," and they "might not really be able to get a good model of what a warm empathic parent is, which might make them a little bit more at risk of having difficulties being empathic themselves." Also, living with "an alcoholic parent" exposes them to a "culture of avoidance" and they may "learn that it's not good to deal with problems."

According to the analysis of themes, P9 identifies in K1's autobiography "crime trauma" (sexual abuse) and "illness" (anxiety within herself and alcoholic parent). In terms of "Family dynamics and relationships", are themes of "parents' marital problems" and potential "attachment difficulties". "Resources and strengths" are identified in terms of robustness – "somebody who

has a lot of vitality and felt energy from the protocol." In "not being a victim" K1 potentially portrays herself as an "overcomer". The theme "capacity for resolution" is represented by the candidate displaying insight - "how she came out of it and the insight of how this impacted her and how this made her as a person." "Obstacles and limitations" are alluded to as "learned defences" (avoidance) and possibly, an "impaired capacity to be empathic" with others.

Least suitable - On the other end of the scale, K3 is ranked the least suitable applicant for an interview invite:

> *It doesn't make sense to me. I mean there's a lot of things there - why the person chooses - you know like they emphasise choice but isolation over people, rebellion over conformity, happy childhood. So I'm not sure what that's about. I also think that they said that they had little discipline…I think this person is a rebel…is going to have some authority issues, is going to be challenging…And somebody who is used to having choice and exercising their choice is going to struggle with that [M1]; going to struggle with you know being guided, being supervised. [And] …he says here that: 'The family code is based on tradition, morals and thankfully humour.' Now…it can't be all roses if you are thankful of humour. What's going on? So I do feel that there's something this person is hiding. They're closed off, they're not accessible and they are probably…they are…ja there's a fantasy of denial, a fantasy of family, happy childhood. I also do feel that there is a little bit of narcissism in this person: 'Very popular and sporty and I made all these choices.'…There's a lot of look at me…I – I – I. And this person… 'chose isolation over people.' I would really wonder why he'd want to be in psychology.*

P9's concerns regarding K3 are as follows: In the category "Obstacles and limitations", "defences" are represented by mechanisms of denial and minimisation (through humour). The theme, "narcissistic dynamics and needs", may be evidenced in K9's perception of the candidate displaying self-absorbedness and grandiosity in "look at me." It appears that P9 is sceptical of whether this candidate would make a "good fit" with the role of psychologist. Also, for P9, K3's statement of a "happy childhood" is considered an unrealistic fantasy. This suggests that the participant holds a "bias against [such] normality". P9's perception of this applicant is that he

was rebellious and authority-challenging – essentially, an adolescent depiction. This suggests a lack of "emotional maturity" and poses a problem in terms of K3's "trainability".

In summary, P9's ranking reflects this selector's thesis that "Some people have had difficult times and they're all over the place and they've held too much without really making sense of it and don't show insight – that's not a good sign. And some have had difficult times - that they've shown some kind of healing quest almost." It appears that, as opposed to K3, who is perceived as defended and inaccessible, this is met in P9's first choice of candidate. According to P9, K1 shows insight as to the impact of her difficulties and a quest for healing and an overcoming of these.

Participant: P10

For this selector, the suitable candidate for a course in clinical psychology at Wits University has to be able to convey "an appropriate self-disclosure." Candidates need to portray a "good-enoughness" of three qualities. Firstly, "an understanding of the [developmental] theory," secondly, the capacity for "the 'reverie'…that comes in the room when you're working with the person," and thirdly, "being aware of your stuff…[the] countertransference and transference stuff…implied in the working." Also, the suitable candidate needs to have, "a genuine capacity to engage" with others.

<u>Most suitable</u> – K4 is ranked by this selector as the most suitable candidate for an interview:

> *...there's something about more of an appropriate disclosure around some kind of childhood trauma as opposed to case one (Case 1). You know the sense that this person (Case 4) is at least invested in trying to look at kind of her past and how it has influenced who she is. And I suspect that at the mention of the therapy and the assessment was about something happening in her life that at least shows that...my fantasy is that she benefited from it and that she found it a really useful time in her life to have looked at something – those type of things. And she does seem to be open to either ongoing therapy – personal therapy – which is of course a very very important aspect of kind of working in this kind*

> *of way. So ja there's a nice capacity for self-reflection and thoughtfulness you know – personal insight.*

According to the analysis of themes, P10's account indentifies in K4's autobiography the following: In the category "Trauma, loss and deprivation", the theme "crime trauma" (sexual abuse). P10 considers this trauma to be appropriately disclosed by K4 and links this to an ability to maintain therapist-patient boundaries: "How clear the boundaries are about what is disclosed and what you don't disclose." P10 perceives K4 to be "motivated" to "look at her past and how it has influenced who she is." This further suggests that this candidate displays a capacity for self-reflection, insight and thinking and thus, the theme "capacity for resolution".

Least suitable – K3 is ranked the least suitable applicant to be invited for an interview:

> *My first impression of this autobiography is a real reluctance to disclose…it's kind of very, very factual…and even lacks maybe the depth or disclosing one would appropriately do for a job interview. There isn't a psychological mindedness to it. I sort of fantasise about an extremely guarded person and would worry about a capacity to engage. I would worry about a capacity for empathy. Those are the personal attributes that I would be a bit concerned about.*

P10 raises further concern: "This statement around 'I was very popular and sporty, though I frequently chose isolation over people.' The things around secrecy – just being unwilling to disclose - a defensiveness I suppose." The selector states that because of K3's defensiveness "I would worry about a capacity for empathy and engagement," and "they would lose patients easily, wouldn't be able to track…probably quite judgmental." Also, K6 may be overly rigid in relation to the therapy process and frame: "I think the person would get stuck…very very restricted in the way they would be able to work…. I suppose, critical, more inflexible...I suspect the person would probably be really rigid around things around a frame, but it wouldn't be a holding kind of experience for the person on the other end."

In describing potential issues for such a candidate working in the transference-countertransference dynamic, P10 states,

> *...being extremely guarded and defended…one would see very little of a willingness to disclose around countertransference issues: In the process notes, in the bringing to supervision, because that would feel exposing. [And] I think that there would be a resistance to…engaging with the transference and countertransference stuff…When you kind of have – I'll use a Bion term – when the alpha function of the therapist in the room doesn't allow for all of it to be present - for a disclosing of all of it you know - it really restricts the therapy in a way that isn't as full to the patient*.

P10's perception of K6 represents themes in the category "Obstacles and resources" of "countertransference" issues, "defences" and problems in terms of potentially over-holding boundaries which would impede the "therapeutic process and frame". P10 considers K6 to potentially have difficulty being empathic with patients which would affect the "therapy relationship". Also, K6 did not display psychological mindedness. Conversely, P10's ranking of K4 better reflects this selector's criterion of the candidate displaying insight into their own difficulties and a capacity to convey a contained, "boundaried" account of these.

4.8.5 Summary of the implication of woundedness in selectors' rankings of protocols

The overall results of participants' ranking of all the candidate protocols showed a particular trend (see Table 3). Candidates depicting woundedness occupy almost all uppermost positions ("most suitable") and candidates depicting deviant protocols of unwoundedness occupy most positions of the lower rankings ("least suitable"). The analysis of major themes and patterns across all selectors' separate rankings of candidates is presented in categories: "Selectors' impressions of most suitable applicants" and "Selectors' impressions of least suitable applicants" (see Tables 4a and 4b).

4.8.5.1 Selectors' rankings of most suitable candidates

The results of selectors' ranking of the "most suitable" candidate protocol were as follows: Selectors P3, P4, P7, P8 and P9 ranked applicant K1; selectors P5, P6 and P10 ranked applicant K4; selector P2 ranked K5; and selector P1 ranked K3 as the most suitable candidate for an interview. Thus, applicant K1 was most frequently selected as suitable, followed by applicant K4. This finding shows that nine of the ten participants ranked autobiographies depicting narratives of woundedness as most suitable for clinical training.

Selectors' impressions of most suitable applicants

In terms of applicant commonality, all ten participants identified themes that suggested these individuals had negative and traumatic experiences during childhood, whether this was explicitly stated by applicants or not. In this, the dominant themes were "crime trauma" and "negative experiences in family of origin". These were followed by less dominant themes of "illness" and "physical moves".

In the category "Perceptions of childhood experiences in family", three selectors described the theme of "narcissistic dynamics and needs", identified also in features of pseudo-independence and a pattern of 'giving over to other'. Four selectors noted themes of "parents' marital problems", "poor quality of parenting" and/or "parental absence". Two of these selectors further linked these problem family dynamics to candidates assuming roles of "caretaker, parent and mediator" in their families of origin. Emerging from the sub-category "Relational attachment", four selectors posited that applicants had "attachment difficulties" with their primary caregivers.

In terms of applicants' later, adult relationships, three participants described a pattern of "dependent adult relating" and three participants perceived [these] candidates to have benefited from "healing attachments". Three selectors presented the theme of applicants being "lonely and anxious as children" and, from another selector, the dynamic of the "observing" child.

In the category “Calling to psychology”, three selectors linked applicants’ “motivation” to become therapists with the desire to heal themselves and/or others; one selector expressed a lack of motivational link between the applicant and the profession. Another selector identified a “goodness-of-fit” for the parentified child.

From selectors’ perceptions of applicants’ “Resources and strengths”, the emergent themes were “psychological hardiness” and “resolution”. “Psychological hardiness” captured three participants’ perceptions of applicants embodying an internal locus of control, potency and autonomy, robustness and resilience. One selector perceived their choice of candidate to be “emotionally mature”. In terms of “resolution”, one selector perceived a candidate lacking some level of resolution while another considered an applicant possibly foreclosing on their process of resolution. However, the dominant theme was the “capacity for resolution” with nine selectors identifying these psychological qualities in their choice of most suitable candidate. The remaining selector alluded to the candidate being in the process of “working through” his/her issues which implies a “capacity for resolution”.

