"It's both a strength and a drawback".

How Therapists' Personal Qualities Are Experienced in Their Professional Work

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Abstract

Objective: The aim of this study was to gain knowledge about how the integration of personal and professional experiences affects therapeutic work. **Method**: Therapists (N=14) who had been recommended by their leaders at their individual workplaces were interviewed twice with semi-structured qualitative interviews, which were then subjected to thematic and Interpretative Phenomenological Analysis. **Results**: All the therapists in the sample described their personal qualities as an experienced tension between their personal strengths and vulnerabilities in the therapeutic setting. This tension came to expression through four subordinate themes: (a) The tension between perceiving oneself as a helper while dealing with one's own needs for attention and care; (b) The tension between the ability for embodied listening to the patient while tuning into oneself; (c) The tension between staying present while handling aggression and rejection from clients; and (d) The tension in striving for a constructive balance between closeness and distance. **Conclusion**: The results point to ways in which the personal selves of the therapists may affect their professional role-performance. Drawing upon previous research and literature on the topic, the paper discusses how therapists' personal qualities are experienced as affecting their work and suggests several implications for psychotherapy training and practice.

Keywords: therapist personal qualities, therapist development, qualitative research

Historically, the notion of therapists' personal charactertistics exerting an influence on professional performance has been prominent within the helping professions and the field of psychotherapy, and it has most explicitly been formulated in the "wounded healer" tradition (Bugental, 1964; Conti-O'Hare, 1998; Elliott & Guy, 1993; Miller, 1997; Zerubavel & Wright, 2012). The importance of the therapist's emotional availability and presence, as opposed to a strict, professional stance was also addressed by the psychoanalytical community early on (Goldstein & Suzuki, 2015). Carl Rogers wrote about the person of the therapist as "a highly important part of the human equation holding a coherent and developing set of attitudes deeply embedded in his personal organization" (Rogers, 1951, p.19). This idea was supported by theorists suggesting that childhood experiences could be at the root of the choice of a career as a therapist (Burton, 1972; Ford, 1963; Menninger, 1957; Miller, 1997).

Henry, Sims, and Spray (1971, 1973) provided the first substantial empirical investigation of therapists' private and professional lives by conducting an extensive assessment of psychotherapists' backgrounds, development and motivation. They used standardized surveys, intensive, in-depth interviews, as well as projective personality tests. One of the findings from this research was that the majority of psychotherapists came from socio-economic, religious, family and/or cultural backgrounds that had exposed them to several stressful situations, such as being a member of a marginalized religious or cultural group. The authors suggested initially that such stressors possibly made the therapists more sensitive both toward themselves and others (Henry, Sims, & Spray, 1973). Later, Racusin, Abramowitz, and Winter (1981) studied 14 psychotherapists using the same methodology as Henry, Sims, and Spray, and reported that all the participants had suffered from significant interpersonal stress in their upbringing. They argued that such experiences may contribute to the ability for empathic understanding in the therapist, and that they may have had an influence on the decision to become a therapist as an attempt to create a safe space for

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intimate, corrective relationships. Other authors have emphasized the need for such psychological "wounds" to be acknowledged and resolved in order for therapists to be helpful (Dryden & Spurling, 1989; Fussell & Bonney, 1990; Guy, 1987; Kottler, 2017; Liaboe & Guy, 1987; Miller, 1997; Sussman, 1992).

Recent research has revitalized the idea of the person of the therapist as important for client outcomes (Norcross, 2011). Numerous studies have established that a substantial proportion of variability in patient outcomes can be ascribed to differences between therapists (see Baldwin & Imel, 2013; Kim, Wampold, & Bolt, 2006; Norcross, 2011; Wampold, Baldwin, grosse Holtforth, & Imel, 2017), and that the process and outcome of therapy are a result of a complex integration of therapeutic techniques and methods and the personal qualities of both therapists and patients (Ackermann & Hilsenroth, 2003; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Horvath, 2005; Lambert, 2013; Nissen-Lie et al., 2017; Norcross & Lambert, 2011; Wampold & Imel, 2015). Indeed, studies have demonstrated that therapists' self-perceptions and personal well-being are associated with the alliance and outcome of therapy (Heinonen, Lindfors, Laaksonen, & Knekt, 2012; Heinonen, Knekt, Jääskeläinen, & Lindfors, 2014; Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013, Norcross, 2011; Rønnestad & Skovholt, 2013). Rønnestad and Skovholt (2013) argued that optimal therapist development requires an integration between the personal and professional self in which "the practitioner is able to be coherent and genuine when relating to clients" (p. 99), and Nissen-Lie et al. (2017) suggested that therapists' professional skills "must merge in an optimal way with the personal and uniquely subjective aspects of therapists to create effective practice" (p. 49).

