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To cite this article: Marilyn Barnett (2007) What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors, *Psychodynamic Practice*, 13:3, 257-274, DOI: [10.1080/14753630701455796](https://doi.org/10.1080/14753630701455796)

To link to this article: <http://dx.doi.org/10.1080/14753630701455796>



Published online: 09 Jul 2007.



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What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors

MARILYN BARNETT

Abstract

This paper is based on a research study of therapists' unconscious motivations for their choice of profession. The rationale arose from the author's observation of a substantial increase in recent years both in the number of counselling courses on offer and in the number of people wishing to become counsellors and psychotherapists. While many of the newer courses are university based with an emphasis on academic achievement, the practice of therapy continues to take place within a bounded setting and is based on a relationship between therapist and client. Applicants for training commonly express a desire to 'help' and 'understand' others, often with minimal awareness of the origins of that desire. What are the unconscious motivations and gratifications for the would-be therapist? What is the shadow side of altruism and how might that affect what happens in the consulting room? The paper looks at initial attitudes and reasons for choosing to work in the field of psychotherapy/counselling, examines whether these may change over time and with experience, and considers the importance of personal therapy for both the trainee and the qualified therapist. The author interviewed nine experienced psychoanalytic and psychodynamic psychotherapists about their professional and personal histories. Two major themes of early loss and narcissistic needs emerged and these are discussed in conjunction with relevant literature and the concept of the 'wounded healer'. The importance of the relationship between therapist and client is highlighted and the desirability of personal therapy for safe and effective practice is emphasized.

Keywords: *Unconscious motivation, loss, narcissistic needs, training, personal therapy.*

Introduction

In recent years there has been an upsurge in the number of counselling courses available, many with an increased emphasis on academic achievement. Public demand for therapeutic help appears to be growing and it is anticipated that the government will introduce statutory regulation in the near future. Perhaps, therefore, it is both timely and crucial to give not only more careful consideration to the selection and training of those wishing to work in this field, but also to the underlying motivations for making that choice in the first place.

Where does the desire to 'help people', so often given as the reason for wishing to train, originate? What are the unconscious motivations and gratifications for the would-be therapist? Owen (1993) asks why altruistic persons should choose to care for strangers, when the rest of the 'non-caring' world goes about its business. The profession has been variously described as 'impossible' (Freud, 1937), 'eccentric' (Storr, 1980), 'curious' (Sussman, 1992) and 'profoundly odd' (Brown, 2005). What is the 'shadow' side of altruism and what negative effect might that have on our work if not brought to consciousness?

Bion (1979) recognized that an 'emotional storm' is created when two personalities meet and, two decades later, Wosket (1999) has suggested that modern trends to depersonalize counselling may be a sign of reluctance to enter such a storm. Perhaps the popularity of 'self-help' books has much to do with the preferred emphasis on the 'positive' and denial of the 'negative'.

Despite an increasing emphasis on the learning of theories, models and techniques, it is widely believed that it is the relationship between therapist and client which may be of vital importance to the outcome of the work, regardless of theoretical orientation (Crits-Christoph & Gibbons, 2003; Aveline, 2005). Patterns of behaviour and ways of relating are likely to be repeated in the consulting room, the transference and the counter-transference both clamouring for recognition.

In my experience, applicants for counsellor training tend to present themselves as 'strong' and without significant problems, yet further exploration usually reveals a troubled personal history. Mander (2004) stresses the importance of looking for 'the helper in the patient' and 'the patient in the helper' when interviewing training candidates. Erskine (2001) exhorts therapists to question why they are drawn to certain types of client or favour particular theories. Does this not indicate a need for personal therapy, preferably prior to and certainly for the duration of training? Given this, the British Association for Counselling and Psychotherapy's 2005 decision to remove it from its criteria for accreditation, replacing it with a rather vague request for evidence of 'an experience or activity which contributes to your self-awareness', would seem to be misguided. Of further concern, I suggest, is the way in which counsellor trainees can often seem so

intensely focused on getting their 'hours', perhaps losing sight of clients' needs in their haste to gain accreditation and paid counselling work. Are qualities of patience, discretion and humility becoming lost? If the motivations for choosing this field of work remain split off in the unconscious, is there not a very real danger that clients may be used in some way by therapists, rather than helped by them?