In sum, seven participants raised concern regarding these candidates, which fall in the category “Obstacles and limitations”. Three selectors identified candidates who may have therapist-induced “countertransference” evocations. Five selectors identified candidates who may employ “defence” mechanisms. Two selectors raised concern for applicants having difficulty maintaining appropriate therapeutic boundaries (“therapy frame”). One selector considered an applicant to have potential difficulty with being “empathic” with patients and another selector raised concern that the candidate was “too vulnerable” and, as such, clinical training posed a risk to the would-be therapist.

One of the participants acknowledged that her choice of candidate was based on her personal weighting. This introduced the category “Selector bias” and the theme of “personal bias”.

4.8.5.2 Selectors' rankings of least suitable candidates

The results of selectors' ranking of the "least suitable" candidate protocol were as follows: Selectors P1, P2, P4, P5, P6 and P8 ranked applicant K6; selectors P3, P9 and P10 ranked applicant K3; and P7 ranked K5 as the least suitable candidate for an interview. Thus, applicant K6 was most frequently selected as least suitable, followed by applicant K3. This finding shows that in each case, bar one, participants ranked autobiographies depicting narratives of unwoundedness as least suitable for clinical training.

Selectors' impressions of least suitable applicants

In terms of applicant commonality, two selectors identified individuals as having negative and traumatic experiences, whether these were explicitly stated or not. These were represented by themes of "negative experiences in family of origin" and "physical moves". In the category "Perception of childhood experiences in family", one selector identified themes of "family relational difficulties". Five selectors identified the theme of "narcissistic dynamics and needs" in applicants; these were identified in features of applicants portraying a "false self" or an "ideal self", grandiosity and self-absorption and the role of rescuer. From the emergent sub-category "Relational attachment", one selector raised concern around a candidate's capacity for attachment.

No selector referred to these applicants' personality dynamics as children. From two selectors' descriptions of the [now] adult applicants, the theme was "lack of emotional maturity": one selector described an applicant as naive and superficial and another provided an adolescent depiction of a potentially rebellious, authority-challenging candidate.

In the category "Calling to psychology", one selector perceived that one of the applicant's "motivation" to become a therapist was to heal others. Another participant alluded to a "not-good-fit" between a candidate and the role of therapist.

No participant identified any applicant features that fall in the category “Resources and Strengths”.

In sum, all ten participants raised concern regarding these candidates, which fall into the category “Obstacles and limitations”. Every selector perceived these candidates to employ “defence” mechanisms. Three selectors raised concern for applicants experiencing difficulty maintaining “therapy boundaries”. Three selectors identified candidates who may have therapist-induced “countertransference” evocations with patients. Two selectors considered applicants to have potential difficulty establishing the “therapy relationship” with patients and one selector stated that, in light of the candidate’s “vulnerability”, clinical training posed a risk to them. In these cases, applicants’ perceived “lack of capacity for resolution” was better captured in the category “Obstacles and limitations”. Six selectors identified the *absence* of certain associated psychological qualities in candidates; these included a lack of insight and self-awareness, an inability to self-reflect, no psychological mindedness and no evidence for the capacity to think about themselves or their feelings.

From three participants, who appeared sceptical of candidates’ portrayal of seeming normality and/or happiness, the theme “bias against [such] normality” was represented. In addition, three selectors spontaneously voiced their negative countertransference responses toward some of these candidates.

4.8.5.3 Common and distinguishing features between most and least suitable applicants

From the previous results, it is evident that selectors identify certain features and qualities in candidates that distinguish them as the most or the least suitable applicants for clinical training. A comparison of salient themes and patterns, identified in selector rankings, suggested the following:

Selectors’ perceptions of the most suitable candidates were that they all had had negative or traumatic experiences, but in the least suitable cases, this was hardly identified. Whereas suitable applicants were perceived to have had attachment difficulties with their primary caregivers,

selectors made little or no mention of attachments in relation to the least suitable applicants. Both the most and the least suitable candidates were seen to have narcissistic dynamics and defences However, in the most suitable candidates, this was linked to pseudo-independence, caregiver, mediator and parentified child roles and in the least suitable candidates, this was mostly linked to the presence of the "false self". The most suitable candidates were perceived to have been lonely, anxious and observing children, while the least suitable candidates lacked emotional maturity as adults.

Suitable candidates' motivations to become therapists were linked to the desire to heal themselves and others. One of the least suitable applicants was perceived, by one selector, to be motivated to heal others.

Almost as many selectors identified in their choice of most and least suitable candidates, almost as many, and the same, obstacles and limitations in relation to the candidates providing therapy. However, the differentiation between selectors' rankings was apparent in terms of candidates' potential capacity for resolution. Most suitable applicants were perceived as having a capacity for resolution while unsuitable candidates were not.

Lastly, the theme of "selector's personal bias" differed between these groups: participants' spontaneous negative countertransference evocations emerged in relation to their choice of least suitable candidate and, in one case, a selector's personal bias for their choice of most suitable candidate. Based on these specific cases, the former suggests a "bias *against* unwoundedness", and in the latter case, "personal bias".

4.9 Analysis of continuities and discontinuities

This final section of results includes firstly, an analysis of continuities and discontinuities between the researcher and selectors' impressions of woundedness. This is derived from the analysis of the entire autobiographical data set and subsample of protocols, respectively. Secondly, the analysis of discontinuity between selectors will be analysed for deviant rankings

only – selectors' commonly shared impressions have been thematically analysed for continuity in the previous summary (selectors' impressions of most and least suitable applicants).

4.9.1 Researcher and selectors identify autobiographical themes and patterns

From categories "Trauma, loss and deprivation" and "Perception of childhood experiences in family", the most continuous theme, for both the researcher and selectors, was that applicants had negative and traumatic experiences.

Commonly identified themes within the first category were "illness", "crime trauma" and "physical moves". In the second category, "Perception of childhood experiences in family", the researcher and selectors identified themes of "problem families and relationships" and "adultified childhood roles".

Selectors' accounts of applicants' negative and traumatic life events were congruent with the researcher's finding of applicants holding "negative" perceptions of their childhood experiences. The researcher's finding of applicants holding "positive" or "ambivalent" perceptions of childhood experiences and families of origin were evidenced and *interpreted* in selectors' accounts. Selectors appeared sceptical of applicants portraying a "positive" perception of their childhoods and these were generally considered to reflect the applicant being in denial. Selectors' impressions of applicants portraying "ambivalent" perceptions of their families of origin were interpreted more positively as an indication of candidates' ability to hold onto both good and bad experiences.

In the category, "Perception of self", the researcher's presentation of applicants who felt "alone and insecure" as children, was consistent with selectors' identification of themes of "lonely" and "anxious" children. The researcher did not identify the selectors' themes of would-be therapists having been "observing outsiders" or that they were "emotionally attuned" and "less defended" than others. The researcher's second theme in this category, the "overcomer", was more or less congruent with participants' depiction of candidates embodying "overcoming" capacities and

resilience. Based on selectors' various accounts, these qualities were captured by the researcher as "psychological hardiness".

There were two themes that emerged from selectors' accounts only. The first was the theme "narcissistic dynamics and needs". Selectors identified these in [applicant] features such as unmet childhood needs, narcissistic defences and dynamics. Next, were selector identified themes of applicants' patterns of relational attachments. In this, the sub-category "Relational attachments" included themes of "attachment difficulties", a pattern of "dependent adult relating" and "healing attachments".

Thus, themes that stemmed from selectors' impressions of candidates' personality psychodynamics and relational attachments, as well as the various interpretations of applicants' perceptions (negative, positive and ambivalent), were not found in the researcher's results. This absence reflects the researcher's primarily data-driven description of explicit autobiographical statements only, compared to selectors' description *and* interpretation of the autobiographical data.

4.9.2 Analysis of discontinuity between selectors

Three participants selected autobiographical protocols that were uncommon or deviant in comparison to the popular rankings of others.

One selector, P1, chose applicant K3 as the most suitable applicant for an interview. As such, this represents the only protocol of unwoundedness in the uppermost position of rankings. P1 noted that there appeared to be "contradiction" in this applicant's narrative, however, the writer portrayed a sense of responsibility and an internal locus of control and this was of personal import to the participant. In addition to this, P1 may be "very cautious" of selecting applicants depicting narratives of woundedness as evidenced in the popularly selected protocols of most suitable applicants (K1 and K4). The following extract suggests that this selector may hold some bias against woundedness:

> *I would have thought that people with severe trauma and sexual abuse histories, we would be very cautious even though that wouldn't be exclusionary - of course we wouldn't exclude somebody. But we do know that the reality unfortunately, that for many people it has a huge disturbance on their relationships.* (P1)

One selector, P2, ranked applicant K5 as the most suitable applicant for an interview. As other selectors had, P2 identified themes of "negative and traumatic experiences" in this applicant's narrative and "Obstacles and limitations" in relation to them providing therapy. However this candidate was perceived to embody qualities of resilience and emotional maturity and psychological capacities that implied a capacity for resolution. It would appear though, that in comparison to P2's choice of least suitable applicant K6, the preference for this applicant lay in P2's "bias against [seeming] normality": That is, whereas K6 presented a positive "façade", K5 had not tried to portray herself in a "positive way or that she's just risen above this terrible stuff that's happened to her."

Conversely, one selector, P7, ranked K5 as the least suitable candidate for an interview. For P7, this same applicant lacked psychological integration of historical events, a depth of understanding and emotional maturity. The overriding concern, however, was that K5 was fragile and clinical training would be a "rough" process for her.

In sum, it would appear that there is no consistent pattern between selectors' choices that would explain the discontinuity between them. If a tentative finding could be made, it would possibly best captured by the theme of selectors "personal biases". As the last selector, P7, states in closing, "I think the fairness of the paper selection - you always wonder: Is it to do with what the selectors...their biases, their own personal stuff?"