Qualitative studies have contributed in a significant way to our understanding of how personal and professional qualities are interconnected and associated with therapists' clinical competence and development (Farber, Manevich, Metzger, & Saypol, 2005; Goldfried, 2001;

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Jennings & Skovholt, 1999; Kissil, Carneiro, & Aponte, 2017; Moltu & Binder, 2011; Norcross & Farber, 2005; Orlinsky, 2005; Råbu, Moltu, Binder, & McLeod, 2016; Skovholt & Jennings, 2004; Sullivan, Skovholt, & Jennings, 2005). In their extensive study of psychotherapists from more than 20 countries, Orlinsky and Rønnestad (2005) found that nearly half of the participants reported that their development as therapists was influenced by the need to explore and resolve their own problems. Skovholt and Rønnestad (1992; Rønnestad & Skovholt, 2013) interviewed 100 therapists in different developmental phases. They found that highly senior therapists seemed to achieve a deeper integration of their personal and professional qualities than their less experienced colleagues. Furthermore, the authors argued that a certain degree of emotional stress in childhood probably has a positive influence on the development as a therapist (Rønnestad & Skovholt, 2013; Skovholt & Rønnestad, 1992). In their study of master therapists, Jennings and Skovholt (1999) identified several common themes related to the therapist's personal life: e.g., an ability for emotional receptivity and a non-defensive openness to feedback; an awareness of how one's own emotional health affects the quality of therapeutic work; a genuine interest in people; the development of the ability to listen; and caring for the welfare of others. The participants linked these abilities to their own emotional "wounds" that could be traced back to their personal history. Furthermore, these master therapists experienced their ability to handle emotionally straining moments with clients as being contingent upon the extent to which they had dealt with their own personal pain (Jennings & Skovholt, 1999). Regarding the question of cross-cultural transferability, several studies support that many of these therapists' characteristics are inter-culturally valid, while other qualitites, such as, for example, the therapists' degree of openness or an individual versus a collective focus, have been hypothesized to be possibly more culturally bound (cf. Jennings, D' Rozario, Goh, Sovereign,

Brogger, & Skovholt, 2008; Orlinsky & Rønnestad, 2005; Řihácek, Kahancová, Jennings, Roubal, & Vybíral, 2016).

In sum, a substantial body of literature suggests a link between therapists' personal life experiences and their professional role performance. The results from quantitative studies imply that the intra- and interpersonal functioning of the therapist surfaces in his or hers work with clients, affecting both the alliance and outcome ratings obtained from the clients' point of view (Ackermann & Hilsenroth, 2003; Anderson et al., 2009; Horvath, 2005; Nissen-Lie et al., 2017; Wampold & Imel, 2015). Qualitative studies appear to document the personal origins of desirable therapist characteristics, such as the ability to listen, having a genuine interest and empathy for other people, and possibly the ability to handle negative emotions constructively (Jennings & Skovholt, 1999; Jennings et al., 2008; Moltu & Binder, 2011; Rønnestad & Skovholt, 2013; Skovholt & Jennings, 2004; Sullivan et al., 2005). In addition, the literature on countertransference and writings from the clinical field emphasize the importance of therapists' personal lives and personal attributes for their therapeutic work (Ellis, 2005; Farber et al., 2005; Hayes, 2002; Gelso & Hayes, 2007; Kottler, 2017; Orlinsky, 2005).

Few studies in this realm have focused explicitly on investigating the relationship between the personal and professional in the context of current therapeutic work, that is, referring to specific ongoing therapeutic processes with particular clients. Thus, our knowledge about how the interplay of the personal and the professional actually takes place is relatively scarce. To gain more insight into these processes, it is necessary to explore therapists' inherent personal traits and their own experience of their personal qualities and life history as potentially relevant for, and present in, their professional work setting (cf. Baldwin & Imel, 2013; Gelso & Hayes, 2007; Gelso & Perez-Rojas, 2017; Hayes, 2002; Hayes, Gelso, & Hummel, 2011). Through a qualitative in-depth investigation, the present study pursued the

following research questions: How do psychotherapists experience their personal qualities as being present in their therapeutic work? In what ways are personal experiences seen as a potential facilitator or a hindrance in one's current work as a therapist?

Method

This qualitative study was part of a larger collaborative project examining constructive psychotherapy processes in 14 therapist-patient dyads combining four qualitative interviews of each therapist with two interviews of each patient. The current study is based on the analyses of the two initial interviews with each therapist concerning their background and personal history (interview 3 and 4 in the larger project focused on a particular therapy process with a particular patient). To ensure methodological integrity (Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2017), we used a phenomenological and hermeneutical approach that supported our research goals aiming to get close to the participants' lived experiences.