Literature review

Biographical and autobiographical accounts of well-known and respected analysts and therapists have shown how personal experiences, especially those of childhood, influenced their choice of profession (Phillips, 1988; Dryden & Spurling, 1989; Hazell, 1996; Dunne, 2000; Herman, 2001).

A clear illustration of this is to be found in a beautifully written biography of Harry Guntrip, based on Guntrip's personal notes of his analyses with Fairbairn and Winnicott over a period of 20 years (Hazell, 1996). Disturbing dreams and psychosomatic illness in the form of debilitating exhaustion had troubled Guntrip at key points in his life. He had suffered total amnesia of the trauma he had experienced at the age of three and a half years when he witnessed his 18-month-old brother, Percy, lying dead on his mother's lap. In the transference Winnicott had been able to make contact with Guntrip's lost infant self to whom his own mother had failed to relate. While the trauma had remained repressed Guntrip felt that his work had been an 'all-out attempt' to 'mother Percies' and himself (Hazell, 1996, p. 224). Both Fairbairn and Winnicott had considered it the reason he became a psychotherapist.

The two main themes that emerged from my reading of the literature concerned experiences of loss and deprivation, especially in early life, and the failure of carers to meet the normal narcissistic needs of childhood. The resultant painful effects of early loss often lead to difficulties in respect of intimacy, dependency and separation and, where there has been narcissistic injury, to issues around control, selfless giving and a need to be needed. Resulting defences mask an underlying sense of vulnerability.

Experiences of loss

Jung also became ill (with eczema) when at the age of 3 years he experienced the traumatic 'loss' of his mother, albeit a temporary separation. Melanie Klein suffered multiple family bereavements and material deprivation following the early death of her father when she was 18 years of age, an unhappy marriage ended in divorce and these experiences were compounded in her professional life when her analyst, Karl Abraham, died in 1925.

Therapists who have experienced loss, rejection and loneliness in childhood and are prone to depression may resist challenge or interpretation, for fear of provoking an angry response or of losing clients (Storr, 1980). They may view the role of therapist as presenting a unique opportunity to experience an intimacy which has previously eluded them, especially as it is a 'one-way only' type of intimacy, enabling them to remain at a safe distance, without personal involvement. However, the underlying grief, together with anger and frustration may result in either a temptation to break boundaries or, conversely, in extreme inflexibility and a tendency to intellectualize. Perhaps also there is a fine line between healthy curiosity and voyeurism.

If their own dependency needs were unmet in infancy, therapists may fear the emergence of such feelings in their clients, perhaps resolving their dilemma by choosing short-term work only. On the other hand, therapists may prolong a client's dependence on them by responding only as a rather idealized mother figure, in an attempt to heal their own insecurities. Sussman (1992) has suggested that voluntary counselling organizations may even encourage counsellors to deny their own dependent needs. Taking this a step further, is it possible that those who manage such organizations may also be prone to denying such needs in themselves and consequently risk infantilizing their workforce?

Tait (1997) has drawn attention to the portrayal by the media of therapists' exploitation of the dependency of clients. The fact that abuse of this sort can and does happen is a worrying indication of what may occur if therapists unconsciously project their own neediness into clients and surely underlines the importance of rigorous and in-depth training, along with personal therapy.

A strong maternal identification on the part of the therapist may create difficulties in respect of separation. As with mother and infant, there must be separation in order for growth to occur. It is essential that the therapist can think not only *with* the client, but *about* the client also. Empathy alone is insufficient.