4.10 Thematic charts: Tables 1 – 4

Table 1: Thematic chart of protocol subsample (K1 – K30)

(A)Trauma, loss & deprivation	(B) Perceptions of childhood experiences in family	Emotional/ psychological effects (A & B)
Death **Loss & separation* K13, K14, K17, K18, K21, K22, K23, K24, K25, K26, K27. Illness **Physical/ psychological difficulties* K1, K2, K3, K9, K11, K13, K14, K19, K20, K23, K24, K26, K27, K28, K29, K30. Physical moves **Separation, instability* K3, K4, K12, K14, K15, K17, K21, K24, K27. Crime trauma **Psychic wounding* K1, K4, K5, K8, K17, K18, K20, K22, K25, K26, K28	Negative **Problems in family & life difficulties* K1, K2, K5, K9, K11, K15, K16, K17, K25, K27, K29. Positive **Happy, close, stable* K3, K13, K18, K22, K24, K26, K30. Ambivalent **Mixed: positive & negative* K4, K8, K7, K12, K14, Family relationships & dynamics **Negative portrayal of:* Mother: K1, K2, K9, K14, K15. Father: K1, K5, K16, K17. **Positive portrayal of*: Mother: K5, K16 Father: K4, K14 Both parents: K30 Parents' marital relations **Loving/ Long term*: K20, K26 **Problem marriages*: K1, K2, K5, K9, K12, K15, K17, K29. Role in the family **Caregiver, mediator or parentified* K2, K5, K15, K16, K23, K29.	Psychic wounding / discomfort /distress **life-changing events* K1, K4, K5, K7, K8, K9, K12, K17, K18, K20, K22, K25, K26, K27, K28, K30 Perceptions of 'self' **Alone & insecure* K1, K3, K5, K7, K9, K12, K13, K15, K21, K26. **The overcomer* K1, K5, K7, K8, K9, K16, K18, K19, K22, K23, K27, K28.

**Themes*

Table 2: Thematic chart of protocol subsample (K1 – K6)

Case / Category	K1	K2	K3	K4	K5	K6
(A) Trauma, loss & deprivation	**Crime trauma* Sexual abuse **Illness* Anxiety/ Panic/ drugs & alcohol	**Illness* Psycho-somatic Sister's parasuicide	**Illness* Comfort in drugs & alcohol **Physical move* Separation difficulty	**Crime trauma* Relative in-appropriate **Physical moves* Emigration / frequent relocation	**Crime trauma* Physical/ verbal abuse	
(B) Perceptions of childhood experiences in family	**Negative* Problems in family **Relations* Mother unaware/ Father absent **Parents' marriage* Divorced	**Negative* Problems in family **Relations* Enmeshed/ Communi-cation problems **Parents' marriage* Divorced **Role in family* Peacemaker /parental	**Positive* Happy childhood	**Ambivalent* Happy & plagued **Relations* Positive - father	**Negative* Problems in family **Relations* Negative - father Positive - mother **Parents' marriage* Conflictual **Role in family* Mediator	
(A &B) Emotional & psycho-logical effects	**Wounding* Life-changing **Alone* **Over-comer*		**Alone* Chose isolation	**Wounding* Life-changing **Insecure* instability	**Wounding* Life-changing **Insecure* Trust issues	

Index: **Themes* / Narratives of 'woundedness (K1, K2, K4, K5) and unwoundedness (K3, K6)

Table 3: Selector-participants' ranking - in the order of most to least suitable applicant

Selector-participant	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**	**P10**
Most suitable candidate	K3	K5	K1	K1	K4	K4	K1	K1	K1	K4
	K2	K3	K4	K4	K1	K1	K4	K2	K4	K2
	K4	K1	K2	K2	K5	K2	K6	K4	K2	K1
	K1	K4	K5	K5	K2	K5	K2	K5	K5	K5
	K5	K2	K6	K3	K3	K3	K3	K3	K6	K6
Least suitable candidate	K6	K6	K3	K6	K6	K6	K5	K6	K3	K3

Index: ☐ Narratives of woundedness ▨ Narratives of unwoundedness

Table 4a: Thematic chart of most suitable applicants

Selectors' perceptions of applicants' common life events and experiences

Trauma, loss & deprivation	Childhood experiences in family		Candidates' personality dynamics	Calling to psychology
Illness (P3, P8, P9)	Narcissistic dynamics & needs	Family relationships & dynamics	Observer (P3)	"Good fit" (P3)
Physical moves (P5)	Deprived of normal childhood needs (P7, P8)	Parents' marital problems (P3, P9)	Lonely (P4, P8)	Motivation to heal self & others (P3, P6, P10)
Crime trauma (P3, P4, P5, P6, P7, P8, P9, P10)	Role of mediator/ parentified child (P3, P7)	Absent parents (P7, P8)	Anxious (P7, P8)	
Unspecified (P1)	Dynamic of 'giving over to other' (P3)	Attachment difficulties *Parent-child* (P2, P4, P8, P9)		No link to motivation (P1)
	Pseudo-independence (P7)	*Adult relating* Dependent (P3, P4, P5)		
		Healing attachment (P6, P7, P8)		

Selectors' perceptions of applicants' resources/strengths and obstacles/limitations

Resources & Strengths		Obstacles & limitations
Psychological 'hardiness'	Resolution	Counter- transference (P2, P3, P8)
Internal locus of control, 'potency' & autonomy (P1)	Capacity for resolution (P2, P3, P4, P5, P6, P7, P8, P9, P10)	Defences (P3, P5, P7, P8, P9)
Resilience & emotional maturity (P2)	Some lack, but in process (P1)	Therapy relationship (P4)
Robustness /overcomer (P9)	Possible Foreclosure of (P5)	Therapy frame (P4, P8)
		Empathy difficulty (P9)
		Risk to therapist (P4)

Table 4b: Thematic chart of least suitable applicants

Selectors' perceptions of applicants' common life events and experiences

Trauma, loss & deprivation	Childhood experiences in family		Candidates' personality dynamics	Calling to psychology
Physical moves (P3)	Narcissistic dynamics & needs	Family relationships & dynamics	Lacked maturity (P7)	Motivation To heal others (P4)
	Narcissistic dynamics The 'rescuer' (P4) Grandiose, self-absorbed (P9) 'False self' (P2, P5) 'Ideal self' (P6)	Enmeshed (P7) Problem relationships (P7) <u>Attachment difficulties</u> Poor ability (P8)	Rebel/ lacks discipline (P9)	Not-good–fit (P9)

Selectors' perceptions of applicants' resources/strengths and obstacles/limitations

Resources & Strengths	Obstacles & limitations	
	Obstacles	Resolution
	Counter-transference (P3, P4, T7, P10) Defenses (P1, P2, P3, P4, P5, P6, P7, P8, P9, P10) Therapy frame (P4, P7, P10) Therapy relationship (P6, P10) Trainability (P7, P9) Vulnerability (P7)	Inability to self-reflect, (P2, P3) Unaware/ unthinking about self (P4) Lack of insight/ psychological mindedness (P3, P7, P8, P10)

CHAPTER 5: Discussion

5.1 Introduction

The first purpose of this research was to explore trends and patterns in applicants' narratives of woundedness. In this chapter the researcher presents the significance of the collated themes and patterns in relation to the reviewed literature on the wounded healer as psychotherapist, by examining patterns in life events and childhood experiences in the family of origin, as well as the related emotional and psychological impact of these on the individual.

The second purpose of the research was to explore the implications of these seeming patterns and trends in woundedness, according to selectors, for the therapeutic process. The third was to investigate the implication of these seeming patterns and trends in woundedness for selectors evaluating applicants' psychological training suitability for clinical masters. The researcher will discuss these findings against the reviewed literature by looking specifically at empathy, psychological hardiness, emotional maturity and vulnerability as potential resources to the therapy process and impressing favourably upon selectors; and countertransference evocations, relational difficulties, narcissistic dynamics and needs, trainability, and difficulty maintaining the therapeutic frame as potential obstacles to the therapy process and impressing less favourably on selectors.

Next, with a view to reconciling the two claims in the literature review, the necessity claim (that the healer's woundedness is necessary in order to heal) and the opposing claim (that the healer's woundedness hinders the patient's healing), the researcher addresses subsidiary questions. Firstly, whether selectors see woundedness as necessary for selection suitability and secondly, how do selectors distinguish between candidates who are potential wounded healers and those who are merely wounded? The data suggests that selectors do distinguish between these candidates and that they use certain criteria to make their choice of the suitable candidate. Lastly, the researcher attempts to resolve an apparent inconsistency in the data by considering the

objection that the phenomenon of therapists' woundedness is less important than the literature may suggest.

5.2 Applicants' narratives of woundedness

The data suggested two areas in which there were trends and patterns of woundedness in applicants' narratives. The first was negative and traumatic life events and childhood experiences in the family of origin and, the second, the associated emotional and psychological effects of these. Life events common to would-be therapists included illness, death, physical moves and crime trauma. Death and physical moves were associated with emotions of loss, instability and separation. Illness was associated with physical and/or psychological disturbance, and crime trauma was more often associated with traumatic psychic injury. Common experiences in families, such as parental discord, divorce and unmet childhood needs, produced feelings of anxiety, fear and resentment and, in some individuals, narcissistic injury. The major themes that emerged from the autobiographies and interviews corresponded with the central themes arising from the researcher's reading of the literature.

5.2.1 Life events: histories of trauma, loss and deprivation

All applicants, bar two, reported negative and traumatic experiences during the course of their lives. As in other studies (Barnett, 2007; Burton, 1972; DiCaccavo, 2002; Farber et al., 2005; Fussell & Bonney, 1990; Goldberg, 1993; Guy, 1987; Sussman, 1992) applicants recounted experiences of personal loss, separation, bereavement, illness and disability, divorce and death. In addition to this, and particular to this study, were various accounts of crime trauma.