Participants

Therapists. We recruited 14 therapists (4 males, 10 females) from nine public outpatient clinics in the metropolitan areas of two main cities in Norway. The ages of the participants were 29-57 years; two were psychiatrists, and 12 were clinical psychologists. All the participants had completed or were completing a post-graduate clinical training program in psychotherapy while working full time as clinicians. Eleven had received their formal training at Norwegian universities, consisting of a six-year program of professional studies in psychology or medicine, followed by a five-year clinical training program. Their theoretical affiliations were psychodynamic (n=9), eclectic/integrative (n=3) and cognitive/cognitive behavioral (n=2). All the participants mainly performed clinical work and psychotherapy with adult clients.

Researchers. The authors are clinical psychologists and/or (associate) professors involved in research, teaching and clinical practice. They are trained in various forms of psychotherapeutic approaches (psychodynamic, integrative and humanistic), and have 10-30 years of clinical experience.

Procedures

Recruitment. To recruit a sample of skilled therapists working with patients in naturalistic settings, we approached nine managers of psychiatric outpatient clinics in two metropolitan areas in Norway by e-mail and asked them to nominate two of their staff members who were "…actively working with clients, and whom they considered to be particularly trusted and effective clinicians". We contacted the nominated therapists and provided them with written information about the broader aim of the larger collaborative project, which was described as follows: "To understand how therapists draw upon different sources of formal knowledge as well as more personal experiences in their therapeutic work". Of the 32 nominated therapists, 16 declined to participate due to lack of time, and two paused their participation due to major life events. Hence, 14 therapists completed the interviews used in the present investigation.

Interviews. After the therapists had given their written consent to participate in the project, one of the researchers contacted each participant to make an appointment for the first interview. We informed the participants that this interview would focus on their personal background, and that the second interview would be a continuation of the first, with the possibility of exploring the central themes in greater depth. The same researcher conducted both interviews, either in the office of the therapist or the researcher, during a time-span of approximately 6-12 months. The first author conducted 16 interviews, the second author 4 interviews, the third author 4 interviews and the fifth author 4 interviews. The interviews lasted 60-90 minutes and were recorded and transcribed verbatim. The interviews were semi-

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structured, open-ended conversations that revolved around the main research question as stated in the project description (i.e. how do effective psychotherapists draw upon and combine knowledge arising from life experience and professional knowledge?).

The questions in the interview guide (see table 1 below for examples) served as a starting point in the first interview to establish an exploratory dialogue about how the therapists reflected upon any relevant personal experiences and characteristics they observed as potentially having an impact on their professional domain. Given the context of the research interviews, the data material did not represent the participants' thoughts around their personal qualities in general, but rather their reflections upon how their personal qualities come into play in specific relation to their role as therapists. When provided with an opportunity to go deeper into the matters over the course of the two research interviews, the participants elaborated on specific topics, providing a nuanced description with more depth and complexity. Based on the initial analyses (reading/re-reading and initial notes) of the first interview, central themes in the narrative of each participant were identified and discussed with the other members of the research group, generating relevant follow-up questions that were elaborated on in the second interview with each participant. This design offered the advantage of providing an opportunity to expand on central ideas and to clarify nuances in the report together with the participant. See table 1 for examples from the interview guide, as well as examples of the follow-up questions based on the first interview for interview 2.

<div align="center">Insert Table 1 about here</div>

Data Analysis

We based our analyses of the data on the methods of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkins, 2009) and thematic analysis (Braun & Clarke, 2006). Both methods involve the conceptualization of the meaning of experiences reported by the respondents. We conducted the analysis in two phases. Initially, we transcribed all the first

interviews and the connected comments made by each researcher and analyzed them according to step 1-2 (reading/re-reading and initial noting, see below). This phase prepared each interviewer for the second interview. Then, we analyzed both interviews together, case-by-case, in five steps in accordance with the recommendations made by Smith et al. (2009) and as described in the following:

(1) *Reading and re-reading*: The first author conducted an initial reading of all the interviews, sorting the content into general categories, such as "mainly personal domain" and "mainly professional domain", as well as a category consisting of examples of possible integration between the two domains. All the interviewers in the research group then read the interviews case-by-case to obtain an in-depth knowledge of the material.

(2) *Initial noting/exploratory commenting*: While reading and re-reading all the interviews, the first author took notes to capture different aspects of the content. The notes could address both the descriptive and linguistic level, capturing how the therapist's language reflected his/her meaning and content, and the conceptual level, which deals with the transcript data in an interpretative way, involving the researcher's own reflections on the material.

(3) Based on step 1-2, the first author condensed the material into discrete chunks of data searching for *recurrent themes and common/differing experiences* both within and across cases. Through this process, we sought to maintain the complexity and close connection between the exploratory comments and the original transcripts.

(4) The next step involved *searching for connections across emerging themes* within and across cases to produce a structure that permitted intelligible representation and communication. The larger research group continually discussed the activities in step 3-4. This allowed for a stepwise collaborative process that led to a consensus regarding the structure, central meaning patterns and tentative themes (Smith et al., 2009).