Narcissistic injury

According to legend, the reflected image of Narcissus was one of perfection. The 'shadow', the disowned part, remained out of sight and out of conscious awareness. If the person of the therapist is the instrument of change, it follows that therapists' level of consciousness of their own shadow is of considerable significance and much of the existing literature relates to this (Guy, 1987; Sussman, 1992; Wosket, 1999; Wheeler, 2002). A study undertaken among school counsellors revealed that the needs most satisfied through the practice of psychotherapy were narcissistic in nature (Guttman & Daniels, 2001). An exploration of the level of narcissistic

injury among trainee counselling psychologists concluded that therapeutic work could be affected if trainees failed to examine their own narcissism (Halewood & Tribe, 2003). Symington (1993) has emphasized the importance of therapists grasping the 'narcissistic currents' in themselves and reminds us of the narcissist's use of projection in order to destroy self-knowledge.

Narcissistic injury results in individuals whose spontaneity and 'true selves' were not responded to or validated by their early caregivers and who subsequently develop a 'false self' (Winnicott (1990 [1960])). The danger for would-be therapists might therefore lie in striving for perfection and a desire to foster an idealized image of themselves to defend against their own limitations and vulnerabilities. Feelings of inferiority and experiences of humiliation may give rise to a need to feel loved and admired. Evaluation of trainee therapists' ability may feel like an evaluation of the self as a person (Wosket, 1999) and fear of 'failure' will affect his practice and inhibit his client's use of him. Winnicott (1984 [1947]) has described how the therapist, in the best interest of his client's development, needs to be able to hate appropriately, as a function of the real relationship.

Situations in childhood may have contributed to an inability to tolerate gaps, uncertainties, periods of 'not-knowing', resulting in a therapist's desire to take charge of a session and steer the course of the therapy, rather than allowing adequate space for the client's own feelings and thought processes to emerge.

Dependent and aggressive feelings, linked to early maternal separations, may give rise to a tendency to be self-sacrificing. Searles (1999 [1967], p. 81), writing of the 'Dedicated physician', describes how we can unconsciously look to our clients 'to provide our life with its central meaning, to give us a *raison d'être*, to make real our idealized self-image'.

Therapists may have had early experiences of narcissistic parenting in which they became parents to their parents. As children they were good, compliant, 'invisible', putting the needs of others before their own (DiCaccavo, 2002). This may give them a special sensitivity to the needs of their clients but they may also feel overly responsible for making the client better and guilty if this does not happen. Mander (2004) gives an illustration of a helper who became trapped in this role as a defence against underlying rage and guilt. Winnicott describes an early experience of his depressed, withdrawn mother in his poem, 'The Tree'. He recalls how, stretched out on the lap of his weeping mother, he learned 'to make her smile, to stem her tears, to undo her guilt, to cure her inward death' and ends with the words 'to enliven her was my living' (Phillips, 1988, p. 29).

An ongoing search for identity may be a major influence in the choice of psychotherapy as a profession (Dryden & Spurling, 1989). For students who undergo personal therapy as part of their training the opportunity to develop a healthy identification with their therapist may be of crucial

importance in cases where previous identifications may have involved an undifferentiated dependency. Geller (2005) is appreciative of the ways in which identifications and counter-identifications with his therapists helped to shape his attitudes towards aspects of practice that are not normally covered during training. He lists these as conversational style, financial matters, the importance of 'embodying consciousness' and 'the centrality of presence'. One of the psychotherapists interviewed by me felt that her own therapist had given her a sense of how to conduct herself when the unexpected occurred and how to manage what she described rather neatly as 'the tricky business'.

Throughout the literature there are many references to the concept of the 'wounded healer' (Sussman, 1992; Coltart, 1996; Burton & Topham, 1997; Cain, 2000; Herman, 2001; Wheeler, 2002; Mander, 2004). It has been suggested that it is necessary 'to link the wound and the wish' at the assessment stage of applicants for training (Mander, 2004, p. 166). Wheeler (2002) says that the important thing is not that applicants have themselves been wounded but how they have dealt with those wounds. Wounded healers are those who have usefully explored their own motivations and gained sufficient insight to help others.