The predominance of the theme of illness in childhood and/or family of origin is supported by the literature (Burton, 1972; Elliot & Guy, 1993; Fussell & Bonney, 1990; Goldberg, 1993; Racusin et. al., 1981, cited in Farber et al., 2005). However, whereas Burton (1972) found it was therapists that sustained physical illness, in this study, physical and psychological disability were predominantly associated with substance abuse and mental illness, as found by Elliot and Guy

(1993); and, in line with Racusin and colleagues' (1981, cited in Farber et al., 2005) study, illness was often located in family members.

Secondary to illness, and equally represented in the autobiographies, were death, physical moves and crime trauma. Death and physical moves were mostly associated with themes of loss, separation and instability. One-third of applicants reported having lost a significant person through death in adolescence or adulthood. In most cases, this was an immediate family member. This finding is supported by results of previous studies (Elliot & Guy, 1993; Fussell & Bonney, 1990). One-third of autobiographers recounted physical moves, particularly during early childhood and adolescence. This finding reflects Burton's (1972) thesis that therapists often came from disrupted or disjointed families. The author's depiction of therapists having had "families on the move" and fathers in particular "busy making it" is evidenced by K4: "My dad, a humble **** by trade worked very hard and subsequently was promoted frequently and consequently we had to relocate frequently."

The theme of crime trauma was represented in one-third of applicants' autobiographies and associated with having been psychically traumatised. K17 illustrates the intensity of this experience in saying, "The armed robbery was traumatic because it was the first time I faced life and death." Other applicants reported experiences of hijackings, physical assault, child molestation and, in one case, a spouse was murdered. This finding reflects the South African context in which this study was undertaken and its high crime rate[7]. As previously mentioned in the literature review, there appears to be a gap in the literature that specifically addresses the theme of therapists' personal experiences of trauma as traditionally understood. That is, retaining the "catastrophic overtones" (McWilliams, 1994) of the Freudian meaning of trauma in which there is a psychic wounding of the mind by events.

7 This also suggests that, in this context, selectors are more likely to be faced with evaluating applicants depicting narratives of woundedness for clinical training than most. Interestingly, bar one selector (P5), who alluded to the idea that living in South Africa exposes one to trauma, this was not evidenced in selectors' accounts. This lack of specific mention suggests that these participants may have somewhat "normalised" the occurrence of life-threatening trauma in their daily lives and work.

5.2.2 Childhood experiences in family

In Fussell and Bonney's (1990) study, psychotherapists perceived their family of origin and their childhood happiness in more negative terms than physicists did. Similarly, in this study, the trend was that more applicants conveyed a negative perception of their childhoods than not. These perceptions were mostly related to family difficulties, with parents' problem marriages being the dominant theme. This is in contrast to Norcross and Guy's (1989) study in which therapists described their parents' marriages as having been 'at least functional' to 'entirely successful'. Also, in contrast to Halewood and Tribe (2003), who found trainee students holding a negative perception of parent-child relations (on specific variables) describing them in a positive light, this study found that applicants with negative and ambivalent perceptions of childhood experiences described their parents more in a negative than a positive light. Applying Halewood and Tribe's (2003) interpretation in the converse, this suggests that individuals holding negative perceptions of their childhoods in this study were *not* reluctant to criticise their parents. And drawing from Miller's (1981) argument, suggests that they had *not* repressed their histories or maintained the illusion that they had a good childhood or relationships in these.

Next, were the more ambivalent accounts of a few applicants who provided some description, both negative and positive, of their parents and child-parent relations. Although referring to mother-child relationships, Norcross and Guy (1989) suggest that these individuals hold a considerable amount of ambivalence in relation to parental figures. However, based on Halpern's (2003) paper on attachment (AAI), these ambivalences are more likely signs of anxious child-parent attachments; that is, of candidates who offer a positive or idealised presentation of their parents but are unable to support this with example. K14's statement provides a case in point: "I had a reasonably successful childhood…my father was a passionate and intelligent man…he had been an alcoholic for many years." This interpretation may be further supported by Leiper and Casares' (2000) argument that a number of therapists are insecurely attached.

Moreover, for the most part, selectors did not agree with applicants' perceptions of positive childhood experiences in their family of origin. Applicants' "close family" systems were more often interpreted by participants as enmeshed family systems and statements such as "happy

childhoods" were considered to reflect the defence mechanism of denial. As Miller (1981) previously postulated, it may be that participant-selectors perceived these applicants to have repressed their histories, maintaining an illusion that they had a good childhood.

Accounts of childhood roles emerged only from applicants who presented a negative perception of their childhoods. Applicants' depictions of these roles were supported by selectors' accounts and the literature (Burton, 1972; DiCacccavo, 2002, Fussell & Bonney, 1990; Goldberg, 1993; Maeder, 1989; Miller, 1981; Nikcevic et al., 2007; Norcross & Guy, 1989; Rascusin et. al., 1981, cited in Farber et al., 2005). That is, in the context of illness, poverty and problem families these individuals describe having adopted roles of mediator, parent and/or caregiver. As DiCaccavo (2002) has suggested, these applicants recounted assuming overt caretaker roles, such as looking after siblings, to more covert roles, such as the family peacemaker. Selectors agreed with these individuals' depictions of dysfunctional family dynamics and posited that, for one reason or another, these children felt their parents were unable to look after them as suggested by Miller (1981).

5.2.3 Emotional and psychological effects of life events and childhood experiences in family

For many applicants, their troubled families and traumatic events in particular, were emphasised as being life-changing in that they had a significant psychological impact on them. It may be inferred that these experiences caused a range of effects from psychic wounding as traditionally understood (experiences of excessive, unmanaged stimulation that overwhelm the individual's existing defences) to discomfort and distress (Garland, 1999; McWilliams, 1994). This means that many future therapists may have incurred a range of injurious psychic effects as a result.

From "perceptions of 'self'", one-third of applicants depicted themselves as lonely, anxious and insecure children and adolescents. Collectively, these self-images described individuals experiencing difficulty and mostly in relation to their problematic family environments. Selectors' perceptions of these individuals' self-images agreed with this. They added that some were watchful observers in their social and family environments. As children they may have been more sensitive, emotionally attuned and less defended than others. Taken against the

background of these writers' family problems and life struggles, these images reflect other authors' (Burton, 1972; Goldberg, 1993; Henry et al., 1971, cited in Farber et al., 2005; Miller, 1981) theses that future therapists are often sensitive children who develop a heightened and keenly attuned sense of inner life and that, for these children, growing up is a daily struggle.

Family relocations and children being sent to live with relatives or to boarding school were associated with emotional instability, adjustment and separation difficulties as suggested by Barnett (2007). Casement's (2006) personal note of how frequent moves impacted his ability to form relational attachments was raised by selectors in terms of applicants' disrupted attachments. In agreement with this, P4 said, "Moves [do] impact on the developing self and the...attachment stuff." One selector-participant associated illness with instability in the family of origin and anxiety in an applicant him/herself. As P9 says of a child living with an alcoholic parent, "That child will grow up in an environment where things are unpredictable – they're scared a lot." These findings suggest that individuals suffer negative psychological effects of illness, irrespective of whether this is located in themselves or a family member.

Selector-participants frequently perceived applicants to have received poor quality parenting and have attachment difficulties due to family problems and/or frequent physical relocation. In addition to this, selectors proposed that, as a result of dysfunctional dynamics and emotional deprivation, some applicants developed narcissistic defences and dynamics in an attempt to help or 'fix' the problems within their families. This is compatible with Miller's (1981) theory that these individuals suffered narcissistic injury as a result of caregivers failing to respond to, or validate their children. In line with the literature (Halewood & Tribe, 2003; Miller, 1981; Winnicott, 1960), selectors associated these roles with narcissistic dynamics and defences in features of pseudo-independence, the "false self" and strivings such as omnipotence, perfectionism, "driven-ness", a need for control and admiration.

What may be further related to this, and from this study, was the theme that some individuals show a pattern of dependent adult relating in their later relationships. Some applicants described partners as their "rock", providing them stability and "unqualified love". Selectors generally perceived these relationships positively and considered these to be healing attachments. A

tentative hypothesis may be that these relational attachments were healing in providing what Miller (1981) argues these individuals needed as children: the primary need to be acknowledged, affirmed and respected for who they really are at any given time. Perhaps these applicants looked for what their parents did not give them – the presence of someone who is completely aware of them and will take them seriously. Moving beyond Miller's (1981) theory, this implies that in an atmosphere of respect and tolerance for their feelings, some future therapists may be able to develop secure attachments and ameliorate their earlier relational difficulties.

Some selectors' accounts suggested that future therapists tended to be socially unconventional and may have had to assert their independence in their families of origin. The only sourced reference to this is Henry et al.'s (1971, cited in Farber et al., 2005) contention that psychotherapists had intense struggles for independence during the critical juncture between adolescence and early adulthood. What may be inferred from this, and selectors' accounts, is that some future therapists opposed a system of societal or family norms, which in a way set them apart or differentiated them from others. Although it is commonly known that adolescence is a period in which young adults often "buck the system", Miller's (1981) theory may add to this by arguing that in problem family relations, these individuals had not attained sufficient separation-individuation. Perhaps these individuals' unconventionality may be understood as their attempt to attain or renegotiate separation-individuation at a later stage of their development.

5.2.3.1 Equipped and called to psychology

It is to experiences of trauma, loss and deprivation that the dominant theme of applicants' self-perception of becoming "overcomers" is linked. These self-depictions were of "survivors" who felt they had gained personal resources and capacities through overcoming adversity. This is congruent with the literature (Cain, 2000; Campbell, 1968, cited in Goldberg, 1993) on the motif of wounded healers in that their journey of suffering had afforded them resources based on their own recovery. This was reflected by K19 who said, "My own pain and healing has had a profound impact...and has resulted in my compassion and empathy... [for]...others."