(5) Finally, we reviewed and discussed the themes in the research group on multiple occasions until we reached an *agreement about the number of themes and their descriptive names* among the group members.

Through a continuous movement between the gradually condensed material, the recurrent themes and the researchers' interpretative activity, the common features in the therapists' spontaneous accounts of their ongoing management of personal strengths and vulnerabilities in their professional role emerged. Table 2 exemplifies how the analysis proceeded through specific content, interpretative activity and emergent themes.

Insert Table 2 about here

Reflexivity

In quantitative as well as in qualitative research, the researcher's intentions and theoretical affiliation will give direction to the research design and the researcher's interpretations (McLeod, 2011). In order to reduce bias and to enable the productive use of the researchers' pre-understandings of the topics in question, the researchers wrote down their immediate thoughts after the interviews. They also engaged in reflexive writing tasks and discussions about their experiences with their own personal qualities as having an impact on their own professional domain when working as therapists (McLeod, 2013).

Ethics

The Regional Committee for Medical and Health Research Ethics and the Norwegian Social Science Data Services approved the main study (reference withheld for anonymous review). All the participants signed a consent form, and we stored the audio-files and transcribed the materials in a database specifically developed for sensitive data. We altered private details about the participants to ensure their anonymity.

Results

The analyses yielded the superordinate theme *Experienced tension between personal strengths and vulnerabilities in the professional domain.* Four constituent sub-themes expressed different facets of how this tension came forward in the participants' experiences and its interaction with the professional therapeutic role. In the following, we will describe both the superordinate theme as well as the sub-themes in detail.

Superordinate Theme: Experienced Tension between Personal Strengths and Vulnerabilities in the Therapeutic Setting

The term *tension* captures a common feature in the content of the therapists' spontaneous accounts of their ongoing management of personal strengths and vulnerabilities ("I as a person") in interaction with their professional role ("Me as a therapist"). The following quote exemplifies how this tension typically could be expressed by the participants:

> …I see my ability to listen as both a strength and a drawback. I was a child who from an early age stopped talking about myself. I did not pay attention to myself, and I was very sensitive toward the needs of others. This is the flipside of the story about why I became a therapist. It started very quietly, at an early age. I became an observer – one that puts himself aside to make sure the other one is okay.

This quote illustrates how the ability to listen creates tension for this particular therapist by both representing a personal vulnerability, and at the same time, a resource in the professional domain. On a linguistic level, the therapists often communicated this tension through words and expressions implying contradictions or conflicts, such as "struggle", "challenge", "on the other hand", "however", "at the same time" and the like:

> It stays with me, this issue of not having too much focus on my own history or myself… On the other hand, it is very easy for me to connect to the lives and stories

of other people. In meeting with another person, I think of it as a resource. However,

it is a strength that makes me tired, even burned-out sometimes.

The first set of sub-themes comprised: (a) *The tension between perceiving oneself as a helper while dealing with one's own needs for attention and care,* and *(b) The tension between the ability for embodied listening to the patient while tuning into oneself.* These two sub-themes convey and summarize important personal qualities that the therapists initially described as positive assets in their professional domain. The second set of sub-themes comprised: c) *The tension between staying present while handling aggression and rejection from clients* and d) *The tension in striving for a constructive balance between closeness and distance*. These two sub-themes capture differing aspects of experienced vulnerability related to issues the therapists mainly experienced as struggles in the therapeutic setting.

Table 3 shows the distribution of themes among the therapists. The term *most* indicates that all (or all but one) of the participants addressed the respective theme, *many* indicates over half of the sample and *some* indicates that under half of the sample articulated a certain topic (cf. Hill, 2012).

Insert Table 3 about here

The first two sub-themes described a strong disposition to perceive oneself as a helper, as well as an experience of a deep-rooted ability to listen. Most of the participants linked these themes to their upbringing and early relationships, and many saw them as something that might have motivated them to choose a career as a therapist.

(a) The tension between perceiving oneself as a helper while dealing with one's own needs for attention and care. This sub-theme captures a central experience in many participants' personal narrative of being a helper as tied to an experience of having had to focus on other people's needs from early on:

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> To take care of others felt like the normal thing to do. I have done it since I was a
> kid. As an adult, I suddenly realized that this was a pattern – this helping behavior is
> something I have been doing all along. It just comes natural to me.

The perception of being a helper seemed to have been instrumental in many of the participants' choice to become a therapist, adding meaning and importance to their work, as well as a sense of coping and possessing an interpersonal and emotional surplus. The participants mainly thought of their experiences of being important in the lives of others as a strength, which gave them confidence and a sense of safety in the therapeutic position and in meeting with clients. At the same time, this perceived ability to help entailed a cost related to early experiences and relationships in their childhood and upbringing, as this quotation illustrates:

> I have never struggled to feel empathy. This has come easy for me from an early
> age; I do not find it very hard. At the same time, I think this sensitivity towards the
> other, towards what the patient thinks and feels links to my own experiences with
> conflicts and hurtful experiences from my upbringing.