Trainees and practitioners can experience high levels of stress and anxiety. One of the aims of a study of graduates from a UK university counselling programme, was to research which methods were considered to be 'most useful for reducing *unnecessary* pains associated with *learning* counselling' (Truell, 2001, p. 68, my emphasis). Perhaps pain is a necessary part of the process of becoming a therapist and maybe counselling is more than something to be 'learned'.

Study design and methodology

Walsh (1996) has described unconsciousness as the *sine qua non* of qualitative research, adding that the way in which the researcher conceives of the unconscious will influence the methods he employs. It has also been noted how the unconscious, as part of the complexity of the person, is one of the main issues for researchers who choose qualitative methods (McLeod, 1996).

As a clinician first and foremost, I view the practice of psychotherapy as having an inescapably personal dimension and therefore a constantly changing dynamic and I believe the enquiry method needs to reflect this. A narrative research methodology seemed, for me, a natural choice. While clearly not in the role of therapist with the participants, my training and experience enabled me to contain, reflect upon and, at a later stage, to analyse and interpret the stories that they shared with me.

The particular demands of narrative research have been well documented (Walsh, 1996; Smythe & Murray, 2000, 2001; Gottlieb & Lasser, 2001)

and it has been criticized by positivistic thinkers for being less scientific than traditional research as interpretations are concerned with *implicit* meaning. Yet it has also been suggested that objective observation is a 'myth', as every researcher carries his own assumptions (Walsh, 1996).

Eleven experienced therapists were initially approached by personal letter, of whom nine (two men and seven women) agreed to participate. Their original training had taken place within five different training bodies, the number of years in practice varied between 12 and almost 30, giving an average of 16 years, and the study embraced a wide geographical area (six counties). Although known to me by name and reputation on account of significant contributions made as supervisors, trainers and writers in addition to their clinical work, I had no pre-existing detailed knowledge of their early years and personal histories. A brief factual questionnaire was returned in advance of each hour-long interview which was semi-structured and audio-taped. Following 'immersion' (McCormack, 2004) and 'saturation' (Smythe & Murray, 2001) in the transcripts, recurring themes and categories emerged, leading to an analysis from that data of the most significant factors. The need for reflexivity is great if a balance is to be found between the desire for knowledge and ethical practice. Britton (1998) speaks of 'triangular psychic space', an intermediate area of experience outside a belief system where subjective beliefs may be objectively viewed. Just as the therapist's own narcissism may struggle with the need to behave ethically in the clinical situation, so too there is a danger of the researcher's own agenda and desire for supporting evidence getting in the way at times. Several authors view 'process consenting' to be more appropriate to narrative research than a single informed consent form, believing it to offer greater protection and freedom (Grafanaki, 1996; McLeod, 1996; Smythe & Murray, 2000; West, 2002). There were a few occasions when, conscious of a heightened emotional state and intuitively feeling that perhaps a participant was saying more than they might wish to, I chose to check out that they were happy to continue. I believe my clinical experience served me well at times like these and enabled me to sustain and contain the more difficult feelings. Some participants felt that the interview had prompted new memories or new perspectives on past events and situations, in ways that they had not anticipated and which they found helpful.

Anonymity and confidentiality are more difficult in qualitative research as people are not being 'translated into numbers' (McLeod, 1996). Mindful of this, tape-recordings were heard only by me as I transcribed them myself and they were destroyed once I no longer had use of them for the project. I also left the choice of interview venue to the participants as, despite resulting in many miles of travel for me, I felt this ensured their privacy and comfort as far as possible.

I acknowledge the limitations of this small-scale enquiry. The participants all work either psychoanalytically or psychodynamically, as I do.

While this may be seen by some as a biased view, I would suggest that any practitioner may have unconscious reasons for entering this profession, regardless of theoretical orientation.

Discussion

The two major themes that emerged from my interviews corresponded with the central themes arising from my reading of the literature. All nine made reference to experiences of early loss and deprivation and eight to narcissistic needs.