And for some, as suggested by previous authors (Barnett, 2007; Casement, 2006; Dryden & Spurling, 1989; Dunne, 2000; Phillips, 1988, Sussman, 1992), their personal histories profoundly shaped their choice of becoming psychologists. As K28 stated, "I dealt with this [trauma] and gained renewed strength and unfailing determination to answer the calling of Clinical psychology". This statement further illustrates the link between candidates seeking psychological training and the influence of their negative and traumatic life experiences – an association strongly supported by selector accounts.

Some selectors associated the role of therapist affording care-providing children a "good fit" with their inner dynamics and an extension of their childhood role. This is well supported by the reviewed literature (Barnett, 2007; Burton, 1972; DiCaccavo, 2002; Fussell & Bonney, 1990; Goldberg, 1993; Leiper & Casares, 2000; Maeder, 1989; Miller, 1981; Norcross & Guy, 1989; Racusin, et al., 1981, cited in Farber et al., 2005) and illustrated by P7 who said, "Parentified children have been training since they were about six to be therapists because they are extremely aware and sensitive of the 'other' person's emotions...they become very good at reading others... 'chameleon-ing'...listening and containing...the family situation." This similarly reflects DiCaccavo's (2002) description of the "invisible" parentified child who assumes the role of the "good" child in their problem family of origin.

There was clear participant consensus that aspiring therapists seek psychological training in an attempt to heal themselves. This concurs with the suggestion posed in the literature review that the wish to resolve personal problems is an important motivation to seek psychological training (Goldberg, 1993; Henry et al., 1971, cited in Farber et al., 2005; Maeder, 1989; Sussman, 1992). Furthermore, selectors appeared to regard applicants who were not making the link between their need to heal themselves and/or their having being drawn to the field of psychology because of their earlier difficulties as worrying. P2's query makes the point: "So why would someone want to come and do this hard work? And is it because of some seen status, or are they able to because of their own life experiences?" This statement highlights a second point similarly made by Sussman (1992); that is, for selectors, applicants' motives, whether conscious or unconscious, are strongly rooted in their pasts.

5.3 The implication of woundedness for clinical training and practice

In this section the researcher discusses the implication of these patterns and trends of woundedness for selectors evaluating applicants' suitability for clinical training and in relation to the therapeutic process. The researcher will look specifically at empathy, psychological hardiness, emotional maturity and vulnerability as resources of the potential competent therapist; and countertransference evocations, relational difficulties, narcissistic dynamics and needs, trainability and difficulty maintaining the therapeutic process and frame as obstacles to being a competent therapist.

The researcher's association of applicants' woundedness bearing on the therapy process is supported by Wheeler's (2007) argument that, "Such wounds have much to contribute to the therapeutic endeavour but they can also inhibit it" (p. 247). Aligned with this, and summed up by a participant in this study (P3), this means, "It all comes with tags."

5.3.1 Resources and strengths

Selectors emphasised that potential therapists must display a capacity for empathy. This emphasis is supported by the literature that proposes that empathic understanding is a valuable therapeutic asset and the most important variable to discriminate between more and less effective therapists (Chippindall & Watts, 1999). In line with Trusty and colleagues' (2005) concept of emotional empathy, selectors viewed this as an individual's ability to feel their patients' feelings. Participants mainly attributed this essential quality to individuals having personally experienced their own difficulties. This concurs with authors (Chippindall & Watts, 1999; Goldberg, 1993; Guy, 1987; Hayes, 2002; Storr, 1990; Sussman, 1992) who argue that empathy comes from having personally experienced pain and suffering. Closely describing Hayes' (2002) internal point of reference, P2 says, "When somebody comes and talks to you about having dealt with something like maybe you've gone through...you just know where they're at...And it gives you an ability to know quite quickly and quite deeply what's going on with the person."

However, some selectors argued that the capacity for empathy stems from good quality parenting in which children receive sensitive, responsive care. This view reflects attachment theorists' perspective that those with secure attachments have the highest level of empathy because of good quality parental care[8] (Lopez, 1995; 1987; Pistole, 1989, 1999; Pistole & Watkins, 1995, cited in Trusty et al., 2005). As evidenced in the literature review, this view is contested by other authors (Goldberg, 1993; Guy, 1987; Hayes, 2002; Miller, 1981; Sussman, 1992, Trusty et al., 2005) who argue that it is the healer's *wounds* that inform and sensitise him/her to the pain in others. In this case, wounded candidates would be more empathic with their patients.

As with empathy, candidates conveying psychological hardiness or resilience were associated by selectors with their having experienced difficulty. Comparable to this was applicants' self-perceptions of becoming overcomers in having personally experienced and survived adversity. Linking this directly to the motif of the wounded healer, P6 says, "[As with] wounded healers...in some ways someone who has been through very difficult stuff, and has found ways to survive, potentially has access to what can be difficult in...a patient's experience...some kind of sense of surviving something and of that being quite a process sometimes." In this and selectors' various accounts, the meaning of "resiliency", defined in this study as "power of recovery" (Oxford English Dictionary, 2009) is alluded to. This is also in line with the reviewed literature on the wounded healer (Adler, 1956, cited in Groesbeck, 1975; Cain, 2000; Campbell, 1968, cited in Goldberg, 1993; Guggenbühl-Craig, 1971; 1968; Jung, in Dunne, 2000; Mander, 2004; Neumann, 1959) and suggests that selectors see candidates who have experienced and worked through their own personal difficulties as embodying a psychological hardiness that may benefit their future patients.

One selector, however, associated resiliency with innate psychological capacities, present at birth and/or secure early attachments. The latter would refer again, to features of good quality parental care. But the former alludes to Hartmann's (Sadock & Sadock, 2003) concept of "normality"; that is, the idea that some individuals are born with psychological capacities that are largely free

[8] The discrepancy between selectors' accounts mirrors the debate in the reviewed literature – essentially, whether those with insecure or secure attachments are better therapists.

from inner conflicts and potentiate the ego's ability to adapt to reality and become autonomous[9]. Nonetheless, whichever its source, it was apparent in this study that selectors considered psychological hardiness a favourable asset in applicants wishing to become psychotherapists.

Less emphasised by selectors, was the requisite that candidates be emotionally mature. P2 explained that, "You can't go deep if you don't have the emotional maturity… [and] you can't be a therapist then." Comparable to selectors' perceptions of psychological hardiness and the capacity for empathy, this resource was attributed to having sat with and faced personal difficulty. It allowed therapists a depth of understanding their patients, and guided their work. The theme of emotional maturity is similarly less emphasised in the literature and mostly alluded to in terms of the wounded healer necessarily having a level of wholeness and personal integration in order to be of help and guide others on their journey of suffering (Goldberg, 1993).

The least dominant theme in terms of wounded candidates' resources and strengths was vulnerability. A few selectors stated that applicants needed sufficient ego strength to sit with their own and others' pain and vulnerability without becoming defended or overwhelmed by this. Being perceived as "too vulnerable" was regarded as an obstruction to providing therapy and a limitation in posing potential risks to wounded candidates' psychological well-being during training. Furthermore, one selector's comment suggests that vulnerability may be perceived by some as a lack of psychological hardiness or robustness: As P4 said, "My worry about one (K1) is how robust this person is. They've been through huge traumas, huge anxieties…But I would worry about this person's vulnerability."

Selectors' lack of emphasis of candidates' vulnerability as a resource in their work does not reflect the weighting of this evidenced in the literature on the wounded healer. From the first, the Jungian (in Dunne, 2000) understanding is that the notion of the wounded healer epitomises vulnerability – therapists have to be vulnerable to be deeply affected by their patients' illnesses in order to be of help (Sussman, 1992; Wheeler, 2007). And, as Groesbeck (1975) stresses, the

9 This interpretation should be regarded cautiously, but it does seem suggestive of a tentative hypothesis: That is, along with the idea that future therapists tend to be intuitive and perceptive children (Goldberg, 1993; Henry et al., 1971, cited in Farber et al., 2005; Miller, 1981) and that these are some of the very psychological capacities Hartmann considers to be autonomous of the ego's conflicts, these individuals may be more able to adapt to their life difficulties. This would support Hartmann's conceptualisation of "normality" rather than the Coltart's (1993) caricature of individuals relatively free from suffering.

power of healing relies on the therapist's vulnerability being activated. In this case, only wounded candidates would embody this crucial capacity. This imperative was not evidenced in selectors' accounts. However, what they did allude to was Groesbeck's (1975) thesis that this dynamic healing process can only take place if therapists do not project their own wounds onto the patient. This most importantly presupposes that the candidate be in touch with their own unresolved issues. This is recognised by P2 who linked a candidate's vulnerability to a lack of psychological resolution in the following statement: "They haven't done enough work and they're too fragile and they will be harmful to themselves as well as to others." This implies that selectors associate "too vulnerable" with "too psychologically unresolved" and suggests that for their own sake and that of other's, these candidates should not be selected for clinical training.

5.3.2 Obstacles and limitations

Following directly from this were the concerns of *every* selector in terms of wounded candidates' unresolved issues impeding the patient's provision of therapy. Their main concern was that these individuals were likely to have countertransference evocations and employ defence mechanisms against their woundedness. This is directly in line with Freud's initial meaning of countertransference impeding the therapy process (Lemma, 2003) and echoes the strong concern evidenced in the literature. That is, in light of their own traumatic histories, wounded healers are particularly vulnerable to therapist-induced countertransferences and, as such, pose a risk to their patients' therapies (Cain, 2000). No selector proposed, as other authors (Hayes, 2002; Heimann, 1950; Sedgwick, 1994, cited in Wheeler, 2007) had, that countertransference, if judiciously used, is a technical tool and not a hindrance to their patient's therapy. It is clear that applicants perceived as psychologically unresolved would be considered to have "blind spots" and would thus be less able to use their countertransference beneficially. In light of this strongly voiced concern, selectors may evaluate these candidates unsuitable for clinical training.