The appraisal of these conflicting needs varied, with some participants explicitly emphasizing their negative aspects: "I feel I could do better without … the hurtful feelings of not being important, all the time being attentive to not taking up too much space, not being better than other people are". Many of the participants related their experienced struggle attending to and caring for themselves to their tendency to focus on the needs of others: "I feel I have always been a helper, both in the personal and professional arena… I have been very good at taking care of others, but not so good at taking care of myself, helping myself". For some of the therapists, the cost of being a helper seemed to be that they developed a strong sense of self-sufficiency that prevented them from asking for help when they needed attention, care or support, creating a need to deal with this tension on both a personal and professional level.

(b) The tension between the ability for embodied listening to the patient while tuning into oneself. The second sub-theme in this group concerned a particular listening mode that most of the participants reported to be a strength in their professional work: a finely tuned embodied receptivity towards other peoples' feelings and needs. This ability involved an awareness of the non-verbal and emotional content expressed by the other: "I listen a lot to the unspoken and the non-verbal. Being with many patients with severe problems, it is in many ways the same as being with infants". Many of the participants described the development of this ability for heightened sensitivity as something that helped them to observe and listen with their whole body, including their own emotional reactions: "I have felt a strong need to start listening with the more emotional, bodily and more authentic parts of me – parts that correspond more with my history and my vulnerabilities as a therapist, maybe". Many also experienced an ability to establish a deep emotional connection with other people through this sensitivity and way of listening, and they saw such contact as a necessary condition for change, facilitating an atmosphere of safety and acceptance. Most of the therapists saw this capacity to listen in a deep and non-verbal way as a highly useful tool in the professional domain. At the same time, some participants stated that they found it easier and more interesting to understand the history of other people than their own, and for many, this tendency seemed to be part of a more complex origin that involved a history of "having to" listen:

> I was the child who never caused any problems, never ran away or… They would place me in a playground and I would stay there… I think I was a very easy kid. Over-adjusted in terms of being extremely sensitive to signals coming from others… if someone got yelled at, I would instinctively try to fix it. If my father left the door unlocked, I would close it…

This ability was associated with the necessity of tuning into "the other" in order to understand, make meaning of, and ultimately, to adapt their early relationships in order to achieve acceptance and emotional safety:

> My role as a child was to provide support. I always made sure my father was happy, because he had a bad temper. I was extremely good at averting his anger by saying the right things, being nice and not too demanding… Take his hand if that was what he needed. I was very good at noticing what he needed.

Thus, gaining knowledge and understanding through this deep mode of listening to the other can create an implicit obligation to take responsibility by adjusting and adapting to the other person's needs, with the risk of losing sight of oneself. Ultimately, not keeping in touch with one's own history could lead to feelings of inadequacy and exhaustion.

While the sub-themes a) and b) mainly related to the participants' experiences during their early relationships and upbringing, the sub-themes c) and d) largely refer to what happens when their perception of being "the good helper" is confronted with acting-out or hostile feelings from the patient. Most participants emphasized the importance of being aware of these challenges in order to maintain a therapeutic stance.

(c) The tension between staying present while handling aggression and rejection from clients. This third sub-theme consisted of a set of experiences that participants reflected upon as primarily challenging, namely coping with feelings of aggression and rejection in oneself and others:

> When I am not allowed to be the helper, I can become very confused. I know that other therapists feel anger and irritation – that very seldom happens to me. It is as if I just expect myself to endure it, and to handle it.

The therapists' inclination to be empathic helpers made them feel vulnerable when confronted with hostility and anger: "I wish I could endure it better; to contain the aggression coming

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from the client … when you are supposed to be the one that should make things better, to be accused of not being helpful is very painful". Some participants related this challenge to their own relational history of exposure to negative emotions or hostility, and many reported that sadness, anxiety and depression in patients were easier to contain than rejection, anger and devaluation directed towards themselves as therapists: "I am a bit evasive when it comes to conflicts. I am more capable of relating to feelings of sadness, sorrow and hopelessness than anger, hatred and aggression". The participants described different strategies and reactions in trying to handle such challenging emotions. The strategies included both staying in a more passive therapeutic position of listening and containing the material coming from the patient, as well as more active work to be able to sustain a therapeutic position when confronted with straining emotional interactions:

> To confront and meet negative affect can be difficult, but it is also very important. It can be a kind of avoidance in just staying in the listening and containing position. Daring to confront and daring to handle the reaction that you might get in return.