Early loss and deprivation

Each therapist had suffered some form of loss before the age of 20 years, although in only one instance had this been through death. Interestingly it seemed to be the loss or absence of fathers, for a variety of reasons, which led to the subsequent loss or emotional absence of the mother, most often to depression. This is in marked contrast to the findings of Norcross and Guy (1989) where fathers had played a prominent part in the lives of the therapists involved in that study and had been influential in a positive way.

Two therapists had attended boarding schools and two others had lived away from home while at school. They had suffered feelings of abandonment and, in the words of one, 'that horrible, sickening rejection that no-one talks about'. This therapist had experienced constant moves and frequent changes of school, reflecting the recollections of John Rowan (1989) who never dared to get too attached to anyone or any place, knowing that he would be leaving again. For the therapist in my study the discomfort around moving house continued into adulthood, being painfully reawakened when her therapist too moved house, necessitating the ending of her therapy. Another participant, relatively new to this country, had felt abandoned when her father had found new employment and moved to a different area, taking her mother and much younger sister with him and leaving her behind in order to continue her education. She told me: 'My parents had all the best of intentions and motives and in a way it was for *my sake* that they abandoned me', but despite insight and understanding it had been a traumatic experience, fuelled by earlier personal and transgenerational losses.

The subject of intimacy was important for all the interviewees, usually resulting from a perceived lack in their childhood of anyone who was truly available to listen or in whom they could confide. By contrast, others frequently confided in them, the role of confidante almost becoming a form of identity. Burch (2004, p. 369) feels that 'many of us come into this profession because we need this sense of contact with people, but we are frightened of knowing this'. Without exception they had experienced

periods of loneliness in childhood. They had felt different to and apart from their peers in various ways. Counselling and psychotherapy are solitary professions but they do afford the opportunity for human contact without long-term commitment, thereby avoiding loneliness. One therapist felt his interest in psychotherapy had begun at a very early age because he had 'always been interested in and attracted to intimate relationships'. Describing his mother as his 'first patient', he said:

she would talk to me . . . in quite an inappropriately intimate and trusting fashion, but I think actually listening to her and attempting to make an appropriate response to what she was telling me was the first experience that I had of being in a therapeutic role with a distressed individual.

This therapist firmly believed that being 'therapist' to his mother had motivated his choice of profession but felt that he had always been conscious of it and, unlike the other participants, did not feel that his own therapy had contributed further understanding.

Two therapists had assumed the role of confidante at boarding school, mirroring the experience described by Kaslow (2005). Another believed that an unconscious motivation for her choice of profession had been experiencing difficulties in her own personal relationships and she recalled her realization as a teenager that her need always to be right was preventing intimacy and leaving her without friends.

Feelings of isolation in childhood were common. One participant had grown up in the countryside with no local friends and believed that her mother's own feelings of loneliness and isolation had prevented interaction with her. Conveying a rather poignant image of a solitary child, she told me:

I used to play alone . . . I remember that, because I used to wander down into the fields and my mother would make me wear a red hat so that she'd know where I'd gone.

Later, as a young adult, this therapist could find no-one in whom to confide about a distressing situation and had become seriously depressed. She believed that experience had played a crucial part in her decision to train.

A 'solitary child' was the self-description of another whose father would compare her with her best friend, saying 'she's always spirited, always laughing, always playing and when I look at you next to her, you're always in your own thoughts, in your own self'.

Feelings of introversion, of being in her own world in childhood and, perhaps to a lesser extent, in adolescence, were echoed by yet another. Speaking of possible reasons for choosing to work as a psychotherapist, she suggested 'wanting to be sort of close in with someone . . . in that sort of role, to be important to someone'.

Seven therapists spoke of experiences of depression earlier in their lives, either their own or their mother's, sometimes both. Sussman (1992) has indicated a common theme of depression in the predisposition of analysts and how the work can help them feel more alive and Storr (1980) writes of an analyst friend who had found many of his trainee patients had had depressed mothers.

One therapist told me how, immediately after further education, he had gone to teach at what was then termed a 'school for maladjusted children'. He described it in this way:

A very maladjusted young man went off to teach similarly maladjusted young people . . . I was very depressed myself at that time.