As Barnett (2007) has argued, selectors associated the risk of wounded candidates' earlier trauma with over-identifying with their patients. There was concern that these candidates would not maintain appropriate therapeutic "separateness" so that they could think about the patient and not just with the patient. This was reflected in P8's concern for one candidate with a history of

sexual abuse and another, from an enmeshed family system: “Whether they’re going to be to hold the boundaries...or taking on too much of the persons stuff or over-identifying with them or sort of their ability to think about projections rather than just take them on.” It also speaks of Bion’s (1993) capacity for “reverie” being compromised; that wounded candidates may not have the capacity to take on their patients’ projections, to hold both their patients and their own anxiety without becoming overwhelmed by it, and to keep on thinking in this process.

Participants stressed the essential requisite that potential trainees must be able to build and maintain the therapeutic relationship. Selectors’ weighting of this is supported by the literature (Black et al., 2005; Halpern, 2003) and reflected in P1’s statement that, “Your primary mode of healing as a therapist is your relationship with your patient.” This, and other selectors’ emphasis of the quintessential therapy relationship, is supported by Guy’s (1987) thesis that it is primarily through intimate and meaningful relationship that change in the patient comes about. Mostly, selectors were concerned that in the light of their early attachment difficulties, wounded candidates may struggle with building a relationship with their patients. But they were also concerned about the appropriateness of these relations. For instance, anxiously attached applicants may hold on to patients for fear of separateness, or conversely, if closeness was perceived as threatening in their primary relations, they may create too much distance from patients. These concerns point to Barnett’s (2007) argument that if therapists’ own dependency needs were not met in childhood, they may fear dependency in their patients or foster these feelings in their patients in an attempt to heal their own insecurities. It also points to selectors being apprehensive about choosing applicants for psychological training if they are perceived to have attachment difficulties.

In light of their emotionally deprived object relations and unmet childhood needs, wounded candidates were perceived by many selectors to have developed narcissistic dynamics, defences and strivings (as discussed). Participants raised concerns that concur with Halewood and Tribe’s (2003) worry that these individuals may struggle with not trying to ‘fix’ or rescue patients. For instance, P2’s concern is, “Can she sit with that and that there’s nothing you can do? You...just sit and feel how it feels. And how tragic it is sometimes....can she sit there and hold that and not escape into some kind of rescue fantasy...?” In addition to this, for selectors in this study, the

problem occurs as Wheeler (2007) contends. That is, when these therapists' needs to enhance their own sense of self-worth precede those of their patients, it is at the expense of their patients' therapies. Selector P3's statement captures this exactly: "Their motives are power and narcissism - 'I'm important and special.' And they will sometimes act in the interests of their own ego and not in the interests of the patient...The session is full of 'show-offy' bits to make them look good, but there's actually a little bit of an empathy failure in the way they've managed the patient." This view further concurs with Barnett's (2007) point that therapists with narcissistic issues are intolerant of failure, are grandiose and crave love and attention. And, as Sussman (1992) posits, these individuals have developed an inflated ego-ideal and are lured to a profession that allows for fantasies of perfection, omnipotence and grandiosity. Participants similarly recognised that, for these individuals, the therapist role becomes an avenue to meet their needs.

As such, applicants perceived to be motivated by the wish to exercise power and control and/or being placed on a "pedestal" by others may discriminate against them for selection. Also, selectors appeared to regard a candidate presenting a "false self" quite negatively. Whereas Winnicott (1965/1975) posits that the "false self" can very easily be mistaken for health, selector accounts did not reflect this. Rather, it seemed that, owing to the seeming absence of the "true self", these individuals were seen as inauthentic and worrying for selectors. P3 highlights this by saying: "You haven't got an authentic person in the room…I don't know what is sitting in front of me and I'm not training it and making it go out and see patients until I know what it is." This participant's concern is compounded by DiCaccavo's (2006) that, "...with no practised authentic emotional voice of their own, therapists are at risk of inserting their own unarticulated feelings into a client's articulated emotional suffering" (p. 475).

There was further concern that because of dysfunctional family dynamics, some applicants may not uphold the therapeutic frame. In particular, individuals from enmeshed family systems would struggle with maintaining professional therapeutic boundaries. And, considering P6's heed that "Therapy is potentially also enmeshing", this posed concern for selectors. P10 raised this issue in relation to such a candidate: "I suspect the person would probably be really rigid around things around a frame, but it wouldn't be a holding kind of experience for the person on the other end." Barnett (2007) explains that underlying the therapist's tendency to break boundaries or become

inflexible around them is grief, anger and frustration. DiCaccavo's (2006) concern regarding parentified children may also be applied here: Boundary-breaks reflect therapists' lack of understanding of how their boundaries were not respected as children. P3's warning that, "They're more likely to repeat the family pattern" reflects these authors' general concern that, without awareness and understanding of their earlier family dynamics, this pattern will continue and most likely impede the therapy process.

Lastly, selectors raised further concern for the psychological well-being of wounded candidates during training. The literature supports these concerns, in particular, those concerning candidates' psychological well-being due to the severe stressors of training interacting with the personality of the individual (Coltart, 1993; Guy, 1987; Halewood & Tribe, 2003; Sussman, 1992; Wheeler, 2002). As other authors (Guy, 1987; Halewood & Tribe, 2003) have stated, selectors in this study were concerned that, for those displaying narcissistic dynamics and for parentified children in particular, there is an increased risk of burnout due to their sense of over-responsibility, a failure to seek help and/or to look after themselves. In the context of training, selectors mostly considered candidates portraying narcissistic dynamics problematic in relation to issues with supervision. Wheeler's (2007) point was similarly raised by selectors that these individuals may struggle with being open to feedback and taking criticism.

The literature suggests that defences of feeling important and omnipotent work to hide their sense of vulnerability and may mask their feelings of worthlessness and sense of failure (Barnett, 2007; Wheeler, 2007). Selectors' accounts reflected such consideration. For instance P4 said, "The process of the course does often address those defences and I think sometimes it can dismantle some of them and leave people feeling quite vulnerable." Supported by Halewood and Tribe's (2003) study is the statement of a selector in this study who posed that individuals with low self-esteem may suffer further injury as the work load and emotional demands of the course increase and they start to feel they are floundering. In addition to this, participant-selectors were concerned that if candidates' defences were challenged during the training process, they may feel out of control and become unduly emotionally vulnerable.

5.3 The implication of woundedness for selection

Almost all participants selected applicants presenting narratives of woundedness as most suitable for clinical training and almost all participants selected applicants presenting narratives of unwoundedness as least suitable. Moreover, participants consistently selected as most suitable applicants, those whose life histories closely resembled the dominant themes and patterns of woundedness across *all* autobiographical texts. These narratives predominantly represented individuals who had negative and traumatic experiences, especially during childhood. There were reports of applicants being alone and anxious as children and adolescents. They grew up in problem families in which there was marital discord. Within these individuals' life stories, selectors identified adultified childhood roles with associated themes of narcissistic dynamics and needs. Selectors posited that some applicants may have had poor quality parenting and attachment difficulties with their primary objects.

Because of the strong indication that selectors evaluated candidates depicting narratives of woundedness as more suitable for clinical training than candidates who did not, it appeared that they considered woundedness necessary for selection suitability. This would support the view that it is *necessary* for psychotherapists to have been wounded so that they may draw on their own woundedness as a resource in helping heal others (Adler, 1956, cited in Groesbeck, 1975; Campbell, 1968, cited in Goldberg, 1993; Chippindall & Watts, 1999; Guggenbühl-Craig, 1971; Hayes, 2002; Heimann, 1968; Jung, in Dunne, 2000; Mander, 2004; Neumann, 1959).

However, clearly, participants had numerous concerns about selecting applicants depicting narratives of woundedness, both for the individual themselves and their patients' therapies. These concerns aligned selectors' perceptions of wounded candidates with the view that the healer's woundedness could hinder the therapeutic process, owing to the inherent problems associated with this. Specifically and well supported by the literature (Barnett, 2007; Black et al., 2005; Cain, 2000; DiCaccavo, 2006; Glickhauf-Hughes & Mehlman, 1995; Hayes, 2002; Halewood & Tribe, 2003; Maeder, 1989, Storr, 1990; Sussman, 1992; Wheeler, 2007), selector-participants were concerned that wounded candidates may struggle with issues around countertransference, the therapeutic relationship, narcissistic dynamics and needs and the

therapeutic frame. In addition to this, participants in this study were concerned that these individuals would experience difficulties in the training process. In light of this, and as Cain (2000) has said of the medical profession, one may propose that these participants would be equally wary of selecting applicants depicting narratives of woundedness for clinical training and practice.

5.3.1 Distinguishing the potential wounded healer from those merely wounded

From participants' various accounts, selectors distinguish between candidates who are potential wounded healers from those who are merely wounded, in their capacity for resolution. Almost all participants identified these psychological qualities in their choice of most suitable candidates. These findings suggest that selectors seek candidates who display an ability to reflect on and work through their difficulties. P2 argues for this criterion, "Generally it's not about what they've been through. It's their ability to work with it and sit with it and acknowledge it." This is further supported by Wheeler (2007) who similarly says that it is not the fact that the candidate *has* suffered traumatic experiences but rather *how* they have dealt with it that is important in determining suitability. By implication, this means that selectors consider the capacity for resolution as a necessary requisite in candidates for clinical training.

Participants variously attributed this capacity to psychological qualities such as insightfulness, self-awareness and self-reflectiveness, psychological mindedness, ego strength, a capacity to think about, and acknowledge difficult feelings. It stands to reason that selectors would seek individuals who display these psychological capacities in order to "work through" their inner conflicts and unresolved issues. Or, as Polansky (1991) puts it, the bringing to light of the unconscious steps that led to the person's emotional conflict, as well as the resolution of the contending feelings or parts of the self.