Most of the participants recognized the tendency to avoid such challenging feelings as maladaptive, and at the same time, expressed a wish to work with and increase their tolerance of such negative affect:

> Aggression and devaluation easily puts me off, and I feel that as therapists, we have to work on our capacity for that. Personally, I think it is important to give the client a sense that these emotions are nothing to fear. It is essential to stay emotionally connected and adequately activated according to the situation.

Some described that what started as a potential vulnerability developed over time, leading them to contain more of themselves and others:

> I feel my work as a therapist has dragged me through dark and muddy places, but I think this has been something useful and has turned out to be a strength that I would not be without. I do not want my idealizing defense mechanisms back.

This focus on the importance of such "working through" their own issues was a general feature in the participants' statements about themselves.

(d) The tension in the striving for a constructive balance between closeness and distance. All the participants addressed the importance of maintaining an optimal distance between themselves and their clients in the interaction between personal strengths and vulnerabilities. This theme concerns the therapists' stance on different aspects of boundaries in therapy, for example, how much space there is for one's personal, authentic self:

> How much can I be myself with the patient, without me as a person becoming the center of attention? I want to show a lot of myself with much compassion and warmth, and at the same time, keep the focus and the boundaries in a professional setting or a therapeutic process.

Striving for a constructive balance between closeness and distance concerns what the participants perceived as boundaries for the therapist's tasks and responsibilities and the need to create a safe and healthy environment where change can take place. The participants said that boundaries that were "too strict" or "too loose" could pose a challenge in their therapeutic work, necessitating both cognitive and emotional processing: "I do struggle with boundaries… Essentially, that I lack or have very weak boundaries regarding what is acceptable or not. When this happens, I do not consider it very therapeutic". The participants addressed the question of what constitutes good boundaries as a dynamic process in which they continuously engaged and which could not be answered in a final manner. The following quotation serves to illustrate this point:

> As a therapist, I feel I have been somewhat easy to exploit. At the same time, I have the capacity to observe my own interaction with the client, and I see this as a great asset. I feel I have grown and learned to push back projections in the therapeutic setting, and in this way, I have created more space for the "authentic me".

The participants described this inner work and reflexivity as something that actively guided their work with clients, helping them to adjust the boundaries of the therapeutic relationship through their attempts to create or control emotional distance:

> When things get tough, I do not solve it by creating distance. For example, in one therapy, I spent the first year in a state of terrible confusion. It was very straining for me emotionally and personally. However, I managed to persist, and I think this was decisive for how the therapy process later developed in a constructive way.

In sum, the participants experienced their personal strengths and vulnerabilities as creating tension when interacting with their therapist role. The first two sub-themes convey important personal experiences that the therapists initially described as positive assets in their professional domain, although they held the opportunity to become vulnerabilities under certain circumstances. The second set of sub-themes capture differing aspects of experienced personal vulnerability related to issues the therapists mainly experienced as struggles in the therapeutic setting, which at the same time held the opportunity to become resourceful assets when handled in an adequate way.

Discussion

Through in-depth qualitative interviews, the current study aimed to investigate how therapists experienced their personal experiences as playing a role in their professional work. The main finding was that the participants experienced their personal qualities as representing a tension affecting their work performance by being both a resource but at the same time also potential

limitation in the professional domain, as captured in the superordinate theme *Experienced tension between personal strengths and vulnerabilities in the therapeutic setting.* This tension was specifically expressed through the four sub-themes of being a helper, embodied listening, handling aggression and rejection, and balancing closeness and distance.

In general, our results support contributions from the clinical domain emphasizing the personal as significant (Dryden & Spurling, 1989; Ellis, 2005; Farber et al., 2005; Kottler, 2017; Miller, 1997; Norcross & Farber, 2005; Orlinsky, 2005), as well as earlier studies indicating the personal roots of important therapist characteristics that affect therapeutic work. What were perceived by the participants in our study as personal strengths in the professional domain were, to a large degree, congruent with results from the master therapist research tradition (Jennings et al., 2008; Skovholt & Jennings; 2004) and research on favorable therapist characteristics (Ackerman & Hilsenroth, 2003; Anderson et al., 2009).

The first sub-theme of "being a helper" as part of one's personal identity from an early stage, highlights the relevance and the necessity of the personal components in the helping professions (Elliott & Guy, 1993; Zerubavel & Wright, 2012). The second and third sub-themes of "embodied listening" and "dealing with anger and rejection" directly speak to earlier research suggesting that the ability to listen, genuine interest and the ability to handle emotionally straining situations are distinguishing characteristics of high-performing therapists (Jennings et al., 2008; Jennings & Skovholt, 1999; Moltu & Binder, 2011; Rønnestad & Skovholt, 2013; Skovholt & Jennings, 2004; Sullivan et al., 2005). The fourth sub-theme dealing with boundaries and the tension in keeping the balance between closeness and distance between the therapist and the client relates to the ability to create optimal distance (Scheff, 1981), the discussion of how much room there is for the exposure of the person of the therapist (Knox & Hill, 2003; Rogers, 1951) and the therapist's capability for

ongoing moment-to-moment responsiveness in the communication with the client (Stiles, Honos-Webb, & Surko, 1998).