The mother of one had become very depressed after the death of the father and, a teenager herself at the time, she had found it difficult to 'rebel' or even to be openly joyful about events in her own life. Another had developed an extraordinary sensitivity to her mother's mood, telling me:

I think unconsciously I was trying to keep her out of madness, out of depression. She suffered severe depression and was either over-exuberant, over-enthusiastic and too much for all of us, or she'd go into a *deathly* depression where she was completely unavailable.

Severe maternal depression had created considerable anxiety in at least two more therapists when young. One said: 'my mother became quite psychotic and I became very frightened she was going to kill herself'.

It has been suggested that many therapists may be heavily defended against their own dependency needs and that an increasing trend towards short-term therapy may in part be linked with an avoidance of dependent ties between the therapeutic couple (Sussman, 1992). Therapists who express anxiety about the client's ability to manage without them during breaks and holidays may actually be saying more about their own dependence on the client in order to feel important and appreciated and may be hindering the process of change and individuation. An overprotective tendency may result in a therapist becoming like a 'smothering' mother, offering too much love and too little interpretation. A therapist needs to be able not only to empathize by identifying with the client but also to be sufficiently separate to think objectively.

A recurring theme of unmet dependency needs and resulting separation difficulties was revealed in the interviews of seven of the therapists in this study. One felt that the experience of having a mother who had felt dependent on her for her very survival had resulted in feeling 'greedy' for her own friendships, to the point of being clinging. Another who had been

pushed into a premature independence earlier in life, believed that her own therapy had provided the first opportunity for her to experience feelings of dependence in a helpful way.

Perhaps this therapist was voicing a general feeling when she said:

There's some sense of wanting to follow the lost object in some way.
To find a way to both follow and to separate from.

Narcissistic needs

Narcissistic needs are always present in infancy and early childhood and may be met through a 'good-enough' environment and parenting. If, however, unfavourable circumstances prevent that from happening, the effects may persist, unconsciously, into adulthood, resulting in characteristics of intolerance of failure, grandiosity and cravings for love and attention.

As already noted, fathers in this study seemed to have been absent in some way and Mollon (1993) reminds us that no father was available to Narcissus either.

Early feelings of shame may lead to patterns of self-sacrifice and the need to become idealized parental figures to clients, resulting in therapists' overvaluation of themselves and a projection of all that is bad into clients. Working with a negative transference may prove especially difficult so that a therapist accepts all that is thrown at him without challenge, thought or interpretation. The unhappy consequence may be little prospect of change in the client and increased stress, if not 'burn-out' for the therapist.

The therapists in this study had experienced shame in various ways. These included parental disapproval, difficulties adapting to changes of environment, early trauma, family illness and secrets, parental limitations and family poverty. One said: 'having been really poor, you realise how shameful it feels...you feel *terribly* ashamed'. Another had found it difficult to accept her parents as ordinary people and felt that 'one's always ashamed of one's own limitations and family limitations – there's pride and shame'.

The need to care for others is closely linked to feelings of shame and insecurity. Therapists may become self-sacrificing in order to avoid losing clients, just as they had felt compelled to put the needs of their parents first in order to feel secure. Two therapists in this study had assumed a 'caring role' within their peer groups at boarding school, managing their own homesickness by tending the homesickness of others. Several had been 'parents' to their own parents, not only taking care 'of' but also 'around' fragile and depressed mothers. They would monitor situations, be alert to changes in atmosphere and intuitively

'know' when difficulties or dangers threatened. Two therapists described it in this way:

I developed this extraordinary sensitivity to (my mother's) mood, always trying unconsciously to keep her out of madness, out of depression.

I would watch my mother all the time and try and work out where she was and what was happening to her.

Would-be therapists who have been 'watchful' children sometimes find it difficult to challenge a client or tolerate expressions of anger in the consulting room.