Thus, the view that woundedness hinders healing can be understood more clearly as the claim that woundedness, without resolution, hinders the healing process. But this is a misuse of the concept of the wounded healer since the very meaning of the concept of the wounded healer is based on the idea of recovery - that these ancient healers' magical powers were attained *through*

recovery from suffering and illness (Cain, 2000; Dunne, 2000; Groesbeck, 1975). Wounded healers acknowledge their inner conflicts, and work to resolve them, thereby transforming their personal suffering and mastery into a direct resource and curative power. It follows from this, that the wounded healer necessarily suffered *and* has the psychological capacity to work to resolve their difficulties. Compatible with this theory is Chippindall and Watts's (1999) study that shows selectors seeing healing potential necessarily arising, not merely from personal suffering, but in having worked through this.

Similarly, in the reviewed literature, authors (Halewood & Tribe, 2003; Reeves, 1999, cited in DiCaccavo, 2006) highlight the important issue of the psychotherapist's own resolution. Therapists need to develop self-awareness and acquire understanding of their earlier difficulties and dysfunctional family dynamics. Mander (2004) argues that the candidate must have the capacity for self-reflection. Cain (2000) and Hayes (2002) suggest the capacity for self-reflection and awareness in proposing that therapists need to be in touch with their own wounded side. Storr's (1990) emphasis that the therapist shows a relative absence of repression suggests conscious awareness and resolution of inner conflicts and earlier difficulties.

This emphasis further leads to, and may explain, selectors' seeming scepticism toward applicants portraying themselves as resolved, happy or without difficulty. The reviewed literature (Coltart, 1993; Eisendorfer, 1959; Tolentino & Zapparoli, 1968; Wheeler, 2002) suggests that the psychotherapeutic community is wary of seemingly unwounded or psychologically undisturbed candidates in its ranks. And indeed, Coltart's (1993) thesis that candidates depicting her caricature of "normal" were unlikely to be accepted for psychodynamic training was evidenced in this study. As such, the researcher posited that these selectors held a bias against such normality or, at least, a bias against candidates portraying unwoundedness for two reasons. Firstly, if the candidate is indeed unwounded then he/she will fail to meet the necessary criteria of being wounded in order to be a good healer (above the researcher suggested that selectors do perceive woundedness as necessary for being a competent therapist). Secondly, if the candidate is wounded but thinks he/she is not, then he/she will be unaware of his/her own emotional difficulties (Eisendorfer, 1959) and therefore will lack the capacity for resolution (again, also perceived by selectors as a necessary condition for being a competent therapist).

Thus, based on a sum of the findings, the researcher proposes that selectors distinguish most suitable candidates for clinical training as bearing emotional and psychological effects of negative and traumatic experiences and, importantly, that they display psychological capacities which suggest they have the ability to work through and resolve these inner conflicts and earlier difficulties. This argument, being based on these findings, re-emphasises the necessity of the healer's resolution and suggests that selectors seek potential "resolved-wounded-healers" for clinical training at Wits University.

Finally, in resolution, wounded therapists hold the emotional capacity to manage the tasks involved in clinical training and practice. In having endured and worked through their own personal journey of suffering, "resolved-wounded-therapists" embody a psychological hardiness that the merely wounded, now understood to be wounded by life and without the capacity for resolution, are likely to be without. Furthermore, candidates who display a lack of self-awareness or the capacity for resolution impress poorly on selectors. Conversely, candidates displaying the capacity for resolution impress favourably upon selectors as potential "resolved-wounded-healers". This suggests that the capacity for resolution becomes a *necessary* requisite for selectors evaluating applicants for clinical masters psychological training.

5.4 Reconciling the two opposing claims about woundedness

In the last, we may return to the first question raised by the reviewed literature: How are two apparently opposing views prevalent in the literature reconciled? The first, that it is *necessary* for healers to have been wounded to be able to heal, and the second, that the healer's woundedness could hinder the therapeutic process. In the theme "capacity for resolution", these opposing views are reconciled. Thus we can reconcile the two claims, the necessity claim and the opposing claim, by arguing that the healer's woundedness aids the patient's healing if they are resolved; but, woundedness hinders the patient's healing if the healer is unresolved.

5.5 Resolving an apparent inconsistency in the data

Some selectors disputed the claim that woundedness was considered a necessary precondition to be selected for clinical training or a predictor of becoming a good therapist. This argument would

seemingly dispel the corollary discussion that there is a "good fit" between wounded candidates and the competent therapist. Furthermore, considering that, for these selectors, suffering is considered inevitable in the course of normal development, woundedness would seem a non-distinguishing feature in that it inherently lies in every candidate. Instead, selectors' rankings reflected that there was another distinguishing feature that they sought, either explicitly or implicitly, to make their choice.

However, although these selectors may appear to be disputing the necessity of woundedness for being a good therapist, the fact that they were looking for another distinguishing feature in addition to woundedness in explaining a competent therapist, suggests that these selectors are objecting to the *sufficiency* rather than the necessity of woundedness for being a good healer.

CHAPTER 6: Conclusion

The final chapter of this research comprises six sections: the value of having used novel data, the validity of the results, the limitations of the study, suggestions for future research, implications of the study, and the researcher's personal reflection.

6.1 Novel data: applicants to clinical training

By exploring *applicants'* autobiographies, the researcher hoped to "tap" the inner existing reality of untrained therapist-subjects and generate novel data to the topic of inquiry. According to Sussman (1992) this approach avoids a method caveat of past research; the main concern being that owing to the emphasis on self-exploration, trained and trainee therapist-participants were likely to have conscious insights into the nature of their woundedness and provide psychologically informed understandings of these. There is some evidence that this approach provided novel data relevant to the inquiry of therapists' woundedness.

Firstly, the data itself moved beyond describing common life events and experiences in family of origin (such as death, illness and divorce) to the emotional and psychological effects of these from an insider's perspective. In other words, the data facilitated the investigation of the impact of common life experiences on the 'person of the therapist' beyond explication of what these experiences were to, perhaps more importantly, how these influenced an individual's *own particular personality dynamic.*

Secondly, because of these individuals' [possible] lack of conscious insight, the unconscious meanings of what their written statements conveyed most likely eluded them. For instance, some applicants' depictions of their later relationships may have been an attempt to convey relational 'wellness' but also, from selectors' accounts, elicited a newly emergent theme of "dependent attachment relations". Thus, this data may offer new insights into the nature of aspiring therapists' woundedness that may expand on existing theory and be useful for selectors evaluating applicants' suitability to enter the psychological profession.

6.2 Validity

As discussed in the methods section, the research design employed in this study aimed to promote good qualitative research practice (Guba & Lincoln, 1981). A particular strength of this design was that data triangulation provided multiple perspectives against which the researcher could check her understanding of the data (Kelly, 1999; Terre Blanche & Durrheim, 1999). Essentially, placing the researcher's findings alongside selectors' accounts minimised the risk of her biasing the results of the study and thus improved the chance of validity.

However, what could not be minimised was the risk of self-report bias by autobiography writers. That is, in the particular context of applicants for clinical training, these individuals would most likely be highly self-conscious and 'slant' the presentation of their life experiences because selectors will read these. It stands to reason that these individuals' portrayal of their life experiences may be influenced by their desire to meet selectors' expectations of what the suitable candidate looks like. Selectors similarly recognised that applicants write the "suitable" autobiography in attempting to meet the training institute's perceived requirements. One way of addressing this threat to validity, is to understand these results as particular to the context of this study. Validity is lent to the contextualisation of these results by participant-selectors' agreement that although the sample of autobiographies was varied, they were similar and representative of protocols in previous selection processes.

Analysis of continuities and discontinuities between the researcher's findings and selectors' accounts (of applicants' life events and experiences in family of origin) showed considerable continuity in terms of the main themes in all categories[10]. This promotes the confirmability of these findings. Likewise, the compatibility between the researcher's findings and selectors' accounts gives credibility and dependability to the study's results.

[10] Discontinuities evidenced in the researcher's findings and selectors' interpretation of the protocols reflected the researcher's data-driven description of explicit statements, and participants more interpretive impressions and responses.

Between selectors themselves, there was considerable continuity in terms of their ranking of candidates. However, with regards to the analysis of rankings, the researcher noted that, in some cases, participants did not ascribe only one candidate to positions of "most" or "least" suitable applicant, and she ranked these on the basis of their rationale. Although this would suggest that, in these cases, the results may have been biased by the researcher's interpretation of selectors' impressions, the overall results show a clear pattern of selectors' rankings: candidates depicting woundedness occupy almost all uppermost positions, and candidates depicting deviant protocols of unwoundedness occupy most positions of the lower rankings (as per Table 3). In other words, had the researcher ascribed the *other* "most" or "least" suitable candidate to these positions, the overall results would have remained the same. This would suggest the researcher's results of selectors' rankings are valid[11].

6.3 Limitations of the study

The selector-participant sample was biased along several variables, including gender and race. Also, selectors were interviewed from a specific training institute (Wits University) which is predominantly psychodynamic in orientation. This compromises the generalisability of the findings. However, the aim of the study was not to generate generalisable information, but to explore a particular concern and generate descriptions of the phenomenon.

A limitation for the researcher using autobiographical data was that it restricted depth of understanding. Had the researcher been able to explore these individuals' historical experiences more deeply, this would have provided much richer data and may have lent to more daring interpretations. Also, on the basis of writers' small encapsulated narratives, the researcher was unable to comment on applicants' relational attachments. This is more often provided in the context of the interview setting in which information is elicited from applicants' speech, the coherence of their narratives and disruptions in these, etcetera.

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[11] It is prudent to mention here that the autobiographical-paper selection (focused on in this study) only forms the first of a long process and many other factors will come in that will interact with the applicant's personality and selectors' impressions of these individuals. In this case, there may be a change in the results of specific cases of "most" and "least" suitable candidates. However, it is unlikely that selectors' requisite perceptions of the potential competent therapist would change.