If we imagine the tension arising from the personal qualities across all four sub-themes as consisting of both a strength-pole and a vulnerability-pole, this corresponds to the idea of the wounded healer archetype as consisting of both "the wounded" and "the one who heals" (Hayes, 2002). Thus, the tension can be seen as an expression of such "wounded" and "healing" parts in each therapist, posing the opportunity for both expanded insight and a richer range of personal knowledge upon which to draw in their therapeutic work. At the same time, our results show that the activation of unacknowledged personal issues and vulnerabilities can become a threat to overwhelm the therapist (see Hayes, 2002; Hayes et al., 2011). In line with this, research on managing counter-transference stresses the importance of inner elaboration and working through one's own issues to avoid reactive acting-out and being able to direct these personal elements to the benefit of the patient (Gelso & Hayes, 2007; Hayes et al., 2011; Moltu, Binder & Nielsen, 2010). Increasing the awareness of how one's own personal "seesaw" of strengths and vulnerabilities can both facilitate identification with clients, as well as improve the ability to differentiate and stay grounded in the therapist role (Kissil et al., 2017).

Such awareness, and the ability for bifurcated attention (i.e. attention both inwards and outwards at the same time), has both been found to characterize effective therapists, regardless of their theoretical orientation and technique (Hayes & Vinca, 2017). The therapists in our study demonstrated a willingness to expose such vulnerability and to reflect openly on both the upside and the downside of their personal self in relation to their therapeutic work. They also recognized the necessity of being able to acknowledge when this does not happen; for example, when their personal vulnerabilities pose a challenge or a possible source of enactment, premature closure or disengagement, obstructing the therapeutic

process (see Rønnestad & Skovholt, 2013). By showing how therapists' personal strengths and vulnerabilities are related, our results may add a deeper appreciation of the experienced tension between the personal and professional selves of psychotherapists. The results also call attention to the notion that therapists' personal vulnerability is something that can be actively and purposefully utilized, rather than just something that should be "resolved". This provides nuance to what we regard as legitimate and desirable therapist qualities (Jennings & Skovholt, 1999; Kissil et al., 2017; Rønnestad & Skovholt, 2013). Furthermore, the narratives of the participants can add meaning to concepts such as *increased awareness of the complexity of the therapeutic process* (Rønnestad & Skovholt, 2013, p. 99) and an *optimal higher integration between the personal and professional* (Nissen-Lie et al., 2017, p. 49) by illustrating the dynamic "work-in-progress"-like quality that characterizes these reflective and integrative processes. Thus, the findings both support and complement the existing literature on the link between therapists' personal backgrounds and their professional domain (cf. Henry et al., 1971, 1973; Miller, 1997; Racusin et al., 1981), therapists' personal narratives from the clinical domain (cf. Ellis, 2005; Farber et al., 2005; Kottler, 2017; Orlinsky, 2005), and the literature on master therapists (cf. Jennings & Skovholt, 1999; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2013). By providing support for the previous findings, this time, from a European and Scandinavian context, the present study adds to the literature by pointing to a common, cross-cultural ground for therapists' personal variables, regardless of differing values, education, and health systems (cf. Heinonen et al., 2012, 2014; Jennings et al., 2008; Orlinsky & Rønnestad, 2005, Řiháček et al., 2016; Rønnestad & Skovholt, 2013).

The results have implications for the way we think about the "personal factor" in the development and training of psychotherapists. The ability to reflect upon one's own personal contribution to therapeutic processes as both constructive and potentially limiting seems to be a central theme that should be stimulated in all phases of therapist development. For example,

students could systematically be encouraged to consider their motivation for entering a helping profession, as well as urged to think about what kind of personal "core" issues they would regard as potential strengths and/or limitations in their training. Psychotherapy training could generally focus more on self-awareness and on the therapists' ability to access their own ongoing thoughts, feelings and memories in their therapeutic work. How students enrolled in psychotherapy training programs reflect upon such matters, as well as how such bifurcated attention and merging of the personal and professional in the therapist is experienced from the clients' point of view (i.e. how it affects their experience of treatment and their outcomes) would be interesting matters to explore in future research.