Unconscious guilt and a need for reparation may lead to a desire to heal (Searles, 1999 [1966]). Seven of the nine therapists referred to feelings of guilt, mainly in respect of the mother, of causing her distress by not being good enough or loving enough or not meeting her expectations of the sort of child she had wanted. For one therapist, adult understanding and realization of her mother's depression had been accompanied by 'very deep guilty feelings' concerning the strength of her own anger during an extraordinarily difficult period of her childhood. For another, guilty feelings had arisen in respect of the initial relief she had experienced following the premature death of her demanding, perfectionist father when she was 16 years of age. This had since set her wondering about a possible link between her sense of guilt, her desire to mend and her choice of psychotherapy as a profession. She felt that perhaps she had been attempting to rescue and restore father in order to 'have an adult conversation about it with him'. She explained:

I'm really talking about ambivalence – love and hate – and how this could not be reconciled between me and my father because of his early departure. How I could not make it better, ever.

Another participant believed that her own unconscious motivation for choosing to train, initially as a counsellor and later as a psychotherapist, had been 'some kind of search and some kind of reparation'. Perhaps there is a tendency for children of troubled families to become psychotherapists in an attempt to put 'the familial Humpty Dumpty back together again' (Brown, 2005, p. 951).

Frequently a desire to help others is given as a reason for counsellor training and trainees in particular may have a strong need to be needed and an attitude of being able to work with any issue and any client. Such feelings of importance and omnipotence may hide a sense of their own vulnerability and be an attempt to compensate for feelings of humiliation in childhood. There is perhaps a danger of people with obsessional characteristics being

drawn to the profession in a desire to master emotions intellectually, both their own and those of others. In reality the converse is true. While, in the transference, the client may view the therapist as the one who holds all the answers, true compassion is expressed in the ability to lovingly sustain difficult feelings and a sense of helplessness and to survive periods of not understanding or not knowing (Banham, 2004).

The illusion of a comfortable lifestyle and a need to become an important figure in the life of another may well be an initial attraction to would-be therapists who have felt deprived of love and attention earlier on. Sussman (1992) warns of the danger of 'unconditional positive regard' being misused by therapists who need to maintain an idealized transference as a defence against inner feelings of inferiority. The therapist may be just too 'nice' for any real change to occur. The pool of Narcissus may become a very stagnant one.

Conclusion

I suggest that therapists' *real* reasons for choosing to work as counsellors or psychotherapists can be better understood with hindsight and professional maturity.

Most of the therapists I interviewed revealed similar personality traits as children. They had tended to be rather introverted, often solitary, the 'odd one out'. Inner feelings of anxiety and lack of confidence had sometimes been masked by an outward show of boisterousness or efforts to amuse and entertain. A common experience seemed to be a special sensitivity to the needs of others and a readiness to comply in order to maintain feelings of security and well-being. For some, a reparative urge was in place at an early age and the roots of a desire to heal and mend lay in the dynamics of the original family. All had suffered loss in various forms. Early lives had felt restrained and restricted in some way, owing to the demands and needs of others which always took priority and this pattern had continued into adulthood. In their conversations with me it was evident that they were still very much in touch with early experience and were not denying their pain. On the contrary, they knew those particular wounds would never be entirely healed but they had reached a place where they could think about them objectively as well as subjectively and were therefore able to help others in a wholesome way.

The wounded healer

The image of the wounded healer recurs throughout mythology, art and religion. Therapists need to be able to acknowledge the client in themselves. Cain (2000) asks whether so-called 'healthy' therapists are more effective than wounded healers, or whether they might actually be

hindered by their lack of personal experience with mental illness and the healing process. Burton and Topham (1997) note the similarity between wounded healers and clients in terms of experiences of loss, adding: 'It is perhaps what one *does* with one's woundedness that is in question', while Wheeler (2002) usefully reminds us that training is not a substitute for therapy.

Personal therapy

There has been considerable debate over the desirability of personal therapy as a training requirement for counsellors. A study of the levels of stress experienced by six counsellors during their counsellor training noted that most university-based training programmes in the United Kingdom did not require trainees to receive counselling for themselves (Truell, 2001). Empathy and intuition, although natural to some people, may not necessarily lead in the direction of true reparativeness. There has to have been trauma (Coltart, 1996) and 'only those individuals who know they have been deeply helped by their personal therapy have it in them to become healers in a vital sense' (Herman, 2001, p. 162).