6.4 Suggestions for further research

Despite its limitations, this study yielded interesting data and suggests possible avenues of investigation for future research.

It may be useful to extend this project by statistically testing the developing hypothesis: that is, an applicant's perceived woundedness and capacity for resolution plays a favourable role for selectors deciding their suitability for clinical training.

This study could also be re-conducted using a more diverse sample of selectors in terms of race and gender. The subjective life experience of participants from other demographic groups may lend further understanding to the phenomenon of woundedness evidenced in this study. Also, extending this sample beyond a predominantly psychodynamic institute would be beneficial. Comparison with a different school of training would serve to highlight both the unique and common therapist variables considered necessary to be selected for clinical psychological training.

In this research, the theme of "crime trauma" in the experience of applicants was evidenced. The researcher has noted that there appears to be a gap in the literature that specifically addresses the *first-hand* experience of therapists' trauma on the 'person of the therapist' and the therapeutic process. If indeed it is the case that through crime trauma many would-be and practicing therapists are psychically wounded, this becomes highly relevant – firstly, to their therapeutic capacity, and secondly, as a phenomenon that should be further investigated in the South African context especially. Selectors and trainee supervisors may benefit from being informed of the presence and bearing the effects traumatic distress may have on trainee therapists and their work[12]. It may also be interesting to explore whether crime trauma is particular to applicants for clinical training in South Africa or if this is more widely spread. Comparing this study's results of applicants' life histories with those of applicants living in a first world country may yield this information.

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[12] Especially considering that, in the South African context, it is highly likely that at some point these individuals will provide therapy for patients who have also been affected by crime trauma.

6.5 Implications of the study

The results of the study support the researcher's conceptualisation of woundedness understood as, "the emotional and psychological effects of negative and traumatic life experiences on the individual". Applicants' narratives reflected the researcher's link between negative and traumatic life events and the wounding psychological impact of these on the aspiring 'person of the therapist'. This finding has implications for the selection process, clinical training and practice.

Most psychotherapy training programmes require that trainees undergo personal therapy. Because of the prevalence of adverse childhood experiences among individuals who train and work in the field, this requisite appears necessary. However, considering Halewood and Tribe's (2003) finding of the common presence of narcissistic injury among trainee psychologists who had *already* attended forty hours of personal therapy, the concern becomes that there may be a number of quite 'unresolved' qualified therapists working in the field. This concern places further emphasis on the importance of selectors choosing candidates with the capacity to work through their psychological issues. This study's findings may add to the value of this process - that selectors may distinguish potential wounded healers from those merely wounded in their capacity for resolution. This, in turn, may ensure that the woundedness of candidates is lent in the best possible way to the therapeutic process.

6.6 The researcher's personal reflection

This project has been worthwhile for me to have undertaken as a psychotherapist in training. It has allowed me to make links between my own negative and traumatic experiences and the psychological impact of these on my person. Because of this, I am better able to understand my own personality dynamics, needs and defences against my woundedness and the impact this can have on the therapy process for my patients. It is my hope that this research can likewise make a similar impact on other readers.

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Appendix A: Subject Information Letter (applicants)

Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559

Hello, my name is Gavin Ivey and I am currently supervising a research project for a Masters student at the University of the Witwatersrand. My supervisee is conducting this project for the purposes of obtaining a MA degree in Clinical Psychology at the University. Because of the focus of this study, and in upholding your right to confidentiality, I am writing you on the supervisee's behalf. The researchers' focus is that of life experiences that have inclined people to apply for professional training in clinical psychology. We would like to invite you to participate in this study.

Some time in the past you submitted an application for admission to the MA Clinical Psychology programme at the University of the Witwatersrand. In this document you stated what has led you to want to become a clinical psychologist, provided a self-description and an account of some key experiences that have shaped you as a person. Participation in this research will entail your written consent for the researcher to use this *portion of the document only*, as part of the data set (hereafter referred to as 'autobiography'). While your autobiography contains details of your personal experiences, all identifying information, such as your name and ID number, will be deleted by me. As such you will remain anonymous. The researching supervisee will only be handed 'censored' autobiographies (all identifying information deleted) once they have been processed by myself. Your autobiography will only be looked at in relation to all other autobiographies. The results and all details pertaining to individual participants will remain entirely confidential. Selected quotes may be drawn from certain autobiographies, and appear in the presentation and analysis of findings, but the researcher will ensure that these in no way identify the writer.

Your participation in this research is entirely voluntary. Your non-response to this email will be understood to mean a refusal of consent, in which case your autobiographical data will not be used. Should you wish to re-submit in the future for admission to the MA Clinical Psychology programme at the University of the Witwatersrand, you will not be advantaged or disadvantaged in any way for choosing to participate or not participate in this study. Furthermore, you are at liberty to withdraw from participation at any stage during the research process. Should you agree to participate in this study, please state your consent explicitly in your response via email to the senders' address. This will constitute informed consent for the researcher to include your [anonymous] autobiography in the data set. It will also mean consent to the use of selected quotes in the report and, in the event that this study is published, in a professional psychology journal.

Your time in reading and considering this request is appreciated - it will ensure that this research yields useful results, relevant to potential and qualified psychologists. Should you agree to participate and are interested in the results of the study you may contact me for a summary of the findings toward the end of 2008. If you have any questions please free feel to contact me.

Yours sincerely

Prof. Gavin Ivey
Clinical Psychology Masters Programme Coordinator
Tel: (011)7174529
Email: Gavin.Ivey@wits.ac.za

Appendix B: Subject Information Letter (selectors)

Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559

Hello, my name is Theresa Partington and I am currently conducting research towards my Masters Degree in Clinical Psychology at the University of the Witwatersrand. My supervisor is Professor Gavin Ivey and the focus of my research is the 'person of the therapist' – in particular, I aim to investigate themes and patterns in the earlier experiences of those seeking a career in clinical psychology. To date, this research has only been done using therapists or masters-level trainees as participants. This project aims to elicit novel data in using a sample of autobiographical documents of [past] candidates applying for clinical psychology training. Part of the research aims to explore selectors' impressions of applicants based on their autobiographies and, the implications of these in evaluating psychological training suitability and selection. I would like to invite you to participate in this study.

Participation will entail reading six such autobiographies of previous applicants (these documents do not exceed 1 page). After this phase you will be requested to participate in an individual interview that will last for 45-60 minutes. It will be conducted at a time and location that is suitable to you.

All interviews will be audio-taped to ensure accuracy in the later analysis. However, the results and all details pertaining to the participants will remain entirely confidential. Identifying details regarding participants will not be disclosed in any form, either as part of the research, or subsequent to that. In the event that selected quotes appear in the report (and possibly a professional journal), no information identifying participants will be included.

Your participation in this research is entirely voluntary, and you will not be advantaged or disadvantaged in anyway for choosing to participate or not participate in this study. Furthermore, participants are at liberty to withdraw participation at any stage during the interview or research process. In case of voluntary withdrawal, participants will have the right to request that material pertaining to their own interview be destroyed.

The completed report will be made available to you, should you wish to read it, after the degree has been awarded. If you have any questions please free feel to contact me. Thank you for your time.

The attached consent forms must be signed by all participants.

Should you wish to participate please contact me on either 082-334-2932 or email: wpcs@iafrica.com.

Regards,

Theresa Partington

Appendix C.1: Consent Form (interview)

Statement of consent

I, _____ consent to being interviewed by

Theresa Partington_____ for the purpose of her research project.

I understand that:

- Participation in this interview is voluntary.
- That I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify me will be included in the research report and my responses will remain confidential.
- Relevant quotes from my interview may be used under condition that they do not identify me to potential readers.

Signed_____

Appendix C.2: Consent Form (recording)

Statement of consent

I, _____ consent to my interview with

Theresa Partington _____ being tape-recorded. I understand that:

- The tapes will transcribed by the researcher and the data will analysed.
- All tape recordings will be destroyed after the research is complete.
- No information identifying participants will be used in the transcripts or the research report.

Signed _____

Appendix D: Interview Protocol

(Date)

Dear (Psychologist)

As previously mentioned, participation in this research project entails:

1. Reading 6 autographical documents (each 1 page in length).
2. A 45-60 minute follow-up interview.

Please find these documents attached. The original documents have been typed verbatim with the aim of presenting the authors' exact transcript (including grammar, spelling etc.) as far as possible. In reading these, please bear in mind that:

> **The researcher aims firstly, to explore trends and patterns in the earlier experiences of those seeking a career in clinical psychology; and second, to explore selectors' impressions of applicants based on their autobiographies and the implications of these in evaluating psychological training suitability and selection.**

I will be contacting you in a fortnight to set up the interview at your convenience.

Once again, your participation in this study is appreciated.

Regards

Theresa Partington
Student Researcher
Cell No: 082 334 2932
Email: wpcs@iafrica.com

Appendix E: Interview Guide

From the autobiography protocol:

1. What is your impression of the protocols you have read?

2. What information or protocol features gives you these impressions?

3. Please rank the protocols in terms of your impression of the author's suitability or unsuitability to be invited for an interview in the selection process for clinical training.

4. Of all the applicant protocols, which do you consider most suitable for clinical training?

    4.1 What specific features of the applicant's protocol made a favourable impression for clinical training suitability?

    4.2 Why do you consider these qualities/features to be important for a potential therapist?

    4.3 How may these qualities/features impact the therapeutic process?

5. Of all the applicant protocols, which do you feel indicates low suitability for clinical training?

    5.1 What specific features of the applicant's protocol made an unfavourable impression for clinical training suitability?

    5.2 Why do you consider these qualities/features indicate low suitability for a potential therapist?

    5.3 How may these qualities/features impact the therapeutic process?

6. Of all the qualities/features you have identified, which is the most important for a potential psychologist?