Finally, there seems to be a gap between the research on treatment and psychotherapy, on the one hand, and the narratives and writings stemming from the clinical domain, on the other (Castonguay & Hill, 2017; Stiles et al., 1998). While much recent research has focused on specifying the active ingredients in different models of treatment, interest in the personal aspect of the therapeutic relationship and the personal characteristics of the therapists has been less pronounced. In contrast, the clinical field often emphasizes the personal components when describing the developmental and therapeutic processes of therapists (cf. Ellis, 2005; Farber et al., 2005; Kottler, 2017; Norcross & Farber, 2005; Orlinsky, 2005). This disparity runs the risk of reducing clinicians' interest in research and its applicability, which is undesirable because psychotherapy research aims to improve the work of practitioners by increasing their competence and the best clinical practice. To provide close descriptions of clinicians' own experiences of what they perceive as significant for their professional role performance could reduce such a gap between the research and the practitioners.

Strengths and Limitations

A common critique of qualitative studies is their lack of generalizability due to small sample sizes. However, the strengths of qualitative methods are their ability to examine

variation within a phenomenon (not within a population), generate descriptions of lived experiences, and investigate a phenomenon in all its complexity (Levitt, 2015). Several meta-analyses show that the average number of participants in qualitative studies is 13, which suggests that a sample size of 14, as used in the present study, should be sufficient to obtain robust findings (Levitt et al., 2017; Malterud, Siersma, & Guassora, 2016). In addition, our interview design strengthened the fidelity and sensitivity of the results by offering the opportunity to expand on central ideas over time and to clarify unclear or implicit aspects of the accounts produced by the informants (i.e. "member checking").

The selection criteria used in our study posed several potential limitations. We wanted to study well-functioning therapists, but we lacked outcome measures that could inform us about the overall effectiveness of these therapists. We recruited participants based on their managers' overall impression of their general competence, but we knew little about the managers' preferences or motives in the nomination process. Nevertheless, the strong engagement in clinical work and training voiced by the participants and the recommendations from their managers indicate that they are likely to be skilled and "good-enough" therapists.

Most of the participants were educated and trained in a Norwegian cultural context, and all of them worked in Norwegian public outpatient clinics. This could reduce the relevance of the results because of the lack of transferability to therapists educated and trained in other cultural contexts, but it could also constitute a strength because the participants' thorough education and post-graduate training give confidence to the professional aspects of these therapists' development and therapeutic practice.

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Table 1 *Examples from the Interview Guide*

Questions from the interview guide, Int.1:	*What kind of personal characteristics/qualities would you describe as important in your work/choice of work?*
	Have you experienced personal issues as problematic or as obstacles in your therapeutic work?
	In what way do you feel your experiences as a therapist have had any impact on your personal/professional life?
	What characterizes a good therapist? *What made you become a therapist?*
Example of customized follow-up questions, Int. 2:	*Last time, you described ways of handling your own suffering. What are your thoughts on how one moves on from suffering to change?*
	I've been thinking about the story you told me…What you can change and what you can't change – the limits of what you can achieve. Could we reflect a bit on that, and do you see any parallels to your own life?

Note: Int. = Interview.

Table 2 *The process of IPA analysis, with examples from three participants*

Content	Exploratory comments made by researcher	Possible emerging themes
"… because I think of that as a resource, and a good quality for me as a therapist, that I am very conscious of being attentive toward others… In a way learned to understand and to listen to other people, to see them, really."	Ambivalence? Take the perspective of/ be affected by the other, but at the cost of oneself? Having to take care of the other, expressing a responsibility linked to becoming aware of the needs of the other. A strong self-awareness connected to the question of: How does my behaviour affect others? Responsibility.	A deep-rooted sense of commitment and empathy to others' needs and feelings at the cost of oneself? *Sub-theme (b)*
"The hardest part for me as a therapist, also linked to my limitations as a therapist, is that I am afraid of rejection. Afraid to lose and let go."	Perceived limitation as therapist linked to personal-rooted anxiety for relational losses/ rupture? Expressed awareness of the need to balance distance and closeness in relation to the patients.	Rigidity vs. lack of boundaries (keeping distance vs. getting too close). *Sub-theme (c, d)*
"What do I want? What are my needs? My feelings… This is something I carry with me, trying not to be ashamed of my own wishes and needs. That there is room for me."	Explicit expressed wish to understand oneself and others. A possible coherence between the therapist's own experiences/needs and the conceptualization of the needs of other people?	Using the understanding of oneself in order to understand the other as a basic tenet/underlying, permeating feature. *Superordinate theme, sub-theme (a, d)*

Table 3 *Distribution of themes*

Therapist:	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Sub-theme (a) x = 7 (x) = 3	(x)	x	x	x		x		(x)	x	x	x			(x)
Sub-theme (b) x = 11 (x) = 1	x	x		x	x	x	(x)	x	x	x	x	x	x	
Sub-theme (c) x = 10 (x) = 3	x	(x)	x	(x)	x	x	x	x	x		(x)	x	x	x
Sub-theme (d) x =12 (x) = 2	x	(x)	x	x	(x)	x	x	x	x	x	x	x	x	x

Note: x = Theme explicitly addressed; (x) = Theme implicitly addressed