Applicants may initially feel indignant at the thought of needing counselling themselves but are reluctant to consider what needs of their own they might be attempting to meet by becoming a counsellor. Some are outraged at the additional cost to their training but seem blind to the possible cost to clients in terms of the danger of their own 'acting out'. Loewenthal (2001, pp. 2–3) wonders whether the emphasis on relationship is becoming lost and whether, attracted by the technical, some therapists may be 'wishing to avoid a personal therapy that would explore their abilities to meet others'.

A more recent critique of the desirability of personal counselling as a compulsory component of training considers the question of the loss of autonomy (Muller, 2004). I would argue that students may not at the beginning of their training be in a position to make a consciously *informed* choice in respect of their own need for therapy and yet may still be expected to seek 'placements' early on. Spurling (2003) describes personal therapy as the '*medium par excellence*' for the acquisition of knowledge of the therapist's more psychotic parts and emphasizes its importance for a counsellor's ability to sustain, think about and use their counter-transference.

One recurring argument against personal therapy is that it may not be consistent with the therapist's core model. I think that this loses sight of its main purpose. The practitioner's own therapy is not just a modelling exercise with the client in mind but rather an exploratory exercise with the therapist in mind. Interestingly, in those European countries where

psychotherapy is already regulated by the government, personal therapy is obligatory for those wishing to be accredited in the health care system, including those practising cognitive behavioural therapy (Geller, 2005). Research has also shown that cognitive behavioural therapists are most likely to opt for a different orientation to their own for personal therapy and that over half choose psychodynamic psychotherapy (Laireiter & Willutzki, 2005).

Almost a decade ago Mander (1997) wrote of her concern at the sudden proliferation of courses and drew attention to two sorts of impulse to help, one that is healthy and one that is unhealthy. The healthy impulse arises from the human need for object relationship and is linked with good memories of being cared for and understood. The unhealthy impulse is linked to the helper's own narcissistic needs arising from lack of suitable care and understanding. She also regarded the most important 'tool of our trade' to be 'the relationship of listening, containing and processing' (Mander, 1997, p. 34). Meanwhile Lasky (2005, p. 21) asks: 'Is there any kind of work in this world where the tools never get dulled, chipped, or broken?'. He reminds us that, in order to achieve understanding, we have to allow what is going on to reverberate within us and that which reverberates within us has to be contained and transformed. This links of course with the importance of supervision, not as a substitute for personal therapy but in addition to it.

Intellectual curiosity

I sometimes wonder whether today's increasing emphasis on academic research in the field of psychotherapy and counselling is altogether desirable. For whose benefit is it *really*? Is the importance of the uniqueness of each person who seeks help and of the relationship between therapist and client in danger of being lost? McLeod (2003), reviewing a large scale survey undertaken in the USA, reports that it was ongoing clinical experience and personal therapy, rather than research, which proved to be of significantly more value to practitioners. In my view, the premature encouragement of fledgling therapists to embark on research projects before they have acquired sufficient clinical experience is perhaps of particular concern. The lure of the intellect and the seduction of certainty may serve as a defence against relating to another in a creative and fulfilling way, for the therapist as well as the client (Winnicott, 1984 [1949]; Corrigan & Gordon, 1995).

What brings you here?

This is a question therapists often ask of clients at the initial meeting. We wish to learn more about them, to find out what has motivated them to seek

our help and why at that particular time. I suggest that the same question is one that not only therapists but perhaps also those in other helping professions might usefully and regularly be asking of themselves.

Acknowledgements

My thanks go to the nine psychotherapists who agreed to be interviewed for my research. I am deeply grateful to them for their interest, their generosity of spirit and their willingness to share with me their personal experience. I also wish to thank Fiona Gardner for her quiet support and encouragement.

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